Sussex Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Regency Ward Caburn Ward Pavilion Ward	Mill View Hospital	RX213
Amberly Ward Bodiam Ward	Department of Psychiatry	RX2E7
Coral Ward Jade Ward Amber Ward	Langley Green Hospital	RX2P0
Maple Ward Rowan Ward	Meadowfield Hospital	RX277
Woodlands Ward	Woodlands Ward	RX2L6
Oaklands Centre for Acute Care	Oaklands Ward	RX26N

This report describes our judgement of the quality of care at this provider. It 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

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

The service had taken most of the action that we required them to take following the September 2016 inspection. The most notable exception was that the trust had not ensured that all staff had undertaken mandatory training.

We found the following issues that need to improve:

- All staff had access to mandatory training. However this core service did not meet the trust's own 75% mandatory training compliance target in four out of 22 subjects. The trust monitored training through a RAG (red, amber green) rating scale to monitor progress across all mandatory training subject areas for all trust services.
- Wards generally followed National Institute for Health and Care Excellence guidance and the trust's rapid tranquilisation policy when monitoring patients' physical health after administration of rapid tranquilisation. However there were gaps on three physical health monitoring records across Coral, Amber and Pavilion wards, so these did not demonstrate that these checks had been carried out.
- Although medicines management practice was generally satisfactory across all of the wards, on Amber ward an audit carried out in March 2017 indicated that in 33 (48%) of the medicine administration charts there was an error.
- Eleven out of 12 wards we inspected demonstrated learning from incidents. However, a patient had set fire to their room on Woodlands ward in December 2016. During our inspection we observed patients of Woodlands using their own cigarette lighters smoking in the courtyard. Staff we spoke with told us they did not encourage or enforce patients to hand in lighters following leave from the ward, or carry out searches, which did not demonstrate learning from this incident. Of all the wards we visited, Woodlands ward was the only one that had not implemented the trust smoke-free and smoking cessation policy, in place since 8 March 2017.
- The seclusion room on Amber ward in Langley Green Hospital did not have a mirror or closed circuit television to enable staff to monitor the blind spots in the room. The seclusion room mattress could be used by patients to block the window or the door. However, the trust had a plan in place to renovate this seclusion room.
- Staff on Maple ward did not record what patients were wearing prior to them leaving the ward on escorted or unescorted leave. This could have assisted staff to identify a patient if they went absent without leave in the community. This was a recommendation in the trust's leave of absence policy.

However, we also found the following areas of good practice:

- The wards had good observation policies and procedures to minimise risks to the safety of patients. Risk assessments and risk monitoring of patients had improved and was good across all the wards.
- All 12 wards had developed detailed ligature risk assessments that clearly identified the risk areas and mitigation in place to minimise risks. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. All wards developed a risk footprint ward map. These maps were colour coded to indicate the risks in the environment, such as ligature points and levels of staff observations required in these areas to maintain patient safety.
- All 12 wards were generally clean, well furnished and well maintained. Wards carried out regular infection control and prevention audits. The clinic rooms across all the wardswere clean, fully equipped with functioning equipment and emergency medicines.
- The trust undertook a focussed recruitment drive and wards across the core service were becoming permanently staffed. All ward managers told us that they were able to increase staffing levels daily to meet the changing needs of the patient groups across the wards, for example when there was increased risks and need for increased patient observations.

Summary of findings

- Staff told us that there was adequate medical cover on all wards day and night to attend quickly if there was a medical emergency.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Please see above

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: Linda Burke, Inspector (mental health) Care Quality Commission (CQC)

The team that inspected these services comprised of one CQC head of hospitals inspection, one CQC inspection manager, six CQC inspectors and four specialist advisors who were senior nurses with experience of working in mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether Sussex Partnership NHS Foundation Trust had made improvements to the safety of their acute wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection of the trust in September 2016. We had also received notification of the death of a person who had been cared for on the wards, and we followed up the findings of a recent Coroner inquest. We therefore needed to assess what actions the trust had taken in response to their investigations of the circumstances of these deaths.

When we last inspected the trust in September 2016, we rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** overall. We rated the core service as requires improvement for safe, effective, responsive and well-led, and good for caring.

For the purposes of this inspection, we only inspected against the Safe key question for this core service and in accordance with Care Quality Commission methodology, we will not be applying a rating for the findings from the inspection in April 2017.

When the CQC inspected the trust in September 2016, we found that the trust had breached regulations. We issued the trust with three requirement notices for acute wards for adults of working age and psychiatric intensive care units. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 10 Dignity and respect

Regulation 12 Safe care and treatment

Regulation 18 Staffing

Following our last inspection, we told the trust it must take the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that medicines and equipment are in date and in working order.
- The trust must ensure that medicines prescribed to people detained under the Mental Health Act are documented and include the route of administration and the maximum dose to be administered.
- The trust must ensure that mandatory training compliance across all subjects meets the trust's compliance targets. This was a requirement following our inspection in September 2016.
- The trust must ensure that all patient risk assessments are updated and patients at risk of harm to themselves are kept safe.
- The trust must ensure that patients on Amber ward have access to phones to make calls in private while on the ward.
- The trust must ensure that sufficient action is taken to manage ligature risks to patients.

How we carried out this inspection

We asked the following question of the service:

- Is it safe?

Before the inspection visit, we reviewed information that we held about these services. During the inspection we sought feedback from patients in individual and focus group settings.

Summary of findings

During the inspection visit, the inspection team:

- visited all 12 of the wards at the six hospital sites and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 40 patients who were using the service
- spoke with the managers or deputy managers for each of the wards
- spoke with 75 other staff members; including doctors, nurses, health care assistants, junior doctors, a physical health lead, pharmacist, occupational therapists, domestic staff and hospital matrons
- looked at 99 patient medicine records
- carried out a specific check of the medicines management on all 12 wards
- reviewed 72 risk assessments for patients on all wards
- attended two shift handovers and one ward round meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about the provider

The acute wards for adults of working age and psychiatric intensive care units at Sussex Partnership NHS Foundation Trust provide 199 beds across six sites throughout Sussex. There are two psychiatric intensive care units: 12 male and female beds on Amber ward at Langley Green Hospital and 10 male beds on Pavilion ward at Mill View Hospital. The acute wards are outlined below:

Mill View Hospital:

Regency ward is a 20 bedded male adult mental health inpatient service.

Caburn ward is a 20 bedded female adult mental health inpatient service.

Pavilion ward is a 10 bedded male psychiatric intensive care unit.

Department of Psychiatry, Eastbourne General Hospital:

Bodiam ward is an 18 bedded male adult mental health inpatient service.

Amberley ward is an 18 bedded female adult mental health inpatient service.

Woodlands Conquest Hospital:

Woodlands ward is a 23 bedded mixed gender adult mental health inpatient service.

Oaklands Centre for Acute Care:

Oaklands ward is a 16 bedded mixed gender adult mental health inpatient service.

Meadowfield Hospital:

Maple Ward is a 17 bedded mixed gender adult mental health inpatient service.

Rowan Ward is a 17 bedded mixed gender adult mental health inpatient service.

Langley Green Hospital:

Amber Ward is a 12 bedded mixed gender psychiatric intensive care unit.

Coral Ward is a 19 bedded mixed gender adult mental health inpatient service.

Jade Ward is a 19 bedded mixed gender adult mental health inpatient service.

Following our previous inspection in September 2016, we rated this core service as requires improvement. This was because:

Amber ward did not meet the fundamental standards related to dignity and respect of patients (Regulation 10). The wards did not meet the fundamental standards related to safe care and treatment of patients (Regulation 12) or staff (Regulation 18). We issued requirement notices in respect of Regulation 12 and 18, and a warning notice in respect of Regulation 12 for the trust to take action.

Summary of findings

What people who use the provider's services say

Patients we spoke with generally told us that staff treated them with respect and dignity. They told us they felt safe and that staff were caring and supportive towards them. However, two patients told us that they were not involved in their care and did not understand why they could not leave their ward despite asking staff on several occasions.

Patients we spoke with reported that the wards and their bedrooms were clean and that domestic staff always asked permission to clean their rooms before entering.

Patients told us they found staff approachable and that there was enough staff available for them to speak with, although two patients on Amber ward told us that nurses were often busy writing notes in their offices. Patients on Coral and Jade ward told us that staff were always present and out on the wards.

Good practice

- Staff had brought in a number of innovative practices aimed at reducing patient stress, for example use of a coping therapeutic key ring, protected patient and staff time from Monday to Friday, and a Friday pampering evening on Caburn ward. Staff used mindfulness techniques with patients while in seclusion on Pavilion ward.
- Staff on Regency ward use the Broset violence scale to help predict violence and aggression on the wards which helped them be better prepared to avoid incidents on the ward.
- Staff on Coral ward in Langley Green Hospital met every morning after handover to have a 'huddle' meeting to review and discuss risks associated with all patients on the wards. This was also an opportunity to review observations levels and support communication regarding risk across the team.
- The senior managers at Langley Green Hospital told us of the quality improvement work they had undertaken with staff to reduce incidents at the service. They showed the data collated in regard to this work, which showed that incidents had reduced gradually across all three wards during the period November 2016 to February 2017.This supported a renewed effort of staff to build supportive and therapeutic relationships with patients. For example, on Jade ward there were 22 incidents in November 2016, 17 in December 2016, 15 in January 2017 and eight in February 2017.
- The matron in Langley Green Hospital held monthly 'lessons learnt' sessions to enable staff to discuss changes and learnings following incidents and informed the public of these discussions via the hospital's twitter account.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all staff follow the trust's smoke free policy by asking patients to hand in their cigarette lighters.
- The trust must ensure that physical health and general observations are noted accurately for patients as required.
- The trust must ensure that Amber ward has an investigation and improvement plan to manage high levels of missed doses identified in the March 2017 Mind The Gap audit.
- The trust must ensure that all wards meet the trust's training completion targets for all mandatory training and ensure that all staff receive fire patient (onsite) training, as the compliance target rate of 65% of staff was low.

Summary of findings

- The trust must ensure that staff record eye sight observations as required according to the trust's patient observation policy.

Action the provider SHOULD take to improve

- The trust should ensure that corridors and public areas in Mill View Hospital are routinely cleared when patients are escorted from Caburn ward to the seclusion room to protect their privacy and dignity.
- The trust should ensure that all patients have photographic identification on their medicine records as recommended by the trust's photographs in medication administration policy or indicate if the patient has declined to have a photograph taken.
- The trust should ensure that patient bedrooms are tidy on Amber ward.
- The trust should ensure that ligature risk assessments contain detailed narrative on how ligature risk locations on wards are mitigated by staff and the estates department.
- The trust should ensure that incident reports are submitted following incidents involving rapid tranquilisation.
- The trust should review the mattress used in the seclusion room on Amber ward to minimise risks of barricading and creating additional hazards within the room. There should also be a fully operational two way intercom, closed circuit television monitoring and convex mirrors.
- The trust should ensure that staff record what patients are wearing prior to them leaving the ward on escorted or unescorted leave as recommended in the trust's leave of absence policy.

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

See under Overall Summary.

Our findings

Safe and clean environment

- We carried out a tour of each of the 12 wards. All wards were clean, well furnished and well maintained. Wards carried out regular infection control and prevention audits. We found that nine of the wards had blind spots, where staff did not have clear lines of sight of all areas. The associated risks were mitigated by use of convex mirrors, closed circuit television monitors, and staff patrols. Ward staff adjusted observation levels regularly depending on patient and ward risk. There were good lines of sight on Maple, Rowan and Oaklands wards which were monitored by staff stationed at central points on each ward.
- When we inspected in September 2016 the trust did not meet the fundamental standard related to safe care and treatment with regards to managing ligature risks to patients (Regulation 12). At this inspection we found the trust had taken a number of steps to make the wards safer.

  All 12 wards had ligature risk assessments which detailed the location and risk rating for each ligature point throughout the ward. The risk assessments noted that each risk area was mitigated by staff observation and through individual risk assessment. However, some further work was needed to ensure that details of the actions the estates department would take and deadlines when the actions would be completed by were recorded.

  A risk footprint ward map was displayed in 11 out of 12 nursing stations. These showed all areas of the ward, which were colour coded to indicate the risk level due to environmental issues such as ligature points, and described staff observations levels required in these areas to maintain patient safety. A risk footprint ward map was not displayed in the nursing station on Amber ward which meant there was no visual prompt to remind staff where areas of risk across the ward were situated. We raised this with the ward manager during our inspection and they arranged for a copy to be displayed immediately. Ligature cutters were clearly displayed in the nursing stations and clinic rooms across all wards. Ligature cutters were also kept with the observation recording board on Woodlands ward so a member of staff had access to these in case of an emergency during each observation round.

  On two wards two bathroom doors had been replaced with foam non ligature doors.
- All wards we inspected complied with the Department of Health Eliminating Mixed Sex Accommodation guidance. There were no breaches at the time of our inspection. The ward manager of Oaklands mixed gender acute ward told us that on the rare occasion when they had to admit a member of the opposite gender onto a same gender ward, for example a male patient onto a female ward, due to an emergency admission, they completed an incident form and the guidance breach was reported to the daily bed management meeting. The matron then prioritised a move for that patient to a more appropriate gender specific ward. Coral ward was a mixed gender ward with separate male and female sleeping wings. During our inspection there were high numbers of male patients on the ward. This meant that three male patients were admitted to the female wing. Staff assessed all three male patients as low risk with no known risks towards females. Staff mitigated risks regarding the higher number of males on the ward by carrying out intermittent observations. However, after the first day of our visit we raised our concerns with the trust that the observation levels were not sufficient to ensure risks were minimised. Staff increased the observations levels from intermittent to eyesight with immediate effect.
- During our last inspection, we noted that some clinical equipment was missing, broken or out of date. At this

inspection we found that the clinic rooms across all the wards were clean, fully equipped with functioning equipment and emergency medicines which were generally checked weekly to ensure they were fit for purpose and safe to use in an emergency. Staff at Langley Green Hospital checked their emergency resuscitation equipment daily. Handwashing guidance and information for staff was displayed in all clinic room areas. Staff checked the temperatures of clinic fridges daily and we found these to be within the required range to ensure the efficacy of the medicines stored.

- The seclusion room on Pavilion ward in Mill View Hospital allowed for clear observation, two way communication, had toilet facilities and had a clock. However, the seclusion room on Amber ward in Langley Green Hospital did not have a mirror or closed circuit television to enable staff to monitor the blind spots in the room. The communication intercom worked, however it took staff 15 minutes to get it to work during our inspection, where the staff identified this as an intermittent fault. The seclusion room mattress could be used by patients to block the window or the door. Staff told us they called the response team if patients blocked the door and staff needed to gain entry. The ward manager informed us that the trust had an approved refurbishment plan in place to improve the condition of the seclusion room. The seclusion room on Amber ward had anti ligature clothing and blankets for patients use if necessary.
- Health care assistants carried out daily ward environmental risk assessments. This included checking for broken furniture and items across the wards which could be used by patients to harm themselves or others. We reviewed Langley Green Hospital's environmental security checklist which required the nominated ward shift security nurses to check items such as door security, availability of hand gel and cleanliness of the sluice rooms across the wards. However, we found laundry detergent in the locked laundry rooms on Pavilion and Caburn wards in Mill View Hospital. We brought this to the attention of the matron during our inspection.
- All staff across the wards carried personal alarms. We witnessed staff using alarms to signal for assistance during our inspection. In all instances we observed team members attending quickly to offer support and interventions to keep patients and staff safe.

Safe staffing

- During our inspections in January 2015 and September 2016 the trust used high numbers of agency and bank staff due to staff shortages. The CQC recommended at the time that the trust resolve its staffing issues to ensure consistency of delivery of care to patients. In April 2017 the trust reported they had reduced vacancy levels across a number of wards following a focused recruitment drive. Three out of 12 wards had nursing vacancies lower than the trust average vacancy rate of 13% (Regency – 10%, Caburn – 12%, and Rowan – 13%) and two out of 12 for nursing assistant vacancies (Regency and Caburn wards). However, the number of vacancies on some of the wards had reduced since our inspection in September 2016. For example, nursing vacancies on Bodiam ward had reduced from 34% to 22%. The senior manager at Langley Green Hospital told us that recent recruitment had halved their use of agency staff in the past three months. Nursing assistant vacancies on Amberley ward and Oaklands wards had reduced from 41% to 36% and from 23% to 15% respectively.
- All wards used the National Institute of Health and Care Excellence guide for acute hospital staffing to estimate the number and grade of nurses required on each shift. Ward managers monitored staffing levels and reported this in a monthly safer staffing report to the trust board. Numbers of staff required for each shift on the wards were matched by the numbers on shift.
- All wards used bank staff when needed for increased observation levels or due to staff sickness. Wards used bank staff who were familiar to the wards and the matron of Langley Green Hospital told us they offered contracts to bank staff to enable consistency in the care provided to patients.
- All ward managers told us that they were able to increase staffing levels daily to meet the changing needs of the patient groups across the wards, for example when there was need for increased patient observation.

Are services safe?

- A qualified nurse was present in communal areas during all shifts, and we observed this during the inspection.
- Staff and patients we spoke with told us that generally there were enough staff so that patients always had regular one to one time with their named nurse. There were enough staff across the wards to carry out physical interventions such as blood pressure and temperature monitoring.
- During our inspection in September 2016, staff and patients told us that activities were often cancelled due to lack of staff. At this inspection staff and patients across the wards told us that escorted leave and ward activities were rarely cancelled because of improved staff levels. Staff on Caburn ward in Mill View Hospital told us that the occupational therapist supported them to carry out art and other activities with patients to offer a range of groups if other activities were cancelled due to staff sickness or annual leave. However, patients and staff we spoke with on Oaklands ward said that activities and leave were cancelled due to staff shortages approximately once a week.
- Staff told us that there was adequate medical cover on all wards day and night to attend wards quickly if there was a medical emergency. However, the ward manager on Caburn ward told us there was a lack of consistency with junior doctors on that ward. They had junior doctors for four months and then they had a week without any cover. The ward manager told us that longer placements would help junior doctors input into their ward.
- When we inspected in September 2016 the trust did not meet the fundamental standard related to staffing with regards to mandatory training (Regulation 18). At this inspection we found that improvements were still needed in this area.

  The trust had set a target that 75% of staff should have completed training in most of the topics that the trust had deemed as being mandatory. There were four topics for which the trust had set a target of 65%. These were fire onsite (inpatient), fire onsite (non-inpatient), Mental Capacity Act, Deprivation of Liberty Safeguards and Mental Health Act training which was 65%. The trust did not meet its 75% mandatory training compliance target across this core service in four topics. These were adult immediate life support (ILS) (73%), medicines management for registered nurses (72%), moving and handling level 2 (40%) and prevention management of violence and aggression disengagement and conflict resolution (PMVA) (41%). This core service reached the trust's compliance training target for fire onsite (inpatient) of 65%, which is a low compliance target rate. Despite this, five individual wards did not meet this target (Oaklands – 63%, Maple – 43%, Rowan – 59%, Amberley – 48%, Bodiam – 38%). This was a concern that not all staff received this training following a ward fire incident on Woodlands ward in December 2016.

  The trust informed us that delays in staff receiving PMVA training resulted from the trust taking time to re-train their PMVA training team to deliver the approved training model. The trust also took steps to develop an in-house ILS training team to make this training more available for staff and to reduce reliance on external training providers. This development led to low numbers being trained for a period of time leading up to our inspection, however a full training programme is now available for staff to attend. Each ward had a training champion who acted as a lead to ensure staff access the new training programme to ensure higher completion levels across all wards.
- The trust introduced a RAG (red, amber green) rating scale to monitor progress across all mandatory training subject areas for all trust services. This enabled managers and subject leads to identify areas which failed to meet the required standards and monitor improvements against agreed plans. The reports included the overall percentages and those for specific subjects.The executive team received weekly reports against which progress was monitored. Reports were presented to the executive assurance committee and trust board.

Assessing and managing risk to patients and staff

- There were two seclusion rooms across this core service, one each on Pavilion and Amber psychiatric intensive care units (PICU) for the formal seclusion of patients. Between October 2016 and March 2017 there were 30 incidents involving seclusion for adult acute wards. Staff on the PICU had used seclusion on 50 occasions during the same period. Thirty-four of these had been on Pavilion ward. There were no incidents of seclusion noted for this period for patients from Amberley, Jade, Rowan and Oaklands wards.

Are services safe?

- During the period October 2016 to March 2017 there were a total 247 incidents of restraint which involved 136 individual patients within the adult acute inpatient wards. Within the PICU wards, there were 63 incidents involving 34 individual patients for the same period. Woodlands and Caburn wards had the highest levels of restraint during this period with 57 and 47 incidents recorded respectively.
- The Department of Health's 2014 guidance Positive and Proactive Care states that providers should work to reduce the use of all restrictive interventions and focus on the use of preventative approaches and de-escalation. At the time of inspection, across the trust acute wards, 21 of the restraint incidents involved 15 different patients using the prone (face down) position for six months to March 2017 (which was a reduction from 23 in the six months to September 2016). Across both PICU wards there were 16 restraint incidents with 12 different patients in the prone position for the same period. Pavilion ward had the highest level of restraint with nine recorded incidents.
- During the period October 2016 to March 2017 there were 105 incidents of rapid tranquilisation across the acute wards. During the same period, there were 15 incidents of rapid tranquilisation in the two PICU wards. The pharmacist in Mill View Hospital showed us a new medicine chart they had introduced since our inspection in September 2016. The new chart supported improvements in medicines management by offering staff guidance on how and when to review patients after the administration of intramuscular rapid tranquilisation. This practice was also monitored using a new internal inspection tool. Since our inspection in September 2016, the trust had introduced the practice of only validating intramuscular rapid tranquilisation prescriptions for a period of 96 hours. If the medicine was not used, then the responsible clinician cancelled the prescription. This was a significant change from the practice we reviewed during our September inspection when all patients were prescribed this medicine throughout their admission without clinical review to review the prescribing rationale.
- Wards generally followed National Institute for Health and Care Excellence guidance and the trust's rapid tranquilisation policy when monitoring patients' physical health after nursing staff administered rapid tranquilisation. For example, carrying out physical observations at required intervals and observing approved minimum observations if the patient refused physical observations. However, some improvements were still needed in this area.

  On Pavilion ward the staff monitored the physical health of a patient following administration of rapid tranquilisation according to the trust's approved intervals, however the staff had not noted the timings of each observation. On Bodiam ward staff had not written up or submitted an incident form following an incident resulting in the rapid tranquilisation of a patient. We raised this with the ward manager during our inspection. On Rowan Ward we reviewed one patient record detailing physical observations made after the patient was administered rapid tranquilisation. On Jade ward one patient was administered with rapid tranquilisation. However, staff had not carried out any physical health observations during the first 90 minutes following the incident, as per the trust's rapid tranquilisation policy. On Amber ward staff recorded one patient's respiration levels but not their consciousness levels which should have been noted together as a minimum as the patient refused fuller health monitoring. This was not in accordance with the trust's rapid tranquilisation policy. Furthermore, staff recorded the patient's respiration levels on the seclusion records rather than on the physical health and rapid tranquilisation charts where they should have recorded the observation levels.
- When we inspected in September 2016, we found that the trust did not meet the fundamental standard related to safe care and treatment with regards to updating patients' risk assessments following incidents (Regulation 12). When we inspected in in April 2017, we found that the trust had improved risk assessment and monitoring of patients across all the wards we visited. We reviewed 72 patient risk assessments. All patients were risk assessed by the consultant and lead nurse on admission using a risk assessment template on the trust's electronic system which was reviewed regularly. The risk assessments we reviewed were generally comprehensive, had clear risk management plans and were reviewed by staff regularly. Staff updated patients' risk assessments with identified risks following incidents across the wards which were clearly reflected in patients' care plans. However, one out of six risk

assessments we reviewed on Caburn ward did not contain any detail of risks identified for the patient. We raised this with the matron and ward manager during our inspection.

- Staff on Coral ward in Langley Green Hospital met every morning after handover to have a 'huddle' meeting to review and discuss risks associated with all patients on the wards. This was also an opportunity to review observations levels and support communication regarding risk across the team.
- Staff on Regency ward in Mill View Hospital trialled the use of the Broset Violence Checklist which assisted staff to predict imminent patient violent behaviour. Members of the ward team met each morning after handover to rate the observed behaviour of each patient on the ward. Staff formulated aggression management plans for patients who scored over a certain threshold for the coming shift. The consultant was involved in discussions if additional medicines were required. These meetings enabled staff to be prepared in the event of a patient becoming violent during the next shift and to identify which patients may need to move to more intensive observation in the psychiatric intensive care units. Staff on Regency ward said they built rapport quickly with patients and found that information sharing using the Broset checklist increased their confidence in managing aggression on the ward.
- The trust has sought to avoid blanket rules and the decision to allow patient's access to belongings that could potentially be used for self-harm, such as belts, is based upon individual risk assessment and safety planning. Staff reviewed risk assessments throughout patients' admissions to ensure it was safe for them to have particular belongings, such as belts, and this was communicated to patients. Staff discussed risks associated with belts with patients, for example, in community meetings where some patients had their belts and some did not following risk assessments. This meant that patients could discuss the importance of keeping each other safe. A list of banned items, such as knives, scissors, drugs and alcohol, was displayed in each ward and was noted in the patient's handbooks
- Each ward entrance door displayed a sign explaining the rights of informal patients who wanted to leave the ward. Informal patients were able to leave the wards after discussion and risk assessment with the most senior member of nursing staff on duty. However, staff on Maple ward did not record what patients were wearing prior to them leaving the ward on escorted or unescorted leave.This could have assisted staff to identify a patient if they went absent without leave in the community. This was a recommendation in the trust's leave of absence policy. Maple, Rowan and Oaklands wards had open ward policies where the ward doors were unlocked unless patients were assessed as being at risk of leaving the ward without appropriate authorised leave. The door to Oaklands ward was locked on the day of our inspection to manage the safety of a patient who was assessed as being a high risk of leaving the ward un-supervised/without appropriate leave. The doors to Amberley and Bodiam wards were open to allow patients to move freely from their ward area to the communal hospital area.
- All wards had good observation policies and procedures. All new members of staff, including bank staff and agency staff, completed an observation skills and knowledge test to demonstrate that they understood the trust's observation policy prior to working on the wards. The test examined staff's understanding of different levels and types of observation used on the wards and how to observe patients when they were asleep. The tests were signed off by the nurse in charge. All staff we spoke with told us that all patients were placed on eyesight observations on admission until they were assessed by the consultant who then reviewed the observation levels required according to patient risk. However, we did not see that eye sight observation levels were recorded for patients immediately following their admission to Coral ward. We noted that one entry for each of two patients on Regency, who were on intermittent observation levels, was not made in their notes. Staff told us they reviewed patient observation levels in daily morning handover meetings and reviewed them throughout each shift. The health care assistants we spoke with in Mill View Hospital told us about their role in carrying out patient observations across the wards. They felt that their feedback to the wider team was valued and was added to risk management discussions at a senior level with the consultants and ward managers, for example to increase observations if there were concerns about a patient's safety.

Are services safe?

- Two members of staff, who were the same gender as the patient being searched, searched patients' belongings and clothing on admission and on return from ward leave using hand pat search technique over the patients' clothing. Staff on Regency ward in Mill View Hospital told us they carried out more searches on patients to ensure they were not carrying lighters on the ward following the smoking ban recently introduced by the trust. However, staff on Woodlands ward told us they did not encourage patients to hand in their cigarette lighters after returning from leave despite this being a risk item on the ward and following a ward fire incident in December 2016. We raised this with the trust at the time of our inspection as this did not indicate learning following the previous fire incident.
- Staff we spoke with told us that they used de-escalation techniques including verbal communication and distraction techniques, such as use of the calm room, before restraint was used as a final option with patients. The psychologist on Caburn ward developed a coping keyring which staff used with patients. The keyring consisted of a number of small credit card sized cards which listed distraction techniques for patients to use alone or with the assistance of staff. Techniques included relaxation breathing exercises, encouraging statements, and lists of activities to do such as walking and reading.
- We reviewed four patient seclusion records on Pavilion and Amber wards. The seclusion paperwork was generally in good order and included details of physical health monitoring. We saw evidence that staff spoke with patients after periods of seclusion to discuss the incident and agree how further seclusion could be avoided.
- At Mill View Hospital staff escorted patients from Caburn ward along two corridors, through the hospital reception and past the hospital café to the seclusion room which was situated close to Pavillion ward. Staff we spoke with told us that, whenever possible, members of staff cleared the corridors ahead of the patient to protect their privacy and dignity.
- The trust submitted 16 safeguarding referrals for the wards we inspected between October 2016 and March 2017.Staff we spoke with knew how to make a safeguarding alert, and some shared examples of alerts they had made. Overall, the percentage of staff working in this core service who had completed children and adult safeguarding training was above the trust target of 75%. However, four out of 12 individual wards had children safeguarding level 3 training completion levels below the trust target of 75% (Oaklands ward – 59%, Maple ward 55%, Coral ward 71%, and Amberley ward 67%).
- We reviewed 99 patients' medicine records. There was generally good medicines management practice across all of the wards. This included how staff stored, dispensed and reconciled patients' medicines. Pharmacists visit the wards most days and assisted in weekly and monthly audits. They also attended ward rounds to assist with reviews of patients' medicines. Staff at Mill View Hospital and Langley Green Hospital told us that two nurses audited each other's medicine charts at the end of each shift to ensure that any errors, such as missing signatures, were corrected as a matter of urgency. However, we noted a date error that had not been picked up in these checks of the medicine chart for one patient on Amber ward, where staff wrote that a patient had received medicines twice on one day instead of on two consecutive days. Pharmacists carried out Mind The Gap audits on all wards to monitor missed doses and recording errors. On Amber ward an audit carried out in March 2017 indicated that in 33 (48%) of the medicine administration charts there was an error. We did not see evidence of an investigation or improvement plan to improve the outcomes. We raised this with the ward manager during our inspection.

  The pharmacist at Mill View Hospital told us they carried out internal inspections at six weekly intervals to review medicines management and physical healthcare focussing on issues such as medicines storage, evidence of patient falls plans being in place, and if medicine was administered at clinically approved intervals. The internal inspection identified that nurses did not always check previous doses administered to patients. This was raised as an incident on their electronic recording system and was discussed with the nurses in supervision and reflective practice.
- Patient photographs were not attached to four out of 17 medicine charts on Maple ward and two out of 15 charts on Oaklands. The charts also did not note why there

were no photographs present. The trust's photographs in medication administration policy recommended that all medicine charts should have patient photographs to assist in the reduction of medicine errors.

- Mill View Hospital had a family visiting room. All visits were risk assessed and visits involving children were raised with the safeguarding team.

Track record on safety

- There were 15 serious incidents during the period October 2016 to March 2017. All ward managers had incident sheets which displayed times, days, locations, types of incidents which enabled ward managers to identify trends in incidents occurring across the wards.
- Each serious incident form we reviewed noted event timelines, severity and likelihood of incident re-occurrence, and learning for each ward to ensure improved safety for patients, including the need for improved information sharing.
- The senior managers at Langley Green Hospital told us of the quality improvement work they had undertaken with staff since the last inspection to reduce incidents at the service. They showed the data collated in regard to this work, which showed that incidents had reduced gradually across all three wards during the period November 2016 to February 2017. This supported a renewed effort of staff to build supportive and therapeutic relationships with patients. For example, on Jade ward there were 22 incidents in November 2016, 17 in December 2016, 15 in January 2017 and 8 in February 2017.

Reporting incidents and learning from when things go wrong

- Staff received feedback and de-briefs from ward managers following investigations and incidents. This was done immediately after an incident, in fortnightly team meetings, weekly reflective practice sessions and in written business bulletins. A serious incident occurred during our inspection. One ward manager explained to us that staff involved in the incident were de-briefed immediately after the event to ensure they were safe to return to work and a management briefing was held two hours after the incident to review actions taken and what could have been done differently. The matron in Langley Green Hospital held monthly 'lessons learnt' sessions to enable staff to discuss changes and learnings following incidents and informed the public of these discussions via the hospital's twitter account.
- All substantive staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. Bank staff told us how they reported incidents to senior staff and assisted them during the reporting process. Ward managers reviewed all incidents and forwarded them to the appropriate general manager and matron who passed them to the patient safety team for further review. This system ensured that senior managers within the trust were alerted to incidents in a timely manner and monitored the investigation responses. Ward managers used incident information to monitor for themes in incidents, for example falls, aggression, ill health.
- The wards we inspected demonstrated learning from incidents. For example, the trust installed a security air lock to Caburn ward's entrance door following a review of a number of incidents when patients went absent without leave and where there were threats to patient safety from a small number of patients' visitors. Caburn ward also noted that there was an increase of incidents on Friday evenings following new patient admissions. In response to this the occupational therapy team developed and introduced a Friday pamper evening for patients which included beauty treatment sessions and hot chocolate drinks in a relaxed and calm environment. Staff we spoke with reported a reduced number of weekend incidents following the introduction of this new programme which also encouraged patient self-care. The trust replaced bathroom doors in two rooms with non-ligature foam doors on Woodlands and Caburn wards following incidents of self-harm.However, there was an exception on Woodlands ward where there was a lack of learning from an incident which occurred in December 2016 where a patient had set fire to their room. During our inspection we observed patients with access to cigarette lighters on the ward following return from leave. Staff told us they did not encourage patients to hand in their lighters despite them being a risk item. There was a risk that patients with lighters in their possession on the wards could use them to set fires or self-harm. This meant there was a lack of learning or change in procedure following the fire incident to ensure patient and ward safety.

Are services safe?

- Staff were open and transparent and explained to patients when things went wrong. We saw evidence of letters from the ward manager to two patients on Regency ward explaining the next steps in investigations into incidents they were involved in.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff on Coral ward did not record eyesight observations made on patients following their admission to the ward prior to the patient's observation review with the ward consultant. Staff did not record observation times for two patients on intermittent observation levels on one occasion on Regency ward. Patients on Woodlands ward had access to cigarette lighters despite the trust having a smoke-free policy and following a fire incident on the ward in December 2016. Staff on Jade and Amber wards did not always ensure that physical health and general observations were recorded accurately for patients. Amber ward did not have an investigation or improvement plan to monitor the high levels of missed medicine doses identified in the March 2017 Mind The Gap audit carried out by the ward pharmacist. This is a breach of Regulation 12 (2)(a)(b) and (g)

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 18 HSCA (RA) Regulations 2014 Staffing This core service did not reach the trust's training completion target in four out of 22 mandatory training subjects.

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 18 (2)(a)