Care Quality Commission

North Staffordshire Combined Healthcare NHS Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RLY88	Harplands Hospital	Ward 1	ST4 6TH
RLY88	Harplands Hospital	Ward 2	ST4 6TH
RLY88	Harplands Hospital	Ward 3	ST4 6TH

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

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

Summary of findings

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

Summary of findings

Ratings

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

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

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Information about the service	9
Our inspection team	9
Why we carried out this inspection	9
How we carried out this inspection	9
What people who use the provider's services say	10
Good practice	10
Areas for improvement	10

Detailed findings from this inspection

Locations inspected	12
Mental Health Act responsibilities	12
Mental Capacity Act and Deprivation of Liberty Safeguards	12
Findings by our five questions	14
Action we have told the provider to take	28

Summary of findings

Overall summary

We rated the acute wards for adults of working age as **requires improvement** because:

- There was no seclusion room compliant with the Mental Health Act (MHA) 1983 Code of Practice (2015);
- There were blind spots on all wards, which meant staff could not always ensure patients' safety;
- There were a number of ligature risks throughout the wards, including pierced grills beneath the windows of Ward 1 that were not effectively managed;
- There was no clear evidence of review of risk assessments after incidents;
- We observed blood spillage not dealt with in the appropriate manner in line with legislation and guidance;
- We found an informal patient on Ward 3 who was prevented from leaving the ward without apparent legal authority;
- Recovery focus was limited and inconsistent in care plans. There was poor evidence of patient involvement;
- Non clinical moves occurred between wards;
- Not all staff had a good understanding of the Mental Capacity Act (MCA) 2005;
- The failure to record fully the administration or omission of medication was evident on all three wards.

However:

- Staff demonstrated kindness and compassion in their interactions with patients.
- Patients appeared to be involved in their care; they spoke positively about staff and said they were respectful, kind and caring.
- Relatives spoke positively about the care patients were receiving. They felt they were involved in the patients' care.
- Systems were in place to learn from incidents.
- Staff knew how to support patients to make a complaint and they received feedback on the outcome of complaints on their respective wards.

Summary of findings

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

Are services safe?

We rated safe as **requires improvement** because:

- There were ligature risks throughout the wards, including pierced grills beneath the windows of Ward 1 that were not effectively managed;
- There was no seclusion room that met the Mental Health Act 1983 Code of Practice; guidance (2015). Patients were secluded in their bedroom, or the annexe;
- Documentation of risk was inconsistent and staff did not review risk management plans following incidents;
- There were blind spots on all wards, which meant staff could not always ensure patients' safety;
- We found an informal patient on Ward 3 who was prevented from leaving the ward without apparent legal authority;
- Following blood spillage we observed staff wiping blood from a corridor floor with tissue and without protective wear;
- We saw evidence of missed doses of medication that staff had not signed for.

However:

- Each of the wards had fully equipped clinic rooms with equipment regularly checked and monitored.
- Staff carried pinpoint alarms and responded promptly to alarms when raised.
- Wards managed risks by increasing observations.
- There were systems in place to learn from incidents.

Requires improvement

Are services effective?

We rated effective as **requires improvement** because:

- Recovery focus was limited and inconsistent in the care plans – the plans appeared pre-populated and did not reflect the individual patient's perspective. The care plans were non-holistic and not recovery orientated. Care plans used generic phrases and evidence of active patient involvement was poor;
- Staff told us and we also observed, that comprehensive risk assessments did not accompany patients when transferring to another ward. There were no clear guidelines on the review of risk assessments before transfer;
- Assessments of capacity to consent to treatment did not meet the guidance set out in the Mental Health Act (1983) Code of Practice;

Requires improvement

Summary of findings

- When people were detained under the Mental Health Act (1983), we saw the correct legal documentation authorising treatment was not always completed accurately. We also found the necessary checks and scrutiny of the treatment documentation to ensure safe and legal prescribing were not always being carried out;
- Some staff lacked understanding about who might not have capacity to make specific decisions. Not all staff had a good understanding of the principles of the Mental Capacity Act (MCA) 2005.

However:

- There was evidence of physical examination taking place following admission and evidence of active participation of patients in those reviews.
- Within the MDT meetings, we observed there was full participation of mental health disciplines.
- All three wards had a Non-Medical Nurse Prescriber, including one who was a Responsible Clinician (RC) who supported the medical staff.

Are services caring?

We rated caring as good because:

Good

- Staff demonstrated kindness and a compassionate manner in their interactions with patients;
- Patients appeared to be involved in their care and spoke positively about staff - saying they were respectful, kind and caring;
- Relatives spoke positively about the care the patients were receiving; they felt they were involved in the patients' care;
- On all three wards, there was an admission pack that included information about the acute wards. Staff gave these to patients when admitted to the service.

However:

- Records we viewed did not show involvement of patients in their care planning.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

Requires improvement

- Non-clinical moves occurred between wards. There was evidence of patients being moved within ward 1 to accommodate the mixed sex ratio causing some confusion for acutely unwell patients;
- Staff told us there was not always a bed available in in South Staffordshire and Shropshire NHS Foundation Trust, which was the closest PICU used by the trust. Therefore, patients had been admitted further out of area;
- Bed occupancy was more than 100%;
- There were no designated multi-faith rooms on the wards;
- Staff told us the discharge notifications did not always happen within the trust timeframe of seven days.

However:

- Patients on all the wards had access to snacks and drinks throughout the day and night.
- All wards had access to recreational rooms.
- There was an activity worker for each ward.
- Staff knew how to support patients to make a complaint and received feedback on the outcome of complaints on their respective wards.

Are services well-led?

We rated responsive as requires improvement because:

Requires improvement

- Staff were not familiar with the trust's visions and values. Staff told us they heard about them only weeks before the CQC inspection and some staff had no knowledge of the trust's Safe, Personalised, Accessible, Recovery focused quality priorities;
- Staff had limited understanding of Mental Capacity Act (MCA) principles;
- Some staff told us they knew their senior management team up to matron level, but not above that;
- Some staff told us morale had been low due to staffing issues.

However:

- Staff on the wards spoke highly of their line manager and felt their work was valued by them.

Summary of findings

Information about the service

The acute wards for adults of working age provided by North Staffordshire Combined Healthcare NHS Trust are part of the trust's Adult Inpatient Directorate. The trust does not have a Psychiatric Intensive Care Unit (PICU).

Harplands Hospital has three acute wards for adults of working age - Ward 1, Ward 2 and Ward 3. Ward 2 and Ward 3 have 22 beds each. Ward 2 is for men only and ward 3 is for women only. Ward 1 is a mixed ward with 14 beds. It offers a greater level of intensive care for adults with acute mental illness.

Our inspection team

The North Staffordshire Combined Healthcare NHS Trust comprehensive inspection was led by:

Chair: Paul Lelliot, Deputy Chief Inspector (Mental Health), CQC.

Head of Inspection: James Mullins, Head of Hospitals (Central West Mental Health), CQC.

Team Leader: Kenrick Jackson, Inspection Manager, CQC.

The team that inspected the three acute wards for adults of working age at Harplands Hospital was made up of eight people: three inspectors, a psychiatrist, two Mental Health Act reviewers, a nurse and an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from carers and families of those who use services.

During the inspection visit, the inspection team:

- Visited all three of the wards at the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients;
- Spoke with 15 patients who were using the service;
- Spoke with the managers or acting managers for each ward;
- Spoke with 30 other staff members; including doctors, nurses, student nurses, activity workers, ward clerks, medical secretaries, the Mental Health Act Legislations Lead, housekeepers, a Community Psychiatric Nurse (CPN), Independent Mental Health Advocates (IMHA) and clinical psychologists;
- Interviewed the Clinical Director with responsibility for inpatient services;
- Attended and observed one hand-over meeting, six ward reviews, one team meeting, two patient meetings and three multi-disciplinary (MDT) meetings.

We also:

- Collected feedback from nine patients using comment cards;

Summary of findings

- Had one letter from a carer left for us on the ward;
- Looked at 21 patient treatment records;
- Had comments through “Share Your Experience” from the CQC website;
- Through our pharmacy inspectors carried out a specific check of medication management on the three wards;
- 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

There were mixed views about the staff on the wards from both patients and relatives. From the nine comment cards we received, the main theme on Ward 2 was that staff were doing well despite the busy environment. Concerns raised on comment cards received during the inspection focused on low staffing levels and high use of bank and agency staff.

Patients and relatives commented positively about the helpfulness and responsiveness of the staff. Patients told us staff were excellent, despite having to work under extreme pressure and frequent flare-ups on the ward. On the CQC website “Share Your Experience” page writers said Healthcare Support Workers were generally outstanding. Relatives told us they were kept informed throughout the treatment of their loved ones and that the wards were accommodating to each individual’s needs. However, comments from patients indicated there was an absence of male staff on the male ward with mainly female staff on night shifts.

Good practice

There was clear evidence within the acute wards that they were recording and learning from incidents. Across the wards, there were regular team meetings every two weeks, where they discussed how to learn from incidents. Managers told us that staff were reporting incidents more consistently and that in the past not all incidents had been reported. Ward 2 staff had been encouraged to log low staffing as part of their incidents. We saw positive learning from incidents including a review of the risk assessment policy in light of an assault on a staff member on Ward 2. Staff told us they had the chance of a formal debrief. Ward managers had introduced a debrief lead - one person was in charge of debriefs and facilitated them on each ward. We sat in one team meeting and observed the discussions following incidents that had taken place earlier in the day.

Areas for improvement

Action the provider MUST take to improve

- Adhere to the requirements of the Mental Health Act (1983) Code of Practice (2015) with regards to a seclusion room. Across all three wards, seclusion was routinely taking place in either patients’ bedroom or the annexe in Ward 1. None of these rooms fitted the criteria for a seclusion room according to the Code of Practice. The review logs did not indicate when reviews should take place, nor highlight which professionals were required at each stage of the review. This was not in line with the Code of Practice. The paperwork did not include the setting where the seclusion was being managed.
- Ensure all ligature risks are undertaken and there is action to reduce those identified ligature risks in Ward 1.
- Ensure informal patients are aware of their right to leave the ward and that there is appropriate legal authority in place if staff prevent an informal patient from leaving.
- Ensure all staff adhere to current legislation and guidance on Control of Substances Hazardous to Health Regulations (COSHH) when cleaning up bodily fluids.

Summary of findings

Action the provider SHOULD take to improve

- Ensure it reviews staff mix on wards, especially male only and female only wards to ensure dignity and privacy at all times.
- Ensure detained patients on wards have information on how to contact CQC in order to complain if needed.
- Ensure all staff have a good understanding of the MCA and consent when treating patients.
- Ensure nursing staff undergo medicines management training.

Care Quality Commission

North Staffordshire Combined Healthcare NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 1, Ward 2 Ward 3	Harplands 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.

- The notice on the exits from the wards did not state clearly that informal patients have a legal right to leave the ward. The Independent Mental Health Advocacy (IMHA) service told us that informal patients felt as restricted as those who were detained.
- Staff on Ward 3 told us they did not carry out personal searches but did ask patients to empty their pockets and show the contents of their bags. If a patient refused to allow staff to search their bags, the bag was kept in the storeroom until the patient agreed. This practice does not meet MHA Code of Practice guidance on searching property.
- Staff did not routinely explain patients' rights. Out of the nine cases we viewed, seven patients had not been made aware of their rights.
- Assist provide the Independent Mental Health Advocacy (IMHA) service on the wards. They were based at Harplands Hospital meaning they could offer a prompt and responsive service to detained patients. We were told IMHA representatives come to the ward weekly to see patients.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not always show understanding of the issue of capacity and consent when treating patients. Assessments of consent to treatment did not include enough information in any of the records of the detained patients we looked at. On Ward 3, the Responsible Clinician (RC) had assessed the patient as lacking capacity to consent to treatment but had wrongly authorised medication on the wrong T2 certificate for consenting patients. As a result, medication had been administered without patients consent.
- Staff had applied for an urgent Deprivation of Liberty Safeguards (DoLS) authorisation for one patient. However, the paperwork showed that staff were confused about the circumstances in which this was necessary. There were no patients subject to DoLS during our visit.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Each ward layout does not allow clear sight lines that enable staff to observe patients. However, staff assessed the appropriate levels of observation and effectively observed patients.
- There were a number of ligature points throughout the wards, including pierced grills beneath the windows of Ward 1 that had not been identified in the most recent ligature audit. We pointed this out to the Ward Manager on Ward 1. The trusts risk register identified the other ligature risks and there was an action plan mitigating these. Ward managers reported that as a way to mitigate the ligature risk staff would have a "ligature risk walk around" the wards, identifying the points especially after a serious incident. This included an environmental ward review weekly and an assessment of all patient observation levels to manage risk. New staff would be shown ligature points as part of their induction onto the wards. Evidence of this was clearly documented by managers, highlighting that it was the responsibility of the nurse in charge to ensure that all their staff we aware of where the ligature points were.
- Staff had an effective system of monitoring blind spots and were able to point out risks and they highlighted that patients would be restricted from those areas unless supervised. We saw evidence of staff deployed throughout the wards monitoring the blind spots.
- The wards reported that high levels of observations were used to mitigate the ligature risks, including patients' property minimised as per protocol and individual risk assessments on admission. Between March 2015 and August 2015 there were 104 ligature incidents, 71% of those were from Ward 1.
- Two patients on Ward 1 self-strangulated during the inspection visit. Neither patient had used ligature points but had tied items of clothing around their necks, requiring ligature cutters to remove. We saw staff respond promptly to both incidents.
- Staff were aware of numerous ligature points throughout the wards, particularly those in bathroom areas. Patients told us that the bathrooms are locked on Ward 3 until after the morning handover. Staff explained this was because they would be unable to maintain observation levels safely during the handover.
- Documentation of risk was inconsistent. There was no evidence of risk assessment of suicide being reviewed following incidents of self-harm.
- All three wards comply with guidance on same sex accommodation. On both Ward 2 and Ward 3 there were two single sex dormitories with four patients sharing. Ward 1 had one dormitory with two patients sharing. There was a separate female only lounge on Ward 1. Ward 1 is a mixed gender ward for acutely unwell and vulnerable patients and beds were flexed depending on patient mix. It also has separate male and female sleeping areas. We spoke to staff and there was evidence that patients who are risk assessed as vulnerable to sexual exploitation are moved to single sex wards. This was evidenced in two cases in Ward 2 and Ward 3. In addition, we reviewed a care plan in place to manage sexually disinhibited behaviour.
- Patients had access to separate male or female only bathroom and toilet facilities each ward.
- There was no seclusion room that met the MHA Code of Practice guidance. Trust seclusion policy was reviewed in July 2015. Prior to this staff told us they were not aware of the seclusion policy they were working with. Patients were secluded in their bedroom or the annexe in Ward 1. Staff were aware that they were secluding patients by restricting them in that way. None of these rooms met the criteria for a seclusion room according to the Code of Practice. There were numerous safety hazards such as furniture including chest of drawers and beds with ligature points; lighting controlled by a switch in the room; poor visibility for staff carrying out observations; blind spots and no clocks. Not all bedrooms used for seclusion had access to a toilet and washing facilities.
- From speaking to staff, there was evidence of frequent use of seclusion within bedrooms. Staff appeared

unclear over the definition of seclusion, and how to document this appropriately. Bedrooms, in their present form, are not suitable for patients who could become aggressive. These rooms contained furniture and fittings that could escalate risks to patient and staff safety. We were told the trust had plans to build their PICU.

- The trust had only recently introduced specially designed forms to record seclusion. Documentation did not provide a through flow process. We found it was not in line with Code of practice. The review logs did not indicate when reviews should take place, nor highlighted which professionals were required at the each stages of the review. This was not in line with the Code of Practice. The seclusion logs in Ward 2 and Ward 3 did not record where the seclusion was being managed, for instance in the bedroom or dayroom.
- Patients were being secluded in the annexe without proper care planning and recording. Although the trust had introduced new seclusion forms, we did not see these forms in the file we viewed. The use of seclusion was recorded in the continuation notes of one patient rather than on specific seclusion paperwork. Entries were not in chronological order on specific forms. We viewed notes of patients recently secluded in their bedrooms – there were no changes recorded to Risk Management plans and no seclusion care planning evident. Staff told us they were aware that not all episodes of seclusion had been adequately recorded.
- Each of the wards had clinics that were equipped with large consultation rooms. These were fully equipped with sinks, couches, scales and BP monitoring equipment. All wards had resus and emergency equipment with emergency drugs in place and checked weekly to ensure it was fit for purpose and service dates were current. Staff would check that medicines were stored securely and within safe temperature ranges. Staff told us they disposed appropriately of sharp objects, such as used needles and syringes, in yellow bins.
- Ward areas were clean with good furnishings and well maintained. The corridors were free of clutter. Records of infection control were completed on the wards. On observation, blood spillage not dealt with appropriately in line with current COSHH legislation and guidance. We observed staff wiping blood off the floor in a corridor with tissue without protective wear following blood spillage. As we expected this to be part of routine care, we brought this to the attention of the ward manager who told us that the staff were aware of infection control principles including hand washing and how to clean spillages.
- We saw that cleaning checklists were maintained and audits undertaken weekly.
- All staff carried personal pinpoint alarms. We were offered these while on the wards. We observed staff responding promptly to alarms including those on other wards. In all of the wards inspected there were no alarm systems in the bedrooms. However, there were alarm systems in the assisted bedroom, bathrooms, toilets and corridors.

Safe staffing

- Staffing establishment on Ward 2 consisted of 10 registered nurses (RN's) and 12 Health Care Assistants (HCA). They had three band 5 RN's, and one HCA vacancy. Forty-three shifts on Ward 2 took place below planned staffing levels over the previous three months, as they were unable to fill the rota. Thirteen shifts took place with only one qualified staff member during the daytime. Ward managers told us they could get additional bank staff who were familiar with the wards, or agency staff as a last resort when required. Staffing was increased in relation to additional observations that were implemented to keep patients safe.
- Daily staffing levels on Ward 3 were six, six and four covering an early, late and night shift. On examination of previous rotas, Ward 3 was able to maintain safe staffing levels despite staff highlighting they had to work shifts in other wards due to staffing levels being stretched because of either sickness or high levels of observations.
- Across the wards their rotas showed there was high use of agency and bank nurses on every shift to maintain staffing levels to cover sickness, special observations, staff leaving and annual leave. However, on occasions not all shifts were covered. Staff told us that bank and agency staff used were familiar with the wards and wards would try to use the same agency staff, we saw evidence of their induction checklist they completed before their shifts. However, doctors from the focus group reported that there was often new and inexperienced staff not familiar with the wards. Staff told us that there had been more staff than usual during the

week we were inspecting. Ward managers were aware of their vacancy levels. Some staff were due to leave and were serving their notice. Managers had scheduled interviews for that week which meant they were actively recruiting. Staff levels were increased due to the demand on 1:1 observations and acuity among the patient group.

- Patients and staff on Ward 2 and Ward 3 reported that the gender mix of staff was not always appropriate. There were no male staff on a number of shifts on Ward 2 where all the patients were male. This was reflected in most of their shifts. This adversely affected the care and dignity of patients. Staff told us of an incident were a patient had to wait a number of days to have a bath, as they were unable to fill the shifts with male staff. On a further visit on Ward 3, which has only female patients, during a night shift, there was a ratio of three male staff and one female staff. Managers commented that it could be difficult to get bank or agency staff of the right mix at short notice to cover sickness.
- Staff and patients told us that planned escorted leave from the wards was sometimes cancelled due to staff shortages. Staff told us there was no audit tool for monitoring how often this happened. They also reported that at times 1:1 therapeutic work was always not maintained with patients due to the staff shortages. We could not see evidence of regular 1:1 in most the patients’ notes reviewed. Staff on Ward 2 told us that staffing levels do not always allow for 1:1 time with patients, except at the weekend when there were less clinical activities.
- Medical staff told us that there was adequate cover available day and night to attend the wards quickly in an emergency. There was a medical cover rota for out of hours. Each ward had one full time consultant based on the ward with a Non-Medical Nurse Practitioner on each ward, one of whom was RC. Ward 3 consultant had left in June 2015 and a new consultant had started that week. Ward 2 had a locum consultant and that post was going to be advertised. Patients had commented on being seen by different doctors during the course of their stay.
- Ward 1 had a part-time junior doctor and relied on the Non-medical Nurse Practitioner.
- Seventy-seven per cent of staff had received mandatory training and refreshed their learning annually in areas such as infection control, safeguarding adults/children, fire safety, MAPA, conflict resolution, CPR, resuscitation, health and safety, MHA training and DoLS, Information Governance and Equality and Diversity. Some non-clinical office based staff on the wards had not received training in breakaway techniques.
- Staff told us there were not always experienced nurses on the wards as there had been lots of newly qualified nursing staff as well as agency and bank staff due to staff leaving. This was evident on Ward 2.

Assessing and managing risk to patients and staff

- During an observed ward review on Ward 3, staff picked up that they had breached their 72-hour trust time frame for doctor or nurse practitioner assessing a new admission. This would have caused a delay in delivering any personalised care to the individual in that environment. They had not identified relevant risks for that patient. Staff within that review highlighted their mistake and undertook the relevant assessments.
- We saw evidence that comprehensive risk assessments did not accompany patients when transferring to another ward. The eight-point risk assessment would accompany the patient even if the full Risk Management Plan had been completed on the previous ward. There were no clear guidelines on the review of risk assessments before transfer.
- Staff had prevented an informal patient from leaving the ward without legal authority. Staff only allowed the patient to leave the ward with an escort or accompanied by a family member. They had also removed their belongings apparently without the patient's consent. The consultant had repeatedly recorded that she had full capacity to make all decisions for herself. Staff on the ward told us that they had placed these restrictions on her because she was detained. However, the patient was not detained at any time during her stay.
- An advocate told us that informal patients sometimes feel they are subject to the same restrictions as detained patients. In all four of the care plans of informal patients that we looked at, there was no consideration on the impact of the restrictive environment. All the wards were

locked. There was a notice by the exit-advising patients to speak to staff if they wish to leave. However, this did not clearly state that informal patients have a right to leave the ward.

- There were some blanket restrictions on all three wards. Leave of absence care plans instructed patients not to drive. There was no consideration in care plans of the impact on patients to these restrictions. They were not patient centred nor did they take into account individual circumstances. On Ward 2, all the patients had their razors, glass items or other sharp objects taken away with no care plans to manage the impact on patients or individual risk assessments to show this was necessary to keep the patient safe. These items were stored in lockers that were only accessible by staff. There was no consideration in care plans of the impact on patients of the restrictive environment.
- Staff told us they did not carry out personal searches but did ask patients to “turn out their pockets” and show the contents of their bags. If a patient would refuse to allow staff to search their bags, the bag kept in the storeroom until the patient agreed. This practice does not meet MHA Code of Practice guidance on searching property.
- There were 36 restraint and rapid tranquilization across the three wards in the last six months. Restraint and rapid tranquilisation did not meet their own policies or NICE guidelines. Only one out of four notes viewed, followed the guidelines. Evidence in the three notes included doctors not reviewing patients within their timeframe, no clear documentation records of physical observations or any refusals highlighted. We did not see records of attempts of debrief with the patient.
- Although staff on Ward 2 told us they never used prone position to restrain patients, there was evidence from patient’s progress notes showing in August 2015 there was use of prone position for up to 10 minutes. DH guidance indicates that this should only be done in exceptional circumstances’. In the last six months there has been 10 prone restraints used.
- The failure to record fully the administration or omission of medication was evident on all three wards. Out of the prescription charts we looked at, we found two patients on Ward 1 and three patients on Ward 2, where there was no signature for administration or reason documented to explain why the medicine had not been given. On Ward 3, we found one patient with a missed administration medicine record for insulin. There was no signature for administration or reason documented to explain why the insulin had not been given. It was not possible to know if the patient had been given their insulin before their evening meal on the 3 September 2015.
- On Ward 1, we observed a nurse administering medication. That nurse interrupted on two occasions by a patient requiring items from the safe. The key for the safe kept with the medication keys, which meant that the nurse stopped the administration of medicines to access the safe.
- The wards were managing risks by increasing observations. The level of observations was determined by staff following the trusts Eight Point Risk Assessment on admission. There was evidence in patients’ notes we viewed that observation levels were reduced as soon as safe to do so in line with the “Least Restrictive Option”. However, observations could be increased by nurses and only decreased by doctors.
- In three out of four records we viewed, there was not always a care plan in place to manage risks identified on admission. In one patient’s set of the notes, Risk Management Plans were not completed within 72 hours of admission as required by the trust.
- Of the patients’ notes we viewed, two out of four patients transferred from other wards had temporary notes. Although a full Risk Management Plan had been completed on the previous ward, these only included a brief eight-point risk assessment.
- We reviewed ligature incidents on Ward 1 and there was no evidence in the notes of staff reviewing risk assessment after the incidents. However, the incidents were reported in the patient progress notes and we observed discussion of risk during a team meeting.
- There were safe procedures in place for children visiting patients. No children allowed on the wards. All the three wards have access to a family room in the corridor, outside the wards to ensure children can visit relatives safely.
- Staff we spoke to had a good understanding of their responsibilities in raising safe guarding concerns. Ward

managers had good links with the safeguarding team. However, the trust had not identified safeguarding as a mandatory training need for some of the non-clinical staff despite the fact that they were on the units with patients.

Track record on safety

- There were seven Serious Incidents (SIRIs) in the last 12 months.
- We were told that a number of staff had been on sick leave due to injury at work on Ward 1 and Ward 2. Due to low staffing numbers, staff on Ward 2 told us they still had to complete their shift following assaults from patients.
- As a way of mitigating some of the incidents, we were told staff were increasing the number of observations on patients that posed risk.

Reporting incidents and learning from when things go wrong

- Medical and nursing staff had good knowledge of the Duty of Candour and were able to give examples when it had been applied.
- According to the serious incidents reported on their system, there were three staff injuries from January to May 2015. Managers commented on staff injury, mainly on Ward 1 and Ward 2. When speaking to the staff they reported that there had been further incidents the previous weekend before our inspection, whilst there had been staff shortages.
- There were regular team meetings on all the wards every two weeks where staff discussed incidents and how to learn from them. Managers told us that staff were reporting incidents more consistently and that in the past not all incidents had been reported. Ward 2 staff had been encouraged to log low staffing as part of their incidents. We saw positive learning from incidents including a review of the risk assessment policy in light of an assault on a staff member on Ward 2. Staff told us they had the chance of a formal debrief. Ward managers had introduced a debrief lead - one person was in charge of debriefs and facilitated them on each ward. We sat in one team meeting and observed the discussions following incidents that had taken place earlier in the day.
- Staff on Ward 2 reported that learning from incidents had improved, especially in managing patients who misuse substances.
- Staff told us they knew how to log incidents on the trust's recording incidents system. They were reviewed by managers and their deputies and forwarded to the trust's safeguarding team if required.
- We were told there had been three major incidents including a patient death in May 2015 in the last six months on Ward 1. The learning from this resulted in an increase in observations within the ward and review of the admission pathway.
- The wards hold weekly patient community meetings and keeps records of these. There is also a notice board to inform patients of action taken by staff in response to their feedback.
- Medicine errors were reported using the incident reporting system. Information was cascaded to the nursing staff team via e-mail and team meetings. On Ward 3, we were also told about a medicine incident that had occurred on the ward where lessons had been learnt over reporting of medication errors.

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

- There was evidence of physical examination taking place following admission. Where patients had refused, it was clearly documented in the MDT notes. We observed a patient on Ward 1, who had physical health concerns. Staff had clearly documented their refusal for treatment in the MDT notes.
- Access to physical healthcare was part of the trusts Commissioning for Quality and Innovation (CQUIN) programme - Goal 1a. and Goal 4, (Cardio metabolic assessment and treatment for patients with psychosis and embedding a safety culture, respectively).
- We observed five ward reviews and two Multi-Disciplinary Team (MDT) meetings and witnessed good information sharing. There was active participation of patients who had written down what they wanted the team to discuss in the review.
- There was evidence of medicine reconciliation done with the GP at point of admission.
- From the care plans we observed, the recovery focus was limited and inconsistent - they appeared prepopulated. Care plans used generic phrases; evidence of active patient involvement was poor.
- All patient notes were paper based. Staff reported the trust was at the start of introducing an electronic system.
- Staff told us they had no control over which admissions they were receiving as this was decided for them by their Access and Home Treatment teams. At times on Ward 1 they were expected to manage high-risk patients until suitable placement, such as PICU, were found. There was evidence of a patient who had been referred for a PICU bed in Norbury and was awaiting approval from managers.

Best practice in treatment and care

- All patients had a Risk Management Plan in their records. However, in three cases, staff had identified risks but there was no related care plan to manage the risks.
- Inpatient units had access to psychological therapies. However, the number of psychologists was limited. The trust had a clinical psychologist offering assessment and formulation, with advice on psychological modalities in accordance with NICE guidelines. There was 1.5 days input for inpatient services by the clinical psychologist. We were told that there are plans for fulltime psychology commencing in October 2015.
- Clinical staff participated actively in documentation audits. Band 6 nurses would rotate across all three of the wards auditing five sets of notes each month.
- Staff had access to relevant training to suite their patient group on Ward 2. The Knowledge and Understanding Framework (KUF) training was available to the staff working with patients with Personality Disorders.

Skilled staff to deliver care

- In the MDT meetings, we observed there was full participation of mental health disciplines, including a Community Psychiatric Nurse who was the link from the community teams and the hospital.
- Each of the three wards had a Non-Medical Nurse prescriber. One of them was also there to support medics as a RC.
- The wards had regular team meetings. Staff were kept up to date with all the relevant issues going on within their wards to ensure good outcomes for patients, by sharing knowledge and information.
- Ward 2 admits a number of women with a diagnosis of Personality Disorder. One staff nurse is a champion for this group of patients, and the trust has supported her application to attend Dialectical Behaviour Therapy (DBT) training to meet the needs of these patients. Staff on the ward also had access to KUF training to help them in supporting patients with Personality Disorder. This showed the ward is considering evidence-based interventions for patients.
- Staff were debriefed following serious incidents. Ward managers and senior nurses offered diffusion and counselling sessions. The trust had introduced a staff stress tool that was filled in after every shift, highlighting stress levels across a Red, Amber and Green (RAG) rating. Staff showed active involvement and good understanding of it.

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- Eighty eight % of staff had undergone the MCA training. Not all the managers or staff had a good understanding on the guiding principles of the MCA. The six HCAs we spoke to across the three wards told us they had not received the training. The trust told us all qualified or unqualified staff that has direct patient contact are required to attend this training.
- Staff reported that there was no bespoke training for suicide prevention and management, despite their patients being a risk.
- Out of 20 staff on Ward 3, 12 staff (60%) had completed their Personal development review (PDR) over the last year. PDR figures for Ward 1 and Ward 2 were not immediately available during the inspection. We made further requests to the trust and the information was not provided. All three wards had no records of clinical supervision.
- There was evidence of on-going improvements in the trust to develop an on going robust clinical supervision processes. Managerial supervision was bi-monthly to all staff. There were scheduled reflective practice sessions across the wards every two weeks. Staff reported that they felt well supported and were able to discuss challenging issues.
- Newly permanent staff received a formal corporate induction within one month of starting. We spoke to newly qualified staff awaiting their induction within that period. Managers told us that new starters would not take charge of the wards until completed their first six months of preceptorship.
- We were told bank and agency staff underwent a basic induction, which included orientation to the wards and handover about the patients. We saw examples of completed forms that were signed off by the nurse in charge of the shift to evidence this.
- We spoke to students who had received local induction and felt supported. However, some highlighted that they were counted in ward numbers when the wards had been short staffed.
- Mandatory training figures overall were below the trust target of 95%; Ward 1 was 84% compliant, Ward 2 was 78% compliant and Ward 3 was 82%.
- The pharmacy team provided medicine management training for junior doctors and nurses. However, the medicine management training for nurses was not mandatory and not always well attended.

Multi-disciplinary and inter-agency team work

- Handover meetings took place each morning on all of the wards. We noted that each patient was discussed and relevant information passed on. Handovers appeared well structured. The handover forms were populated by night staff, typed and updated throughout the day. They included with legal issues, risks discussed and current issues identified. The handover form was colour co-ordinated - red, amber and green - to highlight the risks.
- Chips IT system was being introduced on all of the wards so that access can be gained to community notes.
- We observed a team meeting on Ward 1, which included qualified and unqualified nursing staff, deputy manager and the activities co-ordinator. The main issues discussed were staffing levels, patient concerns, debriefs from incidents and health and safety audits. We viewed previous minutes and they evidenced consistency in the issues discussed.
- We sat in six ward reviews across two wards. We observed involvement of carers and community workers. Diagnosis, medication and risks discussed with patients.
- Clinical psychologists were not part of MDT due to time constraints.
- Medical staff, including the consultants, were present during our inspection. We observed good interactions between ward nursing and medical staff.
- We found clinical pharmacists were actively involved in all aspects of a patient's individual medicine requirements. The pharmacy team were part of the daily ward round which helped identify any medication issues dealt with them immediately. Prescription charts were clearly written and well documented with pharmacist interventions documented on the front of the chart. Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice during the day.

Are services effective?

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Adherence to the MHA and the MHA Code of Practice

- MHA training figures within the acute wards were variable; Ward 1 was 93%, Ward 2 was 91% and Ward 3 was 81% compliant.
- Assessments of capacity to consent to treatment do not meet the guidance set out in the MHA Code of Practice. Staff did not always show understanding of the issue of capacity and consent when treating patients. Assessments of consent to treatment did not include enough information in any of the records of detained patients we looked at. On Ward 3, the Responsible Clinician (RC) had assessed the patient as lacking capacity to consent to treatment but had wrongly authorised medication on the wrong T2 certificate for consenting patients. As a result, medication had been administered without patients consent. On Ward 2, we found one person detained under the MHA (1983) whose legal documentation for treatment for mental disorder had not been completed accurately. The patient had been prescribed an antipsychotic that had not been documented on the T3 or had a subsequent Section 62 authorisation form completed. Therefore, there was no authority to administer this medication. However, in a ward round on Ward 3, we observed the RC discussing the treatment plan with the patient to check that they consented.
- On Ward 2, two of the four section 17-leave forms we viewed, authorising emergency medical leave did not include the nighttime hours. If a patient needed emergency treatment during the night, there would be no authority to allow it. In another set of notes, we found that the use of section 62 to authorise urgent treatment did not meet the necessary threshold: the Responsible Clinician recorded that it was necessary to "prevent deterioration" rather than "serious deterioration". This was not in line with the Code of Practice.
- Staff on Ward 2 had sought appropriate legal advice when deciding whether to authorise ground leave for a patient on section 37/41 of the MHA.
- The detention paperwork was in good order, and included Approved Mental Health Professional (AMHP) reports in all cases. In one case in Ward 1, the AMHP had not contacted the nearest relative, nor given adequate reasons for not doing so.
- In seven out of nine cases, detained patients had not been made aware of all of their rights under Section 132 as required by the MHA Code of Practice. Staff had not always reminded patients of their rights or told them about the IMHA service. One patient told us she had asked why she had been detained but staff did not give her an explanation.
- Staff had prevented one informal patient from leaving the ward without any legal authority. They had made decisions about this patient's right to go on leave and take care of their personal property without consulting them.
- Staff completed training on the MHA as part of their mandatory training; they demonstrated their understanding of their roles and powers under the act. Most staff told us they had not used section 5(4) and always resorted to section 5(2) if an informal patient was asking to take their own discharge.
- An MHA administrator supported the wards with any queries.
- The MHA legislation team provided effective and prompt support for staff who needed advice on the use of the MHA. However, staff on Ward 2 told us they had not received training sessions following the introduction of the revised MHA Code of Practice. The revised code includes important changes in how to manage seclusion and blanket restrictions.
- Some informal patients told us they had their rights explained. However, in some cases we viewed, patients have not been informed of their rights under section 132 on detention, nor reminded of these rights later as necessary. We also spoke to one informal patient who told us that they had been treated as if they had been detained with restrictions on them.
- Assist provide the Independent Mental Health Advocacy (IMHA) service on the wards. They were based at Harplands Hospital meaning they could offer a prompt and responsive service to detained patients. We were told IMHA representatives come to the ward weekly to see patients.
- There was information about how to make complaints on display on all the wards.

Are services effective?

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- Ward 3 has a resource room with information about the IMHA service, the trust complaints procedure and other useful leaflets. However, there was no information on display about the role of the CQC plays in looking into complaints from detained patients on any of the wards.
- The wards had more than 100% bed occupancy over the last five months. The bed occupancy and number of beds exceeded the recommendation by the Royal College of Psychiatry, which is 85%. However, we noted the ward has achieved AIMS accreditation and was going through renewal.

Good practice in applying the MCA

- MCA training figures within the acute wards were; 93% for Ward 1, 91% for Ward 2 and 81% for Ward 3.
- One patient had previously been subject to a DoLS urgent authorisation. The initial DoLS checklist indicated that the patient was free to leave the ward and not subject to continuous supervision. Despite not meeting the threshold for a DoLS, staff had made the application. The Ward Manager informed us that the checklist had been wrongly completed and the application was justified. This apparent confusion suggests staff require more training in the MCA and DoLS.
- There were no patients subject to DoLS during our inspection.
- Some staff lacked understanding about who might not have capacity to make specific decisions. Not all staff had a good understanding of the MCA 2005 and were unable to apply or evidence the five statutory principles.

Are services caring?

Good

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

Our findings

Kindness, dignity, respect and support

- We observed many examples across the wards of staff interacting with patients in a calm, caring and compassionate manner. We spoke to staff who demonstrated positive attitudes towards their patients and showed an understanding of patients' individual needs. We observed more evidence of personalised care than was recorded within the patient care plans. These care plans were not individualised or patient centred.
- Patients were observed being given treatment choices. We observed active patient involvement during reviews.
- We observed positive staff interactions with patients - staff spoke to distressed or agitated patients calmly and gave them emotional support in a caring way.
- Relatives of patients using the service gave us open and positive feedback about the care patients were receiving on the wards.
- Patients we spoke to were positive about staff and felt that they were respectful, kind and caring.
- Staff told us patients are well looked after and would want their family members treated there.
- One of the comment cards completed on the wards indicated that staff were excellent despite having to work under extreme pressure, due to frequent incidents on the wards. Another relative described Ward 3 "of being worthy 5*" if it were a hotel.
- Patients told us that they had 1:1s with staff though this did not always happen, as they were on occasions too busy.

The involvement of people in the care they receive

- On all the wards, patients were given a pack on admission that included information about the service.
- Patients on most of the wards told us that they had been orientated to the wards on admission.
- Relatives were involved in patients care and were invited to attend ward reviews and multidisciplinary meetings.
- Patients were able to involve their carers who were invited to their reviews. Staff were willing to be flexible and were able to adjust visiting times to accommodate carers and relatives who were unable to visit within normal visiting times.
- The information boards on the wards indicated the number and names staff on duty. This was helpful for patients to recognise the staff who will be supporting them.
- There was information displayed on the wards about advocacy services and specifically the Independent Mental Health Advocacy (IMHA) service for patients detained under the MHA. Staff were familiar with the role of advocates and they knew how to contact them on behalf of patients. Some patients we spoke to had accessed the advocacy services.
- Records we viewed did not show involvement of patients in their care planning. Care plans to manage Deliberate Self-Harm behaviour not signed. That patient views were being sought and their active participation in care planning was not evidenced.
- There was no evidence of care plans specific to patients who were being nursed in seclusion. There was an absence of patient participation and views in the seclusion process.
- Patients have access to garden facilities 24 hours a day. There were no restrictions on patients smoking times.
- We observed a patient community meeting. Minutes of these were displayed on wards, clearly highlighting their views and actions taken following concerns raised within the meetings.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- We found evidence that bed occupancy was consistently more than 100% in the last five months.
- In the three wards from July 2015 Ward 1 had five cases of patients admitted out of area when the ward was full. High bed occupancy also meant that on occasions, some patients were required to 'board' on older people's mental health wards until a bed became available on the acute wards.
- On Ward 2, there were 23 patients on the 22-bedded ward with one patient on overnight section 17 leave. If the patient returned early from leave there may not be a bed available, staff told us in these instances patients would have to sleep on other wards. We observed that bed occupancy was more than 100% across all wards in the last five months, allowing for less for responsiveness.
- Non-clinical transfers occurred between wards as a result on bed pressures. There was evidence of patients moved within Ward 1 to accommodate the mixed sex provision ratio causing some confusion with patients and between the wards on the grounds of managing beds during an admission. We saw evidence of two patients moved to another single sex acute ward in order to maintain their feelings of safety & dignity.
- Ward 2 had 42 readmissions in a 90-day period from October 2014. This is in comparison to a readmission rate of 91 across the rest of the trust in the same period.
- The trust did not have its own PICU facility and therefore had to identify beds out of area for patients who required this level of care. In the case of one patient on Ward 1, staff approached three PICU services in order to access a bed without success. Staff told us there was not always a bed available in the closest PICU; therefore, patients went further out of county. Staff we spoke to were unclear regarding their referral policy or pathway to a PICU. Three staff from Ward 2 and Ward 3 referred to Ward 1 as their PICU, two of them in response to the panic alarms on Ward 1 and one of them making reference to this being where they move the more challenging or high risk patients.
- The wards held a weekly delayed discharge meeting the trust has had 77 delayed discharges over six month period since October 2014; 37 from the acute wards at Harplands. On the day of our inspection, Ward 2 had four delayed discharges due to accommodation difficulties, awaiting a specialist placement or a rehabilitation bed. Since March 2015, Ward 3 has had nine delayed discharges, Ward 2 has had 10 and Ward 1 has had five.
- Staff told us the discharge notifications did not always go within the trust timeframe of 7 days.
- We saw evidence that the process for obtaining discharge medications was a good one.

The facilities promote recovery, comfort, dignity and confidentiality

- On all of the wards, patients had a room they could make telephone calls in private. There was no blanket restriction on patients being allowed to keep their mobile phones. However, one informal patient told us that their mobile phone had been taken away from them without clear justification.
- All wards had access to Wi-Fi, recreational rooms, an art room, games room and a gym. Ward 3 had access to two quiet therapy rooms offering relaxation and pampering. Patients told us they liked using these rooms. A staff member had protected time where they were able to offer complementary therapies such as reflexology and Indian head massage once a week. Staff told us that the other wards had access to these rooms if needed. In addition, the wards have each appointed Activity Workers and an additional Activity Worker to cover long-term staff leave of absence. This showed the wards' commitment to maintaining a therapeutic activity programme. We observed them in-group activities with patients on the wards. There were activities offered on some evenings as well. There was one activity worker available to cover all three wards over the weekend. We observed patients taking part in an art session. Patients told us about the activities they enjoy on the ward, such as relaxation.
- Each ward had laundry facilities and staff supported patients in accessing them when required.
- Patients had access to drinks and snacks 24 hours a day. They reported that the food was of a good quality and

Are services responsive to people's needs?

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

they had choices, with staff taking into consideration patients' religious and cultural needs. However, we were told that when choosing Halal food it does not always include a meat option.

- Patients told us they were not always able to personalise bedrooms due to the constant moves within Ward 1. Patients in the dormitories in Ward 2 and 3 highlighted that the shared facilities did not allow them to personalise their rooms.
- Patients had secure facilities on the wards to lock their belongings. However, some patients expressed concern that they were not always able to access their belongings, as staff were often busy when they were approached.
- All the wards had access to gardens in which patients could utilise outside space or smoke 24 hours a day

Meeting the needs of all people who use the service

- There are no provisions to support people with language barriers engaging in psychological therapies. However, staff told us they had access to interpreters and language line when needed.
- There were no designated multi-faith rooms on the wards. Patients had access to appropriate spiritual support. However, the only one displayed on the ward was chaplaincy. No other denominations highlighted.
- Each of the wards had one disabled bedroom large enough to accommodate a wheelchair. There were disabled showers and wash facilities. We observed that the bathrooms had no disabled access. However, there was a hoist on ward 3. Staff could request specialist beds and mattresses, if required.
- Patients told us they were aware on how they could make complaints.

Listening to and learning from concerns and complaints

- In the past 12 months, there were 10 complaints across the acute wards. Of these, two were upheld. None of the complaints were referred to the Parliamentary and Health Services Ombudsman (PHSO).
- In a community meeting that we observed patients discussing some of the complaints made. We saw evidence that patients were aware of how to raise concerns.
- Staff told us they would try to deal with concerns as they arose and they were aware of the formal complaints process.
- Learning lessons were shared with staff through newsletters and emails. In a team meeting, in Ward 1 we observed staff discuss how they had learnt from complaints. We saw evidence from their team meeting notes of staff discussing an incident on the ward with clear action plans.
- Staff knew how to support patients to make a complaint and they received feedback on the outcome of complaints in their respective wards.
- Staff told us patients could complain via Healthwatch, PALS or directly to the ward manager. Advocacy services were also there to support the patients.

Are services well-led?

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

Our findings

Vision and values

- Ward managers and senior staff told us that consideration is being given to move towards mixed sex accommodation on Wards 2 and Ward 3 as a way of managing their beds. The proposed options are to give the wards different functions, by having a triage unit with treatment and admission wards. The trust feels that this would help them manage their beds better given that at present they are limited to the two single sex wards.
- The trust's Vision and Values were on display around the wards. Staff told us these were also on the trust's intranet. However, staff were not yet familiar with them. Some staff had no knowledge of the Safe, Personalised, Accessible, Recovery focused quality priorities. We saw the displays around the wards including in the staff rooms.
- Some staff told us they knew their senior management team up to modern matron level, but not above that.
- Some staff highlighted that senior management made all decisions. The staff described a culture of top down directives being given without regards to understanding the situation and identifying a choice of solutions.
- The inpatient wards had a new standard operating procedure. Staff on the wards were not aware of their inpatient operational policy. Managers told us they were working with the draft policy that had been implemented in June 2015 that had not yet been finalised. Managers were less clear about their policy prior to the time.

Good governance

- All staff on Ward 1 had their Professional Development Review (PDR) completed. However, we were shown evidence that 14 of the staff on Ward 1 staff had no record of having supervision.
- There was a quality and governance meeting attended by senior staff from the wards held monthly discussing incidents and lessons learnt across all the three wards.
- Managers told us they reported to the risk register monthly. They highlighted bed occupancy of over 95% on their register, trust Review Group and their Directorate meeting discussed on this matter. The trust had raised concern over the use of out of area beds, with an action plan of facilitating early discharges into the community with Home Treatment support.
- Staff did not seem confident in the use of and recording of seclusion. The trust had only recently introduced a system for this purpose. Seclusion records were of poor quality and suggested a need for further staff training.
- There was limited understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA) procedures despite 88% of staff having completed the training.
- Student nurses we spoke to highlighted that they did not feel safe on the wards. They had to work in the numbers at times. They also said that staff were under pressure because most experienced staff were leaving. They did not feel they would want to work on the wards permanently.
- There were regular audits on the wards by various staff, including prescription charts, infection control, health and safety and weekly mattress and cover checks. We saw evidence that outcomes of these were discussed within the team meetings. Following audits an action plan was implemented was monitored by the Assurance group that meets monthly. There was a re audit to see if the action plan was working.

Leadership, morale and staff engagement

- On all the wards there was evidence of the regular use of agency staff; on average three bank or agency staff in 24 hours. Ward managers reported that staff retention was low due to staff moving on to higher grades for career development offered within RAID, Street Triage and Home Treatment Teams. Other staff told us they were moving on due to no longer feeling safe on the wards an increase of staff injuries due to assault by patients was confirmed this. Staff sickness ratings were displayed on all of the wards in the corridors.
- The trust's annual Recognising Excellence and Achievement in Combined Healthcare (REACH) awards had seen two of the wards nominated as team of the year and Ward 2 received the Health and Wellbeing Award.
- Some Staff we spoke to stated they were aware of how to raise concerns without fear of victimisation and were

aware of their trusts' whistle blowing process. The trust had introduced a "Dear Caroline" initiative (a forum to address concerns directly with the Chief Executive), to allow staff to raise concerns anonymously.

- Staff on the wards spoke highly of their line manager and felt they valued their work. Staff on Ward 3 showed particularly good morale and felt appreciated by their local ward management team. However, staff on Ward 1 and Ward 2 implicitly expressed that low staffing levels had a negative impact on morale.
- One staff nurse that we spoke with commented that the pharmacy service 'provides vital information, is helpful, very friendly and approachable'

Commitment to quality improvement and innovation

- All Wards had met the standards and had been accredited by the Royal College of Psychiatry Acute Inpatient Mental Health Service (AIMS) with Ward 2 accredited as excellent.
- The introduction of Non-medical Nurse Prescriber roles on all the wards to support the medical staff has improved patient care by reducing waiting time for treatment or review by doctors.
- There were regular acute operational meetings to look into problems and effective solutions across the acute care system. These meetings included matrons, ward managers and consultants. The move towards mixed sex accommodation across the acute care pathway in order to balance bed pressures and bring about flexibility in the wards was discussed. Some staff that we spoke to supported this as they felt this would put less pressure bed shortages. The trust is working with the Clinical Commissioning Groups in order to introduce a Psychiatric Intensive Care Unit on the Harplands Hospital.
- Information about learning from medicine related incidents was shared with staff via staff team meetings. In response to the NHS England and Medicines and Healthcare products Regulatory Agency (MHRA), the trust had appointed a Medicine Safety Officer (MSO). Arrangements were in place to ensure that medicine incidents were documented and investigated. The pharmacy team also undertook monitoring of any changes to ensure safe practice continued. In particular, the pharmacy team had recently undertaken an audit of missed doses where people had not been given their medicine. This identified the need for nursing staff to be careful to document the reason why a medicine was not given.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. Care and treatment must be provided in a safe way for service users. The trust did not ensure the grills beneath all the windows in Ward 1 as a potential ligature risk and were not included in ligature audits therefore not fully managed or mitigated. This was a breach of regulation 12(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment The trust did not have a seclusion room meeting the MHA Code of Practice guidance. Patients were being secluded in their bedroom and annexe where the facilities were not appropriate and safe. This was a breach of regulation 15(1)(c)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment. All premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance. The trust must ensure that all staff adheres to current legislation and guidance when cleaning up bodily fluids. We observed staff wiping blood off the floor in a corridor with tissue and without protective wear following blood spillages. This was a breach of regulation 15 (1)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust must ensure that informal patients are aware of their right to leave the ward. Staff must make sure there is an appropriate legal authority in place if they prevent an informal patient from leaving the ward. This was a breach of regulation 13(5)