Requires improvement

Norfolk and Suffolk NHS Foundation Trust

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

Quality Report

Hellesdon Hospital
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Norwich
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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)
RMYXX	Fermoy Unit: Domiciliary Care Service	Churchill Ward	PE30 4ET
RMY03	Northgate Hospital	Gt Yarmouth and Waveney Acute Service	NR301BU
RMYNG	Woodlands	Avocet	IP4 5PD
RMYNG	Woodlands	Poppy	IP4 5PD
RMYNG	Woodlands	Lark	IP4 5PD
RMYNR	Wedgwood House	Southgate	IP33 2QZ
RMYNR	Wedgwood House	Northgate	IP33 2QZ

Summary of findings

RMY01	Hellesdon Hospital	Rollesby	NR6 5BE
RMY01	Hellesdon Hospital	Glaven	NR6 5BE
RMY01	Hellesdon Hospital	Waveney	NR6 5BE
RMY01	Hellesdon Hospital	Thurne	NR6 5BE

This report describes our judgement of the quality of care provided within this core service by Norfolk and Suffolk 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 Norfolk and Suffolk NHS Foundation Trust and these are brought together to inform our overall judgement of Norfolk and Suffolk NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

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

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

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

Summary of findings

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Overall summary

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

- All wards had carried out extensive work in improving the environment and reducing the risk of harm due to ligatures. There were audits on all wards and action plans in place to remove or manage the risk. However, the size and build of Churchill ward makes it very difficult for staff to manage these risks. All of the beds in Churchill Ward were a ligature risk and although staff documented this and there were management plans in place, it was an area of concern, particularly at night. The plans depend on staff high vigilance and it was easy to foresee occasions where staff may be required to respond to other incidents on the ward and not be able to carry out the level of observation required.
- Staff had not updated some of the ward ligature risk assessments to reflect action taken and some items had been identified for removal for six months without action.
- Ward gardens had blind spots due to shrubbery and bushes. There was CCTV on the wards but staff did not monitor this at all times. Staff did not always supervise the garden areas.
- We had concerns that staff used the S136 suite in the Fermoy unit at night for seclusion. There was one set of notes that indicated it was used in this way and the ward manager confirmed that at night she had been aware this had happened on a rare occasion to reduce patients being disturbed during the night. The S136 suite was not an appropriate area to nurse a patient in seclusion. Staff also reported that the S136 suite on Wedgwood was used for seclusion on occasion. We did not see this on inspection.
- Medication management has improved since the last inspection. However, there were still some key areas that needed addressing. The monitoring of physical health following administration of rapid tranquilisation medication was poor and non-existent at times. Despite internal audit taking place there were still incidents of unacceptable levels of gaps in signature on some medication charts.
- Staff recorded medication fridge temperatures daily but on two wards no action was taken when the temperature was out of range and one ward did not monitor for a whole month. The trust could not be sure that medicines were stored appropriately to ensure their quality and efficacy.
- Staff documentation of when 'as required' medication was given to patients and its efficacy, was poor. Staff did not record the reason the patient required the medication on several occasions. Not all incidents in continuous notes were recorded on the incident reporting system (Datix), nor added to the risk assessment.
- The Trust was non-compliant with national controlled drug legislation when ordering controlled drug medication from another trust from Northgate and Southgate wards.
- There were standardised care plans in place regarding the use of least restrictive practice and staff did not record patient personal views. On Waveney ward, three care plans included a seclusion plan or consideration for transfer to a PICU when this was not clinically indicated. Those care plans were inaccurate.
- Forty two per cent of all restraints resulted in prone restraint. This remained high although it was a 6% reduction of recorded incidents of prone restraint since the inspection in 2014.
- Staff completed risk assessments for patients on admission. Staff did not routinely update the risk assessments. The risk assessments were not accurate in many records we reviewed across the wards and did not reflect all the patients' risks. Staff did not always add incidents that occurred during admission to the risk assessment, and staff did not report all events on the incident reporting system, known as Datix.
- We noted that staff poorly documented seclusion records and events. The electronic record system did not support seamless records and it was difficult to navigate the system. Staff were unable to find information, and we spent a disproportionate length

of time trying to ascertain if the patient received appropriate care. We noted that doctors did not always write entries, there were missing times of when seclusion ended, and staff used terminology such as 'open' seclusion. It was not always clear when seclusion became long-term segregation. It was not possible to confirm if staff regularly offered food and fluids to patients during seclusion, as staff did not routinely record this.

- It was evident that staff did not record all incidents in the continuous notes. We noted staff had not always reported incidents documented in the contemporaneous notes as a Datix incident. This means that the trust did not have a true reflection of incidents on the wards.
- We saw evidence of some capacity assessment outcomes in the patients' continuous notes. There was no rationale in continuous records as how the staff reached a decision.
- Patients on all wards reported that they had experience of staff cancelling Section 17 leave due to staff shortages.
- Staff supervision was patchy, with some ward staff receiving less than two supervisions in a 6 month period.

However:

- It was clear that there had been significant efforts made by the trust to address ligature risks on the wards.
- Clinic rooms were clean and tidy.
- Medicines were stored securely and staff completed monthly audits for safe storage.
- Access to medicines was good and medicines for discharge were readily available.
- The trust provided information routinely regarding serious incident learning. Minutes of meetings demonstrated that staff did share, review and discuss incidents.
- Staff completed and recorded physical health examinations and assessments on admission.
- Many wards had access to a physical health nurse to support teams to ensure that staff supported patients to address their physical health needs. Staff monitored physical observations and physical health problems. Staff discussed physical health needs at weekly multi-disciplinary team meetings and physical health needs were considered in care plans.
- We observed all MHA detention papers were completed correctly, up to date and stored appropriately.
- Staff informed all patients detained under the Mental Health Act (MHA) of their S132 rights on admission.
- All Section 17 forms reviewed were up to date.

Summary of findings

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

Are services safe?

Inadequate

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

- The size and build of Churchill ward made it very difficult for staff to manage all the ligature risks identified on the ward. Although management plans were in place to mitigate these risks, the plans depend on staff high vigilance and it was easy to foresee occasions where staff may be required to respond to other incidents on the ward and not be able to carry out the level of observation required.
- Staff had not updated some of the ward ligature risk assessments to reflect action taken and some items had been identified for removal for six months without action.
- Staff attendance at Immediate Life Support (ILS) training was poor across all the wards.
- The risk assessments were not always accurate in records we reviewed across the wards. Staff did not update the risk assessments after incidents and staff did not report all events on the incident reporting system, known as Datix.
- We noted during the inspection that staff did not carry out physical health monitoring consistently following administration of rapid tranquilisation medication and sometimes there were no entries of staff carrying out these observations. It is important to monitor physical health following rapid tranquilisation due to the increased risk of adverse reaction and potential requirement for medical intervention. Failure to carry out observations can put the patients' health at risk. We also noted that 'as required' medication was not always documented in the continuous notes and where it was, the outcome and the actual medication given was not recorded.
- We had concerns that staff used the S136 suite in the Fermoy unit at night for seclusion. There was one set of notes that indicated it was used in this way and the ward manager confirmed that at night she had been aware this had happened once to reduce other patients being disturbed during the night. The S136 suite was not an appropriate area to nurse a patient in seclusion.
- We noted that staff poorly documented seclusion records and events. The electronic record system did not support seamless records and it was difficult to navigate the system. Staff were unable to find information, and we spent a disproportionate

Summary of findings

length of time trying to ascertain if the patient received appropriate care. We noted that doctors did not always write entries about seclusion reviews, there were missing times of when seclusion ended, and terminology such as 'open' seclusion was used. It was not always clear when seclusion became long-term segregation. There was not always a care plan when the patient was in long term segregation. It was not possible to confirm if staff regularly offered food and fluids to patients during seclusion, as staff did not routinely record this.

- The Trust was non-compliant with national controlled drug legislation when ordering controlled drug medication from another trust for Northgate and Southgate wards.
- We found gaps in signatures on medication charts. These records were unable to show that patients were getting their medicines when they needed them.

However:

- All wards had carried out extensive work in improving the environment and reducing the risk of harm due to ligatures.
- Clinic rooms were clean and tidy.
- All wards had completed comprehensive environmental risk assessments.
- Staff understood and followed the safeguarding systems across all the wards. All staff interviewed could identify what safeguarding was and what to do in the event of a concern. There was evidence of safe reporting and actions taken on all wards.
- The trust provided information to all wards regarding serious incident learning. Minutes of meetings demonstrated that staff reviewed and discussed incidents.

Are services effective?

Requires improvement

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

- The quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs, nor the patients' views. Some care plans were generic. There was evidence of care plans not reflecting all identified risks on some wards.
- Staff documented seclusion care plans poorly. The electronic records system did not support staff accessing information and staff had different interpretation of where to add information on the system.

Summary of findings

- Ward staff participation in supervision was not consistent. All wards reported difficulties in finding time to undertake this. Wards did not meet the trust standard of 10 supervisions in 12 months.
- There was no evidence of local audit for the administration and monitoring of rapid tranquilisation medication.
- The trust provided Mental Capacity Act (MCA) training combined with Mental Health Act (MHA) training. The lowest completion of training was 55%, the highest, 89%. The figures demonstrated a wide variance in meeting this requirement.
- Deprivations of Liberty Safeguards (DoLS) training figures were similar in range with the lowest completion rate of 57% and the highest at 100%.
- Medical staff completed consent to treatment and capacity requirements on the form. However, the continuous notes did not always record decisions or demonstrate how staff reached a best interest decision.
- We saw evidence of capacity assessment outcomes in the patients' contemporaneous notes, however they were sometimes hard to find and not consistently reviewed. There was no rationale in continuous records as to how the staff reached a decision.

However:

- Patient identifiable information was stored safely and securely.
- All new healthcare assistants were required to complete the new Care Certificate.
- New staff underwent a formal induction period to teach them about the ward and trust policies
- Staff carried out regular checks on emergency equipment to ensure it was safe for use at any time.
- Non-refrigerated medicines were stored securely and within safe temperature ranges. Staff regularly carried out audits to ensure safe storage.
- Occupational therapists, discharge teams, physical health nurses and psychologists worked across all the acute wards at Hellesdon hospital. We saw that they worked effectively with patients.
- We observed all MHA detention papers were completed correctly, up to date and stored appropriately.
- Staff informed all patients detained under the Mental Health Act (MHA) of their S132 rights on admission.
- All Section 17 forms reviewed were up to date.
- There was information on the wards informing patients on how to access advocacy services. Care records showed patients were using the advocacy service.

Summary of findings

Are services caring?

Good

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

- Staff responded to patient needs, showed discretion and respect. We observed good relationships between patients and staff on all wards. We saw that staff were passionate and enthusiastic about providing care to patients. We observed positive and meaningful interactions between staff and patients.
- Patients called staff wonderful, respectful, warm and friendly in the majority of cases.
- Patients confirmed that staff invited patients to the multi-disciplinary reviews, along with their family where appropriate.
- Patients said they had access to advocacy. Wards had posters on the wall to inform patients of advocacy services.
- Patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Carers had access to carer meetings in Hellesdon and the trust had implemented the Triangle of Care initiative to encourage carer involvement and provide support.
- Patients were actively involved in the running of the ward through a weekly community meeting. Staff recorded minutes of community meetings.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.

However:

- Staff discussed patients' needs in their care planning meetings. Patients were encouraged to express their view, were listened to and care agreed reflected their wishes. However, care plans contained little evidence of patient involvement with the care planning process.
- Patients on all wards reported that they had experience of staff cancelling Section 17 leave due to staff shortages.
- Some of the viewing panels on bedroom doors were left open. Not all rooms had panels the patients could control. This meant there was a lack of privacy as people could look into their rooms.
- Fourteen patients said they had experienced violence towards them by another patient.
- Family were not always able to attend reviews due to the lack of notice given.
- Care plans did not always contain patients' views, did not have advanced directives, and there was minimal crisis planning.

Summary of findings

Are services responsive to people's needs?

Good

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

- Discharge teams had been introduced by the trust to facilitate a smooth discharge and reduce any delays occurring. One discharge team member was based on Waveney full time to support patient's safe discharge.
- Wards had a quiet area where patients could meet visitors.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and patients gave examples of actions taken to meet these needs.
- Wards had facilities to meet the needs of patients with disabilities, for example, assisted bathrooms.
- Patient information leaflets were visible on all wards and covered a range of subjects including local services, S132 rights, advocacy and how to complain. Staff told us these were available in different languages.
- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs.
- Spiritual support was available to patients for a range of faiths. Information was visible on notice boards and patients used this service.
- All wards had information on how to complain displayed and there were also leaflets which patients could access. Patients when asked during inspection said they knew how to complain.
- Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint. Staff confirmed they knew how to support patients to make a complaint.
- All wards had information on how to complain displayed and there were also leaflets which patients could access. Patients when asked during inspection said they knew how to complain.
- Ward managers told us they shared learning amongst their staff via staff meetings and communications.

However:

- The trust provided data that showed bed occupancy was high on all wards. Trust figures between 1 October 2015 and 31 March 2016 demonstrated that all acute wards had high occupancy rates. Churchill ward had the highest occupancy of 113% and Southgate was significantly lower with an occupancy rate of 72%. During inspection, there were beds available on five wards that staff acknowledged was unusual.

Summary of findings

- Staff reported that bed occupancy was always a challenge and at times had used beds that were categorised as a red leave bed (a bed where a patient has gone on leave but there was a high risk of early return to the ward). There was no evidence of this during the inspection.
- On one ward, 20 patients had to share one toilet and one bathroom for several weeks during a period of refurbishment. This was insufficient to meet demand. A second toilet refurbishment was completed during inspection.
- Three wards still had shared bedrooms.

Are services well-led?

Requires improvement

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement for well led because:

- Mandatory training was patchy across the service with some wards having poor attendance rates for specific training. Not all staff had received regular supervision or an annual appraisal.
- Supervision on the wards did not take place regularly. The CQC report had highlighted this following the inspection in 2014.
- Some staff at Woodlands and Wedgwood House told us middle management were rarely on site. There was a lack of understanding by staff of the middle manager role.
- The trust used acuity tools to determine safe staffing levels. However, wards employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable to cover higher levels of patient need. There was a high reliance on the use of bank and agency staff and, on occasion, wards operated short of staff when bank or agency staff were not available. This may have contributed to the poor record keeping on the wards.
- There remained areas that had not sufficiently improved since the inspection in 2014, specifically medication management, Churchill ward environment, seclusion documentation, number of prone restraints and staff supervision.
- The storage and administration of medication was not safe on every ward. The CQC report had highlighted this following the inspection in 2014.
- We saw that there was poor monitoring of physical health following administration of rapid tranquilisation medication. The CQC report had highlighted this following the inspection in 2014.
- Prone restraint on the wards remained high, although there had been a reduction of prone restraints from 48% to 42% following restraint. The CQC report had highlighted this following the inspection in 2014.

Summary of findings

- Seclusion records were patchy and records showed medical response outside of trust guidelines in some care records.
- There was no evidence of auditing the seclusion process and records against policy.
- Staff did not always fully document capacity assessments; in particular, the rationale for how decisions were reached was not evident. The CQC report had highlighted this following the inspection in 2014.
- The trust had robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. However, whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and an unacceptable number of ligature risks remained on Churchill ward. Risk assessments on two other wards identified items that required removal in January 2016. The trust had not had the items removed at the time of the inspection. The CQC report had highlighted the management of ligatures on the ward as a concern following the inspection in 2014.

However:

- Staff we spoke with were aware of the trust's vision and values. There were posters on wards and in corridors with the vision and values displayed.
- Staff were able to tell us who the most senior managers in the trust were, and said they had visited the wards.
- Staff told us that the ward managers were highly visible on the wards, approachable and supportive. Teams were cohesive and enthusiastic. Staff told us that they felt part of a team and received support from each other.
- Staff participated in clinical audit and had access to clinical dashboards, which provided information about completion of clinical documentation such as care plans and risk assessments.
- The trust had developed reports to monitor performance. Ward managers were able to demonstrate knowledge and involvement in inputting and using the report.
- The trust had robust procedures for raising safeguarding concerns for patients.
- The trust had procedures for implementing, recording, storing and auditing Mental Health Act paperwork.
- The ward managers confirmed they felt supported by their managers. Most staff felt supported by their ward manager.
- Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Norfolk and Suffolk Foundation Trust were part of the trust's acute division. The wards were situated on five sites, the Queen Elizabeth Hospital, Hellesdon Hospital, Woodlands, Wedgwood House and Northgate Hospital in Great Yarmouth across Norfolk and Suffolk.

Norfolk Services

Queen Elizabeth Hospital Fermoy Unit held an acute in-patient ward, Churchill ward, which was a mixed sex 15-bedded ward.

Hellesdon Hospital hosts four wards. Three of these wards, Thurne, Waveney and Glaven were acute in-patient wards ranging from 12 to 21 beds. Glaven and Waveney were single sex wards, Thurne was mixed sex. One ward, Rollesby, was a 10 bedded mixed sex psychiatric intensive care unit.

Northgate Hospital in Great Yarmouth had one mixed sex 20 bedded ward called Great Yarmouth and Waveney Acute Ward.

Suffolk Services

Wedgwood House was based on the West Suffolk Hospital site and held two wards, Northgate (21 bedded) and Southgate (20 bedded) which were both mixed sex wards.

Woodlands was based at the Ipswich Hospital site and held two 21 bedded mixed sex acute wards and one 10 bedded mixed sex psychiatric intensive care unit.

The Care Quality Commission carried out a comprehensive inspection of the trust in 2014 and the outcome was that the trust was placed in special measures. The 2014 inspection report noted, in the adult and psychiatric intensive care units section, the following concerns:

- We found ligature risks within most of the ward environments, some of which had not been identified by the service. Not all wards had a layout with a clear line of sight.
- There were concerns about privacy and dignity and arrangements for mixed sex accommodation.
- The storage, dispensing, administration and disposal of medication was not safe on every ward.
- We were concerned about the high number of restraints where the patient had been held face down and were also concerned that episodes of seclusion may not have ended as quickly as possible.
- There was no wider system for learning and sharing issues to prevent them happening again.
- The Trust did not ensure there were sufficient staff at all times to provide care to meet patients' needs.
- The trust did not carry out assessments of capacity and record these in the care records.
- Staff did not always fully document capacity assessments, in particular the rationale for how decisions were reached.
- Mandatory training was patchy across the service with some wards having poor attendance rates for specific training.
- Not all staff had received supervision or an annual appraisal
- Not all procedures under the Mental Health Act (MHA) were followed.
- Patients were unable to access beds in their local acute psychiatric service in a timely manner due to shortage of local beds.
- Carers reported that following a relative's death, response by the trust was minimal and there had been very little communication.
- There was no clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board to the wards were unclear at local level.

Summary of findings

- Staff did not feel supported or valued by senior or locality managers and was not aware of the trust vision. Staff reported low morale and powerless to make positive changes.

During this inspection, we found that the trust had not addressed all of these issues. Specifically we found that:

- The storage, dispensing, administration and disposal of medication was not safe on every ward.
- We remained concerned about the high number of restraints where staff had held the patient face down.
- Staff still had not always fully document capacity assessments, in particular the rationale for how they reached decisions.
- Mandatory training remained patchy across the service with some wards having poor attendance rates for specific training.
- Not all staff had received regular supervision and appraisals were not all completed

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliott, Deputy Chief Inspector (lead for mental health), Care Quality Commission

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Manager: Lyn Critchley, Inspection Manager mental health hospitals CQC

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of 10 people: three inspectors, six specialist advisors (one consultant psychiatrist, two nurses, a clinical psychologist, social worker and mental health act reviewer), and one expert by experience.

The team would like to thank all those who met and spoke to the team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- Visited all wards at the five hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with 51 patients who were using the service
- Interviewed 11 ward managers

Summary of findings

- Spoke with 84 other staff members individually, including doctors, nurses, student nurses, activity co-ordinators, psychologists, pharmacists, administrators and support workers
- Met with one carer
- Reviewed 70 care and treatment records of patients
- Carried out a specific check of the medication management on all wards
- Collected feedback from patients using comment cards and direct interview
- 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

All patients on the wards were positive about their care and treatment and felt that staff were compassionate, caring and responsive. Some did say they did not have the opportunity to be involved in the development of their care plan. Families and carers had the opportunity to be involved in care reviews. Patients told us they felt cared for, comfortable, had access to activities throughout the day and said food was acceptable. Not all patients felt safe on the ward and we read in care records that several patients had assaulted fellow patients.

Focus group feedback was variable. Some patients described care that was less than acceptable. Patients reported staff not listening to them and not having input into decisions about their care, nor being enable to be involved in their own care plans.

Carers had the opportunity to attend the focus group or meet individually with the inspection team. They described poor communication between themselves, the wards and the senior management team. Some carers who had suffered bereavement felt the senior trust team response to their loss was limited and lacking compassion.

Areas for improvement

Action the provider MUST take to improve

- The trust must take action to remove identified ligature risks and ensure there are clear lines of site in the gardens.
- The trust must take action to improve Churchill ward environment and support staff by either removing or providing a practical plan to manage all the ligature risks.
- The trust must ensure the practice of using the S136 suite for seclusion in Churchill stops and ensure staff have sufficient training and guidance to support people who may meet the requirement for seclusion.
- The trust must ensure that all wards have sufficiently trained staff to be able to respond to incidents of violence on the ward.
- The trust must consistently monitor and maintain refrigerated medication at correct temperatures in all areas.
- The trust must ensure it is compliant with national controlled drug legislation when ordering controlled drug medication from another trust.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on-violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure that appropriate arrangements are in place for accurate recording and monitoring of the administration of medicines.
- The trust must ensure changes to risk are reflected in the current risk assessment and care plan.
- The trust must ensure all care plans are accurate, person centred and reflect the views of the patient.
- The trust must ensure both seclusion care plans and long term care plans and documentation must be fully documented by all professionals involved to ensure clarity.
- The trust must ensure all incidents are reporting using the incident reporting system in place.
- The trust must ensure staff receive regular and effective supervision.

Summary of findings

Action the provider SHOULD take to improve

- The trust should work with local commissioners to ensure there are sufficient beds to meet the demands of the local population.
- The trust should ensure that staff do not cancel patient Section 17 leave unless clinically indicated.
- The trust should ensure there is clear documented evidence of how staff reach capacity decisions.
- The trust should ensure that any as required medication is documented fully in the continuous notes, giving the name of the medication, dose, and the reason for giving it and efficacy.
- The trust should ensure care plans accurately reflect the needs and risks of the patient and demonstrate efforts to use the least restrictive practice, involving the patient in all discussions.
- The trust should ensure the health care records electronic system can be navigated and used by staff in such a way that it enhances care provision.
- The trust should review the use of shared bedrooms.

Norfolk and Suffolk 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
Churchill Ward	Fermoy Unit
Thurne Ward	Hellesdon
Glaven Ward	Hellesdon
Waveney Ward	Hellesdon
Rollesby Ward	Hellesdon
Lark Ward	Woodlands
Avocet Ward	Woodlands
Poppy Ward	Woodlands
Northgate Ward	Wedgwood House
Southgate	Wedgwood House
Great Yarmouth and Waveney Ward	Northgate Hospital

Detailed findings

Mental Health Act responsibilities

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

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- The trust provided Mental Capacity Act (MCA) training combined with Mental Health Act (MHA) training. The lowest completion of training was 55% the highest 89%. The figures demonstrated a wide variance in meeting this requirement.
- We observed all MHA detention papers were completed correctly, up to date and stored appropriately.
- Medical staff completed consent to treatment and capacity requirements on the form. However, the continuous notes did not always record decisions or demonstrate how staff reached the decision. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA.
- One patient had no second opinion approved doctor (SOAD) referral or T3 and the patient was having covert medication. There was no evidence of staffing referring the patient to tribunal.
- Staff informed all patients detained under the Mental Health Act (MHA) of their S132 rights on admission.
- All Section 17 forms reviewed were up to date.
- Staff read S132 rights on admission and repeated them to the patient as per policy.
- There was information on the wards informing patients on how to access advocacy services. Care records showed patients were using the advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust provided Deprivations of Liberty Safeguards (DoLS) training. The lowest completion of training was 57%, the highest 100%. The figures demonstrated a wide variance in meeting this requirement.
- We saw evidence of some capacity assessment outcomes in the patients' contemporaneous notes. Staff documented capacity at care reviews but this was not consistent and it was not clear how staff reached a decision.
- The electronic record system did have a small section to record the outcome of a capacity assessment. Not all wards were aware of this. One patient was deemed to have fluctuation capacity, but there was no plan to manage this.
- Staff had varying degrees of knowledge about Deprivation of Liberty Safeguards (DoLS). Between 1 July 2015 and 31 March 2016, three applications for DoLS had been made on the acute wards.
- Patients had access to advocacy services and patients could self-refer, or staff would refer on their behalf. Advocacy services visited the ward weekly and there were phone numbers and information displayed on all the wards explaining the services and contact details.

Inadequate

Are services safe?

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

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

Our findings

Acute Wards

Safe and clean environment

- All wards had ligature risk assessments. A ligature point is a fixed item to which a person could tie something for the purpose of self-strangulation. Waveney ward assessment was not up to date. Works staff had completed some tasks but staff had not removed the items from the assessment. Staff had identified other items as requiring removal for over six months and no action had been taken. Staff had not identified door closures on the ligature risk assessment. Thurne ward garden area had numerous ligature points and staff had not identified them all in the risk assessment. Staff did not always supervise the garden area, which meant there was a risk to patient safety. Thurne ward risk assessment did not address the emergency cord in the bathroom as a ligature risk in their assessment and there was a blind spot along the male corridor.
- Churchill ward had a comprehensive locally developed ligature risk assessment in addition to the trust annual assessment. However, the size and build of the ward made it very difficult for staff to manage these risks. Staff had identified all of the beds in Churchill ward as a ligature risk and there were management plans in place to mitigate this. However, the plans depend on staff high vigilance and it was easy to foresee occasions where staff may be required to respond to other incidents on the ward and not be able to carry out the level of observation required.
- Ward gardens had blind spots due to shrubbery and bushes. There was CCTV on the wards but staff did not monitor or supervise the garden areas at all times. This meant that there was a potential of patient harm that may go unnoticed, causing a risk to patient safety.
- Most of the acute wards were mixed sex and they did mostly comply with standards of ensuring separation of male and females in bedroom areas, the provision of separate bathing facilities and separate female only lounges. The exception was that male patients requiring seclusion from either Northgate or Southgate ward had to walk through the female bedroom corridor on Southgate ward. The garden on Waveney ward, which was a female only ward, was overlooked by a male ward.
- The trust had processes for the storage, recording and administering of medication. Clinic rooms were clean and tidy. Staff recorded fridge temperatures daily except on Churchill ward in May 2016. Another fridge was being used which was not monitored for the whole month. On three occasions in July 2016, the fridge temperature was significantly out of range but there was no evidence of staff informing the pharmacist. On Northgate ward, staff recorded the fridge temperature as significantly high for a four-month period with no action taken. The trust could not be sure that medicines were stored appropriately to ensure their quality and efficacy.
- We found clinical pharmacists were involved in patients' individual medicine requirements, including involvement in multi-disciplinary meetings.
- When patients were allergic to any medicine, staff recorded it on the patients prescription chart.
- On Churchill ward, the legal status of the patient was not recorded on all charts, so staff were unable to verify legal status when administering medication.
- Staff checked emergency medication and equipment was in date and stored correctly.
- The seclusion room used by Poppy and Avocet ward had a telephone with a cord used to communicate with patients in the room. When the patient is stepping down from seclusion, the patient may access the wider suite area. Therefore, the cord posed a risk to patient safety as it could be used as a ligature. Staff were aware of this risk and had asked for the phone to be removed and an alternative two way communication system to be installed. Avocet seclusion did not have a clock, the toilet and washbasin were adjacent to the seclusion room. Poppy seclusion area had a clock but the wrong time was showing.
- We observed wards were clean and staff displayed cleaning schedules. Patients reported that wards were clean and comfortable.

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- The latest patient led assessment of the care environment audit (PLACE) showed an average of 99.5% across the acute and psychiatric intensive care unit wards for cleanliness. The trust scored higher than the England average for 2015, which was 98%.
- All wards had completed comprehensive environmental risk assessments.
- There was not a consistent approach to the use of call bells. Some wards had call bells in certain areas such as the toilet and bathroom areas. Most wards did not have call bells in the bedrooms. Poppy ward had two rooms with call bells but staff had turned them off. Staff told us that they only turned them on if there was a need or a patient with mobility difficulties was on the ward.

Safe staffing

- The trust told us recruitment to vacant positions was ongoing. The trust reported difficulties in recruiting into vacant positions for qualified nurses. Ward managers all declared between six and eight vacant qualified positions on all wards during inspection.
- Between 1 January 2016 and 31 March 2016 there were 3710 shifts filled with bank or agency staff and 657 unfilled shifts across all acute wards.
- The trust demonstrated extensive efforts to recruit staff. Each ward also used regular agency and bank nurses to mitigate the risk. There was evidence of these staff receiving mandatory training, however not all could access the electronic records system. This was a risk to patient safety as we could not be assured all information contained in the notes reflected events on the ward. Record keeping across the wards was inconsistent and an inability to recruit to vacancies could be a factor. Staff shortages were reflected on the trust risk register.
- Five wards had a qualified nurse fill rate of less than the trust target of 90%. Figures ranged from 76% to 85%.
- Two regular agency staff we interviewed had not received prevention and management of aggression training, although there was sufficiently trained staff on duty during inspection.
- All ward managers reported they were able to request extra staff when required. However, managers were not able to cover all the shifts with bank and agency, which meant there was not sufficient staff on all shifts.
- All wards displayed staffing figures on the ward each day so staff and patients could see the staffing levels and skill mix.
- There was significant use of bank and agency on all wards. Most wards had a system in place to ensure that the bank and agency staff received an appropriate handover, which included use of alarms, risks and knowledge of their environment. Churchill ward in particular were able to demonstrate an effective system of informing staff of ligature points. This was of particular importance due to the number of ligature points on this ward.
- Staff and patients confirmed that staff had cancelled patient's escorted leave at times due to staff shortage. However, the trust does not routinely collect data on this so we relied on staff and patient reports.
- We observed staff handovers and found them to be comprehensive.
- Bank, agency and regular staff were required to undertake prevention and management of aggression training. However, training figures show that not all wards were meeting the trust target of 80%. This creates a risk of there being insufficiently trained staff on duty to carry out approved interventions.
- Explanation given by ward managers for seclusion reviews not taking place within the trust policy timeframe was because during out of hours, there was not always adequate medical cover to respond immediately. In Norfolk the doctors out of hours covered a wide geographical area so may be some distance from the required site. Staff were able to contact doctors at all times for advice and guidance.
- The trust required staff to complete mandatory training. Figures received from the ward managers regarding completion varied from ward to ward. Immediate Life Support completion figures ranged from 32% in Great Yarmouth and Waveney (GYW) ward with the highest completion rate being just 69%. The average

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compliance was 80% for the wards as an overall figure. Failure of staff to complete mandatory training meant that not all staff had the required skills to carry out their role safely.

Assessing and managing risk to patients and staff

- The trust provided data for between 1 October 2015 and 31 March 2016, which confirmed there were 125 episodes of seclusion across the acute adult in patient wards. The trust reported four incidents of long-term segregation.
- There were 78 occasions when staff had used rapid tranquilisation in the acute wards between 1 October 2015 and 31 March 2016.
- The trust supplied data that showed between 1 October 2015 and 31 March 2016. There were 434 incidents of restraint. One hundred and thirty four resulted in the use of prone restraint. The highest use of restraint was recorded on Thurne ward with 76 incidents, 22 of which were in the prone (face down) position. The Department of Health guidelines, Positive and Proactive Care (2015) placed particular emphasis on the reduction of the use of prone restraint. The trust has implemented new training for staff in order to reduce the number of prone restraints used on the wards. Data provided by the trust show that 42% of all restraints result in a prone restraint.
- All ward staff interviewed stated that a debrief following an incident was carried out for staff, but not for the patient. There was no documented evidence of either debriefing.
- Staff completed risk assessments for patients on admission, although staff did not routinely update them. The risk assessments were not accurate in many records we reviewed across the wards and did not reflect all the patients' risks. Four records on Churchill did not reflect all the risks and the incidents that had occurred during admission, Waveney ward risk assessment was incomplete on four records reviewed. Glaven, Poppy and Northgate also had at least one patient risk assessment incomplete. Staff did not always add incidents that occurred during admission to the risk assessment and staff did not report all events on the incident reporting system, known as Datix.
- There were standardised care plans in place regarding the use of least restrictive practice and no personal views were reflected. On Waveney ward, three care plans included a seclusion plan or consideration for transfer to a PICU when this was not clinically indicated. Those care plans were inaccurate.
- Staff used rapid tranquilisation on 78 occasions between 1 October 2015 and 31 March 2016. We noted during the inspection that staff did not consistently complete physical health monitoring after administration of rapid tranquilisation and sometimes there were no entries by staff of any effort to carry out these observations. It is important to monitor physical health following rapid tranquilisation due to the increased risk of adverse reaction and potential requirement for medical intervention. Failure to carry out observations can put the patients' health at risk.
- A policy covering rapid tranquilisation, which included up to date NICE guidance, was available on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. However, we found that staff did not always document the monitoring of patients physical health post-rapid tranquilisation on all wards and we saw that staff did not always report the incident using the incident reporting system as stated in the Trust's policy. The Trust used this data to monitor its' use of Rapid Tranquilisation as it did not carry out a specific audit, this would result in an under reporting of its use.
- Seclusion is defined as "the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others". There were seclusion rooms based in Wedgwood House, Woodlands and Hellesdon for acute in-patient services. Seclusions rooms based in the PICU at Hellesdon and Woodlands could be accessed by the acute wards. Churchill ward did not have a dedicated seclusion room. This was an isolated ward with no other in-patient wards nearby. Staff said that when seclusion was required, they would attempt to de-escalate using the garden, occasionally the patient bedroom or the S136 suite. There were no seclusion records for one patient who had used the S136 suite despite evidence in the notes that it was used for this purpose.
- Great Yarmouth and Waveney also had no seclusion room and staff reported using bedrooms where

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necessary. If a patient required seclusion on Northgate ward, staff had to support the patient to the seclusion room downstairs on Southgate. This involved the use of a lift, and a walk through the female bedroom area.

- We noted that staff poorly documented seclusion records and events. The electronic record system did not support seamless records and it was difficult to navigate the system. Staff were unable to find information, and we spent a disproportionate length of time trying to ascertain if the patients received appropriate care. We noted that doctors did not always write entries when reviewing patients, there were missing times of when seclusion ended, and terminology such as 'open' seclusion was used. It was not always clear when seclusion became long-term segregation. It was not possible to confirm if staff regularly offered food and fluids to patients during seclusion, as staff did not routinely record this.
- The trust had policies and procedures in place for the use of observations and staff were familiar with this process.
- Staff understood and followed the safeguarding systems across all the wards. All staff interviewed could identify what safeguarding was and what to do in the event of a concern. There was evidence of safe reporting and actions taken on all wards.
- Medicines were stored securely and staff completed monthly audits for safe storage.
- Access to medicines was good and medicines for discharge were available.
- Controlled drugs are drugs that require additional controls because of their potential for abuse. The Standards for Medicines Management by the Nursing and Midwifery Council states 'It is recommended that for the administration of controlled drugs a secondary signatory is required within secondary care'. On Thurne ward, staff incorrectly crossed through six of the nine incorrect entries. A second member of staff did not countersign records for crossing through errors of controlled drugs on these occasions. On Northgate, there were four incorrect crossings out. Controlled drugs are medicines that require additional controls because of their potential for abuse.
- The Trust was non-compliant with national controlled drug legislation when ordering controlled drug medication from another trust at Northgate and Southgate wards.
- We saw appropriate arrangements in place for recording the administration of medicines. These records were clear and completed, except at the Woodlands Unit where we found gaps in staff signatures on five occasions on Avocet ward. These records were unable to show that patients were getting their medicines when they needed them.
- There was no evidence of review of 'as required' (PRN) medication if being used for more than 7 days on Glaven and Thurne for one patient on each ward. At the time of inspection PRN medication had not been reviewed for 14 days.
- There were notices on the ward walls and doors confirming the ability for informal patients to leave the ward. An informal patient is someone who has not been detained under the Mental Health Act and has the right to free access to and from the ward.
- There were effective safeguarding systems in place. Staff demonstrated awareness, knowledge and understanding of the safeguarding process.
- There were safe procedures in place for children that visited the ward.

Track record on safety

- Trust information stated that there were 25 serious incidents reported from the acute and PICU wards for the period 26 May 2015 to 18 May 2016. Eleven were still under review.
- The trust had implemented measures to ensure lessons were learned on the wards and these were documented in staff meetings.
- There were five in-patient deaths on the acute wards between July 2015 and February 2016. These had all been investigated.

Reporting incidents and learning from when things go wrong

- Staff described the electronic system used to report incidents (Datix) and their role in the reporting process. Each ward had access to the online electronic system.

All ward staff were able to use the system. However, from review of care records, it was clear that staff did not record all incidents. We noted incidents in the progress notes that staff did not report as a Datix. This meant that the trust did not have a true reflection of incidents on the wards and therefore were unable to monitor and act on incidents and trends that may develop using these criteria.

- The trust provided information to all wards regarding serious incident learning. Minutes of meetings demonstrated that incidents were reviewed and discussed.

Psychiatric Intensive Care Unit

Safe and clean environment

- It was clear that there had been significant efforts made by the trust to address ligature risks on the wards.
- Both wards had comprehensive environmental ligature risk assessments. Lark ward did not identify a window in the female corridor as a ligature point on their ligature risk assessment. We told the ward manager of this risk.
- Entrance onto Lark ward was via a double air lock as required by NAPICU (National Association of Psychiatric Care Unit) standards. Each door should be closed before the next door is opened to reduce the risk of a patient leaving the ward without authority. However, it was possible to have both doors open at the same time on Lark ward.
- Both PICU wards were mixed sex. They did comply with standards to ensure separation of male and females in bedrooms areas, bathing facilities and separate female only lounges. However on Lark ward, if the enhanced care area was occupied, patients were unable to use the female only lounge, nor could they access the only bath on the ward. All bedrooms had an en-suite shower and toilet.
- There was a system where patients held swipe cards to access their own male or female corridors to reduce the risk of patients accessing the wrong corridors.
- Clinic rooms were clean and tidy.
- Controlled drugs are drugs that require additional controls because of their potential for abuse. The Standards for Medicines Management by the nursing and Midwifery Council states 'It is recommended that for the administration of Controlled Drugs a secondary signatory is required within secondary care'. Both wards adhered to this standard.
- The seclusion room used by Lark ward had a telephone with a cord used to communicate with patients in the room. When the patient steps down from seclusion, the patient may access the wider suite area. Therefore, the cord posed a risk to patient safety as it could be used as a ligature. Staff knew of this risk and had asked for the phone to be removed and an alternative two-way communication system to be installed. Maintenance staff had not carried out this work at the time of inspection.
- Rollesby ward had two seclusion rooms. One did not have toilet facilities within the seclusion suite. This meant that if a patient needed to use the room, staff had to provide disposable products for patients to use. There was no two-way intercom in this room also. Patients and staff had to shout through the door to communicate. As there were two seclusion rooms, patients used this room less frequently and only if the other room was in use.
- We observed both wards were clean, with the exception of the seclusion room area on Lark ward. This we observed to be dirty and we informed staff of this. Patients reported that wards were clean and comfortable.
- The latest patient led assessment of the care environment audit (PLACE) showed an average of 99.5% across the acute and psychiatric intensive care unit wards for cleanliness. The trust scored higher than the England average for 2015, which was 98%.
- Both wards had completed comprehensive environmental risk assessments. Staff had identified items as requiring removal in January 2016. These items had not been removed at the time of the inspection.

Safe staffing

- The trust told us recruitment to vacant positions was ongoing. The trust reported difficulties in recruiting into vacant positions for qualified nurses. Both PICU ward managers declared fewer vacancies than the acute wards. Some vacancies had recently been filled and were waiting for staff to start in post. Lark ward had a

high level of sickness, acuity of patients and observation levels that could mean extra staff were required. However, there were times where shifts were not filled. Lark ward staffing issues was on the trust risk register.

- Between 1 January 2016 and 31 March 2016 there were 624 shifts filled with bank or agency staff and 65 unfilled shifts across all acute wards.
- The trust demonstrated extensive efforts to recruit staff. Both wards also used regular agency and bank nurses to mitigate the risk. There was evidence of these staff receiving mandatory training, however not all staff could access the electronic records system. This was a risk to patient safety, as we could not be assured all information contained in the notes reflected events on the ward.
- Both ward managers reported they were able to request extra staff when required.
- The two wards provided staffing for the S136 suite. Rollesby ward manager explained that extra staff were provided to support this function. The manager on Lark was less clear regarding funding to manage the S136 suite and reported no extra staff to deliver this function.
- There was significant use of bank and agency on all wards. Lark ward manager was not able to provide evidence of agency induction onto the ward.
- We observed staff handovers and found them to be comprehensive.
- Lark ward had an effective multidisciplinary meeting every morning.
- Bank and agency staff were required to undertake prevention and management of aggression training. Regular staff were mandated to do this. However, training figures show that Lark ward compliance was only 68% whilst Rollesby was 94%. Lark training figures were significantly lower than is safe for a PICU ward where levels of aggression might be higher than the acute wards. This creates a risk of staff being insufficiently trained to carry out approved interventions.
- Ward managers explained that seclusion reviews were not consistently taking place within the trust policy timeframe due to inadequate out of hours medical cover being available to respond immediately. In Norfolk, the out of hours doctor covered a wide geographical area. However, staff were able to contact doctors at all times for advice and guidance.
- The trust required staff to complete mandatory training. Figures received from the ward managers regarding completion varied between the two wards. Immediate Life Support completion figures were 2.5% for Lark and 53% for Rollesby. Overall, training compliance was lower on Lark ward overall at 68% compared with 80% on Rollesby. Failure of staff to complete mandatory training meant that not all staff had the required skills to carry out their role safely.
- There were safe procedures in place for children that visited the ward.

Assessing and managing risk to patients and staff

- The trust provided data for between 1 October 2015 and 31 March 2016, which confirmed there were 120 episodes of seclusion across PICU wards. The trust reported five episodes of long-term segregation.
- There were 75 occasions when staff had used rapid tranquilisation between 1 October 2015 and 31 March 2016.
- We reviewed 11 sets of care records during inspection.
- The trust supplied data which showed between 1 October 2015 and 31 March 2016, there were 281 incidents of restraint. One hundred and forty three resulted in the use of prone restraint. The highest use of restraint was recorded on Rollesby ward with167 incidents, 96 of which were in the prone (face down) position. Lark ward figures were significantly lower with 114 restraints, of which 47 were prone. The Department of Health guidelines, Positive and Proactive Care (2015) placed particular emphasis on the reduction of the use of prone restraint. The trust has implemented new training for staff in order to reduce the number of prone restraints used on the wards.
- Staff completed risk assessments for patients on admission. Staff did not always update the risk assessments. The risk assessments were not accurate in three records on Lark and one on Rollesby ward. Staff did not always add incidents that occurred during admission to the risk assessment, and staff did not

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report all events on the incident reporting system, known as Datix. One patient on Lark had an identified risk that was not reflected in the care plan. Staff confirmed this was an omission.

- Staff used rapid tranquilisation on 75 occasions following prone restraint between 1 October 2015 and 31 March 2016. We noted during the inspection, that staff did not carry out physical health monitoring consistently and sometimes there were no entries of staff recording observations and attempts to carry out observations. It is important to monitor physical health following rapid tranquilisation due to the increased risk of adverse reaction and potential requirement for medical intervention. Failure to carry out observations can put the patients' health at risk.
- A policy covering rapid tranquilisation, which included up to date National Institute for Excellence (NICE) guidance, was available on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. However, we found that staff did not always document the monitoring of patients vital signs post rapid tranquilisation on all wards and we saw that staff did not always report the incident using the incident reporting system as stated in the Trust's policy. The Trust used this data to monitor its' use of Rapid Tranquilisation as it did not carry out a specific audit, this would result in an under reporting of its use.
- Seclusion is defined as "the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others". There were seclusion rooms based in both PICU wards. Rollesby had two and Lark one.
- We noted that staff poorly documented seclusion records and events. The electronic record system did not support seamless records and it was difficult to navigate the system. Staff were unable to find information, and we spent a disproportionate length of time trying to ascertain if the patient received appropriate care. On both wards, we noted that doctors did not always write entries in the appropriate section of the system but used the continuous records to record events. There were missing times of when seclusion started or ended, and staff used terminology such as 'open' seclusion. It was not always clear when seclusion became long-term segregation. Seclusion care plans did not demonstrate a comprehensive seamless account of the patients' time in seclusion. It was not possible to confirm if staff regularly offered food and fluids to patients during seclusion, as staff did not routinely record this.
- On Lark ward we observed a risk identified in the risk assessment which was not reflected in the patient's plan of care in seclusion. This may have had a significant impact on the patient's physical health and wellbeing.
- One patient set of records on Lark ward showed that the doctor did not complete a review within one hour of initiating seclusion as per policy. There was evidence of doctor reviews not happening at the correct times following initial review on both wards, as outlined in the trust policy.
- The trust had policies and procedures in place for use of observation and staff were familiar with this process.
- There were effective safeguarding systems in place. Staff demonstrated awareness, knowledge and understanding of the safeguarding process.
- The trust had processes for the storage, recording and administering of medication
- We found clinical pharmacists were involved in patients' individual medicine requirements, including involvement in multi-disciplinary meetings.
- When patients were allergic to any medicine, staff recorded it on the patients prescription chart.
- Medicines were stored securely and staff completed monthly audits for safe storage.
- Staff carried out regular checks on emergency equipment to ensure it was safe for use at any time.
- Medicines were stored securely and within safe temperature ranges. Staff regularly carried out audits to ensure safe storage.
- We saw appropriate arrangements in place for recording the administration of medicines. These records were clear, however, we found a number of missed medication doses on Lark Ward. One patient on Lark ward had 19 gaps of signature on one chart. These records were unable to show that patients were getting their medicines when they needed them.

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- There was no evidence of local audit for the administration and monitoring of rapid tranquilisation medication.
- There was no evidence of review of 'as required' (PRN) medication being reviewed if used for more than 7 days on Lark ward.
- Staff documentation of when as required medication was given to patients and its efficacy was not recorded on several occasions. There were occasions when staff administered as required medication and there was no evidence of the reason in the continuous notes or the entry was incomplete. On Lark ward not all incidents in continuous notes were recorded on the incident reporting system (Datix), nor added to the risk assessment.
- There were safe procedures in place for children that visited the ward.

Track record on safety

- Trust information stated that there were 25 serious incidents reported from the acute and PICU wards for the period 26 May 2015 to 18 May 2016. Eleven were still under review. There were no separate figures provided for PICU wards only.
- The trust have implemented measures to ensure lessons were learned on the wards and these are documented in staff meetings.

Reporting incidents and learning from when things go wrong

- Staff described the electronic system used to report incidents (Datix) and their role in the reporting process. Each ward had access to the online electronic system. All ward staff were able to use the system. However, from review of care records, it was clear that staff did not record all incidents. We noted incidents in the continuous notes that staff did not report as a Datix. This meant that the trust did not have a true reflection of incidents on the wards and were unable to monitor accurately and act on incidents and trends that may develop using these criteria.
- All ward staff interviewed stated that a debrief following an incident was carried out for staff, but not for the patient. There was no documented evidence of debriefing.
- The trust provided Information to the wards regarding serious incident learning and this was evident clearly on the wards.
- Minutes of meetings demonstrated that staff reviewed and discussed learning from incidents.

Are services effective?

Requires improvement

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

Our findings

Acute wards

Assessment of needs and planning of care

- Staff carried out comprehensive and timely assessments following admission to the ward.
- Staff completed and recorded physical health examinations and assessments on admission.
- Many wards had access to a physical health nurse to support teams to ensure that staff supported patients to address their physical health needs.
- Staff monitored physical observations and physical health problems. Staff discussed physical health needs at weekly multi-disciplinary team meetings and physical health needs were reflected in care plans. However, staff did not apply this consistently in all care records reviewed.
- The quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs. Staff did not update care plans on all wards. Three care plans on Waveney referred to the patient as male when the patients were female.
- Three care plans were inaccurate stating consideration for a PICU bed or seclusion when this was not clinically indicated.
- Care plans were generic and did not always consider patient views.
- There was little evidence of patients being involved in the creation of care plans, with the exception of Poppy and Northgate who did evidence patient involvement. Most wards did not offer patients a copy of their care routinely with the exception of Poppy, Northgate and Southgate.
- Patient identifiable information was stored safely and securely.

Best practice in treatment and care

- Psychological therapy was available on all wards although this was only in the form of an initial assessment for wards in Hellesdon.
- Staff made referrals for assessment and treatment for physical healthcare needs to the local acute hospital.
- We reviewed the medication administration records of all patients. Medical staff prescribed medicines in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Prescription charts were clear and well documented with pharmacist interventions documented on the chart.
- There was no evidence of local audit for the administration and monitoring of rapid tranquilisation medication.
- Staff completed health of the nation outcome scales (HoNOS). Staff used HoNOS scores to allocate patients to pathways of care, known as 'clusters', based on groups of patients with similar diagnosis and individual needs.
- Staff participated in clinical audit on either a weekly or a monthly basis. We saw examples of audits for infection control, medication, and physical health checks.

Skilled staff to deliver care

- Ward staff consisted of nurses, psychiatrists, occupational therapists, health care support workers, activity co-ordinators, pharmacists and psychologists. This meant that patients had access to a variety of skills and experience for care and treatment.
- New staff underwent a formal induction period to teach them about the ward and trust policies.
- Staff were able to access specialised training.
- All new healthcare assistants were required to complete the new Care Certificate.
- Ward staff participation in supervision was not consistent. The ward manager and deputy ward managers supervised their junior colleagues. All wards reported difficulties in finding time to undertake this. Ward managers all kept local records that demonstrated staff received supervision but not as frequently as trust policy required. None of the wards met the trust standard of 10 supervisions in 12 months.
- Appraisalis a method by which the job performance of an employee is documented and evaluated. The trust provided data that showed wide variations between the wards of appraisal rates. The highest completion rate

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was Avocet ward with 82% completed in January 2016, the lowest was Waveney ward with just 28% completed at the same period. Evidence on all wards during inspection showed a compliance rate of around 80% or above with the exception of Churchill ward where the manager was unable to provide data, although confirmed appraisal rates were currently less than 30%.

Multi-disciplinary and inter-agency team work

- There was evidence of comprehensive handovers, multidisciplinary meetings and bed management meetings.
- Staff held ward reviews, which included nurses, patients, psychiatrists and carers. Occasionally pharmacists and occupational therapists, discharge team staff members and physical health nurses were invited as appropriate. There was little evidence of care coordinators attending reviews. Families did not always get the opportunity to attend due to the short notice of some reviews.
- We observed detailed handovers between shifts.
- Occupational therapists, discharge teams, physical health nurses and psychologists worked across all wards. We saw that they worked effectively with patients and the multi-disciplinary team, community teams and crisis teams.

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

- The trust provided Mental Capacity Act (MCA) training combined with Mental Health Act (MHA) training. The lowest completion of training was 55% on Northgate ward and the highest on Poppy ward, at 89%. The figures demonstrated a wide variance in meeting this requirement.
- We observed all MHA detention papers were completed correctly, up to date and stored appropriately.
- Medical staff completed consent to treatment and capacity requirements on the form. However the continuous notes did not always record decisions or demonstrate how a decision was reached. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA.
- One patient on Glaven ward had no second opinion approved doctor (SOAD) referral or T3 and the patient was having covert medication. There was no evidence of staff referring the patient to a tribunal.
- Staff informed all patients detained under the Mental Health Act (MHA) of their S132 rights on admission. However, on Waveney ward, one patient had refused rights and staff had not attempted to repeat them.
- All Section 17 forms reviewed were up to date. It was not always clear when staff offered patients a copy of the paperwork. Section 17 paperwork describes leave arrangements for patients completed by the consultant psychiatrist in charge of the patient's care. Providers have a legal obligation to ensure patients know their rights. Staff must offer patients a copy of the form. Staff must tick the form and a patient must be given the opportunity to sign the form.
- There was information on the wards informing patients on how to access advocacy services. Care records showed patients were using the advocacy service.
- All records reviewed demonstrated that staff informed patients of their right to an Independent Mental Health Advocate under S132 rights.

Good practice in applying the Mental Capacity Act

- Deprivations of Liberty Safeguards (DoLS) training figures completion ranged from 57% on Thurne ward to 100% on Northgate ward Northgate ward was the only ward to meet the requirement for DoLS training completion.
- Staff interviewed were able to demonstrate knowledge of the principles of the mental capacity act 2005 to varying degrees.
- We saw evidence of some capacity assessment outcomes in the patients' contemporaneous notes, however these were hard to find. There was no rationale in continuous records as to how the staff reached a decision on the capacity of the patient.
- The electronic record system did have a small section to record the outcome of a capacity assessment but it did not allow staff to record how the decision was reached. Not all wards were aware of this. Where a patient was not deemed to have capacity, there was no record of the

Are services effective?

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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.

best interest decision, evidence of review, or specifically what the decision was about. Staff recorded that one patient was deemed to have fluctuation capacity, but there was no plan to manage this.

- Staff had varying degrees of knowledge about Deprivation of Liberty Safeguards (DoLS). Between 1 July 2015 and 31 March 2016, three applications for DoLS had been made on the acute wards.
- Patients had access to advocacy services and patients could self-refer, or staff would refer on their behalf. Advocacy services visited the ward weekly and there were phone numbers and information displayed on all the wards explaining the services and contact details.

Psychiatric Intensive Care Unit

Assessment of needs and planning of care

- Staff carried out comprehensive and timely assessments following admission to the ward.
- Staff completed and recorded physical health examinations and assessments on admission or updated these if the patient had transferred from another ward.
- Staff ensured that they assessed the physical health needs of the patient and followed up as appropriate. One exception was a patient on Lark who did not have a care plan goal relating to one of the identified needs in their risk assessment.
- Staff monitored physical observations and physical health problems. Staff discussed physical health needs at weekly multi-disciplinary team meetings and staff documented physical health goals in care plans. However, staff did not apply this consistently in all care records reviewed.
- The quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs. There was evidence of care plans not reflecting all identified risks on Lark ward.
- Care plan goals relating to the use of least restrictive practice were not personalised in the majority of care plans. There were standardised care plans in place regarding using least restrictive means.
- Of the 12 care plans reviewed, eight did not reflect the patient involvement or view.
- Staff documented seclusion care plans poorly. The electronic records system did not support staff accessing information and staff had different interpretation of where to add information on the system.
- Patient identifiable information was stored safely and securely.

Best practice in treatment and care

- We reviewed the medication administration records of all patients. Medical staff prescribed medicines in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Prescription charts were clear and well documented with pharmacist interventions documented on the chart.
- Psychological therapy was available on both wards although this was only in the form of initial assessment for Rollesby ward. Lark ward also had access to a complimentary therapist.
- Staff made referrals for assessment and treatment for physical healthcare needs to the local acute hospital.
- On Lark ward a patients nutrition and hydration needs were not recorded and monitored in the patients care plan and there was no evidence of this being monitored.
- Staff participated in clinical audit on either a weekly or a monthly basis. Staff completed health of the nation outcome scales (HoNOS). Staff used HoNOS scores to allocate patients to pathways of care, known as 'clusters', based on groups of patients with similar diagnosis and individual needs.

Skilled staff to deliver care

- Ward staff consisted of nurses, psychiatrists, occupational therapists, health care support workers, activity co-ordinators, pharmacists, physical health nurses, a discharge team and psychologists. This meant that patients had access to a variety of skills and experience for care and treatment.
- New staff underwent a formal induction period to teach them about the ward and trust policies.
- Staff underwent a formal induction period to teach them about the ward and trust policies.

Are services effective?

Requires improvement

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

- Staff were able to access specialised training
- All new healthcare assistants were required to complete the new Care Certificate.
- Ward staff participation in supervision was not consistent. The ward manager and deputy ward managers supervised their junior colleagues. All wards reported difficulties in finding time to undertake this. Neither of the wards met the trust standard of 10 supervisions in 12 months. Lark supervision records showed some staff had received two supervision sessions or less in six months.
- An appraisal is a method by which the job performance of an employee is documented and evaluated. The trust provided data which showed wide variations between the wards of appraisal rates. Rollesby ward's completion rate in January 2016 was 85% whereas Lark ward was significantly lower at 58%.

Multi-disciplinary and inter-agency work

- There was evidence of comprehensive handovers, multidisciplinary meetings and bed management meetings. Lark ward bed occupancy was 67% and Rollesby 95% for the period between 1 October 2015 and 31 March 2016. There were beds available on both wards during the inspection.
- Staff held ward reviews, which included nurses, patients, psychiatrists and carers. Pharmacists and occupational therapists, discharge team and physical health nurses were invited as appropriate. There was little evidence of care coordinators attending reviews. Families did not always get the opportunity to attend due to the short notice of some reviews.
- Occupational therapists, discharge teams, physical health nurses and psychologists worked in both wards. We saw that they worked effectively with patients.

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

- Mental Health Act (MHA) training completion figures for Rollesby ward were 71% and 53% for Lark ward. The figures demonstrated a wide variance in meeting this requirement.
- We observed all MHA detention papers were completed correctly, up to date and stored appropriately.
- Medical staff completed consent to treatment and capacity requirements on the form. However, the continuous notes did not always record decisions or demonstrate how a decision was reached. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA.
- Staff read patients their rights as per S132 reading of rights criteria.
- All Section 17 forms reviewed were up to date. It was not always clear when staff offered patients a copy of the paperwork. Section 17 paperwork describes leave arrangements for patients completed by the consultant psychiatrist in charge of the patient's care. Providers have a legal obligation to ensure patients know their rights. Staff must offer patients a copy of the form. Staff must tick the form and a patient must be given the opportunity to sign the form.
- There was information on the wards informing patients on how to access advocacy services. Care records showed patients were using the advocacy service.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act (MCA) training completion figures for both Rollesby and Lark wards was 69%.
- Deprivations of Liberty Safeguards (DoLS) training figures for Rollesby ward were 79% and 65% for Lark ward. Both wards fell below the trust target.
- We saw capacity assessment outcomes in the patients' contemporaneous notes, however they were hard to find and not consistently reviewed. There was no rationale in continuous records as how the staff reached a decision.
- The electronic record system did have a small section to record the outcome of a capacity assessment, however, Lark ward were not aware of this.
- Staff had varying degrees of knowledge about Deprivation of Liberty Safeguards (DoLS). Between 1 July 2015 and 31 March 2016, no application for DoLS had been made on the PICU wards.

Are services effective?

Requires improvement

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

- Patients had access to advocacy services and patients could self-refer, or staff would refer on their behalf. Advocacy services visited the ward weekly and there were phone numbers and information displayed on all the wards explaining the services and contact details.

Good

Are services caring?

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

Our findings

Acute wards

Kindness, dignity, respect and support

- We spoke with 47 patients receiving care and treatment on the acute wards and observed how staff cared for patients. Patients told us staff were kind and compassionate. Patients called staff wonderful, respectful, warm and friendly in the majority of cases.
- We saw staff respond to patient needs, show discretion and respect. Patients told us staff knocked before entering their rooms.
- Staff were passionate and enthusiastic about providing care to patients. We observed positive and meaningful interactions between staff and patients.
- Many patients confirmed that on admission staff showed them around the ward and that staff gave them sufficient information about the ward.
- Three wards, Churchill, Glaven and Waveney, still had shared bedroom arrangements that patients viewed negatively.
- Patients on all wards reported that they had experience of staff cancelling Section 17 leave due to staff shortages.
- Patients said there were many activities on the wards but very little at weekends.
- Twelve patients said they had experienced violence towards them by another patient.

The involvement of people in the care that they receive

- Staff discussed patients' needs in their care planning meetings. We observed three reviews. The patients in these reviews were encouraged to express their view, were listened to and care agreed reflected their wishes. However, care plans contained little evidence of patient involvement with the care planning process. For example, of 59 care plans reviewed, 48 did not reflect the patient involvement or view. Care plans did not have advanced directives, and there was minimal crisis planning.
- Some patients signed their care plans and confirmed staff offered them a copy. However, patients and staff confirmed staff did not routinely offer patients a copy of their care plan. Patients on Waveney ward said they were not involved in their care plans and we observed that those asked were not in receipt of a copy.
- Patients said they had access to advocacy. Wards had posters on the wall to inform patients of advocacy services.
- Patients confirmed that family were involved in their care with consent.
- Family were not always able to attend reviews due to the lack of notice given. Nursing staff on Waveney organised and invited carers to reviews due to lack of administrative support. This added further pressure on the nursing team.
- Patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Carers had access to carer meetings in Hellesdon and the trust had implemented the Triangle of Care initiative to encourage carer involvement and provide support.
- Patients were actively involved in the running of the ward through a weekly community meeting. Staff recorded minutes of community meetings.
- We saw little evidence of advanced decisions in place in patients care plans.

Psychiatric Intensive Care Unit

Kindness, dignity, respect and support

- We spoke with four patients receiving care and treatment on the psychiatric intensive care units (PICU's) and observed how staff cared for patients. Patients told us staff were kind and compassionate. Five patients declined to speak to us.
- We observed staff interactions with patients. Staff responded to patient needs, showed discretion and respect. We observed good relationships between patients and staff on both wards. Patients told us staff knocked before entering their rooms, and we observed staff speaking positively with patients.

Good

Are services caring?

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

- Staff were passionate and enthusiastic about providing care to patients. We observed positive and meaningful interactions between staff and patients.
- Patients on both wards reported that they had experienced cancellation of Section 17 leave due to staff shortages.
- Patients said there were many activities on the wards but very little at weekends. In Lark ward there was also a complimentary therapist who was well received by patients.
- Two patients said they had experienced violence towards them by another patient.
- Patients called staff wonderful, respectful, warm and friendly in the majority of cases.
- Patients confirmed that family were involved in their care with consent.
- Family were not always able to attend reviews due to the lack of notice given.

The involvement of people in the care they receive

- We observed a multidisciplinary meeting that was held each morning on Lark ward. A member of our team observed the meeting, reported it was comprehensive, and had good use of specialist's skills in reviewing patients' current wellbeing.
- Staff discussed patients' needs in their care planning meetings. We observed one review where we saw the patient actively involved and was encouraged to express their view. However, care plan records contained little evidence of patient involvement with the care planning process. For example, care plans did not contain patients' views, nor were there clear crisis plans in several of the care plans reviewed. This was especially evident on Lark ward.
- We saw in patient records that some patients signed their care plans. However, patients and staff confirmed staff did not routinely offer patients a copy of their care plan.
- Patients said they had access to advocacy. Wards had posters on the wall to inform patients of advocacy services.
- Patients confirmed that staff invited patients to the multi-disciplinary reviews, along with their family where appropriate.
- Patients welcomed the variety of activities on the ward. This included, Tai Chi, circuit training, music, cooking, complimentary therapies. One patient on Lark ward wrote a play, which included staff and patient participation, which they performed on the ward one weekend.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Carers had access to carer meetings in Hellesdon and the trust had implemented the Triangle of Care initiative across all areas to encourage carer involvement and provide support.
- Both wards had patient community meetings, however, Lark ward's meeting was not held consistently. The ward manager told us that it could not always be held depending on the patient acuity.
- We did not see advance statements in place in patients care plans.

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

Acute wards

Access and discharge

- The trust provided data that showed bed occupancy was high on all wards. Trust figures between 1 October 2015 and 31 March 2016 demonstrated that all acute wards had high occupancy rates. Churchill ward had the highest occupancy of 113% and Southgate was significantly lower with an occupancy rate of 72%. During inspection, there were beds available on all wards with the exception of Waveney and Northgate. Waveney was using a leave bed to ensure patients could access the service.
- There were 14 patients placed out of area between 1 October 2015 and 31 March 2016. At the time of the inspection there were two patients placed outside of the Trust and 13 placed within the trust but not local to their home.
- One ward manager informed us that bed occupancy was always a challenge and at times they had to use beds that was categorised as a red leave bed (a bed were a patient has gone on leave but there was a high risk of early return to the ward). There was a risk that a patient may not return to the same ward following leave in these circumstances.
- Discharge teams had been introduced by the trust to facilitate a smooth discharge and reduce any delays occurring. One discharge team member was based on Waveney ward full time to support patients' safe discharge.
- Staff reported that the crisis team were able to support wards with early discharge arrangements to help with flow through and patient safety. We did not see evidence of this during inspection.
- Following discharge there was a system in place to contact patients to assess their welfare. The ward staff telephoned the patient 48 hours after discharge, and then, either the crisis resolution and home treatment team (CRHTT) or community teams, would visit within 7 days of discharge from the ward.
- The trust provided data that showed there were 23 delayed discharges between 1 October 2015 and 31 March 2016 and 219 readmissions for the same period. The highest readmission rate was in Great Yarmouth and Waveney Acute ward with 35 readmissions in that period.

The facilities promote recovery, comfort, dignity and confidentiality

- On Thurne ward, patients had to share one toilet and one bathroom for several weeks during a period of refurbishment.This was insufficient to meet demand. A second toilet was completed during inspection.
- Wards had a quiet area where patients could meet visitors.
- Patients could access a phone to make private calls, although many patients did have access to their own mobile phone.
- There were garden areas on all the wards that patient could access throughout the day and evening.
- Staff left the viewing panels on bedroom doors open on some wards. Patients were unable to close the panels on several of the wards. This affected patient privacy and dignity.
- Patients did not have keys to lock and unlock their bedroom doors on some wards. Others had a swipe card in place that staff gave to patients so they could lock and unlock their bedroom.
- The bedrooms did not have secure space for patients to lock valuables in their rooms. There was a locked cupboard on the wards where items could be handed to staff for safekeeping.
- Activities were available at weekends on the wards.

Meeting the needs of all people who use the service

- Wards had facilities to meet the needs of patients with disabilities, for example, assisted bathrooms.
- Patient information leaflets were visible on all wards and covered a range of subjects including local services, S132 rights, advocacy and how to complain. Staff confirmed these were available in different languages.
- Staff were able to access a translation service if required.

Are services responsive to people's needs?

Good

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

- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and patients gave examples of actions taken to meet these needs.
- Spiritual support was available to patients for a range of faiths. Information was visible on notice boards and patients used this service.

Listening to and learning from concerns and complaints

- There were 88 complaints across the acute in-patient wards in the 12 month period to 31 March 2016. Nine complaints were fully upheld, 25 were partially upheld and one was referred to the Ombudsman.
- All wards had information on how to complain displayed and there were leaflets which patients could access. Patients when asked during inspection said they knew how to complain.
- Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint. Staff confirmed they knew how to support patients to make a complaint.
- Ward managers told us they shared learning amongst their staff via staff meetings and communications.

Psychiatric Intensive Care Unit

Access and Discharge

- The trust provided data which showed bed occupancy was high on all wards. Trust figures between 1 October 2015 and 31 March 2016 demonstrated that Rollesby ward bed occupancy was 95%, with Lark occupancy lower at 67%. There were vacant beds on both wards during the inspection. Lark ward had four empty beds.
- There were no out of area patients accessing a PICU bed during the inspection.
- Rollesby ward occupancy was high and Hellesdon acute ward managers had confirmed that there were occasions when they had not been able to access a bed. This was anecdotal information, as there were no figures to support this statement.
- Discharge teams had been introduced by the trust to facilitate a smooth discharge and reduce any delays occurring. Both wards said they sometimes had delays in transferring patients back to the acute wards due to lack of beds. Again, we were unable to evidence these comments.
- The trust provided data that showed there were seven delayed discharges between 1 October 2015 and 31 March 2016 and two re-admissions for the same period.

The facilities promote recovery, comfort, dignity and confidentiality

- Both PICU wards were mixed sex. They both ensured systems were in place to ensure mixed sex guidance was implemented. The exception to this was on Lark ward at certain times. When the enhanced area suite was in use, female patients were unable to access the female only lounge and bath.
- Staff left the viewing panels on bedroom doors open on some wards. Patients were unable to close the panels on several of the wards. This affected patient privacy and dignity.
- Both PICU wards had a swipe card in place that staff gave to patients so they could lock and unlock their bedroom. Staff were able to configure the swipe card so that the doors to the bedroom areas could be locked and patients were given a swipe card to get to the appropriate corridor. This meant that only female patients could access their bedroom corridor and males could only access their corridor.
- The bedrooms did not have secure space for patients to lock valuables in their rooms. There was a cupboard where items can be handed to staff for safekeeping.
- There were no call bells on the PICU wards; staff used observations to ensure patient safety.
- Both wards had access to outdoor space. There was open access to the internal garden on Lark ward. Rollesby patients were able to access the garden under supervision.
- Wards had a quiet area where patients could meet visitors.

Are services responsive to people's needs?

Good

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

- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and patients gave examples of actions taken to meet these needs.

Meeting the needs of all people who use the service

- Wards had facilities to meet the needs of patients with disabilities, for example, assisted bathrooms.
- Patient information leaflets were visible on all wards and covered a range of subjects including local services, S132 rights, advocacy and how to complain.
- We saw there was a range of food choices provided in the menu that catered for patients' dietary, religious and cultural needs.
- Spiritual support was available to patients for a range of faiths. Information was visible on notice boards and patients used this service.

Listening to and learning from concerns and complaints

- There were 10 complaints across the psychiatric intensive care in the 12-month period to 31 March 2016. None of the complaints were fully upheld, three were partially upheld and no complaints were referred to the Ombudsman.
- Both wards had information on how to complain displayed, along with leaflets, which patients could access. Patients, when asked during the inspection, said they knew how to complain.
- Information about the complaints process was available on notice boards.Staff confirmed they knew how to support patients to make a complaint.
- Ward managers told us they shared learning amongst their staff via staff meetings and communications. We saw evidence of this in the meeting minutes.

Are services well-led?

Requires improvement

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

Our findings

Acute wards

Vision and values

- Staff we spoke with understood the trust's vision and values. There were posters on wards and in corridors with the vision and values displayed.
- Staff were able to tell us who the most senior managers in the trust were, and said they had visited the wards.

Good governance

- Mandatory training compliance was variable and in many instances did not meet trust requirement. Figures provided by the trust show five wards fell below 80% completion rate.
- Staff received supervision; however, this was not regular and consistent. All ward managers reported it was difficult to find time to support supervision.
- Staff received appraisals but figures provided by the trust showed that completion rates fell short of trust requirement.
- The trust used acuity tools to determine safe staffing levels. However, wards employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable to cover higher levels of patient need. There was a high reliance on the use of bank and agency staff and, on occasion, wards operated short of staff when bank or agency staff were not available.
- Staff participated in clinical audit and had access to clinical dashboards, which provided information about completion of clinical documentation such as care plans and risk assessments.
- Rapid tranquilisation audits did not routinely take place and we noted that there was poor monitoring of physical health following administration of rapid tranquilisation medication.
- While the trust had audited the seclusion process and records against policy seclusion records were patchy and records showed medical response outside of trust guidelines in some care records.
- There was evidence on all the wards of staff learning from incidents.
- The trust had procedures for raising safeguarding concerns for patients.
- The trust had procedures for implementing, recording, storing and auditing Mental Health Act paperwork.
- The trust had governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. However, whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and an unacceptable number of ligature risks remained on Churchill ward. The ligature risk assessments on Thurne and Waveney identified items to be removed in January 2016 yet the items had not been removed at the time of the inspection.
- The trust had developed reports to monitor performance. Ward managers were able to demonstrate knowledge and involvement in inputting and using the report. However, there remained areas that had not sufficiently improved since the inspection in 2014, specifically medication management, Churchill ward environment, seclusion documentation, number of prone restraints and staff supervision.

Leadership, morale and staff engagement

- Data provided by the trust showed that within the acute wards the sickness rate of permanent staff ranged from 1.5% on Southgate ward to 9% on Poppy ward.
- Staff knew how to raise concerns and most confirmed they would not be afraid to do so; however, some staff said they would not want to do so as they did not feel it would influence change.
- Clinical management systems had been put in place but were not yet well established. Some staff at Woodlands and Wedgwood told us middle management were rarely on site. There was a lack of understanding of the middle manager role by staff.
- The ward managers confirmed they felt supported by their managers and staff said they felt supported by their ward managers.
- Staff told us that the ward managers were highly visible on the wards, approachable and supportive. Teams were cohesive and enthusiastic. Staff told us that they felt part of a team and received support from each other.

Are services well-led?

Requires improvement

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

- Staff reported seeing Senior Trust board members visiting the wards and this was welcomed by staff.
- Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.
- The Occupational Therapist team at Hellesdon did not feel well supported and not everyone felt comfortable raising concerns.

Psychiatric Intensive Care Unit

Vision and Values

- Staff we spoke with were aware of the trust's vision and values. There were posters on wards and in corridors with the vision and values displayed.
- Staff were able to tell us who the most senior managers in the trust were, and said they had visited the wards.

Good governance

- Mandatory training compliance was variable and in many instances did not meet trust requirement. Figures provided by that Lark ward fell below 80% completion rate.
- Staff received supervision; however, this was not regular and consistent. Both managers reported it was difficult to find time to support supervision. Lark ward supervision showed many staff receiving two supervisions or less in the last six months.
- Staff received appraisals but figures provided by the trust showed that completion rates fell short of trust requirement on Lark ward at 58%. Rollesby completion rate was 85%.
- The trust used acuity tools to determine safe staffing levels. However, wards employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable to cover higher levels of patient need. There was a high reliance on the use of bank and agency staff and, on occasion, wards operated short of staff when bank or agency staff were not available. The trust measured staffing according to the number of staff required as the norm. However, when there was increased observation of patients requiring extra staff, staff reported this data was not captured as a shortfall in cover.
- Staff participated in clinical audit and had access to clinical dashboards, which provided information about completion of clinical documentation such as care plans and risk assessments. Lark ward did not carry out recent medication audits and we evidenced many gaps on prescription charts.
- Rapid tranquilisation audits did not routinely take place and we noted that there was poor monitoring of physical health following administration of rapid tranquilisation medication.
- While the trust had audited the seclusion process and records against policy seclusion records were patchy and records showed medical response outside of trust guidelines in some care records.
- The trust had procedures for raising safeguarding concerns for patients.
- The trust had procedures for implementing, recording, storing and auditing Mental Health Act paperwork.
- The trust had governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. There were windows on Lark ward that staff had not identified as a ligature risk, one particular window was in a low observation area in the female corridor.
- The trust had developed reports to monitor performance. Ward managers were able to demonstrate knowledge and involvement in inputting and using the report. However, there remained areas that had not sufficiently improved since the inspection in 2014, specifically medication management, seclusion documentation, number of prone restraints and staff supervision.

Leadership, morale and staff engagement

- Data provided by the trust showed that within the acute wards the sickness rate of permanent staff ranged from 5% on Rollesby ward to 9.5% on Lark ward.
- Staff knew how to raise concerns and most confirmed they would not be afraid to do so.
- Clinical management systems had been put in place but were not yet well established. Some staff at Woodlands told us middle management were rarely on site. There was a lack of understanding of the middle manager role by staff.

Are services well-led?

Requires improvement

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

- The ward managers confirmed they felt supported by their managers. Most staff felt supported by their ward manager.
- Staff told us that the ward managers were highly visible on the wards, approachable and supportive. Teams were cohesive and enthusiastic. Staff told us that they felt part of a team and received support from each other.
- Staff reported seeing Senior Trust board members visiting the wards and this was welcomed by staff.
- Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.

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 • Wards and courtyard areas had potential ligature points that had not been fully managed, mitigated or addressed. • Some ward gardens had poor lines of sight. Staff could not easily observe patients. • The trust had not ensured that all facilities used for seclusion were safe and appropriate and that seclusion was managed within the safeguards of the Mental Health Act Code of Practice. • Refrigerated medication was not consistently maintained at the correct temperatures. • Some incidents were not reported on the incident reporting system or updated on the risk assessments and care plans. • The trust did not comply with national controlled drug legislation when ordering controlled drugs from another trust. • Staff did not all follow policy and procedure in line with current legislation and guidance relating to the administration, monitoring and recording of rapid tranquilisation. **This was a breach of Regulation 12**

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 • Care plans did not reflect patient views and were not person centred.

This section is primarily information for the provider

Requirement notices

- Some care plans were inaccurate.

This was a breach of Regulation 9

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 • There was not a complete, accurate and contemporaneous plan of care in respect of each service user. • Seclusion and long term segregation records were inconsistently documented. **This was a breach of Regulation 17**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staff did not receive appropriate ongoing supervision • Staff did not consistently attend all mandatory training. • Not all staff had received training in the management of aggression. **This was a breach of Regulation 18**