South London and Maudsley NHS Foundation Trust

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

Quality Report

Maudsley Hospital, Denmark Hill, London SE5 8AZ
The Bethlem Royal Hospital, Monk Orchards Road, Beckenham BR3 3BX
Tel: 020 3228 6000
Website: www.slam.nhs.uk

Date of inspection visit: 18 - 19 May 2016
Date of publication: 19/08/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV504	Maudsley Hospital	Aubrey Lewis 3 ward	SE5 8AZ
RV505	The Bethlem Royal Hospital	Gresham 1 ward	BR3 3BX

This report describes our judgement of the quality of care provided within this core service by South London and Maudsley 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 South London and Maudsley Trust and these are brought together to inform our overall judgement of South London and Maudsley Trust.

Summary of findings

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We did not rate the trust on this inspection as it was a focussed inspection. We Focussed on three key areas out of the five that we can inspect.

During our inspection we found some areas of good practice as well as some which required improvement.

Areas of good practice included:

- Staff demonstrated a caring and positive attitude to both patients and visitors to the wards and showed an understanding and concern for their needs. They effectively monitored patients' physical health and responded appropriately to any concerns, making referrals for medical treatment when required.
- Staff took steps to involve the patients in the planning of their own care and treatment. On AL3, staff met individually with patients to discuss their preferences and goals. During meetings with patients on Gresham 1 staff encouraged patients to talk about how they felt about their treatment and to give their opinions regarding their care.
- Staff worked to ensure the safety of all those on both wards. They took steps to reduce the risks of any ligature points and closely monitored and recorded the behaviour of patients. Where patients became unwell staff demonstrated effective skills in reducing the risks of harm to themselves and others.
- The environment on both wards was generally clean and well maintained and clinic rooms were tidy and well managed.

  Areas where the trust was still making improvements after the previous inspection:

- On Gresham 1 some staff and patients expressed concerns that there were not always sufficient numbers of staff to keep the ward safe. The trust was working to recruit staff and there was more to do.
- Also, some risk assessments completed by staff lacked detail about the precise nature of the risks to each patient. The trust was working to improve the quality of the risk assessments.
- Staff did not always update care plans to reflect the changing needs of patients. Also, while staff on AL3 were recording patients' views and preferences regarding their care and treatment, the care plans written by staff were still often generic and contained little recovery planning or detail of patients' opinions or preferences. This was again an area where the trust was aiming to improve.

Areas for improvement were as follows:

- On Gresham 1 an alarm system on the ward to identify the location of any incident had not been working for many weeks, despite the fact that staff had repeatedly reported it broken.
- On AL3 patients were not able to close the windows on their bedroom doors and staff did not always remember to close them from the outside. This undermined patients' privacy and dignity. Work was taking place to address this.
- On AL3 the condition of many patients' rooms was poor and did not provide a sufficiently therapeutic environment. On Gresham 1 there were often no areas for patients to meet their advocate in private.
- There was also a cockroach infestation on AL3 that staff had not been able to successfully address.

Summary of findings

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

Are services safe?

We found that services on both wards were not always safe because:

- Not all staff on Gresham 1 had a personal alarm and the system on the ward that told staff where an alarm had been triggered was still not working after many weeks. This meant that staff did not know where a potential emergency was taking place.
- Two patients' risk assessments lacked important detail regarding how staff could keep those patients safe.
- There was an infestation of cockroaches on AL3. Pest-control officers had attended the ward to take steps to eradicate the problem and staff continued to monitor it.

However:

- Where the layout of the wards prevented staff from having direct lines of sight of patients they had taken steps to reduce the risks from this.
- Staff assessed ligature risks on the wards and took appropriate steps to reduce the risks from them. There were handles and taps in patients' rooms on AL3. The provider was mitigating these risks and also had an action plan in place to replace the handles and taps by the end of November 2016.
- Clinic rooms were clean and well maintained with all equipment and medicines checked regularly.
- Staff managed situations where patients became especially unwell in a manner that was safe and which supported the dignity of patients.
- Staff regularly monitored and recorded the behaviour of patients, and updated these observations after any incidents to support the safety of patients and staff.

Are services effective?

We found that services on both wards generally effective because:

- Staff regularly monitored the physical health of patients, and responded appropriately to any health concerns, including making referrals to external medical services for treatment, where necessary.
- Staff on AL3 had begun regularly meeting with patients to discuss and record their preferences and goals regarding their care and treatment.
- There was a wide range of trained and skilled professionals on both wards to meet theneeds of patients.
- Staff demonstrated good collaborative working to meet patients' needs.

Summary of findings

However:

- Staff did not always update care plans or record in them how staff intended to support their recovery.
- The care plans written by staff on AL3 contained little or no views of the patient.
- It was not always possible for patients on Gresham 1 ward to discuss their care and treatment with an independent advocate in a space that was private and supported their confidentiality.
- Staff on Gresham 1 ward gave medication to one patient detained for longer than three months that was not in accordance with the Mental Health Act regarding consent to treatment.

Are services caring?

We found that services on both wards were caring because:

- In the interactions we observed between staff and patients staff demonstrated a supportive and caring attitude.
- Staff encouraged patients to participate in their care and treatment during their clinical meetings.
- Patients had regular access to independent advocacy services to support them to raise issues on the wards.

However:

- On AL3 staff opened the viewing blinds on the doors of patients' rooms to check on their safety. However, staff then left most of them open for no stated reason. This significantly undermined patients' privacy and dignity.
- The condition of many patients' rooms on AL3 did not provide a sufficiently therapeutic environment for them.

Summary of findings

Information about the service

Aubrey Lewis 3 ward is a 19-bed adult male acute admission ward, located on the third floor of Aubrey Lewis House at Maudsley Hospital, for those aged 16-65, who have severe mental illness. It provides care for residents of the borough of Southwark.

Gresham 1 is an 18 bed adult female acute admission ward at The Bethlem Royal Hospital for those aged 16-65. It provides care for residents of the borough of Croydon. The ward is temporarily located on Fitzmary ward, while refurbishment is taking place at Gresham House.

We last inspected these services as part of a comprehensive inspection of South London and Maudsley NHS Foundation Trust in September 2015. During that inspection we found that the provider had breached some regulations regarding how they must deliver patients' care and treatment. We asked the provider to take steps to address this and the provider responded by putting action plans in place to do this. We noted during this inspection that some of the same breaches of regulations were still taking place, in relation to improving staffing levels, ensuring patients' care plans contained their views and were holistic and ensuring staff updated patients' risk assessments. However, the trust's action plans to address these matters were on going at the time of inspection, with dates for their completion due some time after our visit. The action plan to address staffing levels was due for completion at the end of June 2016, the plan in relation to care plans by the end of July 2016 and that relating to risk assessments at the end of September 2016. Therefore, because this work was on going and not yet completed we will check these areas again at our next inspection.

Our inspection team

The team was comprised of: two CQC inspectors and one Mental Health Act Reviewer.

Why we carried out this inspection

We carried out this focussed inspection in response to concerns raised during visits to Aubrey Lewis 3 ward (AL3) and Gresham 1 ward in March 2016 by a Mental Health Act reviewer.

On AL3 concerns included the poor attitude of some staff towards patients and whether staff were appropriately supporting their dignity and privacy. On Gresham 1 the reviewer's concerns included apparent staffing shortages and problems with alarms on the ward that could potentially affect the safety of staff and patients.

How we carried out this inspection

To fully understand the experience of people who use services we inspected, we asked the following three questions:

- Is it safe?
- Is it effective?
- Is it caring?

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

During the inspection visit, the inspection team:

- Spoke with two ward managers
- Spoke with 17 staff including one deputy ward manager, six nurses, six healthcare assistants, three doctors and an occupational therapist

Summary of findings

- Spoke with eight patients
- Spoke with one independent mental health advocate
- Looked at nine patient records, including their care plans and risk assessments
- Observed two staff handovers
- Looked at five staff supervision records

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

Some patients on both wards said that staff were caring and that the services they received were good.

However, two patients on AL3 were very unhappy about the cockroaches on the ward, saying that staff were not doing enough to remedy this situation and that it made the ward feel unclean. One of these patients was also unhappy about a large notice in their room relating to the legal liabilities of the trust. The patient did not like how the notice made them feel and also observed it was the only colour in an otherwise drab room. Two other patients on the ward said that their rooms were too cold and that the bedding staff gave them was insufficient, although staff did give them more when they asked for it. Another patient was unhappy that they had no shelves in their room that they could put their clothes on.

On Gresham 1 ward, three patients said that staff often seemed too busy to have any time for them. Another said that the continuous changing of staff made it difficult to know who was meant to be caring for patients.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all alarm systems are working.
- The provider must continue to look at how qualified staffing levels can improved on the wards.
- The provider must ensure that care plans are comprehensive, holistic, involve patients and are updated with current information during a patient's stay.
- The provider must ensure that individual patient risk assessments are comprehensively completed and updated during an inpatient's stay and that all risks are reflected.

Action the provider SHOULD take to improve

- The provider should ensure that patients' rooms provide a therapeutic and supportive environment and meet patients' needs.
- The provider should ensure that all necessary steps are taken to address the problems caused by infestations.
- The provider should ensure that staff always support patients' privacy and dignity by only opening panels on patients' doors for the purposes of supporting their safety, or where patients request for them to be open.
- The provider should ensure that private and confidential spaces are available on the wards for patients to meet an independent advocate.
- The provider should ensure that staff give treatment to patients who have been detained for longer than three months in strict accordance with section 58 of the Mental Health Act

South London and Maudsley 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
Aubrey Lewis 3 ward	Maudsley Hospital
Gresham 1 ward	The Bethlem Royal Hospital

Mental Health Act responsibilities

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

- Staff received mandatory training in the MHA and all staff had completed this at the time of our visit.
- In accordance with their legal right patients had access to an Independent Mental Health Advocate (IMHA) on the wards.
- Staff did not always properly complete records regarding patients' consent to treatment under the Act. As a result one patient on Gresham 1 ward received treatment that was not lawful.
- Staff did not always ensure that detained patients understood their legal rights.
- There was not always a private and confidential place on Gresham 1 ward for patients to meet an independent advocate.

Are services safe?

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

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

Our findings

Safe and clean environment

- The layout on the wards meant that staff did not always have direct lines of sight. However, staff had taken steps on both the wards to reduce the risk from this by placing mirrors at specific points so that allowed them to see into corners and areas where there were blind spots.
- Staff undertook regular assessments to identify any ligature risks on the ward so that steps could be taken to reduce those risks. For example, on Aubrey Lewis 3 ward (AL3) staff identified that window handles and taps in patients' rooms were a risk. Records showed that staff took steps to mitigate these risks. Where risk assessments identified that patients were at possible of harm from the ligature points staff undertook regular close observation of them to ensure their safety. The provider also had a plan in place to replace withy handles and taps that were ligature-free. This work was due to be completed in November 2016.
- All wards were compliant with the guidance on same sex accommodation.
- The clinic rooms on both wards were visibly clean and in good order, with all emergency equipment, including for resuscitation, and medicines up to date. Records showed that staff checked all medicines and equipment regularly. Fridges for storing medicines were all at the correct temperatures and staff made up to date checks of these temperatures. Emergency ligature cutters were located in the staff office as well as the clinic room and all staff knew their location.
- The wards did not have seclusion rooms. Where patients became particularly unwell staff used a combination of de-escalation techniques and close observation to manage the situation.
- The wards were visibly clean and well maintained and most furnishings in ward areas were in a good condition. At the time of both unannounced visits to each ward staff were cleaning all parts of the wards.
- Staff on both wards adhered to infection control principles. Hand washing facilities were available throughout the wards and information was posted on information boards regarding the importance of infection control. In one toilet on AL3 we found a sink that was blocked. When we pointed this out to staff they immediately reported it to hospital services responsible for maintenance. However, two patients on AL3 complained about the fact that they regularly saw cockroaches on the ward, especially at night in the dining room. They said that they did not think staff were doing enough to get rid of them as they had been seen on the ward for several weeks. It made them feel that the ward was not clean enough. When we last visited the ward in March 2016 patients had made the same complaint. We asked staff what they what doing to address this problem. They said that this was a problem throughout the entire hospital building. In response, pest control officers had attended the ward twice recently and had put in place measures to address the problem.
- Cleaning records on both wards were up to date.
- Staff on both the wards had personal alarms in order to request help when required. Rooms on all wards also had wall mounted alarms. Records showed that staff regularly tested all alarms to ensure they were functioning properly. All staff on Aubrey Lewis had a personal alarm and used an electronic pinpoint system which told them whereabouts on the ward an alarm had been pressed. However, on Gresham 1 not all staff had personal alarms. Staff had ordered more two months ago, but these had not yet arrived. Also the electronic pinpoint system was not working and had not been working for many weeks, including when a Mental Health Act reviewer had last visited the ward in March 2016. Staff said that they had reported this on several occasions to colleagues responsible for maintaining the building, but no repair had occurred. Staff said that if they needed to activate an alarm but did not have a personal one with them they used alarms located on the walls of the ward. Nevertheless, the insufficient number of personal alarms for staff and the faulty alarm system created a potential risk of harm to everyone on the ward.

Safe staffing

Are services safe?

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

- We looked at staffing levels on both wards because during our previous inspection inspectors found that staffing levels were not always sufficient to meet patients' needs. There were no staff vacancies on AL3 and on Gresham 1 ward there were three vacancies. This represented an improvement to the staffing level on Gresham 1 compared that at the time of the visit of the Mental Health Act Reviewer in March 2016. At that time there were nine vacancies.
- The shift pattern on both wards was divided into three equal shifts. AL3 the staffing level was three qualified nurses and one healthcare assistant (HCA) for the morning shift, three nurses and two HCAs for the afternoon shift and two nurses and two HCAs for the night time. On Gresham 1 the morning shift was covered by three nurses and three HCAs, the same level for the daytime and two qualified and three HCAs at night.
- Managers on both wards were able to request additional staff when required, for example in order to undertake close observations of patients.
- The wards covered staff absences by employing bank and agency staff. However, on Gresham 1 ward it was common for shifts to be unfilled because bank or agency staff were not available. Records showed that 17 shifts were unfilled in March, 10 in February and 13 in January. Staff were taking steps to address this problem, including pre-booking bank and agency in advance to ensure their availability. Also, one qualified nurse had recently begun working on the ward and another had just been recruited. There were very few unfilled shifts on AL3 during the same period.
- Two members of staff on Gresham 1 ward expressed their concerns about the staffing levels and the effect on the patients and staff. One said that patients did not get enough 1:1 time with their personal nurse and that staff were very overworked because of shortages. Another said that when shifts were unfilled the environment could become very challenging and that this had a negative effect on staff morale. Three patients commented that staff were usually very busy and seemed to have little time for them. We also spoke to the independent advocate on the ward who observed that staff often appeared quite stretched, particularly because many were frequently required to undertake close observations of patients who had become unwell. On AL3 ward two members of staff said that staffing levels could become insufficient if the ward was busy and the ward had the responsibility of responding to an alarm raised on an adjacent ward. Following the inspection of the whole trust in 2015 inspectors also found that some services did not always have enough staff to make them safe. In response to insufficient staffing levels the trust had put an action plan in place to provide safe staffing levels for all its services, to be completed by the end of June 2016.
- Staff on both wards said that there were usually enough staff to facilitate patients' leave and activities and patients confirmed this.

Assessing and managing risk to patients and staff

- The wards did not have seclusion rooms. Staff on both wards said when a patient became particularly unwell they first used de-escalation techniques to try and verbally calm them. If further steps were necessary to keep people safe staff put patients under close observation in their rooms until they had become calmer. Where staff did this they did not isolate patients in their rooms, but allowed them to enter the ward areas under close observation.
- We looked at risk assessments because at our previous inspection in 2015 we found that staff had not always completed them in sufficient detail or updated them. On this inspection we looked at a total of 10 risk assessments across both wards. Most patient records included a risk assessment that was written on or around the time of patients' admission to the ward. There was one exception to this. On Gresham 1 ward staff had only completed a risk assessment for one patient three weeks after their admission. Several risk assessments were very specific patients' needs, including potential risks to physical health. However, two assessments on AL3 were less detailed. One listed a series of incidents that a patient had been historically involved in, but said little about the triggers to those incidents or how to manage any heightened risk. The other assessment said that the way to manage the patient's risk was simply to ensure they stay on the ward. The provider had an action plan in place following our previous inspection to remedy the problems we found with risk assessments. This was due for completion at the end of June 2016.

Are services safe?

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

- Staff used recognised risk assessment tools to regularly assess the risks related to patients once they were on the wards. On AL3 staff used a new tool called a Dynamic Appraisal of Situational Aggression (DASA) score. This tool calculated a score for each patient between 0-7 to indicate the level of risk that they presented. The score was based on a variety of factors including verbal threats, negative attitudes, sensitivity to perceived provocation and any unwillingness to follow directions. Compliance with medication was also considered. Patients with scores above four were considered at high risk and would be considered for enhanced observations or a transfer to a psychiatric intensive care unit. This system enabled risk to be reviewed three times each day and ensure that all staff were aware of very up to date information about the risks patients were presenting. The tool had recently been introduced on the ward. One staff member commented that the system was useful but that it that it could give misleading scores. For example, a patient was considered at high risk because they refused certain treatment, even though they were an informal patient and had the right to refuse treatment.
- Blanket restrictions were in place on both wards. These were in response to risks that staff had identified. For example, staff banned the possession of certain items such as matches and lighters. Staff had also done this to ensure that the ward remained a smoking free area, in accordance with national legislation concerning the banning of smoking on hospital grounds. Patients said that staff explained the reasons why items were banned and they thought the restrictions were reasonable.
- Patients in hospital who were not detained under the Mental Health Act ('informal patients') were free to leave the wards. Staff on AL3 ward said that they asked new, informal patients on the ward to not go out for the first 72 hours so that staff could monitor their health, but also confirmed that they could leave during this period if they wished. One informal patient we spoke to said that they were happy with this arrangement and had agreed to stay on the ward. Staff gave informal patients information regarding their rights on Gresham 1 ward which was generally clear and legally correct. However, information that staff on AL3 gave informal patients concerning their rights was not strictly accurate as it suggested that patients needed to request leave from staff. When we pointed this out to staff they immediately changed the information.
- Staff on the wards followed trust procedures on observing patients and searching patients and patient bedrooms.
- Staff on both wards said that they physically restrained patients as little as possible and that the practice was to always first employ calming and de-escalation techniques when a patient became unwell. We observed staff on Gresham 1 engaging in this way on two separate occasions with two different patients. Both times staff responded to a patient who had become unwell using appropriate calming techniques.
- Staff on both wards demonstrated that they knew how to raise safeguarding alerts and procedures and systems were in place to ensure that staff could promptly respond to any reported safeguarding concerns.
- There were dedicated rooms outside the wards where patients could meet child family members.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- We looked at care planning on both wards because during our previous inspection inspectors found that these were not always sufficient to meet patients' needs.
- We reviewed nine care and treatment records of patients across both ward. These demonstrated that staff mostly completed prompt and detailed assessments of patients' needs upon admission.
- The records we looked at showed that staff conducted an initial physical health check of most patients upon admission. However, in one patient record on Gresham 1 ward there was no evidence of a physical staff conducting a physical examination of a patient when they arrived on the ward. Staff also checked the physical health of patients every day by undertaking standard observations such as blood pressure and heart rate. The wards used a National Early Warning Score (NEWS) system to monitor the physical health of patients. This system worked by staff allocating a score to a series of key of physical health measurements such as blood pressure. When a patient's score reached a given level this triggered immediate action from staff such as medical examination of the patient. Staff logged such scores as incidents.
- We reviewed nine care records of patients across both wards. All four care plans we reviewed on AL3 were generic and could have applied to any patient. For example, the goals in one patient's care plan included simple statements such as 'assess and stabilise mental state', 'reduce severity and impact of symptoms' and 'achieve optimal mental state.' There was very little evidence of patient involvement in the care plans that staff had written. The AL3 ward manager said that auditing had identified that the patients' preferences and wishes were not sufficiently recorded. To address this issue the manager had initiated a care planning group which took place after the weekly planning meeting with patients which discussed their activities for the week and other patient issues. The purpose of the group was for staff to sit down with patients to record their care planning wishes. Staff updated these plans every week. They included wishes for patients to do more physical exercise and take up studies. The manager said staff attempted, wherever possible, to meet these wishes. However, it was not clear how staff intended to use the two separate plans together to address patient care and treatment needs.
- On Gresham 1 staff had not updated the care plan of one patient for over four months and had not completed an updated care plan for a patient, instead using a care plan from the service they had previously attended.
- At the last inspection of the acute wards and psychiatric intensive care units in the trust, in September 2015, we identified that care plans were not always comprehensive and holistic and did not demonstrate the patient's involvement. In response to this the trust had put an action plan in place to improve the quality of care plans and ensure that patients were involved in planning their care. At the time of the current inspection we found continuing concerns in this area. The trust action plan was due to be completed by the end of July 2016.
- Staff stored patient information securely and this was accessible to most staff. However, some staff on a number of wards said that because agency staff did not always have access to the electronic record system used by the trust this could cause occasional difficulties. These arose when agency staff were not able to enter notes about patients on the system, or could not access patient records to look at their care plans or risk assessments. This required regular members of staff to perform those tasks instead. However, there were no reported incidents or records of harm to patients caused by this situation.

Best practice in treatment and care

- Staff on both wards were able to refer patients to see a psychologist if they identified a need and psychologists also undertook some group therapy on both of the wards. However, there was not a dedicated psychologist for each of the ward.
- Where necessary staff on both wards referred patients to external healthcare services for treatment including dentistry and chiropody.

Are services effective?

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 on all wards actively participated in clinical audits including safe storage of medication and environmental audits. Staff were also given individual areas to lead on to enable them to take ownership of an area and develop their skills in auditing.

Skilled staff to deliver care

- Staff on both wards had input from a wide range of professionals, including nurses, psychiatrists, occupational therapists and activity co-coordinators. Psychology sessions were available to the wards. All staff were suitably experienced and qualified to support the care and treatment of patients.
- All staff received an induction, which included observation of their practice and mandatory training.
- Staff on AL3 received regular supervision every four to six weeks and yearly appraisals. However, not all staff we spoke to on Gresham 1 had been receiving regular supervision. Two members of staff had not received any supervision for over two months. They said this was because the ward had not a manager for many weeks in the earlier part of the year. A new ward manager had recently been appointed. When we spoke to the new manager they said that the supervision responsibilities for supervisors on the ward had now been established following the recruitment of new staff and that regular, monthly supervision was going to begin shortly. One member of staff confirmed that they had met their new supervisor to agree a date in the next week for their supervision.

Multi-disciplinary and inter-agency team work

- We observed two handover meetings, one on each ward. Both meetings addressed the situation and needs of patients in detail. Staff updated each other regarding patients' status under the Mental Health Act, observation levels, patients' compliance with medication, their food intake, sleep and interactions. Staff discussed patients' activities and information was shared about what had happened on the previous shifts. Staff spoke about patients in a caring and considerate manner.

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

- All staff had completed mandatory training in the MHA and Codes of Practice.
- We reviewed seven patient records across both wards in respect of whether staff had correctly assessed and recorded patient's capacity to consent to treatment under the MHA. In most cases staff had done so. However, in the case of one patient on Gresham 1 ward their doctor had signed a certificate to say that they consented to treatment, even though there was no evidence that the doctor had discussed the matter with them, or had assessed their capacity to consent. This was in breach of the Codes of Practice that direct staff how to discharge their legal duties under the MHA. Moreover, the patient's notes specifically stated to the contrary, that they did not have capacity to consent to treatment. This meant that staff did not treat the patient in accordance with section 58 of the Act. This is because, under section 58, staff may only treat a patient after three months if the patient has capacity to consent and agrees to it, or a doctor decides that a patient either does not have the capacity to consent or is refusing to be treated, but it is still in their best interests to treat them. Neither of these circumstances applied to the patient.
- Most records we looked at showed that staff explained to patients their rights under the Mental Health Act, both upon admission as well as at intervals post admission to ensure that patients understood them. Where patients understood what staff had explained to them concerning their rights they signed a form to acknowledge this. However, one record of a patient on AL3 showed that staff had not explained their rights to them for over a month after admission. Moreover, at the time the patient's detention in hospital was renewed staff recorded that the patient did not have capacity to understand information about their rights. However, there was no evidence of staff attempting either to help the patient understand this information, or to give it to them again in the subsequent five weeks.
- Staff were able to access advice and guidance on issues relating to the MHA from the hospital MHA office.
- Independent advocates regularly visited the wards to meet with patients and staff referred patients to the advocacy service where they identified that patients would benefit from this support. However, on Gresham 1 ward there was little private and confidential space where patients could meet with the advocate. We spoke to the advocate on the ward who said that instead they

Are services effective?

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.

often had to meet patients in the corridor or the canteen, both of which were highly unsuitable as they were not sufficiently private. Sometimes a therapy room could be used, but this was not always available. A family room could also be used, but this was outside the ward and not always accessible for patients. The Codes of Practice to the MHA make clear that staff should ensure where patients wish to meet with an advocate they can do so in private. Staff explained that facilities for patients were limited by the fact that the ward was temporarily located while its original site was undergoing refurbishment. Staff were unable to say when the work would be completed.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- The interactions we observed between patients and staff on both wards were mostly supportive and caring. On AL3 ward we observed staff conversing with patients in a friendly and supportive way as well as taking part in activities with them, including table tennis. Staff also responded promptly to patients' requests for help. One patient was visited by four friends or family members. Staff greeted the visitors in a welcoming and friendly way.
- Generally patients on both wards reported that staff supported them and treated them with respect. However, three patients on Gresham 1 said that staff often seemed too busy to have enough time to interact with them. Another commented that because the staff changed so frequently it was difficult to know who was meant to be caring for the patients.
- Staff on both wards demonstrated that they understood the needs of patients and worked to support them. On AL3 we observed the staff handover meeting. Staff showed a warm, caring and positive attitude towards patients throughout the meeting. Staff expressed sympathy for one patient who was in a difficult situation and discussed how they could help them. When discussing another patient's bad temper staff then talked about them caringly as not being a morning person. On Gresham1 ward, although several patients were clearly unwell, staff demonstrated patience and calmness when interacting with them, asking what activities they would like to do and helping them to arrange family visits.
- To ensure that staff could observe that patients were safe and well in their rooms patient doors on both wards had panels through which staff could look into patients' rooms. On Gresham 1 ward each panel had a curtain that staff could pull across to maintain patient privacy when they were not looking into the rooms. On the day of our visit all curtains on patients' doors were drawn across the panels. On AL3 the viewing panel on each patient door had a blind in it that staff could open and close from the outside, although patients were not able to close them from the inside. However, on the day of our visit to AL3 most of the viewing panels into patients' rooms were open, allowing people passing patients' rooms to look inside. Staff explained that they opened the blinds at night to check on the safety of patients, but did not always remember to close them. Following our arrival on the ward staff began closing the blinds on the doors, but the fact that most were already were open risked undermining patients' privacy and dignity. One patient said that they did not like that their blind was frequently open because it meant that they had no privacy when they were getting undressed. Another said that staff needed to realise that patient privacy was important as their rooms were their only private space. The ward manager explained that new doors had been ordered and all of them would have blinds that patients could close from the inside. In the meantime the manager had recently reminded staff of the need to close the blinds, once staff had checked to see that patients were safe. They provided minutes of the meeting to demonstrate that this had been discussed. They further explained that not all staff currently had the keys required to close the blinds.
- On AL3 the appearance of the patients' rooms did not support a therapeutic environment. We looked inside 12 patients' rooms. Most were drab and grey and required redecoration. The only colour in one room was a large notice placed by staff stating the legal liabilities of the trust in respect of patients' property. The patient whose room it was said they did not like it and asked how the notice was meant to make them feel. One room also had no shelving for the patient to put their clothes. There was a wardrobe for storing them, but without shelves the patient observed that it was like putting their clothes into a large box. Two patients also complained that their bedding was insufficient and that they were cold at night, although staff did provide more bedding if patients asked for it. When we asked about the condition of the patients' rooms the ward manager said that although the general ward area had been refurbished, planned refurbishment of patients' rooms had not yet begun and no starting date was available.

The involvement of people in the care that they receive

- All patients received a welcome pack upon admission, which included information regarding the services in the hospital, patient rights, advocacy and how the wards operated.

Are services caring?

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

- Of the nine care plans we looked at, many were generic and did not contain a sufficient voice of the patient, describing their wishes regarding their care and treatment. All those we examined on AL3 had minimal patient involvement. However, in response the ward had initiated a new patient-led care planning system to better record patients' wishes and preferences about their care and treatment.
- Patients on both wards had access to an independent advocate. Advocates supported patients to raise a variety of issues, including requesting leave, asking for transfer, changing medication and making complaints. The wards displayed information detailing how patients could contact the advocacy service, who the ward advocate was and which day they visited.
- Staff on both wards said that they actively encouraged patients to be involved in their care and treatment and express their wishes and preferences in meetings with staff. The advocate on Gresham 1 confirmed that clinical and nursing staff were keen to hear the views of patients during meetings with them and gave patients the opportunity to participate in their care and treatment.
- Patients met staff at weekly community meetings to raise and discuss any issues they had about their care and treatment. Staff also attended a quarterly acute care forum where they discussed issues relating to patient care and treatment. The independent advocates who worked on the wards also attended in order to represent the views of patients.

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 9 HSCA (RA) Regulations 2014 Person-centred care Some patients did not have care plans that met their individual needs. Patients needed to be offered more opportunities to be engaged in developing their care plans. This was a breach of regulation 9 (1) (a)(b)(c)

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 Individual risk assessments were not consistently up to date and did not always reflect the current risks to individuals. A pinpoint alarm system on Gresham 1 ward was not working and staff therefore did not know the location of potential emergencies. This was a breach of regulation 12 (1) and (2)(a)(b)

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 There were not a sufficient number of suitably qualified, competent, skilled and experienced staff deployed on Gresham 1 ward to keep the ward safe.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 18 (1)