South West London and St George's Mental Health NHS Trust

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

Quality Report

Building 28, Trust Headquarters,
Springfield University Hospital,
London
SW17 7DJ
Tel: 020 3513 5000
Website: www.swlstg-tr.nhs.uk

Date of inspection visit: 13-15 May 2015
Date of publication: 24/08/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQY08	Tolworth Hospital	Lilacs ward	KT6 7QU
RQY01	Springfield University Hospital	Jupiter ward, ward one and ward three	SW17 7DJ
RQY07	Queen Mary's Hospital	Lavender ward	SW15 5PN

This report describes our judgement of the quality of care provided within this core service by South West London and St George's Mental Health 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 South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's Mental Health NHS Trust.

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

- Ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely.
- On Lilacs ward, patient risk assessments and management plans were not always updated following risk incidents. Staff had not always followed risk management plans.
- On Lavender ward some patients were administered 'as required' medicines every night. The reasons why patients required these medicines was not always recorded or reviewed.
- Some equipment on Lilacs and Lavender wards was not maintained on a regular basis to ensure it was fit for purpose.
- On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients needs, and did not reflect their preferences. Many patients were not involved with the development of care plans.
- Staff on Lilacs ward in particular lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent and did not understand their legal responsibilities.
- Staff on several wards did not receive regular supervision.
- Patients on Lilacs ward and ward one did not have access to a regular programme of meaningful activities as these were often cancelled or not being provided.
- Detained patients on Lavender ward did not always have a consent or authorisation certificate in place.

However, on ward three a harm free care pilot had been conducted. This was now on-going. This looked at medicine errors, violence, self harm and falls. This information was presented in an easy to understand way. All wards, except the PICU, provided mixed sex accommodation. These wards adhered to national guidance by having separate male and female areas. Emergency resuscitation equipment was in place and checked regularly. Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. Learning from serious incidents led to improvements in care.

On Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. Some of the wards had recruited peer support workers. The peer support workers were part of the team. They offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward. They also helped staff and patients to work positively together.

Summary of findings

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

Are services safe?

- Ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely.
- On Lilacs ward, patient risk assessments and management plans were not always updated following risk incidents. Staff had not always followed risk management plans.
- On Lavender ward some patients were administered 'as required' medicines every night. The reasons why patients required these medicines was not always recorded or reviewed.
- Some equipment on Lilacs and Lavender wards was not maintained on a regular basis to ensure it was fit for purpose.

However, on ward three a harm free care pilot had been conducted. This was now on-going. This looked at medicine errors, violence, self harm and falls. This information was presented in an easy to understand way. All wards, except the PICU, provided mixed sex accommodation. These wards adhered to national guidance by having separate male and female areas. Emergency resuscitation equipment was in place and checked regularly. Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. Learning from serious incidents led to improvements in care.

Are services effective?

- On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients needs, and did not reflect their preferences. Many patients were not involved with the development of care plans.
- Staff on Lilacs ward in particular lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent and did not understand their legal responsibilities.
- Staff on several wards did not receive regular supervision.
- Patients on Lilacs ward and ward one did not have access to a regular programme of meaningful activities as these were often cancelled or not being provided.
- Detained patients on Lavender ward did not always have a consent or authorisation certificate in place.

Summary of findings

However, on Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. Some of the wards had recruited peer support workers. The peer support workers were part of the team. They offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward. They also helped staff and patients to work positively together.

Summary of findings

Information about the service

The acute inpatient services and psychiatric intensive care unit (PICU) were provided at three different hospitals in south west London. Some patients were detained under the Mental Health Act 1983 and the rest were admitted informally.

During the inspection we visited the following wards:

Lilacs ward, a 20 bed mixed sex acute admissions ward at Tolworth Hospital.

Ward three, a 20 bed mixed sex acute admission ward at Springfield University Hospital .

Jupiter ward, a 23 bed mixed sex acute admission ward at Springfield University Hospital.

Ward one, a 13 bed male psychiatric intensive care unit at Springfield University Hospital.

Lavender ward, a 23 bed mixed sex acute admission ward at Queen Mary's Hospital.

Our inspection team

The inspection team consisted of three CQC inspectors, a pharmacy inspector, one senior nurse and one expert by experience.

Why we carried out this inspection

We carried out this inspection to follow up the findings of our last inspection of the trust in March 2014. We wanted to check whether improvements had been made regarding the management of medicines, risk management and how patients' privacy and dignity was maintained. This inspection was unannounced.

The outstanding concerns were inspected as part of this focussed inspection. We found improvements had been made and the requirements had been met. However, we identified a number of other concerns or the same concerns on different wards. We made three requirement notices where there were breaches in regulations.

How we carried out this inspection

To see whether improvements had been made in key areas since the inspection in March 2014 we focussed on two key questions:

• Is it safe?

• Is it effective?

During the inspection visit, the inspection team:

• visited four acute admission wards on three hospital sites;

• visited the psychiatric intensive care unit (PICU) at Springfield University Hospital;

• spoke with 20 patients using the services;

• spoke with two carers of patients;

• spoke with the managers, acting managers or deputy managers of each ward;

• spoke with 26 staff members including: nurses, health care assistants, doctors, a modern matron and pharmacists;

• attended and observed a ward round;

• looked at 17 clinical records of patients;

• looked at 18 medicine administration records;

• carried out a specific check of the clinic rooms on all wards;

• carried out a specific check of medicines on Lilacs ward; and

Summary of findings

• looked at a range of policies, procedures and documents relating to the running of the services.

What people who use the provider's services say

All of the patients we spoke with said that they felt safe on the ward. Overall, patients said that nursing staff were pleasant and kind. The patients on ward three were complimentary about all of the staff. They particularly praised the occupational therapist, activities co-ordinator and acting ward manager.

Patients on Lilacs ward felt there were issues with agency staff. This was around their commitment and not knowing the patients. They also said there were few activities on the ward. Jupiter ward patients felt there were limited activities available to them. They were also unhappy that the TV had been broken for some time and not replaced.

Good practice

- On ward three a harm free care pilot had been conducted. This was now on-going. This looked at medicine errors, violence, self harm and falls. This information was presented in a way that was easy to understand.
- On Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. It also meant ward rounds were not as long and patients' needs were reviewed daily.
- Some of the wards had recruited peer support workers. They worked on a full or part-time basis. These were people who had experience of, or were using, mental health services. The peer support workers were part of the team. They offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward. They also helped staff and patients to work positively together.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all ligature risk assessments are detailed, specific and consistently assessed. Measures to minimise risks must be explicit and made known to all ward staff.
- The provider must ensure that patient risk assessments and management plans are updated following risk incidents. Environmental risks must be considered and risk management plans followed for all patients.
- The provider must ensure that patients on Lilacs ward are routinely involved with developing their care plans. Care plans must be person centred and reflect patients needs and preferences. Patients should always be offered copies of their care plans.
- The provider must ensure that when patients on Lavender ward have 'as required' medicines the reason for administering these medicines is clearly recorded.
- The provider must ensure that staff on Lilacs ward understand how the Mental Capacity Act and Deprivation of Liberty Safeguards are applicable to their work. They must ensure staff have the knowledge to be able to apply the Mental Capacity Act.

Action the provider SHOULD take to improve

- The provider should ensure that equipment on Lilacs and Lavender wards is maintained on a regular basis, so that it is safe to use and fit for purpose.
- The provider should ensure that all ward staff receive regular supervision.

Summary of findings

- The provider should ensure that an appropriate programme of meaningful activities is provided for patients on Lilacs ward and ward one.
- The provider should ensure that each patient on Lavender ward has a consent (T2) or authorisation (T3) certificate where this applies. This certificate should be attached to the medicine administration record for reference when medicines are administered.

South West London and St George's Mental Health 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
Lilacs ward	Tolworth Hospital
Ward one, ward three and Jupiter ward	Springfield University Hospital
Lavender ward	Queen Mary's Hospital

Mental Health Act responsibilities

- Records showed that patients detained under the Mental Health Act 1983 (MHA) were informed of their rights on a regular basis.
- We reviewed records of patients recently placed in seclusion on ward one. Nursing, medical and multi-disciplinary reviews took place at regular intervals. This was in accordance with the Mental Health Act 1983 Code of Practice.
- On Lavender ward two patients had been treated under the MHA for more than three months. There was no consent (T2) or authorisation (T3) certificate attached to either patients' medicine administration records. Certificates for both patients could not be found. This meant that medicines were being administered without assurance that consent or authorisation had been provided.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were poorly understood by the majority of staff. There was little understanding of the five principles, best interests and lasting power of attorney. This meant that the MCA or DoLS could be applied without the appropriate safeguards for patients. It also meant that situations when the MCA may be applicable may not be recognised. Staff often confused the term 'capacity' with the Mental Health Act definition.
- Lilacs ward staff did not consider that the MCA or DoLS was applicable to their patient group. It was noted that half the patients on the ward were informal patients. Three weeks prior to the inspection an informal patient was admitted to the ward. Upon admission, and for four days, the patient repeatedly said they should not be in hospital. On one occasion the patient said they wanted to leave. There was no record that the patient had been assessed under the MCA or the MHA. This meant the patient could have deprived of their liberty without authorisation. The patient was detained under Section 5 of the MHA on day four of the admission.

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

Summary of findings

- Ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely.
- On Lilacs ward, patient risk assessments and management plans were not always updated following risk incidents. Staff had not always followed risk management plans.
- On Lavender ward some patients were administered 'as required' medicines every night. The reasons why patients required these medicines was not always recorded or reviewed.
- Some equipment on Lilacs and Lavender wards was not maintained on a regular basis to ensure it was fit for purpose.

However, on ward three a harm free care pilot had been conducted. This was now on-going. This looked at medicine errors, violence, self harm and falls. This information was presented in an easy to understand way. All wards, except the PICU, provided mixed sex accommodation. These wards adhered to national guidance by having separate male and female areas. Emergency resuscitation equipment was in place and checked regularly. Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. Learning from serious incidents led to improvements in care.

Our findings

Safe and clean environment

- The ward layouts did not enable all areas to be observed easily. Some wards, such as ward three, had glass 'walls' in parts of the ward. This meant most of the ward could easily be observed. On Lilacs ward, however, there were small corridors in the bedroom areas. No mirrors were in place and staff could not easily observe these areas. A staff member walked around each ward from every fifteen minutes to every hour to observe these areas.
- We identified ligature points on all the wards. Each ward had a ligature risk assessment. However, these varied in the level of detail recorded. On Jupiter ward and ward three, specific details of the risks were recorded. Also recorded were specific measures to control and minimise the risks. Each risk was coded to identify the severity of the risk. We found two ligature risks on ward three which had not been identified. This meant staff may have been unaware of these risks.
- On Lilacs ward, ligature risks were recorded by room. The risks in each room were not always recorded. Measures to minimise the risks were general and not specific. One ligature risk in all of the bedrooms had been assessed to be a different severity in different rooms. It was unclear how the severity of the risks had been assessed. Some work had been undertaken on Lilacs ward to remove ligature risks.
- On ward one the risk assessment did not clearly detail all risks or the control measures for these. A numerical score was used to indicate the severity of risk. This was different from other wards and not part of the providers' policy. Staff did not understand what the scoring meant. The lack of detail in the risk assessments on Lilacs ward and ward one put patients at risk.
- On all wards the ligature risk assessments were not readily available to staff. Only the ward manager or deputy manager could access them. This meant ward staff were not always aware of all of the ligature risks.
- The clinic rooms on each ward were suitable for their purpose. Emergency resuscitation equipment was within its expiry date and was checked daily. Needles, syringes and dressings were also within their use by date.
- On Lilacs ward, the sphygmomanometer, used to measure blood pressure, had last been serviced before 2010. This meant blood pressure recordings may not be accurate. On Lavender ward a portable nebuliser was available for patients with asthma. This had last been serviced in 2011. This meant that medicines given by the nebuliser may not be completely effective.
- Ward one was a psychiatric intensive care unit (PICU). This was the only ward we visited that had a seclusion

room. It was not in use during our visit to the ward. Staff were able to observe all areas of the seclusion room. There was an adjoining shower and toilet. To ensure patient privacy, a roller blind could be used over the observation panel. There was an intercom for communication with staff and a clock was visible.

- The ward areas were cleaned regularly and were well-maintained. The décor and furnishings of most wards promoted a comfortable and modern environment. On some wards, the use of colour made the environment appear less institutional. On Lilacs ward, some of the bedroom corridors and bedrooms appeared to require redecoration. On all wards, patients were able to access fresh air at any time. On ward one, we observed the ward domestic inform a nurse that two toilets were blocked. The nurse immediately reported this to the facilities department to be addressed.
- On Lilacs ward there were weekly hygiene checks. This included checking washbasins, liquid soap, sharps bins and infection control disposables. There were, however, three packs of high energy protein drinks which were past their use by date. Two packs had expired two months previously, the other pack seven weeks previously. We also noted that the fridge temperature in the patients' kitchen had not been checked for four days in the previous week.
- All wards, except the PICU, provided mixed sex accommodation. These wards adhered to national guidance by having separate male and female areas. This included separate bedroom areas, bathrooms and a female only lounge. On Jupiter ward there was a separate, female only, garden.

Safe staffing

- In the previous year, across all wards, 99% of shifts for nurses during the day were filled. At night, 139% of shifts were filled. One hundred and four per cent of healthcare assistant shifts were filled during the day, and 162% were filled at night. All wards required additional staff above normal staffing levels at times. This was often because some patients required continuous support from a member of staff. On Jupiter and Lavender wards there were less nurses working during the day than required. On Jupiter ward an average of 21 shifts per month had one less nurse than required. On Lavender ward this was an average of 19 shifts per month.
- Lilacs ward and ward one had the highest number of staff vacancies. Lilacs ward had eight nurse vacancies. There was also one health care assistant vacancy. Bank and agency staff were used to cover these shifts. Where possible staff who knew the ward and patients were used. The matron informed us that six of the nurse posts had been recruited to.
- On ward three staff told us that additional staff used to be rostered for ward round. This had changed some months previously. Rosters we reviewed confirmed the number of staff available on ward round days. One staff member would respond to emergencies on other wards. Another could provide a high level of support for a single patient. With ward round happening, this could leave two nursing staff available for all of the other patients.
- There was medical cover for each of the wards throughout the 24 hour period.

Assessing and managing risk to patients and staff

- There had been 29 episodes of seclusion in the last six months. These had all taken place on ward one.
- There had been 83 episodes of restraint. These were highest in Jupiter ward (24) and ward three (23). Lavender ward reported there had been only one restraint in six months.
- There were six prone restraints recorded. These were highest in ward one (2) and ward three (2). In March 2015 the national reporting requirements for prone restraint changed. All of the prone restraints recorded occurred after this time. The threshold for the classification of prone restraint was lower following the introduction of new guidance.
- On admission to the ward the risk patients could present to themselves or others was assessed. The risk assessments we viewed varied across the wards. On Jupiter ward there were detailed risk assessments and management plans to minimise risks to patients. Risk assessment and management plans on wards one and three were also detailed and specific. These included risks from bullying, and interventions to manage risks. Risk assessments and management plans were updated weekly and after risk incidents. Staff on ward three described a wide range of interventions they used to reduce risks.

Are services safe?

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

- However, on Lilacs ward one patient had been restrained and received rapid tranquilisation. Their risk assessment and management plan had not been updated following this incident. Another patient had been involved in two risk incidents. Their risk assessment and management plan had also not been updated. A further patient had exposed themselves in a communal area of the ward. This was not identified in the risk management plan, with no plan to support the patients dignity.
- On Lilacs ward there was a notice in the staff office concerning some bedrooms. This stated that patients at increased risk of harm to themselves should not be allocated those bedrooms. We observed that a patient who harmed themselves prior to admission was in one of the bedrooms identified. The patient had been assessed using the ward clinical risk zoning system. The patient was in the red zone indicating the highest risk. Also in their bedroom was a general hospital bed. This bed was not required for medical reasons. This presented a significant ligature risk. Staff had not assessed the risks before the patient moved into the bedroom. The risks presented by the hospital bed did not appear on the ward ligature risk assessment.
- Some patients on the wards presented with a high risk to themselves or others. Some of these patients were supported continuously by a member of staff. On ward one we found that a staff member was allocated to support the patient for the whole shift. This meant the patient and staff member would be together for over seven hours. This had been the case a number of times during the previous two weeks. This practice had the potential to increase risk. The patient could become irritated and frustrated with one member of staff for so long. The level of concentration of the staff member was also likely to decrease over time.
- Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. This was to ensure they were physically well. An incident report was also made. This allowed the provider to monitor the use of rapid tranquilisation.
- On ward three a harm free care pilot had been conducted. This was now on-going. This looked at medicine errors, violence, self harm and falls. This information was presented in an easy to understand way. In the previous month there had been a risk of violence on most days. There had, however, been very few days when violence occurred. This demonstrated that ward staff were managing this risk well.
- Staff had received training in safeguarding adults. They demonstrated a clear understanding of how to raise a safeguarding alert. Staff gave examples of concerns and the actions they had taken.
- Medicines were stored safely. Medicine administration records were completed when medicines were given to patients. On Lilacs ward improvements had been made in the way medicines were managed since the last inspection in March 2014.
- On all wards patients were prescribed 'as required' medicines, which were to be administered only when needed. On Lavender ward one patient had been prescribed 'as required' medicine to help them sleep. Their medicine administration record showed they had been administered this medicine for five nights consecutively. However, there was no record in their progress notes explaining why the medicine had been given. Another patient had the same medicine, and another medicine, at night. This patient had the medicines for six consecutive nights. One night it was recorded that the patient requested these medicines. There was no record of why the medicines had been administered on the other nights. For both of these patients it was not possible to understand why they had been given these medicines.
- Another patient on Lavender ward was prescribed a medicine for sleep regularly. They had received this medicine for almost one month. During this time there had been five medicines reviews and ward rounds. There was no record that the patient's need for this medicine had been reviewed. There was a risk that patients were being given medicines they did not always need.

Track record on safety

- In the previous year there had been two serious incidents on ward three. A number of procedures had subsequently been put in place to minimise such incidents. The procedures put in place were understood by all staff. There were two serious incidents on Lilacs ward and one on Lavender ward. There were no serious incidents on ward one or Jupiter ward.

Are services safe?

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

Reporting incidents and learning from when things go wrong

- Staff reported incidents on the computerised incident reporting system. They showed us examples of where they had made an incident report. Each report was reviewed by the ward manager. Action was taken to minimise reoccurrence.

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.

Summary of findings

- On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients needs, and did not reflect their preferences. Many patients were not involved with the development of care plans.
- Staff on Lilacs ward in particular lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent and did not understand their legal responsibilities.
- Staff on several wards did not receive regular supervision.
- Patients on Lilacs ward and ward one did not have access to a regular programme of meaningful activities as these were often cancelled or not being provided.
- Detained patients on Lavender ward did not always have a consent or authorisation certificate in place.

However, on Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. Some of the wards had recruited peer support workers. The peer support workers were part of the team. They offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward. They also helped staff and patients to work positively together.

Our findings

Assessment of needs and planning of care

- We reviewed the clinical records of 17 patients across the wards we visited. The needs of patients were assessed on admission by a nurse and doctor. The provider's computerised care records were used and ward staff had access to information from other services prior to admission.
- Where patients agreed, an assessment of their physical needs was undertaken on admission. Where patients did not consent, repeated attempts were made during their admission. Daily checks were made of patients' blood pressure, temperature and pulse. This helped identify any deterioration in a patient's physical health and indicated to staff when they should escalate concerns to a doctor. Where patients did not consent, arms length monitoring took place. This involved monitoring patients' respirations and skin colour. This information provided some indication of their physical health status.
- Patient care plans varied across wards. Most patients had detailed care plans. These were specific and measurable and identified patients current needs. Some care plans specifically addressed physical health needs such as the management of diabetes. However, patient involvement with their care plans was not consistent. In some cases we found significant involvement from the patient. In others there was minimal or no involvement.
- Five patients on Lilacs ward told us that they did not know about their care plan. They also said they had not received a copy. One patient told us that their care plan was basic and did not address their needs. We saw one patient's care plan had two elements. One was with regard to receiving information on their rights under the Mental Health Act. The other stated the need to work towards two recovery goals. There was, however, no information about what these goals were. There was no care plan addressing why the patient had been admitted to hospital. Another patient had one care plan relating to anxiety. This care plan did not address all of the patients' needs. Care plans were not always person-centred and did not reflect patients' preferences.
- Clinical records were stored securely on the computerised care records. These could only be accessed with an identity card and password.
- Staff recorded daily information about patient care and treatment in their progress notes. These notes varied across wards and within the wards. There were good examples of thorough, detailed progress notes. There were also progress notes which were very brief and described the patients' activities only. There was little record of engagement with, or understanding of, the patient. Some statements in progress notes were general such as, 'no management problem' or 'settled in mood'.

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.

- There were no psychologists in any of the ward multi-disciplinary teams. On ward one there was no occupational therapist or activity co-ordinator. Staff told us that activities on the ward were nurse led. This, however, depended on nursing staff being available. Patients on some wards spoke of activities 'being promised, but never happening'.
- On ward three there was an occupational therapist and activities co-ordinator. There was a full programme of activities. We observed some of these during the inspection. On Jupiter ward the occupational therapist provided six activities per week. There was no activity co-ordinator on the ward.
- Lilacs ward had an occupational therapist. The activity co-ordinator, however, had been absent for approximately three months. There was no temporary replacement. Four activities on the activity programme did not take place at all. A further ten activities did not take place every week. Some took place every two or three weeks. During the afternoon of our inspection, two groups were planned to take place. Neither of them took place.

Best practice in treatment and care

- Doctors considered National Institute for Health and Care Excellence guidance when prescribing medicines. This helped ensure patients received the most appropriate medicines.
- There was no evidence in care records that patients had received a psychology assessment or treatment. None of the patients we spoke with said they received this. Staff told us that if the multi-disciplinary team decided this was required a referral would be made.
- On ward three there were a number of regular clinical audits taking place. These looked at the completion, and the quality of, documentation. There was a continuous audit cycle on the ward.

Skilled staff to deliver care

- Each ward had a multidisciplinary team (MDT). On most wards the team included nurses , doctors, healthcare assistants, occupational therapists and activities co-ordinators. Pharmacists carried out regular reviews of the prescribing of medicines. Some attended ward rounds when they were able to.
- Nursing staff on Jupiter and Lavender wards had monthly supervision. They also had reflective practice groups. On ward three staff also had supervision monthly. However, in the previous four months between 10 and 18 staff supervision sessions per month had not taken place. This was largely due to a lack of time because of reduced overlap times between the shifts during the day. This meant there were not enough staff to manage the ward safely as well as support supervision sessions. Reflective practice groups took place every two weeks. Staff on ward one and Lilacs ward did not receive regular supervision. There were no reflective practice groups.
- On average 89% of nursing staff had received an appraisal in the previous year. This meant their performance was reviewed and their development planned. On Jupiter and Lavender wards approximately 95% of staff had an appraisal. On those wards, this meant one or two staff had not had an appraisal. On Lilacs ward 83% of nursing staff had an appraisal, and on ward one 70%. On ward three all nursing staff had an appraisal in the previous year.
- Some staff were supported by the provider to undertake additional training. This training was in areas such as family work for psychosis, cognitive behavioural therapy and psychosocial interventions.

Multi-disciplinary and inter-agency team work

- All staff spoke of handovers being hurried. Due to changes in shift times, handover and staff overlap time in the day had been reduced. Previously this was two hours and had been reduced to forty minutes. Nursing staff across all wards spoke of having to stay past their finish time in the day in order to finish handover and complete progress notes. Staff also stayed after their finish time to attend business meetings and reflective practice groups. We were informed by several staff that nursing shift times were being reviewed.
- On Lilacs ward, a morning multi-disciplinary team (MDT) handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. It also meant ward rounds were not as long and patient care was reviewed daily.
- Some of the wards had recruited peer support workers. They worked on a full or part time basis. These were people who had experience of/ or were using mental health services. The peer support workers were part of

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.

the team. They offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward. They also helped staff and patients to work positively together.

- We observed part of a MDT meeting on ward one. The MDT discussed the risks affecting a patient thoroughly as a team and discussed plans for interventions to take place to minimise the risks.
- Staff spoke of having good relationships with community teams and social workers. On Lavender ward the home treatment/crisis team was based on the ward. Staff said this helped working relationships. It also enabled positive joint working on the admission and discharge of patients.

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

- Records showed that patients detained under the Mental Health Act 1983 (MHA) were informed of their rights on a regular basis.
- We reviewed records of patients recently placed in seclusion on ward one. Nursing, medical and multi-disciplinary reviews took place at regular intervals. This was in accordance with the Mental Health Act 1983 Code of Practice.
- On Lavender ward two patients had been treated under the MHA for more than three months. There was no consent (T2) or authorisation (T3) certificate attached to either patients' medicine administration records. Certificates for both patients could not be found. This meant that medicines were being administered without assurance that consent or authorisation had been provided.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were poorly understood by many staff. There was little understanding of the five principles, best interests and lasting power of attorney. This meant that the MCA or DoLS could be applied without the appropriate safeguards for patients. It also meant that situations when the MCA may be applicable may not be recognised. Staff often confused the term 'capacity' with the Mental Health Act definition.
- Lilacs ward staff did not consider that the MCA or DoLS was applicable to their patient group. It was noted that half the patients on the ward were informal patients. Three weeks prior to the inspection an informal patient was admitted to the ward. Upon admission, and for four days, the patient repeatedly said they should not be in hospital. On one occasion the patient said they wanted to leave. There was no record that the patient had been assessed under the MCA or the MHA. This meant the patient could have deprived of their liberty without authorisation. The patient was detained under Section 5 of the MHA on day four of the admission.

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 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate or did not meet their needs and reflect their preferences. On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients' needs and did not reflect their preferences. Many patients were not involved with the development of care plans. This was a breach of regulation 9 (1)(a)(b)(c)(3)(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 11 HSCA (RA) Regulations 2014 Need for consent Staff on Lilacs ward lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent to care and/or treatment and did not understand their legal responsibilities. This is a breach of regulation 11

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always being provided in a safe way:

This section is primarily information for the provider

Requirement notices

On Lilacs ward, patient risk assessments and management plans were not always updated following risk incidents. Staff had not always followed risk management plans.

Ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely.

On Lavender ward some patients were administered 'as required' medicines every night. The reasons why patients required these medicines was not always recorded.

This was a breach of regulation 12 (1)(2)(a)(b)(g)