

Derbyshire Healthcare NHS Foundation Trust

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

Quality Report

The Radbourne Unit
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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)
RXM		Wards 33, 34, 35, 36, enhanced care ward	DE22 3WQ

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

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

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

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Summary of findings

Overall summary

We only looked at parts of the five questions at this inspection that related to the concerns raised.

We did not rate the core service at this inspection as we only inspected the Radbourne Unit and looked at specific issues relating to the concerns we had received.

- There were still some shifts where the skill mix of staff was not appropriate and did not meet the minimum staffing level for the ward.
- Staff were still unclear of and applied inconsistently the trust's policy and guidance on contraband and risky items and the smoke – free policy.
- Some records showed gaps in the monitoring of patients' physical health.

- Staff did not always respect patients' privacy and dignity.
- The trust did not always ensure repairs were completed in a timely manner.
- Managers did not always identify risks to patients and staff and take action to reduce these.

However:

- Patients said that staff were kind and caring and we observed this.
- Staff had good knowledge of the Mental Capacity Act 2005.

Summary of findings

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

Are services safe?

We only looked at parts of the safe question at this inspection that related to the concerns raised.

- The service did not always provide safe care.
- The ward environments were clean but not always well maintained.
- There were not always enough nurses to maintain safe staffing levels or to make sure that patients had one to one time and took part in therapeutic activities.
- Staff did not always assess patients risks in a timely manner.
- Staff were inconsistent in how they applied the rules around contraband (risky) items and smoking tobacco.
- Staff did not always sign to say they had given patients their medicines.

However:

- Staff cleaned and tested the emergency equipment in the clinic rooms to make sure it was safe to use.
- Staff stored patients' medicines safely and pharmacists visited wards daily.
- Staff individually risk assessed the need to search patients and recorded this.

Are services effective?

We only looked at parts of the effective question at this inspection that related to the concerns raised.

- Staff did not always develop holistic, recovery-oriented care plans informed by a comprehensive assessment for each patient.
- Staff did not always complete patients' physical health observations in a timely manner.
- Managers did not ensure that all staff received regular training and supervision.
- Patients did not always have the correct authorisation to take Section 17 leave (permission to leave the hospital).

However:

- Staff informed patients of their rights under the Mental Health Act 1983 and referred them to advocates.
- Staff understood and discharged their roles and responsibilities the Mental Capacity Act 2005.

Summary of findings

Are services caring?

We only looked at parts of the caring question at this inspection that related to the concerns raised.

- Strong wear (clothing that patients could not rip to tie as a ligature) was not provided for patients in seclusion. This impacted on patients' privacy and dignity.
- The trust had not ensured that the seclusion room toilet had been repaired. This meant that if both seclusion rooms were being used, patients in one room had to use a receptacle as a toilet which impacted on their privacy and dignity.
- Patients were not always involved in their care plans.
- Patients did not have regular community meetings to involve them in the running of the ward.

However:

- Patients said that staff were caring, kind and approachable and we observed this during our inspection.
- One patient had an advance decision which they were very involved in.

Are services responsive to people's needs?

We only looked at parts of the responsive question at this inspection that related to the concerns raised.

- There were not enough staff to offer patients regular therapeutic activities and respond to their requests for support with activities.
- There were no handrails in the assisted bathroom on Ward 34 so patients with mobility difficulties were unable to safely access this.

Are services well-led?

We only looked at parts of the well-led question at this inspection that related to the concerns raised.

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not always well managed.
- Ward teams did not have access to all the information they needed to provide safe and effective care.

Summary of findings

Information about the service

The acute wards for adults of working age are provided from two sites. The Hartington Unit is located on the site of Royal Chesterfield Hospital and the Radbourne Unit is located on the site of Royal Derby Hospital. At the time of our inspection, the trust did not have any psychiatric intensive care units. We only inspected the Radbourne Unit at this inspection.

This core service provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

Radbourne Unit has five wards:

- Ward 33: 20 beds, female
- Ward 34: 20 beds, male
- Wards 35: 20 beds, mixed gender
- Ward 36: 20 beds, mixed gender
- Enhanced care ward: 10 beds, mixed gender.

At our previous inspection in June 2018, we rated this core service as Inadequate overall. We rated the safe and well-led key questions as inadequate, effective and responsive key questions as requires improvement and the caring key question as good.

Our inspection team

Two inspectors, one inspection manager, one assistant inspector and a specialist advisor who is a mental health nurse inspected the Radbourne Unit.

Why we carried out this inspection

We inspected the Radbourne Unit only as we had concerns following Mental Health Act reviewer visits to Ward 34 and Ward 36 and received concerns from patient's relatives and staff. The concerns were about staffing levels, experience and knowledge of staff, care planning and activities for patients. Our inspection was

unannounced (staff did not know we were coming) to enable us to observe routine activity. We also held focus groups on 17 October 2018 at the Radbourne Unit. We spoke with 15 staff, five patients and one carer of a patient.

How we carried out this inspection

We did not inspect all key questions but inspected the areas where we had concerns.

During the inspection, the inspection team:

- visited all five wards, looked at the quality of the ward environment, and observed how staff were caring for patients
- spoke with 14 patients
- spoke with 25 staff including nurses, doctors, healthcare assistants, pharmacist, ward managers, heads of nursing, general manager and area service manager
- attended and observed one multidisciplinary team review meeting
- looked at the care records of six patients
- reviewed nine medication charts
- received four comment cards from patients
- held three focus groups on 17 October 2018 where we spoke with 15 staff, five patients and one carer.

Summary of findings

What people who use the provider's services say

Patients told us that staff were nice, supportive, kind and caring. They said that nurses listened to them and told the doctors what they needed. One patient said, "You can't fault the staff." However, all patients said there were not enough staff to give them the time they needed.

Some patients said that they did not feel safe as other patients could be aggressive and there were not enough staff to deal with this. Patients said staff did not have the time to have one to one time with them.

At our focus groups patients told us there were a lot of new staff working on the wards which meant staff did not know them and how to support them.

Patients said staff looked after their physical healthcare well and they always got to see a doctor when they needed to.

Patient said the food was bland and there were lots of potatoes on the menus.

One patient said there was not a lot that could be improved, and their care was just about right.

Patients said the wards were nice and clean.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that all wards and shifts have safe staffing levels.
- The trust must ensure that its observations process is safe and fit for purpose.
- The trust must ensure that all staff are fully aware of the trusts policy and guidance on contraband or risky items and apply it consistently across all wards.
- The trust must ensure that staff regularly assess all patients risks and that there is a clear plan in place as to how these risks are to be managed.
- The trust must ensure that staff complete, record and respond appropriately to patients' physical health needs.
- The trust must ensure that patients on section 17 leave have the correct authorisation and legal documentation in place.

- The trust must ensure that all patients' privacy and dignity is respected at all times.
- The trust must ensure that the core service has a robust programme of clinical audits and that identified actions are addressed.

Action the provider **SHOULD** take to improve

- The trust should ensure that it assesses and adequately mitigates the risks presented by the blind spots on the wards.
- The trust should ensure that repairs are completed in a timely manner.
- The trust should ensure that patients have regular access to a structured programme of recovery-based therapeutic activities both on and off the wards.

Derbyshire Healthcare 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
Wards 33, 34, 35, 36, enhanced care ward	Radbourne Unit

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 informed patients of their rights under the Mental Health Act and referred them to an Independent Mental Health Advocate.

Patients said that they had their Section 17 leave (permission for patients to leave the hospital) however, the correct documentation for this was not in place for one patient.

Staff attached consent to treatment forms to medication charts where applicable which meant that nurses could give patients their medication under the correct legal framework.

Staff displayed information about the rights of informal patients to leave the ward freely when they wanted to.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff on all wards had a good understanding of the Mental Health Act 2005 and its guiding principles.

Staff assessed and recorded capacity to consent appropriately and clearly.

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

We did not look at all aspects of the safe question at this inspection.

Safe and clean environment

Safety of the ward layout

Radbourne Unit had five wards. Wards 33, 34 and 36 were located on the first floor, and Ward 35 and the enhanced care ward were located on the ground floor.

All the wards had similar layouts. On entry to a ward, there was a long corridor that had staff offices, meeting rooms and storerooms. The end of the corridor held the nursing station and opened out into a communal area, which had bedroom corridors to the left and right of it. The bedroom corridors held dormitory bedrooms, some single rooms, and patients' bathrooms and toilets.

The nursing station allowed observation of most areas of the wards although there were some blind spots around corners along the bedroom corridors on all the wards. The wards did not have parabolic mirrors in all areas of the ward to help manage the risks. These were at the ends of corridors with two corners so were not effective. The provider informed us that parabolic mirrors are not a viable solution to reduce the blind spots and that they are exploring the use of closed circuit television cameras and anti-ligature cameras. The wards had access to patient personal alarms which can be issued by staff to specific patients depending on individual risk assessment.

Staff also managed risk through individual risk assessments and observations. However, during our inspection we observed on Wards 33 and 35 there were no staff in the bedroom corridors to reduce these risks. On Ward 36 we saw staff sitting talking with one patient in the dormitory as part of their observations to ensure their safety.

The trust had completed a full ligature risk assessment of each ward in the last 12 months. All wards had ligature anchor points that staff knew about and dealt with appropriately to reduce the risks to patients. For example, staff designated toilets that had door handles that could act as ligature anchor points for staff and visitors only and

locked them when not in use. Other rooms that had ligature anchor points (such as the laundry, some bath and shower rooms, the gardens, the recreation room on ward 33) had supervised access for patients. The furnishings and fittings on the wards were anti-ligature, for example, showers, taps and curtain rails.

Maintenance, cleanliness and infection control

All the wards were visibly clean. Domestic staff were allocated to each ward who cleaned the wards regularly to a high standard.

The trust did not take prompt action to respond to maintenance repairs. For example, on Ward 33, all 20 patients had to use one shower as the drain in the other shower was blocked. Staff said this had been out of use for a long time. On Ward 35, one of the showers was also broken as was a television in the communal lounge. Staff said these had been broken since at least the beginning of October 2018.

Staff followed infection control principles such as hand washing. We saw that hand sanitiser, anti-bacterial wipes and protective gloves were available throughout the units.

Seclusion room

The trust had a purpose-built seclusion suite on the enhanced care ward that contained two separate seclusion rooms. The layout, design and contents of the seclusion rooms complied with the Mental Health Act Code of Practice. The seclusion rooms had anti-ligature fixtures and fittings. The rooms had two-way intercoms, temperature control units, toilet facilities (with automatic taps) and clocks. One of the rooms had adaptations that met the needs of people with limited mobility. Staff had the opportunity to offer sensory-based interventions to secluded patients such as music and aromatherapy that helped them relax in one of the rooms. However, as at our previous inspection in June 2018, one of the seclusion rooms had a toilet area that was out of use. Staff said it had been out of use for an "extended period" and had reported the issue but were still awaiting repair. In the meantime, staff continued to use the seclusion room if needed but locked the toilet door. Staff provided the patient with a receptacle for urgent toilet needs, which impacted on their privacy and dignity.

Are services safe?

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

Clinic room and equipment

All wards had fully equipped clinic rooms that were secure, clean and tidy. On Ward 34, we saw stickers that showed that staff had cleaned and tested the equipment so that it was safe to use.

Safe staffing

Nursing staff

At our previous inspection in June 2018 we found that there were a high number of staff vacancies particularly for registered nurses and that staffing levels were not always safe. Since our previous inspection, the trust had recruited several registered nurses to fill the vacancies. However, many of these had only recently been registered so were not experienced. The trust employed preceptorship (newly qualified nurses are called preceptorship nurses) leads who worked on the wards alongside the nurses to help them to develop. They also arranged monthly preceptorship forums which included training in specialist areas, for example, needs of patients with autism. Before this inspection we were told that preceptorship nurses were leading shifts and did not have the experience to do this which raised concerns about patient safety. We found that there was one shift on Ward 36 where a preceptorship nurse was in charge, however when the preceptorship lead became aware of this they went to the ward to work with them. Staff told us, and we saw that trust managers had put in more experienced staff from other areas of the trust to help to develop skills of the preceptorship nurses and maintain patient safety.

Rotas showed that permanent staff did extra shifts to fill vacancies to help ensure that there were always regular staff on duty. Most bank and agency staff that worked there were also familiar with the wards.

Staffing levels had improved but we still found some shifts were not adequately covered to meet patients' needs and ensure their safety. Each ward had a minimum staff allocation based on the number of patients and their needs.

On Ward 33, there should be two registered nurses and three healthcare assistants on each shift during the day. At night there should be two registered nurses and one healthcare assistant or one registered nurse and two healthcare assistants. We looked at staff rotas for the week before our inspection. On 29 November 2018 night shift the registered nurse was sick, rotas showed that they were not

replaced but there were only three healthcare assistants on duty. There were also two shifts where staff were called to cover other wards which left Ward 33 short by one healthcare assistant. Staff kept the recreation room locked due to ligature risks and patients could only access the room with staff. In the afternoon of our inspection patients wanted to use the room to do some arts and crafts activities. There were not enough staff to facilitate this as although they met their minimum staffing levels there were ward rounds ongoing.

On Ward 34, there were 5.4 band 5 registered nurse vacancies and the trust had advertised these. During the day there should be three registered nurses and two healthcare assistants. On the day of inspection there were two registered nurses, one healthcare assistant and one occupational therapist. They had requested a bank nurse, but this was not filled and they were unable to get staff from another ward. The ward manager said they tried not to include the occupational therapist in the safe staffing numbers as this impacted on patient activities and they shared the occupational therapist with Ward 33.

On Ward 35, there were four band 5 and one band 6 registered nurse vacancies. The trust had recruited one more healthcare assistant than was needed to maintain safe staffing levels and had recently recruited another two registered nurses. During the day there should be three registered nurses and two healthcare assistants. At night there should be two registered nurses and one healthcare assistant. Staff said if they could not get two registered nurses to cover the night shift they got another healthcare assistant so there would be four staff. Rotas showed this for 2nd, 3rd and 4th December nights. The occupational therapist had been included in the staffing numbers on the ward on five day shifts in the week before our inspection. Staff said although this met safe staffing levels it impacted on patients one to one activities.

On Ward 36, there should be three registered nurses and two healthcare assistants during the day on each shift. Rotas showed in the week before our inspection there were three shifts that did not meet this. On two late shifts there were three registered nurses and one healthcare assistant. On another late shift there was two registered nurses and three healthcare assistants.

On each day shift on the enhanced care ward there should be three registered nurses and three healthcare assistants. On the day of inspection, they did not meet this. There

Are services safe?

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were two registered nurses and four healthcare assistants on the early shift and two registered nurses and three healthcare assistants on the late shift. Staff said that the staffing levels impacted on patients access to fresh air, activities and their one to one time with their named nurse.

The trust trained staff in physical intervention training with a focus on least restrictive interventions such as de-escalation known as positive and proactive approach. Not all staff had received this training. On Ward 34 staff told us there should be three staff on each shift who were trained but this was not always possible. We saw on the night shift on the day of our inspection there were only two trained staff. This was the same in three of the night shifts and four early shifts in the week before our inspection. The trust had trained 17 staff from Ward 34 in this and another five staff were booked to do this.

Patients said staffing levels impacted on their one to one time with their named nurse and the activities they can do. One patient said staff were often busy, so they did not like to ask for their one to one time. Patients at focus groups said there were not enough staff for one to one time. Another patient said they had regular one to one with night staff as they had more time. Two of three patients on Ward 35 spoken with told us they did not feel safe due to staffing levels on the ward.

Assessing and managing risk to patients and staff
We did not look at all aspects of the safe question at this inspection.

Safe and clean environment

Safety of the ward layout

Radbourne Unit had five wards. Wards 33, 34 and 36 were located on the first floor, and wards 35 and the enhanced care ward were located on the ground floor.

All the wards had similar layouts. On entry to a ward, there was a long corridor that had staff offices, meeting rooms and storerooms. The end of the corridor held the nursing station and opened out into a communal area, which had bedroom corridors to the left and right of it. The bedroom corridors held dormitory bedrooms, some single rooms, and patients' bathrooms and toilets.

The nursing station allowed observation of most areas of the wards although there were some blind spots around corners along the bedroom corridors on all the wards. The wards did not have parabolic mirrors installed to help

manage the risks. The trust had not taken any action since our previous inspection to reduce the blind spots. Staff managed risk through individual risk assessments and observations. However, during our inspection we observed on Wards 33 and 35 there were no staff in the bedroom corridors to reduce these risks. On Ward 36 we saw staff sitting talking with one patient in the dormitory as part of their observations to ensure their safety.

The trust had completed a full ligature risk assessment of each ward in the last 12 months. All wards had ligature anchor points that staff knew about and dealt with appropriately to reduce the risks to patients. For example, staff designated toilets that had door handles that could act as ligature anchor points for staff and visitors only and locked them when not in use. Other rooms that had ligature anchor points (such as the laundry, some bath and shower rooms, the gardens, the recreation room on ward 33) had supervised access for patients. The furnishings and fittings on the wards were anti-ligature, for example, showers, taps and curtain rails.

Maintenance, cleanliness and infection control

All the wards were visibly clean. Domestic staff were allocated to each ward who cleaned the wards regularly to a high standard.

The trust did not take prompt action to respond to maintenance repairs. For example, on Ward 33, all 20 patients had to use one shower as the drain in the other shower was blocked. Staff said this had been out of use for a long time. On Ward 35, one of the showers was also broken as was one of the ward televisions in the communal lounge. Staff said these had been broken since at least the beginning of October 2018.

Staff followed infection control principles such as handwashing. We saw that hand sanitiser, anti-bacterial wipes and protective gloves were available throughout the units.

Seclusion room

The trust had a purpose-built seclusion suite on the enhanced care ward that contained two separate seclusion rooms. The layout, design and contents of the seclusion rooms complied with the Mental Health Act Code of Practice. The seclusion rooms had anti-ligature fixtures and fittings. The rooms had two-way intercoms, temperature control units, toilet facilities (with automatic taps) and

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clocks. One of the rooms had adaptations that met the needs of people with limited mobility. Staff had the opportunity to offer sensory-based interventions to secluded patients such as music and aromatherapy that helped them relax in one of the rooms. However, as at our previous inspection in June 2018, one of the seclusion rooms had a toilet area that was out of use. Staff said it had been out of use for an “extended period” and had reported the issue but were still awaiting repair. In the meantime, staff continued to use the seclusion room if needed but locked the toilet door. Staff provided the patient with a receptacle for urgent toilet needs, which impacted on their privacy and dignity.

Clinic room and equipment

All wards had fully equipped clinic rooms that were secure, clean and tidy. On Ward 34, we saw stickers that showed that staff had cleaned and tested the equipment so that it was safe to use.

Safe staffing

Nursing staff

At our previous inspection in June 2018 we found that there were a high number of staff vacancies particularly for registered nurses and that staffing levels were not always safe. Since our previous inspection, the trust had recruited several registered nurses to fill the vacancies. However, many of these had only recently been registered so were not experienced. The trust employed preceptorship (newly qualified nurses are called preceptorship nurses) leads who worked on the wards alongside the nurses to help them to develop. They also arranged monthly preceptorship forums which included training in specialist areas, for example, needs of patients with autism. Before this inspection we were told that preceptorship nurses were leading shifts and did not have the experience to do this which raised concerns about patient safety. We found that there was one shift on Ward 36 where a preceptorship nurse was in charge. This was due to unplanned sickness which occurred the night before the shift. The ward staff emailed the head of nursing immediately who worked the shift from 7.30am and the senior nurse came to work early at 11.30am. In addition, the preceptorship lead went to the ward to work with the preceptorship nurse when they

became aware of this to support. Staff told us, and we saw that trust managers had put in more experienced staff from other areas of the trust to help to develop skills of the preceptorship nurses and maintain patient safety.

Rotas showed that permanent staff did extra shifts to fill vacancies to help ensure that there were always regular staff on duty. Most bank and agency staff that worked there were also familiar with the wards.

Staffing levels had improved but we still found some shifts were not adequately covered to meet patients’ needs and ensure their safety. Each ward had a minimum staff allocation based on the number of patients and their needs.

Wards had a skill mix of registered professionals. The first two must be registered mental health nurses or registered learning disability nurses. The third registered professional may be a registered general nurse, ward based occupational therapist or other suitable registered professional, for example social worker following review of competency. If staffing levels cannot be achieved the third registered professional may be replaced in an emergency by a healthcare assistant to maintain a safe level.

On Ward 33, there should be two registered professionals and three healthcare assistants on each shift during the day. At night there should be two registered professionals and one healthcare assistant or one registered professional and two healthcare assistants. We looked at staff rotas for the week before our inspection. On 29 November 2018 night shift the registered professional was sick, rotas showed that they were not replaced but there were only three healthcare assistants on duty. There were also two shifts where staff were called to cover other wards which left Ward 33 short by one healthcare assistant. Staff kept the recreation room locked due to ligature risks and patients could only access the room with staff. In the afternoon of our inspection patients wanted to use the room to do some arts and crafts activities. There were not enough staff to facilitate this as although they met their minimum staffing levels there were ward rounds ongoing.

On Ward 34, there were 5.4 band 5 registered nurse vacancies and the trust had advertised these. During the day there should be three registered professionals and two healthcare assistants. On the day of inspection there were two registered nurses, one healthcare assistant and one occupational therapist. They had requested a bank nurse,

Are services safe?

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but this was not filled and they were unable to get staff from another ward. The ward manager said they tried not to include the occupational therapist in the safe staffing numbers as this impacted on patient activities and they shared the occupational therapist with Ward 33. However, the ward skill mix was achieved. The senior nurse confirmed that they often tried to make the ward based occupational therapist extra to the staff on the rota to increase ward activity above the safe staffing levels.

On Ward 35, there were four band 5 and one band 6 registered nurse vacancies. The trust had recruited one more healthcare assistant than was needed to maintain safe staffing levels and had recently recruited another two registered nurses. During the day there should be three registered professionals and two healthcare assistants. At night there should be two registered professionals and one healthcare assistant. Staff said if they could not get two registered professionals to cover the night shift they got another healthcare assistant so there would be four staff. Rotas showed this for 2nd, 3rd and 4th December nights. The occupational therapist was one of the registered professionals on the ward on five day shifts in the week before our inspection. Staff said although this met safe staffing levels it impacted on patients one to one activities.

On Ward 36, there should be three registered professionals and two healthcare assistants during the day on each shift. Rotas showed in the week before our inspection there were three shifts that did not meet this. On two late shifts there were three registered nurses and one healthcare assistant. On another late shift there was two registered professionals and three healthcare assistants.

On each day shift on the enhanced care ward there should be three registered professionals and three healthcare assistants. On the day of inspection, they did not meet this. There were two registered professionals and four healthcare assistants on the early shift and two registered professionals and three healthcare assistants on the late shift. Staff said that the staffing levels impacted on patients access to fresh air, activities and their one to one time with their named nurse.

The trust trained staff in physical intervention training with a focus on least restrictive interventions such as de-escalation known as positive and proactive approach. Not all staff had received this training. On Ward 34 staff told us there should be three staff on each shift who were trained but this was not always possible. We saw on the night shift

on the day of our inspection there were only two trained staff. This was the same in three of the night shifts and four early shifts in the week before our inspection. The trust had trained 17 staff from Ward 34 in this and another five staff were booked to do this.

Patients said staffing levels impacted on their one to one time with their named nurse and the activities they can do. One patient said staff were often busy, so they did not like to ask for their one to one time. Patients at focus groups said there were not enough staff for one to one time. Another patient said they had regular one to one with night staff as they had more time. Two of three patients on Ward 35 spoken with told us they did not feel safe due to staffing levels on the ward.

Assessing and managing risk to patients and staff

Management of patient risk

Since our previous inspection, the trust had provided phones (hand held devices) for staff to record patient observations. Generally, this had improved the recording of patient observations. However, one staff member said that the signal in the dormitories was poor which meant they had to input the observation details later. There was also a delay for staff to input this if staff on all wards were using the devices at the same time. Staff said this could mean that observations were recorded inaccurately, or they did not record them. On the enhanced care ward, we saw that staff should have recorded one patient's observations every hour on 30 November, but staff did not record this for three hours. Another patient's record showed on 2 December that staff should have recorded their observations every 15 minutes but they had not recorded this for 47 minutes. The provider told us that there are some very small areas of wards where mobile devices are not always effective. In these areas laptops are fully effective. The provider informed staff where these areas are and until more telephone or Wi-Fi areas are boosted to use the laptops.

Staff did not always assess patients risks in a timely manner. One patient was transferred to Ward 36 from the enhanced care ward on 13 November, but staff had not updated their risk assessment since the transfer. Staff had identified the risks to the patient's safety in their care plans but had not stated how these were to be managed. Another patient was admitted to Ward 36 on 5 July 2018, but staff had not completed the patients risk assessment until 30 July 2018.

Are services safe?

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

At our previous inspection in June 2018, we found that staff were not aware of the trusts policy and guidance on contraband and risky items. At our focus groups in October, managers told us that they had met with the trusts least restrictive practice group and drafted a contraband list. They were to consult with patients about this. Staff at this inspection were aware of the policy but said the contraband list had not yet been finalised. They said there was no formal system for handing out contraband items to patients and making sure these were returned, for example, they would give patients their cigarette lighters when going off the ward to smoke but could not be certain they would always be returned. This relied on staff remembering who had the items and asking patients for them.

Staff did not routinely search patients. However, when staff needed to conduct a personal search, they ensured it was done by a staff member of the same gender as the patient and in private. The trust trained staff in searching patients during the positive and proactive training. Staff risk assessed the need to search each patient, gained the patients consent and recorded this.

Use of restrictive interventions

As at our previous inspection, we found that staff did not always adhere to the trust's smoke-free policy although they had tried to implement a tobacco-free environment. Patients said they found the inconsistency of staff response to smoking confusing. Staff on all wards said it was difficult to implement this policy and patients smoked in bedrooms and toilets although knew they were not allowed to. The trust had introduced e burners on the wards a few weeks before this inspection. Patients who smoked received a free

e burner on admission and had to buy these at a cost of £2.50 afterwards. Patients could use these on the wards apart from in the dining room and kitchen. We observed one patient using their e burner in the dining room on one ward and staff asked them to move to a different room. Staff advised patients on admission that they could not smoke tobacco and offered them nicotine replacement therapy and access to smoking cessation support. Patients should go out of the hospital grounds to smoke tobacco. However, patients said they did not do this and often smoked in the car park outside reception to the unit. We observed patients smoking outside reception during our inspection and two patients smoking in the courtyard outside Ward 35.

Before our inspection we were told that staff did not always know which patients were detained and had let detained patients leave the ward unescorted. The doors were locked on all wards but there was a notice which told informal patients of their right to leave the ward. Staff on Ward 33 said that detained patients often tailgated the door and went out when the dinner trolley was brought to the ward.

Medicines management

Staff stored all medicines in locked cabinets or medicine fridges in locked clinic rooms. Staff carried out regular stock checks on controlled drugs and other medicines. The wards had good access to the pharmacy team and visited the wards daily. Pharmacists completed weekly audits of patients' prescription charts. However, we looked at nine patient's prescription charts on the enhanced care ward. We noted four gaps where staff had not signed to say they had given the patients their medicines.

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

We did not look at all aspects of the effective question at this inspection.

Assessment of needs and planning of care

Staff assessed patients' needs including their physical health but did not always update care plans in a timely manner. We looked at two patients care records on Ward 36. Both included a care plan although staff had not updated one to reflect the patients changing needs. Both care plans were not personalised and did not show staff how to meet all the patients' needs. Staff had completed a full physical health examination of both patients on admission and recorded their ongoing physical health care for one patient. However, they had not assessed the physical health care of the other patient for two months.

On Ward 34, we looked at one patients record. Staff had completed the Derbyshire Early Warning Score (DEWS) document for the patient. This quickly assesses the physical health needs of the patient based on vital observations. Staff had assessed that the patient needed to have their physical health observations taken daily. However, staff had not recorded this for three days in November 2018. Staff had put care plans in place for all the patient's needs so that all staff knew how to support the patient to meet their needs.

On the enhanced care ward staff had completed the Derbyshire Early Warning Score (DEWS) for one patient. The patients score highlighted to staff that they needed to retake the patient's observations in 15 minutes and what to do including contacting the doctor if they remained the same. Staff had not recorded that they had taken the patients observations again and had not recorded any further action. We discussed this with managers during feedback. They found that staff had tried to take the patients physical observations after 35 minutes, but the patient was physically aggressive, so it was not safe to continue. They recognised that this was not clearly recorded and asked staff to ensure that times and relevant information is recorded so action is taken to meet patients' needs.

Skilled staff to deliver care

The trust had made some improvements to developing staff, so they were skilled to deliver care. Since our previous inspection, staff said they had supervision with their

manager more often. Nurses who had recently completed their training (preceptorship nurses) told us they were supported to attend the monthly preceptorship forums and were assigned a practice facilitator. The next preceptorship forum was the day after our inspection and included training on autism awareness. The forums were in line with Health Education England requirements. However as at our previous inspection, staff had limited access to staff meetings. On the enhanced care ward staff said there was a meeting in November but no minutes from these were available.

Other staff told us they had completed e-learning on autism and had autism awareness training as part of their induction. Staff told us that psychologists led weekly reflective practice sessions on each ward but due to staffing levels they were not always able to attend these.

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

Records we looked at showed that staff told patients about their rights under the Mental Health Act 1983 where this was relevant. Staff explained the rights in a way that patients understood them and repeated them, if necessary. Patients told us that staff told them about their rights and referred them to an Independent Mental Health Advocate.

Patients told us they had their Section 17 leave (permission for patients to leave the hospital). However, on Ward 36, one patients record showed that their Section 17 leave had expired on 20 November 2018. The patient went on leave from the ward to a general hospital appointment on 21 November 2018 without the relevant Section 17 leave form in place.

Consent to treatment forms were in place and staff attached these to medication charts where applicable. This meant that nurses could administer the medication under the correct legal framework.

The service displayed a notice on all wards to tell informal patients that they could leave the ward freely.

Good practice in applying the Mental Capacity Act

Records we looked at showed that staff on all wards had a good understanding of the Mental Capacity Act and the five statutory principles.

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.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. We reviewed four capacity assessments and saw these were detailed, decision-specific and considered the patient's views as much as possible.

Are services caring?

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

Our findings

We did not look at all aspects of the caring question at this inspection.

Kindness, privacy, dignity, respect, compassion and support

The trust did not always promote the privacy and dignity of patients. On Ward 35, we saw that the shower was broken. Staff told us that female patients that they needed to supervise due to the ligature risks had to use the assisted bathroom. There was a shower over the bath and staff supervised the patient by standing behind the shower curtain. Staff and patients said this impacted on patient's privacy and dignity. We found that where patients clothing had to be removed when in seclusion due to the risks of the patient using their clothes to tie a ligature, they were not provided with 'strong wear' (clothing that can't be ripped to use as a ligature). This meant that they were naked with only a blanket around them which impacted on their privacy, dignity and wellbeing. We asked staff and managers if 'strong wear' was now available. Most staff were unaware what 'strong wear' was. One staff member said they had told managers in August that no 'strong wear' was provided but this was not addressed. Managers had not ordered this until they received feedback following our Mental Health Act visit to Ward 36 in November 2018.

Involvement in care

Involvement of patients

Staff did not always involve patients in their care planning. We looked at six patients care plans. Two did not show that the patient was involved or include their views. Some patients told us they did not have a copy of their care plan although one patient said they were involved in it. One patient told us they had an advance decision in place and had been and continued to be very involved in it.

Patients had good access to advocacy services and there was information about advocacy displayed on the wards. The independent mental health advocate visited the wards regularly.

There were not regular patient community meetings on each ward. On Ward 34, the last minutes available were of a meeting on 11 November 2018, they had been weekly or fortnightly before then. Patients discussed the no smoking policy, requested more activities and gym access and access to the therapy room for relaxation. On the enhanced care ward, staff and patients told us they had not had community meetings for a long time but were now planning to do these weekly. On Ward 35, patients told us there were usually weekly community meetings which they led and the minutes of these were displayed on the ward. However, meetings were sometimes cancelled due to staffing levels.

Are services responsive to people's needs?

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

Our findings

We did not look at all aspects of the responsive question at this inspection.

The facilities promote recovery, comfort, dignity and confidentiality

Staff said that they were not always able to offer patients therapeutic activities due to staffing levels but only able to meet patients' basic needs. Patients on Ward 33 said they could not often use the recreation room as there were not enough staff to supervise. This led to them becoming bored especially in the evenings. We observed one patient organising an arts and craft activity for other patients. They used the dining room as there were not enough staff to

supervise in the recreation room. Staff said, and rotas showed that sometimes the occupational therapist was included in the ward staffing numbers which reduced the amount of therapeutic activities for patients.

Meeting the needs of all people who use the service

Each ward had an assisted bathroom for people who have mobility difficulties but did not meet patients' needs on all wards. For example, on Ward 34 we saw there were no handrails in the bathroom to assist people to use the bath. Staff said they had been removed because of ligature risks. However, staff locked assisted bathrooms to reduce these risks and supervised all patients who used the assisted bathrooms. Therefore, there was no reason to remove these to reduce the risks.

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

We did not look at all aspects of the well - led question at this inspection.

Leadership

Following our previous inspection senior managers in the trust told us they had implemented a 100-day action plan to make the necessary improvements to the Radbourne Unit. At our focus groups in October we found that managers were aware of this plan, but ward staff and patients were not. The implementation of the plan appeared to be slow until our Mental Health Act Reviewer visits to Wards 34 and 36 in November 2018. Following these visits, we raised concerns with the trust managers about the safety of patients at the Radbourne Unit. Since then the trust had moved managers from other areas to

support staff at the Radbourne Unit. In the week before our inspection managers had started daily assurance meetings. At these meetings managers looked at staffing levels and assured themselves that patients were safe and there were enough staff to meet their needs.

Management of risk, issues and performance

Managers did not respond to concerns about patients' privacy and dignity until we raised them following our Mental Health Act Reviewer visit to Ward 36 in November. During that visit we found that a patient had been in seclusion in August 2018 and 'strong wear' (clothing that cannot be ripped to tie a ligature) was not provided to protect the patient's privacy and dignity. Staff told us they had raised this with managers, but they had not addressed this.

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

Treatment of disease, disorder or injury

Regulation

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

- Safe staffing levels not always maintained
- Risk assessments not always updated and management plan not in place
- Observations not recorded as needed for each patient
- Staff lacked knowledge of contraband and risky items policy and applied it inconsistently
- Section 17 leave documentation not in place for all Section 17 leave taken
- Staff did not assess and respond to all patients' physical health observations

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

- Patients not provided with appropriate clothing in seclusion to protect their dignity
- Seclusion room toilet out of order so had to use a receptacle as a toilet

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Managers did not identify risks and take prompt action to reduce these