Requires improvement

Cumbria Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNFG	Dane Garth, Furness General Hospital, Dalton Lane, Barrow-in-Furness	Dova Unit	LA14 4L
RNNBJ	Carleton Clinic, Cumwhinton Drive, Carlisle, Cumbria	Hadrian Unit	CA1 3SX
RNNWG	Westmorland General Hospital, Burton Road, Kendal, Cumbria	Kentmere Ward	LA9 7RG
RNNBJ	Carleton Clinic, Cumwhinton Drive, Carlisle, Cumbria	Rowanwood	CA1 3SX
RNNBX	West Cumberland Hospital, Hensingham, Whitehaven, Cumbria	Yewdale Unit	CA28 8JG

Summary of findings

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Cumbria Partnership NHS Foundation Trust as requires improvement because:

- The recording of capacity to consent to treatment for detained patients could not always be found on the electronic care record system. It was unclear if responsible clinicians were completing capacity assessments at point of assessment.
- There was not a robust system of psychiatric medical cover after 5pm or at weekends on Dova unit, Kentmere ward and Yewdale unit. There was not robust system of psychiatric medical cover after 12 midnight each day at Hadrian unit and Rowanwood.
- Overall, mandatory training compliance was below the trust target of 80%.
- There were missing signatures on medication charts on all wards.
- A significant number of staff were not receiving an annual appraisal.
- There was no dedicated psychology being delivered on two of the wards.

However:

- There were clear processes to report and review incidents.
- Staff used appropriate tools to assess risk and the needs of patients. Risk assessments were regularly reviewed.
- Staff had a good understanding of safeguarding policies and procedures.
- Patients felt well supported by staff and staff demonstrated a good understanding of the needs of patients.
- Handovers and multi-disciplinary meetings were well structured and the introduction of the 'acute admissions pathway' was having a positive impact on daily practice.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There was not a robust system for psychiatric medical cover after 5pm or at weekends on Dova unit, Kentmere ward and Yewdale unit and after 12 midnight on weekdays and weekends at Hadrian unit and Rowanwood.
- There were missing signatures on the medication charts on all wards.
- Overall, mandatory training compliance was below the trust target of 80%.
- The incident response systems in the event of a serious incident at night were not adequate for the two standalone units at Kentmere and Yewdale.

However:

- Staff assessed, managed and minimised ligature risks across all wards.
- Staff used appropriate tools to assess risk and the needs of patients. Risk assessments were regularly reviewed.
- Staff understood safeguarding policies and procedures and could apply these in practice.
- There were sufficient staff to meet patient need.
- Wards were clean, well maintained, with safe spaces for patients. There were good hygiene and infection controls in place.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Detained patients were not being assessed for capacity and ability to consent to be involved in the planning, management and review of their care and treatment.
- Staff were not receiving regular annual appraisals.
- Two of the five wards did not have access to a dedicated psychologist.

However:

- Care plans were mostly comprehensive and holistic. Staff ensured that patients' physical health needs were being met.
- Patients received regular one to one time with their named nurse.

Summary of findings

- Handovers and ward rounds were well structured and comprehensive, with team members sharing the relevant information.
- Clinical staff engaged in clinical audit on a regular basis and amended practice accordingly.
- Staff had regular supervision, which was monitored and recorded.

Are services caring?

Good

We rated caring as good because:

- Staff were kind and caring towards patients. We saw good interactions during the inspection.
- Patients felt well supported by staff.
- Staff demonstrated a good understanding of the needs of patients.
- Family and carers were involved in multi-disciplinary meetings and in patients care and treatment.

However:

- We received mixed feedback from patients about their involvement in the care they received and care plans did not always show patients' comments. Few patients had received a copy of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients requiring acute care were able to access a bed. There was good bed management across the wards.
- Patients had access to a range of activities both on and off the ward including weekends.
- The ward was equipped to support patients with physical disabilities and mobility problems.
- Patients knew how to make a complaint and these were dealt with accordingly.

However:

- Discharge plans were not always in place and some people had been on the wards for several months.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

Summary of findings

- There was not a robust system of out of hours psychiatric medical cover after 5pm or at weekends on Dova unit, Kentmere ward and Yewdale unit. There was not a robust system of psychiatric medical cover after 12 midnight each day at Hadrian unit and Rowanwood.
- Mandatory training compliance remained below 80% across all wards.
- Staff annual appraisal compliance was low across wards.
- The trust had carried out investigations into two serious incidents, however, there was limited assurance that lessons had been learnt from these incidents.
- There was limited assurance that lessons had been learnt from these serious incidents.

However:

- Staff morale was generally good and staff felt their managers supported them.
- Staff were committed to providing good quality care in line with the trust vision and values. We saw these values demonstrated in their work.
- There were governance systems in place that were understood and shared with staff.

Summary of findings

Information about the service

Cumbria Partnership NHS Foundation Trust provides inpatient acute and intensive care services for people of working age with mental health conditions. Services are provided for both patients admitted informally and those compulsorily detained under the Mental Health Act 1983 (MHA).

The trust has four acute wards across four locations for adults who require a hospital admission due to their mental health needs, either for assessment or treatment, or under the Mental Health Act.

The acute wards are:

- Dova Unit is a ward for both men and women based at Furness General Hospital with 20 beds.
- Hadrian Unit is a ward for both men and women based at Carleton Clinic in Carlisle with 25 beds, three of these have been allocated to the assessment centre.
- Kentmere Ward is a ward for both men and women based at Westmorland General Hospital with 11 beds.
- Yewdale Unit is a ward for both men and women based at West Cumberland Hospital with 16 beds.

Cumbria Partnership NHS Foundation Trust also has a ward which provides intensive psychiatric care for people who present more risks and require increased levels of observation and support:

Rowanwood is a ward for both men and women based at Carleton Clinic in Carlisle providing psychiatric intensive care and has 10 beds.

Our inspection team

The team that inspected this core service comprised one inspection manager, two inspectors, one assistant inspector, and two specialist advisors who were mental health nurses.

Why we carried out this inspection

We undertook this inspection to find out whether Cumbria Partnership NHS Foundation Trust had made improvements to their acute wards for adults of working age and psychiatric intensive care unit services since our last comprehensive inspection of the trust in November 2015. The trust had informed us that, since our last inspection, two patients had died while on their acute wards and one while on the psychiatric intensive care unit. We had received two reports in relation to the deaths and were awaiting the third.

When we last inspected the trust in November 2015, we rated acute wards for adults of working age and psychiatric intensive care unit as **requires improvement** overall. We rated the core service as requires improvement for safe, effective, and well led and good for caring and responsive.

Following the November 2015 inspection, we told the trust it must make the following actions to improve acute wards for adults of working age and PICU:

- The trust must review the out-of-hours medical cover available across the wards to ensure there is sufficient medical cover to meet the needs of all patients.
- The trust must ensure that arrangements for single sex accommodation are always adhered to in order to ensure the safety, privacy, and dignity of patients. Clear signage should be in place at the entrance to each gender area informing patients who could enter. There should be a clear process for staff to report any breaches.
- The trust must ensure all staff understand the application of the Mental Capacity Act in practice. Documentation should contain evidence of recording of any decisions made about a patient's capacity.

Summary of findings

- The trust must ensure that mandatory training is completed for all staff to achieve the trust target of 80%.
- The trust must ensure that staff attend basic life support with defibrillator training or intermediate life support.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 10 of the Health & Social Care Act Regulations 2014 Dignity and respect
- Regulation 11 of the Health & Social Care Act Regulations 2014 Need for consent
- Regulation 18 of the Health & Social Care Act Regulations 2014 Staffing

How we carried out this inspection

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

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

This was an unannounced inspection with visits on the 13 14 and 15 February 2017.

Before the inspection, we reviewed information that we held about acute wards for working age and psychiatric intensive care unit services. This included the Mental Health Act monitoring visits, which took place in December 2016 on Hadrian and Kentmere wards.

During the inspection visit, the inspection team:

- visited four acute wards for working age and the psychiatric intensive care unit,
- spoke with 17 patients,
- spoke with the managers for each of the wards,
- spoke with 20 other staff members; including doctors, nurses, health care assistants, occupational therapists and activity coordinators,
- observed three handover meetings,
- observed three multi-disciplinary team meetings,
- reviewed 26 care records,
- carried out a specific check of the medicines management in these teams,
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 17 patients across the five wards. Patients we spoke to had mixed views, although most said they felt safe on the wards and that staff were caring. We were given examples of where staff had brought a birthday cake in for a patient on Kentmere ward. Some patients said that there were a lack of activities on the wards and there were mixed views about the food ranging from the food was excellent to just ok.

All patients said they could access their bedroom at any time and had a secure place to store possessions. Patients had access to drinks and snacks 24 hours a day. We observed staff being visible in the communal ward areas and attentive to the needs of the patients they cared for.

Two patients raised an issue around having set meal times and wanting more TV channels.

Summary of findings

Good practice

The trust had implemented an acute admissions pathway acute. We saw evidence of this being used effectively on each ward. An AAP white board was visible and used during handover meetings. The board listed each patient and gave details about their care and treatment. This included information around their mental health status, if rights had been given, had risk assessments and care plans been updated. The board identified the outstanding tasks for each patient and these were discussed daily to ensure they were completed. Staff and managers felt that the system was working well and had improved working practice. An AAP working group was in place to monitor the pathway across all wards.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that there is a robust out-of-hours psychiatric medical cover available across the wards to ensure there is sufficient medical cover to meet the needs of all patients.
- The trust must ensure that capacity to consent to treatment is assessed and clearly documented on the electronic care record system.
- The trust must ensure that mandatory training is completed for all staff to achieve the trust target of 80%.
- The trust must ensure that medicines management is adequate across all wards.
- The trust must ensure that all staff have an up to date appraisal.
- The trust must ensure that the out of hour's incident response system is safe and effective on Kentmere ward and Yewdale ward.
- The trust must ensure that patients have access to psychological therapies on all wards.

Action the provider SHOULD take to improve

- The trust should ensure that medicines are stored safely in rooms that do not exceed the recommended temperature range.
- The trust should ensure that care plans are always personalised and that patients are fully involved in their care planning.

Cumbria Partnership 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
Dova Ward	Furness General Hospital
Hadrian Unit	Carlton Clinic
Kentmere	Westmorland General Hospital
Rowanwood	Carlton Clinic
Yewdale Unit	West Cumberland Hospital

Mental Health Act responsibilities

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

Mental Health Legislation update training was part of mandatory training; however, fewer than 50% of staff on each ward had completed the training.

At each of the locations, we reviewed the records of people who had been detained under the MHA. An unannounced Mental Health Act review had been completed on Kentmere and Hadrian wards in December 2016. We were unable to find evidence that capacity assessments were being documented prior to the first administration of medication in some of the patient files that we reviewed. We were not always able to find that the responsible clinician had recorded the discussion around consent in every case. Although staff were able to describe and give examples of where the Act was being used in practice, it was difficult to locate the evidence on the electronic care

records system. The information was stored in different places for each record we reviewed. We were unable to locate Mental Capacity Act assessments and best interest decisions to support decisions.

Staff routinely explained to patients what their rights were under the Mental Health Act. We saw that this happened at admission and was routinely repeated. This was discussed and documented for each patient as part of the acute admissions pathway.

We found that some patients were subject to restrictions. These decisions had been made on an individual basis; however, there was no written record of the rationale and decision-making process for some of these decisions. We found that patients on Kentmere were not allowed chargers, or leads to radios. This appeared to be a blanket restriction and was not based on individual risk.

Staff had administrative support from the central Mental Health Act office within the trust and felt able to contact them for advice and support relating to mental health legislation.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was part of mandatory training and all wards except Dova unit (58%) and Kentmere (73%) had achieved the 80% completion rate.

Staff we talked to were able to tell us their understanding in relation to consent to treatment and consent to talk to relatives about a patient's care. Most staff were able to tell us about other decision focused capacity discussions or assessments. However, it was difficult to locate where this was recorded on the electronic care records system. Staff told us that doctors completed capacity assessments for detained patients yet there was little evidence of this in the care records.

None of the patients receiving care and treatment during our inspection were under Deprivation of Liberty Safeguards (DoLS).

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

All wards were visibly clean with good furnishings and well-maintained decoration. We saw cleaning schedules in place on the wards and domestic staff were on duty during the inspection. Cleaning records were up to date.

The layout of the wards did not always allow staff to observe all parts of the wards. Risk had been minimised by the use of mirrors to aid observation. Staff told us that regular observations of patients and risk assessments mitigated this.

The wards did not complete an overall environmental risk assessment but did have individual assessments around fire safety and ligature point audits. The trust also carried out annual patient led assessment of the environments. These were in place on each ward and the review of these found that ligature points were referenced on the audits. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. Mitigations were in place to manage these risks, which included patient observation and individual patient risk assessments. However, a loose bookshelf was found on Kentmere ward, which could pose a risk to patients, and we were unable to locate a risk assessment for this. The investigation into the serious incident on Dova unit also found a number of contributing environmental factors.

All wards provided accommodation for both male and females patients. All wards except Kentmere had ensuite bedrooms. Kentmere provided separate male and female bathrooms. Each ward had a female only lounge.

Clinic rooms were generally clean, tidy and well arranged. Staff did not monitor the fridge temperature on Dova unit on a daily basis. The controlled drugs on Dova unit were not checked weekly. There were some missing dates on the checklist of resuscitation equipment on Yewdale and Dova unit.

Medicines for emergency use were easily accessible. Appropriate equipment for examinations and monitoring of basic medical observations were available. Daily temperature checks of drug cupboards showed they were within the required range. Weekly cleaning of medical equipment took place. However, the blood pressure machine on Dova unit had not been cleaned since August 2016.

Rowanwood psychiatric intensive care unit was the only unit to have a seclusion room. The room was checked during the inspection and we found that previous issues had been resolved. A mirror had been fitted to eliminate blind spots.

Staff adhered to infection control principles such as handwashing and there were dispensers at the entrance to all wards with hand sanitizer. All staff wore uniforms on the ward, which helped identify staff to patients.

Nurse call alarms, to attract the attention of staff as required, were present for patients in bathrooms and bedrooms. All staff members working on the wards carried security alarms.

Safe staffing

The trust provided the following information on staffing levels.

Establishment levels: qualified nurses (WTE) – 67.3

Establishment levels: nursing assistants (WTE) – 67.8

Number of vacancies: qualified nurses (WTE) - 8

Number of vacancies: nursing assistants (WTE) - 0

The trust mainly used bank staff who were familiar with the wards to cover shifts. During November 2016 –January 2017 bank staff covered 659 shifts and agency staff covered 51 shifts.

The numbers for each ward were:

- Dova unit - 114 shifts covered by bank staff 22 shifts covered by agency
- Hadrian unit - 142 shifts covered by bank staff
- Kentmere ward - 98 shifts covered by bank staff 29 shifts covered by agency
- Rowanwood - 302 shifts covered by bank staff
- Yewdale unit 103 shifts covered by bank staff

Requires improvement

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There had been 21 shifts that had not been filled by bank or agency staff during this period. Of these 21 shifts, 15 were on Yewale ward.

Staff sickness rate (%) in 12 month period:

- Dova unit – 3.2%
- Hadrian unit – 2.9%
- Kentmere ward – 2.8%
- Rowanwood – 4.7%
- Yewdale unit – 12.2%

The staffing establishment was different on each of the wards and consisted of the following shifts:

Morning shift (7.00am-3.00pm)

Late shift(1.30pm-9.30pm)

Night shift (9.00pm-7.30am)

Yewdale, Hadrian and Rowanwood had two qualified members of staff allocated to each shift. Dova had two qualified staff on morning and late and one at night while Kentmere had one qualified member of staff on each of the three shifts. This was reflective of the nature of the wards and patient levels.

A twilight shift (4.00pm-12.00am) was being piloted on the wards to assist with the evening handover.

An on call consultant psychiatrist for the south of the region and an on call consultant psychiatrist for the north of the region provided psychiatric medical cover out of hours and at weekends. Psychiatric medical cover was provided up to 5pm weekdays on Dova unit, Kentmere ward and Yewdale unit and up to 12 midnight, seven days a week at Hadrian unit and Rowanwood. Physical screening examinations on admissions were conducted by nursing staff with the requirement for a full physical examination to be completed within 24 hours during core working hours or when the patient consented. Cumbria Health on Call Limited were contacted for medical emergencies. However, any other physical health patients would need to wait until core hours. The prescribing of psychiatric medication out of hours (after 5pm weekdays and weekends at Dova unit, Kentmere ward and Yewdale unit and after 12 midnight at Hadrian unit and Rowanwood) was done over the phone by the on call psychiatrist.

The trust had acknowledged the concerns raised around out of hours medical cover from the previous inspection and had carried out an impact assessment and options paper. However, due to recruitment issues and of funding the out of hours cover this had not been resolved since the last inspection.

Staff were required to complete statutory and mandatory training courses. These included equality and diversity, consent to treatment, mental health legislation, Mental Capacity Act, Deprivation of Liberties Safeguards, prevention and management of violence and aggression, safeguarding children and adults, fire safety, immediate life support, infection prevention and control, rapid tranquilisation and clinical record keeping.

Compliance rates across the wards were variable with many courses not meeting the 80% trust target. Each ward manager kept a local record of compliance against each of the courses. The trust were working on flexible ways to make courses accessible for staff such as e-learning.

The following areas and wards remained below the 80% compliance target.

- Equality and diversity - Dova unit, Rowanwood, Yewdale and Kentmere
- Mental health legislation - all wards under 50%
- Consent to treatment - Dova unit and Rowanwood under 50%
- Safeguarding children – Dova, Kentmere, Rowanwood and Hadrian
- Safeguarding adults - Dova unit and Yewdale
- Fire safety- Dova unit, Kentmere and Rowanwood
- Clinical record keeping- all wards except Hadrian
- Infection control - Hadrian, Rowanwood, Dova unit and Kentmere
- Rapid tranquilisation – Dova unit, Kentmere, Yewdale, Hadrian (0%) Rowanwood (0%)
- Prevention and management of violence and aggression - Dova unit, Kentmere and Rowanwood

A response was received from the trust in relation to staff on Hadrian and Rowanwood having no training in rapid tranquilisation. Although staff had received the initial training, some or all staff had fallen out of the review date

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for this module of training. Plans had been put in place to address this through the provision of training from the trust Principal Pharmacist, for mental health. Further sessions had been arranged, and more immediate measures had been taken for the Pharmacist to attend the wards to provide training sessions to available staff during handover periods.

All inpatient units had been asked to produce a recovery plan, to ensure that the training is brought up to date as soon as possible.

A low number of staff had completed training in basic and immediate life support training at the time of the last inspection. All wards except Rowanwood had improved the compliance level. Hadrian and Rowanwood had improved compliance for immediate life support while Yewdale, Dova and Kentmere had all seen a decrease.

- Basic life support - Dova unit (59%), Hadrian (71%) and Rowanwood (59%)
- Immediate life support - Yewdale (75%) Dova unit (33%) and Rowanwood (67%)

Assessing and managing risk to patients and staff

We reviewed 26 care records and found that risk assessments had been completed upon admission to the ward using the Galatean Risk and Safety Tool risk assessment tool. This complies with the Department of Health Best Practice in Managing Risk guidance (2007) as it covered all the five key areas to risk management that they recommended to be assessed. These were risk of violence, sexual violence, antisocial or offending behaviour, self-harm or suicide and self-neglect or vulnerability. Risk assessments had been reviewed regularly and were up to date. However, it was sometimes unclear how these risk assessments were used to determine daily practice. An example was seen where a patient was identified as being Hepatitis C positive and had an open wound but no risk management plan was in place to support this. The investigation into the serious incident on Dova unit found that the multi-disciplinary team did not utilise all the known information from observations and assessments about the patient's emotional and psychiatric presentation. The escalating issues were not integrated into a holistic formulation of emerging risk and need. We found that a large proportion of the patients on the acute wards were assessed as low risk.

The trust had policies for observations and searching of patients. Staff were able to explain these to us. Searching of patients was not routine but if this was felt to be necessary due to risk to self or others this was done in accordance with the trust policy, which complied with the Mental Health Act code of practice. A recent Mental Health Act monitoring visit had identified that all patients on Hadrian ward were searched when they returned from leave. The ward manager told us that practice had been changed and only those patients with identified risks were now searched. This was recorded when patients returned to the ward.

Risks and observation levels were discussed at daily handover meetings and also at multi-disciplinary team meetings. Patient observations levels were increased or decreased depending on risks. The trust worked on positive risk taking behaviours for the patients on the acute wards. This meant that the increasing of observation levels required strong justification. The review of a serious incident on Dova unit had resulted in all patients being place on level two observation levels for the first 72 hours. We found that a large proportion of patients were on Level one general observations which required staff to check on patients hourly.

There were 68 episodes of restraint between August 2016 and January 2017 involving 39 patients. Hadrian unit reported the highest number with 29, followed by Rowanwood with 22.

Of these restraints, 13 involved prone restraints. This is when the patient is restrained in a face down position. There were 31 episodes of rapid tranquilisation given for patients, seven of these were given after a prone restraint. Staff informed us that rapid tranquillisation was only used when necessary to prevent violence or aggression in patients.

There were 24 episodes of seclusion between August 2016 and January 2017. We reviewed three records of seclusion on Rowanwood and found that on one record the attendance of a doctor at the eight-hour review was not recorded on the electronic system.

We found that two standalone units Yewdale and Kentmere, had no access to external incident response systems in place. Therefore, if a serious incident occurred on these units at night then staff and patients would be left vulnerable. The trust provided us with risk assessments for

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out of hours working on these units, which stated that If a recognised threat was known or there was high acuity of patients then staff numbers would be increased at night. For Yewdale the hospital porters had received the trust prevention and management of violence and aggression training, and the crisis team were connected to the blick alarm system. The out of hours, on-call managers were available to give telephone advice to staff.

The trust were working towards least restrictive practice in terms of restraint and seclusion. Staff had taken part in the 'restrain yourself' project. The project aimed to give staff greater insight into what could trigger aggression and encouraged the use of de-escalation where possible. We found that this was happening in practice across the wards.

Staff understood the safeguarding policy and what action to take following a safeguarding concern. In the period, August 2016 to January 2017 there had been 21 adult safeguarding referrals and four children's safeguarding referrals.

We reviewed 44 medication charts and found variations in the completeness of these. There included unsigned missed doses found on charts, which included prescribed depot medication and missing allergy information. A pharmacist visited each ward and we saw that errors had been highlighted in red pen on the prescription charts. However, it was unclear if a process was in place to check and make these amendments. The medication charts for patients on the psychiatric intensive care unit showed that pharmacy had noted some changes, which needed to be made on the charts but there, was no evidence of this having been actioned. The nurse interviewed could not clarify this had been communicated to the multi-disciplinary team to be resolved. On Dova unit, one patient had 33 administration of doses unsigned in the previous four weeks and there were missed signatures for a further 11 patients. On Kentmere ward, there were issues with three of the 10 patients. One patient had six missed unsigned doses, which included two doses of clozapine.

The Dova unit had an electronic drug cupboard, which was biometric and enabled good stock control.

Track record on safety

There had been two serious incidents recorded between August 2016 and January 2017. One was on Rowanwood and involved an attempted ligature and one was on Dova unit which was a safeguarding incident involving an agency member of staff.

There had also been three deaths on three separate wards in the previous year.

- Dova 4 May 2016
- Hadrian 1 October 2016
- Rowanwood 20 December 2016

We had received the completed reports from two investigations and were awaiting the third. An external person was conducting this investigation and the report was currently in draft form. The ward staff had been consulted on the draft report findings and changes had been made immediately following the incident. These included that all patients were placed on level 2 observations for the first 72 hours after admission. We reviewed the ward action plan and found that this dealt with environmental issues and issues around risk assessment formulation and multidisciplinary working. The investigation into the death of a patient on Hadrian had not identified any learning or recommendations therefore there was no action plan.

Reporting incidents and learning from when things go wrong

Wards had access to an online electronic system to report and record incidents and near misses.

Staff were able to describe the electronic system and their role in the reporting process. Staff had recorded 428 incidents between August 2016 and January 2017.

The majority of staff told us how learning and sharing from incidents took place. This included feedback at staff meetings, in supervision and via email bulletins. Ward managers also ensured that debriefs happened following incidents. This involved discussion of what happened, supporting staff in their emotions and identifying what could have been done differently. Managers told us that discussions of who would be best suited to debrief the patient would also take place during debrief sessions. The walls surrounding Hadrian and Rowanwood had been fitted with anti-climb walls because of patients absconding or attempting to abscond.

Requires improvement

Are services safe?

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Ward managers attended the trust quality and safety meetings where incidents from across the trust were discussed in order to learn lessons and share learning. This was then fed back to ward teams via team meetings. We reviewed team-meeting minutes and saw this was taking place.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

We reviewed 26 care records across the acute and psychiatric intensive care unit wards. We found 19 were detailed, holistic and recovery focussed. There were some variations in the remaining seven with three care plans not being personalised, which meant that patient's involvement, and their comments were not always completed in the records. The remaining four were not holistic and recovery focused. We did see some evidence of patients being involved with the writing of care plans and this helped ensure their care was planned in a person centred way.

When patients were admitted to acute wards and the psychiatric intensive care unit, they spent time with a member of staff who would become their named nurse. This person was responsible for ensuring the patient was settled in, oriented, and had been given information about their admission.

On admission, each patient had an initial planning meeting, which was within 72 hours. This included a diagnostic assessment, risk assessment, medication, legal status, capacity, and observation levels.

A formulation meeting would then take place between the consultant, nurse, care coordinator, and social worker to discuss the patient's treatment plan.

Staff carried out comprehensive assessments of patients' needs upon admission. Junior doctors carried out physical examinations. All patients had an individualised health action plan. Staff carried out relevant physical health monitoring including weight and height measurements, body mass index measurements and blood pressure monitoring. If a patient was admitted out of hours then the examination would be delayed until a doctor was available. If there were any concerns then the wards would contact Cumbria Health on Call Limited or access accident and emergency departments. This assessment included a review of their clinical needs, mental and physical health and spiritual needs. Outcomes of assessments were recorded and individual needs were appropriately documented in the care records. We saw evidence of regular reviews being carried out and records being updated as needs changed.

All the wards had daily multi-disciplinary team handover meetings in which they discussed patient's general health and behaviour over the previous 24 hours and any issues or concerns that had arisen during that time. In addition to this, there were formal multi-disciplinary team meetings. All wards followed a pathway of initial multi-disciplinary meeting on admission followed by a multi-disciplinary team meeting after 72 hours. A further meeting took place to plan discharge. In between these times, the consultant reviewed the patient with the multi-disciplinary team at daily handover meetings and met with the patient if the patient or staff requested.

The trust had introduced an electronic case management system in December 2016. Staff had been trained on the system and all patient records were now stored electronically. We found there were some issues with recording and with some staffs understanding of where to store information. Managers were aware of the issues around recording. An away day for the core service was planned for March 2017 to discuss the issues and agree actions.

Best practice in treatment and care

Staff used health of the nation outcomes scales to assess and record severity and outcomes amongst the patient group. This is a nationally validated outcomes monitoring tool and was done on admission and discharge

Patients had no access to specialist psychological interventions due to staffing issues on two of the five wards. The psychology staff had left the trust and had not yet been replaced. Nursing staff were providing psychologically informed interventions via one to one sessions on these wards. This had been identified as a priority quality improvement project planned for 2017/18 to increase the psychologically informed practice across the wards.

The trust had a governance rolling programme where each ward manager was reviewing a National Institute for Health and Care Excellence guideline to determine how this affected care. This was then shared within the teams.

Skilled staff to deliver care

A range of mental health disciplines worked across the wards. All wards had registered mental health nurses, healthcare support workers, and a dedicated consultant psychiatrist. An occupational therapist was dedicated to each ward who worked alongside activities coordinators. A

Are services effective?

Requires improvement

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

pharmacy technician visited the wards weekly and pharmacists attended ward rounds. However, there was no psychology on Kentmere ward, Dova unit, or Yewdale unit due to recent vacancies. It was unclear if the trust were recruiting to these posts. Hadrian unit had access to psychology support two days per week and Rowanwood had access to one day per week.

New permanent staff underwent a formal induction period. This involved attending a corporate induction as well as a local induction learning about the ward and trust policies. New members of staff also shadowed existing staff before working alone.

Staff working on the wards were required to have regular supervision and appraisals. Trust policy was for staff to receive monthly managerial supervision and clinical supervision four times a year. All staff told us they received supervision and we saw examples of completed supervision records on some wards. Staff said they received supervision on a regular basis.

The trust provided us with information of non-medical staff annual performance appraisals for the 12 months prior to our inspection. This showed the rates for each ward to be - Dova unit 16%, Hadrian unit 90%, Kentmere ward 30%, Rowanwood 36%, Yewdale ward 75%. Rowanwood had a new manager in place and the ward manager on Dova unit was aware of the low completion rates and had been working with the deputy manager to rectify this. Appraisals on Kentmere had been put on hold after the last inspection awaiting a review of the ward.

Staff were supported to access specialist training to support them in their roles. We were given examples of where staff had undertaken cognitive behavioural therapy advanced diploma and leadership training. All staff were supported to attend STORM training. STORM is a self-harm mitigation model developed at the University of Manchester. It offers skills based training in risk assessment and safety planning to frontline staff and members of the community

Multi-disciplinary and inter-agency team work

Staff attended weekly clinical review and multi-disciplinary team meetings. We saw entries within patient care records detailing what had been discussed within these meetings. We observed three multi-disciplinary team meetings across the wards. We found these were comprehensive and well planned. Patients were treated in a polite and dignified way and were involved in the meetings. Patients and family members were able to attend these meetings if they wished and we saw evidence in some records that patients and family members had attended and been involved in discussions.

We observed three nursing staff handovers, which included all staff coming on duty for that shift. The staff member giving handover referred to the 'acute admissions pathway' board and care records to provide all staff with an up to date progress report of each patient. The acute admissions pathway provided prompts for staff to ensure key actions were completed. These included patients' rights under the Mental Health Act, safeguarding concerns and observation levels. The handovers were observed to be very positive and focused. Good detail about the patient's Mental Health Act status, level of observations, leave status, and any changes in risk were discussed. Staff also discussed the activities patients had participated in, therapy sessions and any visits they had received.

We reviewed the information held in care records in relation to handovers and admissions. We saw where possible, admissions were planned and there was input from community teams, crisis teams, and other medical services. Staff told us they received good handovers from community teams and crisis teams when a patient was admitted.

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

The wards worked closely with the Mental Health Act office, which was based at the Carlton clinic. Staff were aware of the office and could contact them with any queries. Each ward had a mixture of formal and informal patients and we saw from records that paperwork had been scanned into the electronic system. Patients were being read their rights and this was monitored using the whiteboards during handovers. Patients had access to section 17 leave and this was recorded in records.

We were unable to find evidence that capacity assessments were being documented prior to the first administration of medication. In 10 of the patient files that we reviewed, we could not find evidence that the responsible clinician had recorded the discussion around consent. In a further eight patient files we were able to locate that a capacity had been discussed but it was unclear what this related to. The staff we spoke to had mixed responses about where they would expect capacity to be recorded.

Are services effective?

Requires improvement

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

Good practice in applying the Mental Capacity Act

Staff we talked to were able to tell us their understanding in relation to consent to treatment and consent to talk to relatives about a patient's care. Most staff were able to tell us about other decision focused capacity discussions or assessments. However, it was difficult to locate where this was recorded on the electronic system. Staff told us that doctors completed capacity assessments yet there was little evidence of this in the care records.

None of the patients receiving care and treatment during our inspection were under Deprivation of Liberty Safeguards (DoLS).

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed that patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed that staff knocked before entering patients' rooms.

We observed how staff interacted with patients throughout our inspection. Staff were kind, caring, and treated patients with respect. Staff engaged with patients in a kind and respectful manner on all of the wards.

Patients we spoke to had mixed views although most said they felt safe on the wards and that staff were caring. We were given examples of where staff had brought a birthday cake in for a patient on Kentmere. Some patients said that there were a lack of activities on the wards and there were mixed views about the food ranging from the food was excellent to just ok.

All patients said they could access their bedroom at any time and had a secure place to store possessions. Patients had access to drinks and snacks 24 hours a day. We observed staff being visible in the communal ward areas and attentive to the needs of the patients they cared for.

The involvement of people in the care that they receive

Patients were provided with a welcome pack on admission. This gave information about the ward, care and treatment, visiting arrangements, personal belongings, as well as information on what would be expected on a daily basis. A carer's information booklet was also available.

Weekly community meetings took place where patients could put forward their views. The patient engagement team visited each ward monthly to speak to patients about their experiences. A standard questionnaire was used where the results were collated and reports produced for each ward. We observed the patient experience team on Dova unit and found them approachable. We were able to review the latest report, which was provided to each ward.

Patients had access to advocacy on the wards and were given information about this.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Data for the bed occupancy and readmission rates was requested for the period August 2016 to January 2017. However, the internal data report had ended on the day that the electronic patient record had been introduced.

Therefore the trust supplied the following data for August 2016 to 13 December 2016

During this period the bed occupancy was:-

- Hadrian Unit 82%
- Rowanwood 82%
- Dova Unit 92%
- Kentmere Ward 86%
- Yewdale Unit 79%

There had been a total of 211 readmissions in the same period:-

- Hadrian Unit 60
- Rowanwood 14
- Dova Unit 52
- Kentmere Ward 9
- Yewdale Unit 76

We saw there was a good bed management system in place with daily telephone conferences between wards. All ward managers attended along with the manager from the access and liaison integration service. Each ward discussed clinical pressures and transfers between wards. Daily telephone conferences clarified possible admissions and helped to decrease delays to discharges for current inpatients.

Transfers to wards nearer a patient's home were always planned. Patient transfers between the acute wards would usually be during the day, but sometimes they took place in the early evening if they were planned with the patient.

There had been 55 delayed discharges between August 2016 and January 2017. We found two patients on Dova unit who had significant physical health problems that had been on the ward for several months. The ward manager was aware of this and was working to find care that is more suitable for these patients.

There had been six out of area placements in the same time.

We requested data on transfers, which showed that in the six month period from July 2016 to December 2016 there had been:

Transfers between acute wards and PICU - 59

Transfers between acute wards - 41

We were told that patients could sometimes be transferred to the psychiatric intensive care unit if there was a significant change to their mental health, and this could not be dealt with on the acute wards. We found that the acuity of patients on the acute wards was generally low and risk assessments supported this.

The facilities promote recovery, comfort, dignity and confidentiality

All acute wards and the psychiatric intensive care unit had a full range of rooms and equipment to support treatment and care. These included a clinic room to examine patients, activity rooms, and areas, which could be used for 1:1 or quiet time. In addition, we found all wards offered patients access to outside space.

Most patients had their own mobile phones and they could use the ward phone if they wanted to.

Patients on all wards were able to access drinks and snacks 24 hours a day. Some patients were able to access the kitchen areas and prepared their own meals. This was done as part of their preparation for discharge helping to enable independent living. Most patients told us the quality of the food was good.

Patients we spoke with told us they were able to access their bedrooms at any time. Patients on all wards were able to secure personal or valuable possessions in either lockers outside of their bedrooms or a security office to which staff had the keys.

All the wards we visited had activities co-ordinators who had put a programme of activities in place for patients. Some activities were specifically recovery focused and were part of patient's individual therapy. Patient records contained personal activity plans, which were discussed and agreed by both patients and staff.

All wards had locks on the main entrances with entry and exit controlled by staff. Signs were displayed on ward doors

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Good

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providing informal patients information about their rights to leave the ward. All ward managers confirmed that informal patients were informed of their right to leave the ward.

Meeting the needs of all people who use the service

All wards were fully accessible to any patients who had mobility aids such as wheelchairs. Patients had access to walk in showers and bathrooms, and there were assisted bathrooms on each ward.

Staff could access interpreter services, although this was rarely required. There were leaflets available to patients on the ward, which were all in English. There were no leaflets on Dova and Yewdale as patients had repeatedly taken these down.

Listening to and learning from concerns and complaints

Patients we spoke with told us they knew how to make a complaint. We saw there was information on all of the wards we visited that told patients how they, or their friends and relatives could raise a concern or complaint.

Ward managers would deal with patient concerns where possible. The trust had a complaints policy in place and any complaints would be investigated and responded to in line with this policy.

Between January 2016 and January 2017 there were 51 complaints across the wards with three upheld. Of the 51 complaints, eight were formal complaints, the two that were upheld related to admissions, discharge, and transfers. Ward managers and staff told us outcomes from complaints were shared through team meetings and 1:1 meetings. We saw feedback recorded in meeting minutes.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust values were "kindness, fairness, ambition, and spirit." Staff were aware of the trust's visions and values. We saw the trust's visions and values were displayed around the wards.

Senior managers in the trust were known and had visited the wards. Ward managers reported they felt supported by their senior managers.

Good governance

Care group 'clinical governance committees' and mechanisms were in place which supported the safe delivery of the service. Ward managers attended these meetings and felt they were making improvements in the quality of the service.

Managers on the wards received monthly data on compliance with required training. However, there were a number of modules from the mandatory training set with compliance rates below the trust target of 80%. Appraisal rates were low on Dova unit, Kentmere and Rowanwood. Ward managers and the trust were aware of this and were putting measures in place to ensure that staff received an appraisal. Appraisal rates were low on Kentmere due to the potential closure, a recovery plan was in place now that the ward was remaining open. All staff we spoke with told us they had regular 1:1 supervision, group supervision and informal supervision took place daily.

The wards had sufficient numbers of staff of the right grades and experience. However, Rowanwood and Yewdale were experiencing some staffing issues due to sickness and vacancies. The out of hours' psychiatric medical cover continued to be an issue. An on call consultant psychiatrist for the south of the region and an on call consultant psychiatrist for the north of the region provided psychiatric medical cover out of hours and at weekends. Psychiatric cover was provided up to 5pm weekdays on Dova unit, Kentmere and Yewdale ward and up to 12 midnight, seven days a week at Hadrian unit and Rowanwood. Since the last inspection, the medical director had carried out an impact assessment and an options report had been presented to the board. However, the trust had not progressed the issue any further and out of hours cover remained the same as found at the last inspection.

Staff were engaging in clinical audit on the wards, which included record keeping audits, medicine audits and infection control audits. An inpatient physical health audit had been carried out in July 2016.

Staff knew how to report incidents and records showed they did this in accordance with trust policy. There was learning from incidents through trust wide clinical governance meetings and ward team meetings. Staff received email bulletins with key messages and learning. However, the investigations into two serious incidents on Dova and Hadrian had taken a considerable amount of time to complete. The incident on Dova unit had taken 10 months to conclude. The incident on Hadrian had taken less time to investigate. This had concluded that there were no recommendations for the trust so there was no action plan.

Staff across acute wards and the psychiatric intensive care unit had a good knowledge and understanding of safeguarding policies and procedures and could apply these in practice.

Ward managers were able to provide us with information on key performance indicators and had a good understanding of where improvements were required. We observed a performance dashboard, which managers had access to which detailed key performance indicators and audit information.

The trust risk register was discussed at monthly care group meetings. Ward managers attended these.

Ward managers confirmed that they had sufficient authority to manage their ward and received administrative support. They told us that they felt well supported by their line manager.

Leadership, morale and staff engagement

The wards appeared to be well managed both on a day-to-day basis and strategically, for example, the ward managers had plans of what they wanted to achieve. Yewdale had temporary arrangements in place for the day-to-day management of the unit.

We received mixed responses around staff morale. Although most staff said this was good, there were issues on Rowanwood and Yewdale. There had been recent changes to management on Rowanwood with a new ward manager and two new deputy ward managers. The ward manager on Yewdale had left and this post had recently

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been filled. Most staff we spoke with told us that they felt part of a team and received support from each other. There was an acknowledgement about low staff morale on Rowanwood and externally facilitated away days had been planned. There had been issues with the communication with staff around the proposed closure of Kentmere after the comprehensive inspection in November 2015. Staff had heard about the closure from the media rather than through the trust. The trust had responded to this on the same day with senior managers attending to give a briefing to all staff along with a letter of apology.

We saw evidence that regular staff meetings took place. All staff were aware of the trust whistleblowing policy and felt confident to raise concerns without fear of victimisation.

The managers were visible on each of the wards and staff spoke highly of them. Staff reported teams worked well together and we observed a positive working culture within the teams.

Commitment to quality improvement and innovation

Hadrian unit and Rowanwood were accredited through the Royal College of Psychiatrists' accreditation for inpatient mental health services programme. Dova unit was awaiting confirmation of their renewal. This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards.

A family and carers pathway was in development and closer links were being developed between local carers services.

A mental health nurse from Carleton clinic had received a National award in February 2017 for standards of excellence from the Royal College and Nursing.

The Kings College London was carrying out homeless research. The researcher worked one day per week on Hadrian unit looking at a homeless hospital discharge study.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was not a robust system of psychiatric medical cover after 5pm or at weekends on Dova unit, Kentmere ward and Yewdale unit. There was not robust system of psychiatric medical cover after 12 midnight each day at Hadrian unit and Rowanwood. The trust were not providing interventions from dedicated psychologists on two out of the five wards. Regulation 18 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not have robust medicines management arrangements in place. There were missing signatures on medication charts on all wards, and no clear processes in place to action this. Regulation 12 (2) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The recording of capacity to consent to treatment could not always be found on the electronic care record system. It was unclear if responsible clinicians were completing capacity assessments at point of assessment. Regulation 11 (1)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Mandatory training compliance remained below the trust target of 80%. Appraisal rates were low on four wards Regulation 18 (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The incident response systems in the event of a serious incident at night were not adequate for the two-standalone units. Regulation 17 (2) (b)