Kent and Medway NHS and Social Care Partnership Trust Littlebrook Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Overall summary

We found the following issues that the service provider needs to improve:

- The wards were not adhering to Department of Health guidance on same-sex accommodation and patients could not access their rooms independently. One ward had their clinic room incorrectly labelled. Furthermore, one bedroom on Willow Suite did not contain a wardrobe or bedside cabinet.
- The service had a high dependence on bank and agency staff that were unable to access all systems and mandatory training. On one ward staff did not have access to a ward induction.
- The service did not promote a uniform approach to recording information in patients' progress notes. This made it difficult to follow patient progress during their time on the ward.

Summary of findings

- Staff, across all wards, had differing levels of compliance in safeguarding training. The service's system to escalate safeguarding referrals was ineffective.
- Patients, on one ward did, not have direct access to psychological assessment or intervention. The service was not currently providing the amount of therapeutic activity specified by the Commissioning for Quality and Innovation (CQUIN).
- Patients, on one ward, felt that staff were not approachable.
- The outside areas on Amberwood ward, Cherrywood ward and Willow suite lacked appropriate seating and required attention make them attractive to patients.
- Amberwood ward and Cherrywood ward had limited patient information on display. Patients were not always getting access to advocacy services.

We noted during this inspection that some issues remained in relation to breaches that had previously been identified on our last inspection. However, we also noted the service had made improvements in some of these areas.

- Willow suite was not offering seclusion facilities that provided two way communication or perception of time. However they had changed bedroom allocation which gave women being secluded more privacy and dignity which was an improvement from the last inspection.
- The quality of patients care plans differed across the service. The poorer quality care plans demonstrated that patients were not actively involved in their care. Furthermore, the services approach to care planning meant that patients' needs were not always identified or monitored regularly. However, since the last inspection improvements had been introduced with a new care plan function on RIO that prompted staff to involve patients, and all staff were now attending care plan training as mandatory.
- The wards did not stock all medicines that were deemed necessary to respond to medical emergencies. Two wards did not appropriately record the temperature of fridges used to store medicines. However, medical equipment was well maintained and checked which was an improvement from the last inspection.
- Detained patients' Mental Health Act documentation relating to leave and reports carried out by approved mental health professionals was not always available and up to date. However, previous breaches of regulation that related to patients not being informed of rights, patients not been allowed to use leave, and meds given without proper consent forms completed, had all been rectified.

However, we also found the following areas of good practice:

- Patients, staff and visitors had access to appropriate alarms systems that maintained their safety.
- The service had good awareness of the potential impact that high use of bank and agency staff could have on patient care. They had introduced initiatives, such as daily meetings to monitor staffing levels, to reduce this potential risk.
- The service was also introducing a staffing system which would include permanent allied health professionals in staffing numbers. This was expected to significantly reduce the dependence on bank and agency staff.
- Clinic rooms were clean and well maintained with all equipment and medicines checked regularly. The service had robust systems in place to ensure patients medicines were administered correctly; this was reinforced by appropriate support from a pharmacist.
- The service had identified that staff required additional guidance to improve the quality of patients care plans. Care planning training had been made mandatory and all permanent staff had been booked onto this. The service had also added a new function to their electronic patients' records system which promoted patient involvement in care planning.
- The service had recently introduced a system to improve staffs' adherence to completing nursing tasks essential to monitoring patients' mental and physical health.
- Patients felt staff were kind and respectful and would offer them support when required. Furthermore, staff respected patients privacy and always knocked on doors and asked for permission to enter.
- The service was actively looking at ways to effectively discharge people from the service. They had recently introduced a checklist which helped staff identify areas which needed to be addressed or was currently a barrier to discharge.

Summary of findings

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Littlebrook Hospital

Services we looked at

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

Summary of this inspection

Our inspection team

The lead inspector for the team that inspected acute wards for adults of working age and psychiatric intensive care units at Littlebrook Hospital was Scott Huckle.

The team comprised of three CQC inspectors, a CQC pharmacist, two specialist advisors with experience in mental health services and two experts by experience who had experience of using services.

Why we carried out this inspection

This was an unannounced inspection after a Mental Health Act reviewer raised concerns following a visit on 28 June 2016. The reviewer found that; patients were not sufficiently involved in their care planning and they were offered limited therapeutic activities; Mental Health Act documents were not always completed correctly; the service relied heavily on bank and agency staff to ensure safe staffing levels were maintained and patients did not have easy access to their bedrooms. We had also received information through our intelligent monitoring programme that suggested; unsettled patients were not being managed effectively; a patient under the age of 18 was being cared for on an adult ward and safeguarding issues were not being reported correctly. Of the enquiries we had received for Littlebrook Hospital, 14 out of 19 had been from patients or carers concerning poor care and treatment.

As this was not a comprehensive inspection we did not pursue all of our key lines of enquiry. We also did not follow up on outstanding breaches from previous inspections as we only visited one location within the core service that the breaches were applied to. Therefore, this report does not indicate an overall judgement of the service. Our resources were directed towards inspecting the current areas of potential concern and this should be considered when reading the report.

How we carried out this inspection

During this inspection we considered areas of the service to make a judgement on the following questions:

- 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 two Mental Health Act reviewer reports and information that we held about the service through our intelligent monitoring processes.

During the inspection visit, the inspection team:

- visited all four wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 14 patients who were using the service and six carers of people who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 18 other staff members; including nurses, healthcare assistants and psychology workers
- looked at 27 treatment records of patients
- carried out a specific check of the medication management on three of the four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

Information about Littlebrook Hospital

Littlebrook Hospital has three acute wards for adults of working age: Amberwood ward, Cherrywood ward and Woodlands ward. Amberwood ward had 17 beds; Cherrywood ward had 17 beds and Woodlands ward has 12 beds. All three wards admitted both men and women. There was one psychiatric intensive care unit, with 12 beds, called the Willow suite that admitted both men and women. Access to all wards was via key pad entry and the doors were locked at all times. These wards were provided by Kent and Medway NHS and Social Care Partnership Trust as part of the trust's acute service line.

The Care Quality Commission had previously undertaken a comprehensive inspection of Kent and Medway NHS and Social Care Partnership Trust in March 2015. During that inspection we inspected 11 acute wards for adults of working age and psychiatric intensive care units, including the four wards located at Littlebrook Hospital. We published a report of that inspection in July 2015 and told the provider they must take action in the following areas; Mental Health Act implementation; patient care planning; maintenance of emergency equipment; effectiveness of monitoring processes; ensuring bed availability on the psychiatric intensive care unit and privacy and dignity during periods of seclusion. We did not follow up on these outstanding breaches as this was a focussed inspection. These outstanding breaches will be followed up at the next comprehensive inspection of Kent and Medway NHS and Social Care Partnership Trust

Our overall judgement rated the core service of acute wards for adults of working age and psychiatric intensive care units as good for caring and requires improvement for safe, effective, responsive and well-led.

What people who use the service say

Patients we spoke with during the inspection told us they were treated well by staff. However, they felt that staff were not forthcoming with support and that they felt the onus was on them to approach staff. Patients who were specifically asked about activities felt they were easy to access and that they found them relaxing and beneficial. However, they felt there should be more activities available with more variation.

We spoke with six carers of people who were currently or had recently used the service. Two carers felt their relative had had a positive experience, two described a negative experience and two described a mixed experience. Positives were around staff being helpful, relatives being supported with issues such as accommodation and relatives recovering whilst on the ward. Negatives were around a carer not feeling their relative was safe, particularly during night shifts, relatives being transferred from calm to unsettled environments with staff not being transparent about the potential difference in environments and consultants not listening to a carer leading to a significant delay in prescribing preferred medication.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that the service provider needs to improve:

- The wards admitted patients of both genders. The location of the bedrooms meant it was not possible to use a system of bed allocation which adhered to Department of Health guidance on same-sex accommodation.
- The service practiced restrictive interventions, such as restraining patients. They did not stock all emergency medicines that were deemed necessary to support patients' potential safety needs during episodes of restraint.
- Willow suite was not offering seclusion facilities that promoted appropriate two way communication or perception of time. Furthermore, one bedroom did not contain a wardrobe or bedside cabinet.
- Willow suite's clinic room was incorrectly labelled. This meant that staff not familiar with the ward could inadvertently allow patients unescorted access to this area.
- The service had a high dependence on bank and agency staff. This affected patient care as some of these staff were unable to access all systems relevant to recording patients' progress. They also did not qualify for or receive the trust's mandatory training.
- The service did not appropriately record the temperature of fridges used to store medicines. This meant it was not possible to guarantee medicines were safe for use.
- All wards demonstrated different levels of compliance towards safeguarding training. This was observed to have a direct result in the quality and quantity of safeguarding referrals made. Furthermore, the service did not have robust systems in place to ensure safeguarding referrals were shared with the appropriate agencies.

However, we also found the following areas of good practice:

- Patients, staff and visitors had access to appropriate alarms systems that maintained their safety.
- The service had good awareness of the potential impact that high use of bank and agency staff could have on patient care. They had introduced initiatives, such as daily meetings to monitor staffing levels, to reduce this potential risk.

Summary of this inspection

- The service was also introducing a staffing system which would include permanent allied health professionals in staffing numbers. This was expected to significantly reduce the dependence on bank and agency staff.
- Clinic rooms were clean and well maintained with all equipment and medicines checked regularly. The service had robust systems in place to ensure patients medicines were administered correctly; this was reinforced by appropriate support from a pharmacist.

Are services effective?

We found the following issues that the service provider needs to improve:

- The quality of patients' care plans differed across the service. This meant that some patients were not actively involved in their care. Furthermore, the services approach to care planning meant that patients' needs were not always identified or monitored regularly.
- Staff members' approach to recording information in patients' progress notes differed considerably across the service. This meant it was sometimes difficult to obtain a clear picture of patients' progress during their time on the ward.
- The service was not currently providing the amount of therapeutic activity specified by the Commissioning for Quality and Innovation (CQUIN). This meant patients were not provided with a full range of therapeutic activities to meet their needs and preference.
- Patients on willow suite did not have direct access to psychological assessment or intervention. Due to long waiting times for psychology referrals, patients would only get access when they transferred to acute services. This meant they were not provided all care options to meet their needs.
- Staff on Willow suite did not have access to a local induction to ensure they were familiar with their role and the environment.
- The service did not always have access to the reports carried out by an approved mental health professional when a patient was detained under the Mental Health Act. Furthermore, documentation relating to detained patients access to leave was not always up to date. This meant that staff could not easily ascertain patients' current leave status.
- Recent changes in how to access advocacy services had not been fully implemented by the service. This meant that patients were not always getting access to these services

However, we also found the following areas of good practice:

Summary of this inspection

- The service had identified that staff required additionally guidance to improve the quality of patients' care plans. Care planning training had been made mandatory and all permanent staff had been booked onto this. The service had also added a new function to their electronic patients' records system which promoted patient involvement in care planning.
- The service had recently introduced a system to improve staffs' adherence to completing nursing tasks essential to monitoring patients' mental and physical health.

Are services caring?

We found the following issues that the service provider needs to improve:

- Patients reported that staff could come across as unapproachable, due to appearing engaged in other activities. This meant they did not always ask for support when needed.
- The service did not have a system which allowed patients to access their rooms independently. This led to patients often leaving their doors open which compromised the security of their belongings.

However, we also found the following areas of good practice:

- Patients reported that staff were kind and respectful and would offer them support when required. Furthermore, staff respected patients privacy and always knocked on doors and asked for permission to enter.

Are services responsive?

We found the following issues that the service provider needs to improve:

- The outside areas on Amberwood ward, Cherrywood ward and Willow suite were not deemed to be of therapeutic benefit to patients. All three lacked appropriate seating and required attention make them attractive to patients.
- Amberwood ward and Cherrywood ward had a lack of patient relevant information on display. Notice boards had been damaged in the weeks prior to the inspection and the service had not implemented a plan to address this issue.

However, we also found the following areas of good practice:

- The service was actively looking at ways to effectively discharge people from the service. They had recently introduced a checklist which helped staff identify areas which needed to be addressed or was currently a barrier to discharge.

Detailed findings from this inspection

Mental Health Act responsibilities

Patients were having their rights explained to them and this was recorded in their care records.

Patients' leave conditions (Section 17) were recorded correctly and uploaded in their care records. However, some Section 17 forms had not been updated to reflect patients current leave status.

Reports written by approved mental health professionals were not always available or contained in patients care records.

Patients did not have easy access to an independent mental health advocate. The process for accessing advocates had recently changed and it was having a negative impact on their accessibility.

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

Safe	
Effective	
Caring	
Responsive	

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Safe and clean environment

- We reviewed all four wards in relation to their adherence to guidance on same-sex accommodation. All wards admitted patients of both genders. However, there were no dedicated bedrooms for either male or female patients. This meant that the gender mix fluctuated and was determined by admissions, discharges and bed availability. Patients on all wards had en-suite facilities which consisted of a toilet, shower and wash basin. Amberwood and Cherrywood wards had identical layouts which consisted of a small corridor with four bedrooms and a long corridor with 13 bedrooms. During our inspection, on Cherrywood ward there were five male patients who occupied the four bedrooms in the small corridor with one male patient occupying the first bedroom in the long corridor. Amberwood ward used a different system to allocate their bedrooms. The four bedrooms in the small corridor were occupied by females who had been identified as having issues which made them vulnerable, for example current or historic episodes of abuse. The first half of the long corridor had bedrooms occupied by male patients with the end of the corridor being occupied by female patients. The ward manager told us that rooms were allocated in this way so that males did not have to walk past female bedrooms. However, this meant that females needed to walk past male bedrooms to access their bedrooms. We saw minutes from a team meeting that showed that these room allocations had followed a visit by the clinical commissioning group. The issue of bedroom zoning had been highlighted and it was minuted that, 'under regulation, females can pass through male areas but the males cannot enter female areas'.
- Both wards had one assisted bathroom located halfway down the long corridor; this provided the only bath on each ward. Most patients would need to walk past bedrooms of opposite gender patients to access this.
- Willow suite and Woodlands ward were currently providing patients with bedrooms in segregated areas of same-sex patients. However, the ward manager on Woodland ward told us that this was not always maintained and was dependent on admissions, discharges and bed availability.
- Amberwood ward, Cherrywood ward and Willow suite had a stock of emergency medicine which was checked regularly. However, it was missing certain medicines which, according to guidance from the National Institute for Health and Care Excellence and the resuscitation council, should be stocked in care settings where restrictive interventions might be used.
- We reviewed the suitability of the seclusion room on Willow suite. Patients had access to a mattress and washing and toileting facilities. Patients did not have a clock within view. The trusts seclusion policy stated that patients should always be aware of time and day. Patients and staff were required to communication through glass which could impact patients' ability to relay their needs to observing staff. We also found that a light was not working.
- One bedroom on Willow suite, which was in use, did not have a wardrobe and bedside table. We were told by staff that this had been damaged and removed three weeks prior to the inspection. The issue had been reported to maintenance but they were unable to provide us with an update on when the issue would be addressed.
- The clinic room on Willow suite was incorrectly labelled as a laundry room. Staff, who were unfamiliar with the environment, for example new agency workers, could accidentally allow patients unescorted access to the clinic room.

- All staff were seen to be carrying personal alarms and nurse call alarms were located appropriately throughout all wards.

Safe staffing

- We reviewed staffing levels on all four wards due to concerns that patients care needs were not being adequately met. Staffing levels on the 17-bedded Amberwood and Cherrywood wards were three qualified staff and three unqualified staff on early and late shifts. Staffing on night shifts was two qualified staff and two unqualified staff. Staffing levels on the 12-bedded Woodlands ward was two qualified staff and two unqualified staff for early, late and night shifts. They also had an unqualified staff working between 8am – 4pm and 4pm – midnight. Staffing levels on the 12-bedded Willow Suite (PICU) were four qualified staff and three unqualified staff on early and late shifts. Staffing on night shifts was two qualified staff and three unqualified staff.
- We viewed staff rotas on all four wards and found high usage of bank and agency staff on Willow suite, Woodlands and Amberwood ward. The previous week's rota on Amberwood ward contained 113 filled shifts, 61 of these being filled by bank and agency staff. Only one shift in the week had been unfilled. Cherrywood had the largest majority of shifts filled by permanent staff. Woodlands ward only had two permanent qualified staff and the ward manager allocated them on different shifts. We were told of the actions being taken to manage the staffing issues on Woodlands ward. Patients on the ward were less acutely unwell with less risk issues. The hospital matron and all team managers met daily to discuss their allocated staffing for the next 24 hours. Staffing could then be reallocated to other wards, if necessary, to maintain safe staffing and adequate staff skill mix on all wards.
- The acute service manager told us they were aware of their high dependency on bank and agency staff and how this negatively impacted on the care they were able to provide. The service felt that attracting good staff was a constant challenge. Salaries were more competitive in the neighbouring trust due to its proximity to London. The staffing issue had been added to the trust's risk register and we were informed of two initiatives the service was using to address the issue. They had employed a recruitment agency (Cohesion) who specialised in recruiting to difficult areas. This arrangement had been introduced three weeks prior to the inspection and effectiveness was unmeasurable. The service was also presenting a business plan to the trust to request that salaries in this area of the trust be bought in line with the neighbouring trust. Currently no feedback was available on this business plan.
- We viewed minutes of Amberwood ward's previous four team meetings. Safer staffing was an agenda item. We observed that new staff were regularly being added to the team and interviewing was ongoing. Regular bank and agency staff had been offered fixed term contracts and this made them eligible for the trust's mandatory training. It was highlighted that having more staff trained in promoting safer and therapeutic services would have a positive impact on patients and staff. The ward manager on Amberwood was aware that current staffing issues were stressful for existing staff. In response, they had arranged a stress management workshop for staff to attend.

Assessing and managing risk to patients and staff

- We reviewed 19 care records across the four wards. We found that all patients had a risk assessment. All risk assessments had been updated within the two weeks prior to the inspection with 13 having been updated the previous week. We saw that identified risks had an associated care plan; however, there was a variance of quality and detail in how staff recorded risk management plans.
- Staff we spoke with had a good understanding around the use of rapid tranquilisation. This included the physical monitoring that should be carried out after use; post event de-briefing and how to report instances of its use.
- Staff on Amberwood and Cherrywood wards audited prescription charts daily to ensure they had been signed correctly. This meant that it was clear whether patients had taken or refused medicine. This system was working well as we observed no errors on the charts. Willow Suite did not carry out this daily audit and we observed two unsigned gaps within the three charts reviewed.
- We saw that medicines reconciliation had been carried out by a trust pharmacist on Amberwood ward.
- All patients on Willow suite had prescribed medicines that were consistent with medicines recorded on their

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

T3 forms (T3 forms record that medicines are prescribed in a person's best interests if they do not, or are unable to, give their consent. Medications on a T3 form are authorised by a Second Opinion Appointed Doctor).

- Patients' prescription charts on Cherrywood ward all had photos attached, except where it was recorded that the patient had not given their consent. This ensured that medicine errors were kept to a minimum. Patient prescription charts on Amberwood ward and Willow suite did not contain patient photos or evidence to show they had not given their consent
- Amberwood ward, Cherrywood ward and Willow suite had effective systems in place to ensure secure storage of medicines, including controlled drugs. This included secure storage of keys to access medicines.
- We carried out a spot check on the controlled drugs on the three wards and found that the balance in the register matched the contents of the cupboard.
- We found medicines to all be within their expiry date. The service had effective systems to ensure medicines were disposed of appropriately.
- Staff on Cherrywood ward and Willow suite only recorded the actual temperature of medicines fridges. Therefore, it was not clear what the maximum and minimum fridge temperature had been during the day. This meant that staff would be unsure if medicines, such as insulin, had been kept stored at temperatures appropriate for safe use.
- We reviewed how safeguarding procedures were followed on the four wards. Staff training for induction to safeguarding was at 99%. Staff were also required to complete separate training in safeguarding adults at level one and two. Completion rates for these, across the four wards, were 79% and 83% respectively. Completion of training in safeguarding children, level one and two, were 99% and 93% respectively. Amberwood ward had 100% staff completion rates across all safeguarding training. Wards with rates below 85% were:
- Willow suite (safeguarding adults level two – 80%, and safeguarding children level two – 79%); Cherrywood ward (safeguarding adults level one – 75%, and safeguarding adults level two – 67%); Woodlands ward (safeguarding adults level one – 50%, and safeguarding adults level two – 83%).
- Within the period 1 January 2016 and 11 July 2016, the wards had made 13 safeguarding referrals to the local authority. Amberwood ward made 10 of these with Woodlands ward making two and Cherrywood ward making one. While viewing patients care records we found examples of incidents, which met the criteria for a safeguarding referral, which had not been referred. For example, a patient under the age of eighteen, who was being cared for on Willow suite due to no bed availability on young peoples' psychiatric intensive care units, who had tied ligatures to themselves in an attempt to self-harm.
- We shared our concerns with the trust around the low quantity of safeguarding referrals we were being made aware of from the local authority. There did appear to be some discrepancies with the numbers as the trust had been making more referrals than the Care Quality Commission had received. This suggested that the systems being used to communicate safeguarding issues between the trust, the local authority and the Care Quality Commission, required attention.

Reporting incidents and learning from when things go wrong

- During our inspection, we did not scrutinise the services approach to reporting incidents or learning from them. However, we were told that staff on Amberwood ward had attended a team day the previous week which was focussed on dealing with incidents and complaints.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- We reviewed the care records of 19 patients across the four wards. We found evidence that care plans were formulated on admission to the wards. It was also evident that new care plans were added during patients' time on the ward. This showed that staff were responding to patients' needs as they arose. Although the care records related to patients who had been on the ward for differing lengths of time, we found that, generally, care plans were not regularly reviewed. This meant that patients' progress or deterioration may not be responded to effectively and could increase the time they spent on the ward.

- All patients had received a physical health check during their time on the ward. We observed that 16 out of 19 patients had care plans which addressed the need for ongoing physical health monitoring.
- Thirteen out of 19 patients had care plans which addressed issues other than just medicine adherence and risk management. These included areas such as engaging in activities; working on positive support networks in the community and planning for discharge. We found these varied in quality, in terms of detail and achievability. For example we viewed a care plan which just outlined the nursing tasks in administering a patient's antipsychotic depot injection. In contrast, we viewed a very detailed care plan for a patient who had been diagnosed with autism spectrum disorder that included family input; adjustments to alleviate stress caused by trust's non-smoking policy and reference to the patient's communication passport which gave staff specific guidance on supporting the patient. The care plan was written in easy read format to encourage the patient's involvement.
- We observed that 10 out of 19 patients had care plans that were recovery focussed. These plans outlined specific goals that the patient was working towards whilst on the ward. However, not all these care plans were reviewed regularly meaning that progress was not monitored effectively.
- We observed that five out of six patients on Amberwood ward had care plans that considered their plans for discharge. However, these were all brief with plans such as inviting their community worker to discharge meetings. The ward manager told us that one patient had received support from staff in applying for funding for a community placement, however, this information was not included in the discharge planning care plan.
- The service recognised that care plans were variable in their quality. They told us that only permanent staff were involved in formulating care plans and this can lead to them being rushed due to time constraints. We were shown evidence that the service had recently added care plan training to their mandatory training to ensure all contracted staff could improve their practice in this area.
- The quality of progress notes in all 19 patients care records was of variable quality. We saw examples of progress notes that specifically referred to patients care plans, and others that contained relevant information that led to an ongoing plan. However, we also saw progress notes which were brief and unspecific to the patient being discussed.
- The ward manager on Amberwood ward showed us a new system they were using to monitor staffs' completion of key tasks required during a patients admission. The system, 'Patient at a Glance', was incorporated into the patient information board displayed in the nurses' office. Staff and management could easily establish whether tasks, such as risk, physical, nutritional, falls and venous thromboembolism assessments had been completed for patients.

Best practice in treatment and care

- We reviewed 13 prescription charts across Amberwood ward, Cherrywood ward and Willow suite and found they were all appropriately signed and dated by the wards doctor.
- Patients' allergies were recorded on all prescription charts across the three wards
- We observed that patients who were prescribed medicines to be used when deemed necessary, for example to manage anxiety, had these reviewed regularly by a doctor. This ensured there was no risk of patients being given medicines inappropriately.
- Patients on the three acute wards had access to psychological input. Four full-time psychology assistants and two clinical psychologists, who worked three days a week each, were allocated to the wards. A clinical psychology lead, who worked four days a week, oversaw the team. The psychology assistant from Woodlands ward told us they screened all patients on admission to explore whether they would benefit from psychological input. The screening tool was comprehensive and used prompts that encouraged patients to give detailed information on the support they needed.
- The clinical psychology lead told us that on an average week they would provide between four and six sessions. The two clinical psychologists would provide approximately 10 sessions each. The four psychology assistants would provide approximately 12 sessions each. These sessions lasted between 40 to 50 minutes.
- We reviewed the current group therapeutic programme for the three wards. It did not contain any groups with a full psychological focus, although all groups were of a

therapeutic nature. The assistant psychologists facilitated the group therapeutic programme alongside occupational therapists. We were told that this programme was likely to be updated in line with the introduction of therapeutic staffing.

- Patients on Willow suite did not have direct access to psychology on the ward. We were told by staff that patients could be referred for psychology. However, due to long waiting times, we were told that normal practice was that patients would access psychology as they progressed through the acute wards pathway.

Skilled staff to deliver care

- Staff we spoke with on all wards told us that the trust pharmacist provided them with appropriate support. They visited the ward at least once a week and regularly attended team meetings.
- The three acute wards used a comprehensive local induction form which meant that new staff, including agency staff, were appropriately familiarised to their roles and the environment. Staff on Willow suite were unable to locate their local induction form or explain to us how new staff were appropriately inducted to their role and environment.

Multi-disciplinary and inter-agency team work

- During our inspection we did not observe any handovers or multi-disciplinary meetings. We were shown a new handover form that had been recently introduced to the service. It included prompts to ensure any risks, reviews, groups attended and nurse one to one time was captured. We were unable to gauge the effectiveness of this initiative as it had not been fully embedded into the service.

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

- We reviewed all twelve patient care records on Willow suite, as they were all detained under The Mental Health Act, to determine adherence to the Mental Health Act and its Code of Practice. We also reviewed a selection of detained patients' care records on the three acute wards.
- We found that patients were having their rights explained to them and this was recorded in their care records.
- Patient leave conditions (Section 17) were recorded correctly and uploaded in their care records. However, we found the most recent Section 17 forms uploaded did not always cover the current date. We were unable to locate hard copies of these forms or records to show that leave had been suspended. This meant that patients may be having a delay in continuing their rights to leave the ward as staff did not have accurate information. We found that patients were given copies of their Section 17 forms, but this was not always recorded in their care records.
- We found that 10 out of 12 patients' care records on Willow suite did not contain a report by an approved mental health professional. The Code of Practice, paragraph 14.93 -14.95, outlines that, even if the approved mental health professional is only able to provide an outline report when the patient is detained or admitted, they must provide a full report to the hospital as soon as possible. We discussed this with the service and they told us they were aware of the difficulties in ensuring the availability of these reports.
- Patients did not have easy access to an independent mental health advocate. This is an advocate who specialises in supporting people detained under the mental health act. Previously, the advocate had visited the ward weekly and made themselves available to patients. However, the current system to access the advocate was via a referral. We found little evidence that these referrals were being made.

Good practice in applying the Mental Capacity Act.

- A Mental Health Act reviewer, in their recent visit, had questioned whether a patient had been correctly assessed as having capacity. We revisited this issue and found that a capacity assessment had been repeated and the outcome was the patient did not have capacity on the grounds they were unable to retain information. This had led to significant improvements in the patient's care plans, including increased input from family.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Kindness, dignity, respect and support

- We saw staff present on all four wards and observed some positive interactions, particularly on Woodlands ward. Staff were responsive to patients, however, we

noted that the interactions were minimal and initiated when a patient approached staff, and not vice versa. We saw staff on Willow suite standing against walls which contributed to them appearing unapproachable.

- Patients we spoke with told us that staff were kind and respectful and that they generally offered support when asked. However, they felt staff appeared busy and engaged in tasks, such as observations and writing notes in the office. This meant patients did not often have meaningful one to one interactions with staff.
- Patients across all wards did not have keys to their bedrooms. Staff would unlock their rooms on request. We saw that some patients would leave their rooms open to ensure they could gain access without staff assistance. Patients' bedrooms contained a secure space where they could store valuables. However, items such as clothing could not be secured.
- Patients were able to lock their doors from inside, although staff were able to gain access. Patients' bedroom doors contained windows with viewing panels. Patients could set these to open or closed from within their rooms and staff could also operate them from outside so they could check on patients' whereabouts. All patients we spoke with told us that staff would knock on their door before entering.
- We were told that the bedroom doors were fitted with the technology to allow patients to have individual keys. However, they were concerned that keys, that were costly to replace, would go missing and were currently looking at systems that would minimalise this concern.

The involvement of people in the care they receive

- Fourteen out of 19 patients had care plans that contained their input and views. Eight of these 14 care plans showed that the patient had high levels of involvement, whereas six care plans showed low to moderate patient involvement. The ward manager on Amberwood ward told us that they had recently started utilising a new care plan feature on RIO, the trust's electronic patient record system, which prompted staff to capture patients' view more effectively. It was evident that care plans using this new feature were capturing patients' views more effectively.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- The service acknowledged that effective discharge planning was an ongoing issue. The ward manager on Amberwood ward showed us a discharge checklist which was being introduced to enable staff to make informed decisions around patients' readiness for discharge. The checklist contained 10 generic domains relating to reasons why the admission was necessary. Under each domain a list of criteria were given to help staff determine whether the patient still met the need for admission. Currently we were unable to gain any feedback or view any audits that could gauge the effectiveness of this initiative.
- We were told that the psychiatric intensive care unit, Willow suite, was always able to take patients from the acute wards if they required more intensive care. However, during our inspection there was a patient on Willow suite who was under the age of 18. We viewed their care records and found that the service had not made sufficient efforts to find a more suitable environment for this patient. We discussed this issue with staff and the service was able to make provisional arrangements for the patient to be transferred to an appropriate setting the following day. However, this location was approximately 50 miles away which meant their support network would have difficulties maintaining face to face contact.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff we spoke with on all wards told us that the systems in place to ensure pharmacy supplied medicines were effective. This meant that they rarely had medicine out of stock and patients received medicines in time to coincide with going on leave or being discharged.
- Patients on all wards had access to an outside space. Amberwood ward and Cherrywood ward had small courtyards accessible from the dining room. Both courtyards had no seating areas and were in need of attention. The lack of seating issue had been

highlighted on both wards during previous Mental Health Act visits (Cherrywood ward on 25 May 2016 and Amberwood ward on 28 June 2016). Staff had told us that arrangements to provide seating were being made. During our inspection, staff did not provide further updates on this issue.

- Patients on Woodlands ward had a suitably sized and orderly outside area which provided seating.
- Patients on Willow suite had access to a courtyard at regular intervals throughout the day. They were accompanied by staff as we were told there had been incidents in the past, such as absconsions and inappropriate sexual behaviour between patients. Patients and staff had access to high visibility jackets to wear in poor weather conditions. The courtyard was overgrown and had no seating. We were told a bench had been removed following a patient using it to abscond. Patients had use of a blanket to sit on.
- We reviewed the programme of therapeutic activities that was on offer over the four wards. Amberwood ward and Cherrywood ward were currently offering 16 hours of therapeutic activities, whilst Woodlands ward was offering 17 hours. The Commissioning for Quality and Innovation (CQUIN) had a target of 25 hours of activities offered per week to each patient. This was to include social, educational and occupational opportunities that is meaningful and supports rehabilitation and recovery.
- We spoke with nine patients across the three wards and asked their views on the activities provided. They thought that activities were easy to access and they were encouraged to attend. Patients who attended activities felt they were beneficial, particularly in helping them relax and relieve boredom. However, they told us they would like more regular activities, with more variety and structure.
- Willow suite had a comprehensive programme of therapeutic activities that met the targets defined by CQUIN. However, we were told by staff and patients that staffing issues often meant that the activity timetable could not always be followed. We were told that two occupational technician posts had recently been filled, and it was anticipated that the level of activities offered would improve.
- The service was in the process of introducing 'therapeutic staffing', and this was expected to start within the next two months. Therapeutic staffing meant that allied health professionals, such as psychology and occupational therapy staff, would be included in the daily staffing numbers. Staff would then be able to offer patients a daily structure, based around therapeutic activities. We viewed a sample day planner that outlined a typical day. It started at 9am with an opportunity for patients to discuss their plans for the day. This was followed by five, one hourly, therapeutic activity sessions and meal times between 10am and 6pm. The therapeutic day concluded with a daily reflection. The service told us the rationale for therapeutic staffing was to provide patients more recovery focussed interventions, whilst also providing staff with more structure to arrange their daily tasks. It was also felt that the inclusion of permanent allied health professionals in the numbers would reduce the dependence on agency nursing staff.

Meeting the needs of all people who use the service

- Amberwood ward and Cherrywood ward had a lack of patient information displayed. This meant some information on areas, such as local services and patients' rights, was not easily accessible and would need to be requested from staff. We were told that a number of these had been damaged approximately three weeks ago. The issue had been reported to maintenance and they were awaiting replacements. Woodlands ward had a variety of patient boards displaying a wide range of information relevant to patients. The psychology assistant told us that the ward was aware that some of the information needed updating and that they had been allocated to address this issue. This task included updating the information boards on all four wards.

Listening to and learning from concerns and complaints

- During our inspection, we did not scrutinise the services approach to managing complaints or learning from them. However, we were told that staff on Amberwood ward had attended a team day the previous week which was focussed on dealing with complaints and incidents.

Outstanding practice and areas for improvement

Outstanding practice

The service had introduced a system called 'Patient at a Glance'. This was incorporated into the patient information board and allowed staff and management to have clear oversight of adherence to essential patient assessments such as; risk, physical, nutritional, falls and venous thromboembolism.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the service is providing accommodation that adheres to guidance on same-sex accommodation
- The provider must take action to ensure all patients have access to psychological assessment and interventions.
- The provider must ensure that all staff are able to identify safeguarding concerns and are competent in how to escalate them.
- The provider must ensure that the systems they use to alert safeguarding referral to the relevant agencies are working appropriately.

Action the provider SHOULD take to improve

- The provider should ensure they stock all medicines recommended for environments that use restrictive practice.
- The provider should ensure the services seclusion facility supports patients in line with their seclusion policy.
- The provider should ensure that all areas within the service environments are labelled correctly.
- The provider should have appropriate systems in place to ensure fridge temperatures are maintained at levels suitable for storing medicines safely.
- The provider should take action to ensure their provision of therapeutic activities is in line with targets recommended by the Commissioning for Quality and Innovation (CQUIN)
- The provider should review its approach to recording progress notes in patients care records.
- The provider should ensure that all staff have access to a local induction relevant to their working environment.
- The provider should have systems in place to ensure Mental Health Act documentation is completed correctly and accessible to staff.
- The provider should improve their systems in relation to patients accessing advocacy services.
- The provider should adopt a system which allows patients to access their bedrooms independently.
- The provider should ensure that outside areas accessible to patients offer comfort and therapeutic benefit.

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 Amberwood ward and Cherrywood ward were not complying with guidance on same sex accommodation. This was 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 9 HSCA (RA) Regulations 2014 Person-centred care Patients on Willow suite did not have direct access to psychological assessment or intervention. Staff had the option of referring patients for psychological assessment but were not doing so due to perceived waiting times. This meant the ward was not offering a comprehensive assessment that met patients' needs and preferences This was a breach of regulation 9 (1) (a)-(c) (3) (a)-(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff were not consistently identifying safeguarding concerns on the ward. Lower levels of compliance with mandatory safeguarding training was having a direct effect on staffs' ability to identify safeguarding concerns

This section is primarily information for the provider

Requirement notices

The systems and processes the service was using to share safeguarding concerns with relevant agencies were not effective.

This was a breach of regulation 13 (2) and 13 (1)