Care Quality Commission

Good

North Staffordshire Combined Healthcare NHS Trust

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

## Quality Report

Trust Headquarters
Bellringer Road
Trentham Lakes South
Stoke-On-Trent
Staffordshire
ST4 8HH
Tel: 01782 273510
Website: www.combined.nhs.uk

Date of inspection visit: 12 - 16 September 2016
Date of publication: 21/02/2017

## Locations inspected

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

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

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

# Summary of findings

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

# Summary of findings

## Ratings

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

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

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

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

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

# Summary of findings

## Contents


### Summary of this inspection

| | Page |
|---|---|
| Overall summary | 5 |
| The five questions we ask about the service and what we found | 6 |
| Information about the service | 10 |
| Our inspection team | 10 |
| Why we carried out this inspection | 10 |
| How we carried out this inspection | 11 |
| What people who use the provider's services say | 11 |
| Good practice | 11 |
| Areas for improvement | 12 |

### Detailed findings from this inspection

| | |
|---|---|
| Locations inspected | 13 |
| Mental Health Act responsibilities | 13 |
| Mental Capacity Act and Deprivation of Liberty Safeguards | 13 |
| Findings by our five questions | 15 |
| Action we have told the provider to take | 30 |

# Summary of findings

## Overall summary

We rated the acute wards for adults of working age and psychiatric intensive care units as good because:

- During the most recent inspection, we found that the service had addressed the issues that led us to rate acute wards for adults of working age as requires improvement following the September 2015 inspection.
- We found that staff identified and mitigated environmental risks such as blind spots and ligature points on the wards. All patients had up-to-date risk assessments that informed risk management plans.
- The new purpose-built seclusion room and seclusion practice adhered to the requirements of the Mental Health Act Code of Practice. Informal patients were aware of their right to leave the ward. They received information on admission about their rights and there were signs on the doors informing them they could leave at their will. Staff had a good understanding of the Mental Capacity Act (MCA) and the associated principles.
- Staff fully adhered to infection control principles. As of 31 August 2016, 93% of staff had received training in infection control. The wards carried out quarterly audits of hygiene and infection control. Emergency drug storage and medicines management was good across all the wards.
- Patients had easy access to information on advocacy, complaints, treatments, and legal rights. Patients had access to weekly community (patients) meetings where they could raise issues and concerns. Patients knew how to make complaints, and received outcomes from their complaints.
- Ward managers ensured a balance of staff skill and gender mix across all wards.

However:

- Patients and visitors could see confidential patient information on the patient information boards in the staff offices.
- There was insufficient detail in the recording of assessments and decisions associated with the capacity to consent.
- The seclusion room observation window was located too high for staff to maintain ongoing observation.
- Patients on ward 1 lacked privacy in their bedrooms because the viewing panels on doors could only be opened and closed from the outside.
- Staff did not consistently document monitoring of patients' vital signs after administering rapid tranquillisation.

# Summary of findings

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

### Are services safe?

Good

We rated safe as **good** because:

- Staff identified and mitigated environmental risks such as blind spots and ligature points on the wards.
- The mixed gender ward complied with the Department of Health gender separation requirements for mixed gender accommodation.
- The acute wards had taken action to reduce their high vacancy levels from 22.5% in July 2016 to 4% in September 2016 (taking into account 14 newly appointed staff due to start in work in the coming weeks).
- Wards were clean and well equipped. Staff fully adhered to infection control principles.
- Staff received mandatory training. The acute wards achieved the trust's average compliance rate of 90% for mandatory training.
- All patients had up-to-date, comprehensive risk assessments that informed risk management and care plans.
- All of the acute wards used the safe wards interventions to ensure they provided a safe and therapeutic environment for patients. Staff used restraint as a last resort when de-escalation (calming down) techniques had failed.
- The acute wards had a separate, well-furnished family room to facilitate safe visits for families and children.
- Staff knew how to report incidents, including safeguarding issues. The provider had robust monitoring systems to review and investigate incidents. Staff received debriefings and support after incidents.

However:

- The seclusion room observation window was located too high for staff to maintain ongoing observation.
- Staff did not consistently document monitoring of patients' vital signs after administering rapid tranquillisation.
- Fridge temperatures exceeded safe levels for medicines storage on 16 occasions in a two-month period. Staff had not reported these as incidents or maintenance issues.
- Shifts were not always fully staffed and the staff required on each shift often fell below 90%.

### Are services effective?

Good

We rated effective as **good** because:

# Summary of findings

- Staff undertook comprehensive assessment and care planning of patients' needs that included mental and physical health needs.
- All wards used recognised outcomes measures such as the health of the nation outcome scales (HoNOS) to assess and measure the health and social functioning of the patients.
- Handovers took place between each shift and were structured, comprehensive and informative. There was good information sharing, with a specific focus on patients' presentations and any changes in their needs and risks.
- Staff received induction, regular supervision and annual appraisals. Staff had the appropriate skills and qualifications for their roles. Regular and effective multidisciplinary team meetings took place, and the wards had access to a wide range of disciplines to support patients' individual needs.
- The acute wards worked in partnership with a range of internal and external services to help meet the specific needs of their patients, for example, housing, substance misuse services, learning disability wards, home treatment teams and community mental health teams.
- Staff adhered to the Mental Health Act (MHA) and the MHA Code of Practice. MHA documentation was accurate, complete and in good order. Staff ensured patients received their rights regularly.
- Staff had a good understanding of the Mental Capacity Act (MCA) and the associated principles. Staff made Deprivation of Liberty Safeguards (DoLS) applications where appropriate. Staff were aware of the trust's MCA and DoLS policy and knew where to seek advice on the MCA.
- Staff participated in wide range of clinical audits that helped identify issues and plan improvements.

However:

- A patient who needed surgical dressings had to do without them for a few days while staff requested and waited for a GP prescription. This placed the patient at increased risk of oedema and restricted his mobility on the ward.
- There was insufficient detail in the recording of assessments and decisions associated with the capacity to consent.

### Are services caring?

We rated caring as **good** because:

**Good**

- Patients described staff as caring, kind and respectful. We observed positive interactions between staff and patients.

# Summary of findings

- Staff knew the patients well and had a good understanding of their needs. Patients confirmed this was the case.
- Patients received orientation to the ward and a range of information, including a welcome booklet, on admission.
- Care planning was holistic and recovery-oriented, and fully involved patients and carers.
- Patients had good access to advocacy services, including independent mental health advocates (IMHA). Patients could invite advocates to attend their care reviews.
- Patients had access to regular community (patients) meetings where they shared their thoughts about the ward environment, the activities on offer and the care that they received.

However:

- Not all patients received copies of their care plans.
- Patients did not have advance decisions (statements containing patients' wishes about their treatment).

### Are services responsive to people's needs?

**Requires improvement**

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

- On all the acute wards, patients and visitors could see confidential patient information on the patient information boards in the staff office.
- The dormitory-style bedrooms on all three wards compromised patients' privacy and dignity.
- The viewing panels on patients' bedroom doors on ward 1 could only be opened and closed from the outside, which reduced the patients' privacy and dignity.
- Bed occupancy across the core service was above 102%. Staff moved patients between wards to accommodate new admissions. At times, patients who returned from leave early had to sleep on other wards.

However:

- Each ward had a range of facilities to meet patients' needs. These included quiet areas, access to outside areas and private meeting areas.
- Patients received a choice of high quality food that met their dietary needs and preferences. Staff involved patients in planning menus. Patients had 24-hour access to drinks and snacks.

# Summary of findings

- Staff offered patients a wide range of activities throughout the week and at weekends. Staff invited patients to suggest activities, which helped promote their inclusion and engagement. Staff offered complementary therapies that had a positive impact on those patients who received it.
- Patients had easy access to a wide range of information on advocacy, complaints, treatments, and legal rights. Information was available in other languages on request. Staff had access to interpreters, where needed.
- Patients knew how to make complaints, and received outcomes from their complaints. Staff took complaints seriously and dealt with them in line with the trust's complaints procedure.

### Are services well-led?

Good

We rated well led as **good** because:

- Staff knew and agreed with the vision and values of the trust that promoted safe, personalised, accessible and recovery-focused services.
- Staff knew who most of the senior management were, and said they occasionally visited the wards.
- Staff received mandatory training, specialist training for their roles, annual appraisals and regular supervision.
- Staff reported good morale within the teams and they felt valued and supported by their teams and managers. Staff felt confident to raise concerns and said managers listened to them.
- The acute wards had effective systems and processes to monitor their service delivery, quality and performance.
- All wards had current Royal College of Psychiatry accreditation for inpatient mental health services (AIMS).
- The trust had plans that showed commitment to service development in acute wards. These included a five-year ligature reduction programme and the building of a psychiatric intensive care unit (PICU) and a seclusion suite on ward 2.

# Summary of findings

## Information about the service

The acute wards for adults of working age provided by North Staffordshire Combined Healthcare NHS Trust are part of the trust's acute division. Services are provided for both patients admitted informally and those detained under the Mental Health Act 1983. The trust currently does not have a psychiatric intensive care unit (PICU).

There are three acute wards based at Harplands Hospital:

- Ward 1 is a mixed-sex ward with 14 beds. It offers intensive care for male and female adults suffering from acute mental illness.
- Ward 2 is a male ward with 22 beds.
- Ward 3 is a female ward with 22 beds.

Care Quality Commission (CQC) last inspected the acute wards in September 2015 as part of a comprehensive inspection of North Staffordshire Combined Health Care NHS Trust. There were two unannounced Mental Health Act reviewer visits between May 2016 and August 2016 within this core service.

## Our inspection team

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

**Chair:** Beatrice Fraenkel, Chair, Mersey Care NHS Foundation Trust.

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

**Team Leader:** Kathryn Mason, Inspection Manager (Mental Health), CQC.

The team that inspected the three acute wards for adults of working age at Harplands Hospital comprised a CQC inspector, a consultant psychiatrist, a Mental Health Act reviewer, a mental health nurse and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

## Why we carried out this inspection

We undertook this inspection to find out whether North Staffordshire Combined NHS Trust had made improvements to its acute wards for adults of working age since our last comprehensive inspection of the trust in September 2015.

When we last inspected, we rated acute wards for adults of working age as requires improvement overall. We rated the core service as requires improvement for Safe, requires improvement for Effective, good for Caring, requires improvement for Responsive and requires improvement for Well-led.

Following the inspection in September 2015, we told the trust that it must:

- adhere to the requirements of the Mental Health Act (1983) Code of Practice (2015) regarding seclusion rooms
- ensure all ligature risks are identified and action taken to reduce them
- ensure informal patients are aware of their right to leave the ward and staff keep the appropriate legal records when they prevent an informal patient from leaving
- ensure all staff comply with the Control of Substances Hazardous to Health Regulations (COSHH) when cleaning up bodily fluids.

We also told the trust that it should:

- ensure it reviews staff mix on wards, especially male-only and female-only wards to ensure patients' dignity and privacy

- ensure detained patients on wards have information on how to contact the CQC
- ensure all staff have a good understanding of the Mental Capacity Act and consent
- ensure nursing staff receive training in medicines management.

We issued the trust with three requirement notices associated with the acute wards for adults of working age. These related to:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment.

## How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three of the wards at the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 15 patients who were using the service
- spoke with eight carers of patients who were using the service
- spoke with the managers for each ward
- spoke with 36 other staff members including doctors, nurses, activity workers, occupational therapies, ward clerks, the Mental Health Act administration lead, housekeepers, domestics, consultant nurse, nurse practitioners and clinical psychologists
- attended and observed three handover meetings, two ward reviews and three multidisciplinary meetings
- attended and observed two patients' meetings, the wellness recovery action plan (WRAP) group and the walking group
- reviewed care records for 22 patients
- reviewed comments and feedback from the CQC website and focus groups
- carried out a specific check of medication management on the three wards
- checked the medication charts of 56 patients
- 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 15 patients. Patients reported that staff treated them with dignity and respect. Patients told us that community meetings gave them the opportunity to contribute to what happens on the ward. The majority of patients told us staff involved them in their care planning and they received copies of their care plans.

## Good practice

Staff on ward 3 offered patients complementary therapies, which patients liked and had positive

outcomes. For example, there was a reduction in the use of PRN (as needed) medication for those patients who engaged in the sessions. As a result, the ward was planning to increase the frequency of the sessions.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure that it protects confidential patient information and ensure that it is not visible to other people.

### Action the provider SHOULD take to improve

- The trust should ensure that decision-specific capacity assessments and outcomes are recorded fully and accurately in patients' files, and are easy to access.
- The trust should ensure that staff can fully observe all areas of the seclusion room.
- The trust should review how the open viewing panels on ward 1 bedroom doors affect patients' privacy and dignity.
- The trust should ensure that staff always record the monitoring of patients' vital signs after rapid tranquillisation.

Care Quality Commission

North Staffordshire Combined Healthcare NHS Trust

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

**Detailed findings**

## Locations inspected

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

## Mental Health Act responsibilities

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

At the time of our inspection, staff compliance with Mental Health Act training in the acute wards was 93%. Ward 1 had the lowest rate with 89%, which was below the trust's target compliance rate of 90%.

Staff demonstrated a good understanding of the different MHA sections. Staff regularly explained to detained patients their rights under the MHA and recorded this in patients' notes. All staff we spoke with knew where to seek further advice and support within the trust on the MHA and MHA Code of Practice.

Effective MHA administration systems ensured that patients' files contained accurately completed and up-to-date documents.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that 94% of staff in the acute wards had received training in the Mental Capacity Act (MCA).

Staff demonstrated a good understanding of the MCA and could clearly explain the five principles. The trust had a detailed policy on how to apply MCA. Staff were aware of the policy and referred to it, when needed. However, the recording of capacity to consent assessments and decisions lacked detail and were difficult to locate in patients' notes.

Good

# 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

- The layout of the wards did not allow staff to observe all parts of the ward and there were blind spots. Staff were aware of the risks to patients' safety caused by the layout. To mitigate the risks, staff assessed the appropriate level of observation required for each patient and observed them in high-risk areas as required.Staff conducted hourly environmental checks and There were convex mirrors placed in the garden areas that helped mitigate the blind spots on wards 2 and 3.
- We reviewed the ligature risk assessment to follow up a regulatory breach identified in the previous inspection in 2015. The trust had planned a five-year ligature reduction programme. Since the last inspection, there had been some environmental improvements to reduce the number of ligature points. A ligature point is anything that a person could use to attach a cord, rope or other material for the purpose of hanging or strangulation. These improvements included anti-ligature beds across the acute wards. We found that all the wards had an updated ligature and environmental risk assessment that identified how staff mitigated the risks where there were ligature points. Staff were aware of the potential ligature points within their wards and knew how to manage them. For example, staff managed risks through close observation and good knowledge of individual patients. Ward managers highlighted any major risks to staff at handovers, team meetings and e-mail communication. Managers ensured that all new and temporary staff had a 'ligature walk-around'.
- Staff were trained in the use of ligature cutters and all staff had quick and easy access to the ligature cutters.
- Ward 1 had both male and female patients. It complied with the for mixed gender accommodation. The ward had separate There was a clearly defined and separate lounge area for female patients. Ward 2 and Ward 3 were single-sex wards.
- Each of the wards had a clean and well-equipped clinic room with equipment such as weighing scales, blood monitoring machines, blood pressure machines and electrocardiography(ECG) machines, all of which were clean, had visible stickers, and had received safety testing. All wards had emergency equipment such as automated external defibrillators and oxygen cylinders and all staff had access to them. Staff checked equipment regularly to ensure it was in good working order, and ready for emergency use. Emergency drug storage was good across all the wards.
- At our previous inspection in 2015, we found that the acute wards did not have a seclusion room. The trust had since built a new seclusion suite on ward 1 that became operational in early September 2016. It was visibly clean and well maintained. The suite contained an anti-ligature bed and a separate anti-ligature toilet and wash area. The main room had an intercom for communication between the staff and the patients, and a convex mirror to help staff observe the patient's health and safety. There was a clock within the seclusion room. The door to the seclusion room had an observation window and metal hatch that staff used to pass food and drink. However, the high position of the observation window in the door made it difficult for staff to observe patients easily. One member of staff said they had struggled to maintain ongoing observation due to the height of the window. We informed the ward staff of our concerns. They said they would take this further.
- The wards were clean, free from clutter, and well maintained with pleasant decor and furnishings. Each ward had allocated domestic staff that cleaned their wards on a daily basis. Cleaning schedules were available on each ward. We reviewed cleaning checklists and audits and found they were completed and up-to-date. Most patients we spoke with said they were happy with the cleanliness and furnishings on the ward.
- In the 2015 patient–led assessment of the caring environment (PLACE), Harplands Hospital scored 99.6%, which was higher than the national average for trust sites of 97.6%. PLACE assessments are self-assessments undertaken by NHS and private/ independent health

care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided.

- As of 31 August 2016, 93% of staff had received training in infection control. We saw good hand hygiene and infection control practice that protected patients and staff against the risks of infection. Staff we spoke with knew how to respond to an infection control concern. The wards carried out quarterly audits of hygiene and infection control. Where audits identified areas for improvement, staff drew up action plans to address the issues. All handwashing areas had posters instructing how to wash hands effectively. Hand gel was widely available throughout the wards.
- Wards undertook monthly environmental risk assessments. Each ward had a dedicated member of staff assigned to undertake audits on health and safety, fire, workplace equipment and control of substances hazardous to health (COSHH). Housekeepers maintained a log of work requests sent to the facilities department and risk assessments to manage short-term environmental problems.
- All staff carried personal alarms that they received at the beginning of each shift. There were no alarm systems in the bedrooms in all of the wards but there were nurse call buttons located throughout the wards such as in the assisted bedrooms, corridors, bathrooms and toilets.

### Safe staffing

- The acute wards had a whole time equivalent of 48.8 nurses and 45.8 nursing assistants. There were 17.6 nurse vacancies, and 3.6 nursing assistants' vacancies. As of 31 July 2016, trust data for whole time equivalent staff for each ward showed:
  - ward 1: 16.3 qualified nurses, 2.5 vacancies; 15.3 nursing assistants, 1.7 vacancies
  - ward 2: 16.3 qualified nurses, 8.3 vacancies; 15.3 nursing assistants, no vacancies
  - ward 3: 16:3 qualified nurses, 6.9 vacancies; 15.3 nursing assistants, 1.9 vacancies.
- The total turnover for the acute wards in the 12 months to 31 July 2016 was 14.2%, which was above the average for all core services of 11.2%. Ward 2 had the highest turnover rate of 19%.
- As of 31 July 2016, the vacancy rate in this core service was 22.5%, above the average for all core services of 8.8%. The trust had actively sought to fill vacancies through open days, recruitment fairs, engagement with return to practice campaigns and preceptorship programmes. Preceptorship is a period of transition for newly qualified nurses during which time they receive support to help develop their confidence. At the time of our inspection, the wards had appointed 14 new staff who were due to start work in late September 2016 and early October 2016. This reduced their actual vacancy levels to 4%.
- The average sickness rate for the acute wards during the 12 months to 31 July 2016 was 7.5%, which was higher than the average sickness level for all core services of 5.22%. Ward 2 had the highest sickness rate of 10.5%. The ward had a number of staff on long-term sick leave owing to physical health issues.
- The trust established staffing levels in line with national institute for health and care excellence (NICE) guidelines on safe staffing for nursing in adult inpatient wards in acute hospitals. The trust had six-monthly staffing reviews to ensure patients received safe care and treatment. However, the numbers of nurses identified in the staffing levels set by the trust did not always match the number on all shifts. Staffing rotas for the month prior to our inspection showed that the wards were occasionally understaffed. Trust data for May 2016 to July 2016 showed 466 shifts left unfilled across the acute wards. Ward 3 had the highest number of shifts left unfilled (274). In June 2016, all three wards had daytime fill rates of below 90%. Wards 1 and 2 consistently had fill rates below 90% for every month across the three-month period. During May and June 2016, ward 2 had the lowest fill rates for qualified nurses on night shifts (56% to 59%).
- There was a high reliance on bank and agency staff to cover vacancies and fill shifts, especially at night. For the three months to 30 April 2016, bank and agency staff covered 1227 shifts. Ward managers requested bank and agency staff who were familiar with the wards, and where possible, booked staff for long periods to ensure

continuity of care for patients. All the ward managers and duty senior nurses worked together to ensure safe staffing levels across all wards. This included moving staff between wards, if necessary. During our inspection, we saw managers adjusting staffing levels to take into account changes in clinical need. The managers ensured a balance of staff skill and gender mix across all wards. They displayed staffing levels for the day.

- At the time of our inspection, wards 1 and 2 had a dedicated consultant psychiatrist and ward 3 had a locum consultant psychiatrist. Ward 3 had experienced three locum consultant psychiatrists in a three-month period between July and September 2016. Patients commented that they saw different doctors during the course of their stay. However, there was sufficient medical cover to meet the needs of patients as each ward had support from junior doctors and non-medical nurse prescribers. All wards had access to the on-call duty doctor out-of-hours for emergencies.
- Staff from all wards told us they rarely cancelled escorted leave. This only happened due to a change in the patient's presentation. Ward staff liaised with community-based staff such as care coordinators and home treatment teams to assist with escorted leave, where appropriate.
- Across the wards, all staff we spoke with confirmed there was enough staff on shift to carry out any physical interventions safely. As of 31 August 2016, 78 out of 86 staff had received training in the management of actual or potential aggression (MAPA).
- As of 5 September 2016, the average mandatory training rate for staff in the acute wards was 90%. This was in line with the trust's compliance target of 90%.

### Assessing and managing risk to patients and staff

- Trust data showed there were 36 episodes of seclusion for this core service from 1 March 2016 to 31 August 2016. Ward 1 had the most seclusion use with 23 episodes, followed by ward 2 (12) and ward 3 (1). During this period, the trust's seclusion room was unavailable for clinical use because it was undergoing refurbishment. The trust implemented interim arrangements, for example, patients with behaviour that challenged received intensive nursing support either in their bedroom or in ward 1 annexe. Alternatively, where a patient's care plan indicated that seclusion might be required frequently, the trust transferred the patient to an out-of-area psychiatric intensive care unit (PICU) bed.
- The trust reported 25 episodes of long-term segregation from 1 March 2016 to 31 August 2016. On further investigation, we found that there were no incidents of long-term segregation in the six months that preceded this period or in subsequent months. We found that the trust had amended its seclusion and long-term segregation policies to reflect their interim arrangements in the absence of a suitable seclusion facility, and to provide greater safeguards for the patient. This resulted in some confusion for staff in classifying seclusion-type practice in that, for a short period, staff tended to record intensive nursing in a patient's bedroom as seclusion, and intensive nursing in ward 1 annexe as long-term segregation. We saw seclusion reports that confirmed that staff applied the principles of seclusion such as close observations and regular external clinical reviews. By the time of our inspection in September 2016, the seclusion facility situated on ward 1 was open and all seclusion took place there in line with trust's policy, revised again in August 2016.
- In the six-month period to 31 August 2015, there were 218 incidents of restraint for this core service, 11 of which were prone (face-down) restraints. The highest number of restraints was on ward 1 with 103 incidents. Ward 3 reported 62 restraints and ward 2 reported 53. On ward 2, all staff were fully aware of the potential physical risks associated with restraint for some patients, as set out in their risk management plan. Safety protocols on how to restrain were in place. We observed this vital information handed over from shift to shift to ensure all staff on duty were aware.
- Staff used restraint as a last resort, after de-escalation techniques had failed. The wards had implemented the safe wards model of care to promote de-escalation. This model seeks to reduce the need for restraint by identifying potential triggers and developing an understanding of another person's perspective. It focuses on improving communication between patients and staff and avoiding confrontations arising from misinterpretations. To develop the approach, the wards had 'knowing each other' boards that displayed photos and names of staff. Staff had also compiled a set of 'mutual expectations' that informed communication

Good

# Are services safe?

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

and behaviour on the ward. These included patience, mutual respect and taking time to listen as key factors for good relationships between staff and patients. We observed staff de-escalating a situation on ward 2 by using talking-down techniques. Staff had identified and recognised the patient's early warning signs and triggers. Staff responded with appropriate techniques such as calming down and distraction.

- Staff recorded any use of PRN ('pro re nata' - as required) medication to calm a patient following an incident as rapid tranquillisation. Rapid tranquillisation is medicine given to patients who are very agitated to help them calm down quickly. Trust data showed that staff gave rapid tranquillisation on 81 occasions in this core service in the six-month period to September 2016. Ward 1 had the highest use of 35 times. On ward 1, we found that staff did not always document the monitoring of patients' vital signs after rapid tranquillisation in line with the relevant NICE guidelines (NG10 Violence and aggression: short-term management in mental health, health and community settings). On three occasions, we found no rapid tranquillisation incident numbers noted against the use of medication given by injection. The trust did not carry out specific audits on practice associated with rapid tranquillisation (such as checking records, frequency of use) but used the incident reporting data to monitor usage. This carried the risk of under-reporting and poor oversight of prescribing practice.
- We looked at 22 care records. Patients had a robust and comprehensive risk assessment and an up-to-date risk management plan completed on admission, which identified how staff were to support them. Staff recorded the information on the electronic patient record system. Staff involved patients in managing their own risks, and monitored changes daily. Most staff received risk assessment training. As of 5 September 2016, wards 2 and 3 had 100% compliance rates while ward 1 achieved 81%.
- Staff were familiar with the trust's policy on observation. They determined the levels of observations from the patient's presentation and their risk assessment. This ranged from hourly observations to constant observations at arm's length. They reviewed observations at all handover meetings, ward reviews and multidisciplinary reviews. Staff explained the rationale for the observation level with the patient. During the inspection, we observed that staff carried out observations discreetly and respectfully.
- Staff imposed reasonable restrictions on the wards to manage identified risks. For example, patients were not allowed restricted items such as, cigarette lighters, aerosols, razors, sharp objects, alcohol or illicit drugs on the wards. Patients could only gain access to the games and laundry rooms on wards when accompanied by a staff member due to the risks present in the environment. Staff explained these restrictions to patients during their orientation to the wards. Staff and patients discussed the restrictions in community meetings.
- Staff searched patients and their bags upon admission for restricted items for safety reasons. Staff searched patients when they returned from leave if indicated in their risk and care plans.
- The acute wards had locked doors. There was a sign on the doors informing informal patients that they could leave at their will. We spoke to informal patients who told us they could leave the ward as long as they told staff they were going out. We looked at five informal patient records and saw that patients received information on admission that explained what informal and voluntary admission meant.
- Staff had a good understanding and knowledge of safeguarding policies and procedures. Safeguarding training compliance in the core service was 82%. Staff were able to describe situations that would lead to a safeguarding referral. Staff knew the internal lead for safeguarding.
- We reviewed 56 prescription charts. We saw appropriate arrangements were in place for recording the administration of medicines. Staff completed medicine reconciliation on all prescription charts. The prescription charts showed patients' allergies. Prescription charts had pharmacist interventions documented on them where appropriate. Staff reported medicine errors using the incident reporting system and resulting information was cascaded to the nursing staff team in ward team meetings
- We found that medicines were not always stored within safe temperature ranges on ward 2. The maximum temperature recorded, while monitoring the refrigerator,

exceeded the recommended temperature on 16 occasions between July 2016 and September 2016. The documented action taken was 'reset' on all occasions. We did not see any incident reports about this.

- There was good access to medicines on all the wards, and medicines for discharge were readily available.
- We saw evidence of assessments for falls and pressure ulcers in patients' notes. Patients vulnerable to falls had a falls assessment and management plan in place. Patients with pressure ulcers had care plans fully addressing how to monitor regularly. They were up-to-date and amended as necessary.
- The wards had shared access to a separate family room to facilitate safe visits for children and families. Ward staff undertook appropriate risk assessments before any visits.

### Track record on safety

- The trust reported five serious incidents between 1 April 2015 and 31 March 2016 for this core service. None of these were never events. Two of the incidents related to assaults by inpatients that met the serious incident criteria.
- Improvements to safety following incidents included exchanging standard beds for anti- ligature beds on all wards and the removal of window grills on ward 1 to reduce ligature points.

### Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. All staff had access to this and were aware of the types of incidents that required reporting.
- Ward managers reviewed all incident forms once submitted. Staff told us they received feedback from investigations in handovers, team meetings and email communications. We reviewed minutes of meetings from all three wards and confirmed staff discussed incidents, key themes and lessons learnt. Ward managers developed action plans to implement changes. We saw examples of weekly emails sent to staff by the ward 2 manager. These gave feedback on each incident and the actions taken.
- Staff we spoke with said managers arranged debriefing sessions after every serious incident and shared learning from when things went wrong. Ward staff had access to a range of support that included reflective practice sessions, adhoc diffusion sessions and access to psychology services. Patients received debriefing following an incident and staff recorded this in the patients' care records.
- We found some good examples of improvements following incidents. The wards had introduced a safety briefing before every handover following an incident in which two patients with the same initials received the wrong medication. The briefing provided a 'short, sharp view' of key safety issues such as patients' allergies and environmental issues. Managers shared the information with non-clinical staff on the ward. Another improvement was that ward round updates were directly entered onto the electronic patient record system so that information could be accessed immediately by other teams if patients were discharged.
- Senior staff and all ward managers attended an incident review group led by the modern matron every week, where they discussed and reviewed all the incidents that took place in Harplands Hospital. The ward 3 manager encouraged staff on the ward to attend as part of their ongoing learning.
- Staff had a good understanding of the duty of candour. During our inspection, we saw an incident on ward 1. The manager demonstrated openness and transparency in line with the trust's policy. The manager explained the incident to all patients, apologised for it, and described the actions taken to prevent it happening again.

# Are services effective?

Good

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

- Staff carried out comprehensive assessments of patients' needs on admission. Assessments included a review of clinical needs as well as mental and physical health needs.
- We looked at 22 care records across the service and found that most of these had good care planning that demonstrated a comprehensive and holistic view of the patient. Care plans were up-to-date and regularly reviewed. Care plans focused on recovery and showed that patients helped devise their plans. In cases where care plans did not contain any patient views, staff had clearly recorded the reasons why, for example, the patient's refusal to engage with it.
- All care records showed that patients had received a physical examination on admission. There was evidence of ongoing physical health monitoring using the modified early warning score (MEWS) assessment tool.
- The acute wards used paper and electronic records. Electronic records held patients' care records. Paper files held detention paperwork, prescription charts and correspondence letters, and staff recorded observations in them. Staff we spoke knew where to find information and could access records easily. Each ward had allocated a champion for the electronic records system to support other staff. Community mental health teams had access to the same electronic records system.

### Best practice in treatment and care

- We reviewed 56 prescription charts and spoke to doctors who were responsible for prescribing medication. We found they adhered to the relevant national guidance from the national institute for health and care excellence (NICE) when prescribing medication.
- Wards had access to psychologists and assistant psychologists who led some of the patient groups such as the emotional coping skills and mindfulness groups. Patients could access one-to-one psychology support including dialectical behaviour therapy (DBT). Wards had a clear acute care pathway. If needed and after discharge, patients could continue psychology support with the same therapist in the community.
- The wards had a holistic approach to each patient and 'parity of esteem', which is a principle by which mental health is given equal priority to physical health. There was clear evidence of continued reviews of physical health with observations repeated, weight monitored and referrals made any specialist opinions required in all but one case. However, for one patient on ward 1, staff had not fully addressed their ongoing physical needs. The patient had clinical dressings prescribed prior to admission. Their surgical dressings went missing on the ward. Ward staff requested and awaited a GP's prescription for further dressings. This meant that the patient went for some days without the surgical dressing, which increased their risk of oedema and reduced their mobility on the ward.
- Staff assessed and treated patients' nutritional and hydration needs, and where needed, referred patients to the dietician for specialist support and treatment. Staff monitored patients' weight. Staff monitored food and fluid intake for those patients vulnerable to poor nutrition.
- All wards used the health of the health of the nation outcome scales (HoNOS) to assess and measure the health and social functioning of the patients. Occupational therapists used the recognised model of human occupation screening (known as MoHOST) tool to assess and monitor progress and recovery.
- Staff on all wards actively participated in a range of clinical audits for monitoring the effectiveness of the services provided. Managers showed us records of audits that included infection control, risk assessments, prescription cards, care plans, physical health monitoring and mattresses. Managers developed action plans to address any issues identified in the audits to improve outcomes for patients.

### Skilled staff to deliver care

- All wards had access to a range of professionals including consultants, junior doctors, nurses, nurse practitioners, psychologists, pharmacists, activity coordinators, housekeepers, occupational therapists, dual diagnosis nurse consultant practitioners, home treatment in-reach workers and physiotherapists. However, ward staff reported a lack of social work input on the wards.

# Are services effective?

Good

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.

- Each ward had an occupational therapist and activity worker who were actively involved in patients' therapeutic treatment. We observed them facilitate the wellness recovery action plan (known as WRAP) and walking groups.
- Physiotherapists attended the wards regularly. They offered group sessions such as exercise groups and individual one-to-one sessions tailored to individual needs. We observed them during their sessions, and patients gave positive feedback.
- Staff had the appropriate skills, experience and qualifications to effectively support the care and treatment of patients. All of the wards had a non-medical nurse prescriber.
- The trust provided a formal induction to all new starters. The trust operated a preceptorship programme for newly qualified staff. Feedback from staff about the preceptorship programme was positive. The trust expected all nursing assistants to complete the care certificate training. Staff said, and records showed that staff received a local induction to the ward and shadowed existing staff before managers included them in the staffing levels.
- Staff received regular one-to-one supervision, in line with the trust's policy. For example, trust data for September 2016 showed clinical supervision rates of 83% for ward 1, 95% for ward 2 and 96% for ward 3. The wards had regular team meetings and reflective practice sessions. Staff said the reflective sessions helped them to work out better strategies for managing situations as a team.
- As of September 2016, appraisal rates for non-medical staff on the acute wards ranged from 92% to 100%.
- Records reviewed showed that managers provided staff with training relevant to their roles. Staff received training in clinical risk management, equality and diversity, anti-ligature, epilepsy awareness, diabetes, personality disorder, the , positive behaviour support and dementia awareness. Nursing staff confirmed managers supported them to undertake continued professional development to meet the Nursing and Midwifery Council (NMC) revalidation and registration requirements. Ward managers had access to team leadership training. The wards adopted paired learning, whereby staff nurses worked closely with doctors, shared practices and mentored each other. The trust had agreed funding for all occupational therapists to attend training on the Vona du Toit model of creative ability (a HoNOS measure that aims to improve patients' function, motivation and independence).
- All ward managers showed an understanding of the staff performance policy and received support from human resources staff to apply it. In the year to September 2016, the acute wards had two cases in which managers had to address staff performance or behaviour.

### Multi-disciplinary and inter-agency team work

- Regular and effective multidisciplinary team meetings took place. Staff said they felt well integrated and adopted a multidisciplinary approach to meet patients' needs. We observed three multidisciplinary meetings. These meetings involved different professionals within the hospital. During the multidisciplinary meetings, staff took an active role in discussions about their patients' needs. Clinical pharmacists reviewed individual patient's medicine requirements. Pharmacist attendance at multidisciplinary meetings was available upon request rather than routine due to limited capacity.
- Each ward had three handover periods during the day, in the morning, afternoon and evening. We observed two staff handovers, which included all staff coming on duty for the next shift. The handovers provided an overview of the current needs and risks of all patients on the ward. Staff discussed patients' progress, risks and levels of observation and planned activities. Staff updated the patient information on the white board to reflect any changes. The handover on ward 1 had some interruptions from ringing telephones and people walking in and out.
- There was evidence of effective communication between the inpatient and community mental health teams. The home treatment in-reach worker attended the ward reviews to facilitate home leave or early discharge. The dual diagnosis consultant nurse supported the acute wards by teaching staff and patients how to manage the effects of drugs and alcohol use.
- Staff worked collaboratively with other professionals in the trust to ensure best outcomes for patients. Across the wards, staff made referrals to relevant healthcare

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.

professionals, such as GPs, district nurses, diabetes specialist nurses, dentists, opticians, physiotherapists and speech and language therapists. Staff worked closely with these professionals to make sure they addressed any changes in patients' health needs in a timely manner. The wards worked in partnership with the learning disabilities team, in line with the green light toolkit model of care for patients with a dual diagnosis of learning disabilities and mental health.

- Some patients had used 'legal highs' (new psychoactive substances) on the wards. The wards worked closely with Lifeline (a local substance misuse service) to provide care for patients with addictions. Lifeline provided drop-in one-to-one support sessions for patients.
- We saw external organisations, such as local supported housing providers, attending reviews and supporting patients on the wards.

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

- Training records showed that 93% of staff had received training in Mental Health Act (MHA). Ward 1 had the lowest compliance rate of 89%, just below the trust's target of 90%.
- There had been an increased focus on the MHA since our previous inspection in September 2015. Staff showed a good understanding of the MHA, the MHA Code of Practice and its guiding principles. The trust had updated their policies to reflect the changes to the MHA Code of Practice (2015). Staff ensured they used the appropriate legal authority to detain patients, for example, section 5(4) MHAand section 5(2) MHA (this allows doctors to detain a patient for up to 72 hours).
- We reviewed 18 capacity to consent or refuse treatment forms. Staff had completed them accurately and attached them to detained patients' prescription charts.
- Patients had their section 132 rights read to them on admission. The patients we spoke with confirmed this and were aware of their rights under the MHA. Staff revisited patients' rights with them regularly and recorded their level of understanding. A range of MHA leaflets, including leaflets about section 132 rights, were available in different languages and displayed on the wards.
- Staff knew about and had access to the trust's central MHA administration office. We saw copies of the new Mental Health Act Code of Practice in the ward offices.
- There was a clear process for scrutinising and checking MHA detention paperwork. There were weekly audits of MHA paperwork to check that requirements were met. The trust's quality and compliance department reviewed the audit findings. Staff received feedback about inaccuracies and errors in team meetings and where necessary, in one-to-one sessions. We found the MHA record keeping and scrutiny satisfactory.
- Asist provided independent mental health advocacy (IMHA) and independent mental capacity advocacy (IMCA) services to the trust. Asist had a base at Harplands Hospital, which helped them offer a prompt and responsive service. We saw posters and leaflets promoting the advocacy service in staff and patient areas. Patients we spoke with were aware of the advocacy service. Staff made referrals to advocates for patients, or they could self-refer.

### Good practice in applying the Mental Capacity Act

- Training records indicated that 94% of staff had received training in Mental Capacity Act (MCA). Ward 1 had the lowest rate with 89%, just below the trust's target rate of 90%.
- In the six months to May 2016, the acute wards made three Deprivation of Liberty Safeguards (DoLS) applications. At the time of our inspection, there were no patients subject to DoLS.
- The trust had a policy on the MCA and DoLS that was available to staff.
- All staff we spoke had a good understanding of the MCA and the five statutory principles. Staff assessed capacity on a decision-specific basis. However, the 18 records we looked at lacked detail. There was no description of the matter requiring a decision, or an explanation for the decision reached. For example, on ward 1, we saw one record where a patient's nursing notes stated they had capacity to consent to treatment when, on the same day, the doctor's notes stated that they did not have capacity to consent to treatment. In each case, the notes did not say what the treatment was so we could

not tell if it was in relation to the same or different issue(s). Furthermore, staff recorded these decisions in the daily notes, which made them difficult to find and refer to easily.

- All staff we spoke to understood and worked within the MCA definition of restraint. Staff described their understanding of least restrictive practices and gave examples.
- The trust displayed information about the MCA on all the acute wards. Staff knew they could contact the trust's MCA lead for advice when needed.

# Are services caring?

Good

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

## Our findings

### Kindness, dignity, respect and support

- We spoke with 15 patients receiving care and treatment and eight carers. Our observations of practice, the discussions we had, and the feedback we received from focus groups showed that staff were caring. Most patients told us staff treated them with dignity and respect. Staff engaged positively with patients. Staff on the wards interacted with patients in a relaxed, kind and polite manner.
- Our discussions with staff showed that they knew and understood the individual needs of their patients. Most patients we spoke with said staff were aware of their individual needs. However, two patients told us staff were sometimes too busy with observations and paperwork to respond to simple requests such as getting a cup of milk.
- The 2015 patient-led assessment of the caring environment (PLACE) score for privacy, dignity and wellbeing was 98% for Harplands Hospital. This was above both the trust average of 97.5% and the national average of 89.7%.

### The involvement of people in the care that they receive

- On admission, staff provided welcome booklets to both patients and carers about the acute wards. The booklets had information explaining how patients could be in control of their care, recovery and physical health. These were freely available on the wards and contained information about staff roles, daily routine, contraband items and visiting hours. Each patient was allocated a named nurse on admission.
- Trust data indicated that as of 5 September 2016, 96% of staff had undergone training on care planning. This was evident in the practice we observed and the way staff worked in partnership with patients. Staff included what patients wanted from their care team, and their strengths and goals in care plans. The majority of patients told us they had been involved in their care planning and had received copies of their care plans. However, two patients told us they had not received a copy of their care plan. Staff encouraged patients to maintain and develop independence, for example, patients carried out their own laundry.
- Patients had access to advocacy services. We saw posters displayed on the wards about advocacy services. independent mental health advocate (IMHA)The advocates attended patients' review meetings, when needed.
- Where appropriate, and with patient consent, carers were invited to multidisciplinary meetings and ward reviews. The carers we spoke with said they felt fully involved in their relative's care and received regular updates from the multidisciplinary teams on the wards.
- The wards had weekly community (patients) meetings facilitated by staff. Staff took notes of these meetings and displayed them on the wards. We observed two patient community meetings. Staff encouraged patients to speak about how the wards were run. For example, they asked patients what activities they would like to do. Wards displayed "you said we did" posters that showed the issues patients raised and the action staff took.
- Managers confirmed that they involved service users in recruitment. Ward 1 staff invited a former patient to attend their away day to talk to about their experience as an inpatient on the ward.
- We did not see any advanced decisions (statements containing patients' wishes about their treatment) within care records. However, staff applied the principles in care planning.

# Are services responsive to people's needs?

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

## Our findings

### Access and discharge

- The acute wards comprised two acute admission wards (2 and 3) and ward 1, which had a higher staff to patient ratio and worked with patients with more complex needs.
- The average bed occupancy for this core service in the six months to 31 August 2016 was between 102% and 104%, the highest was ward 1 with 104%. In the six months to 30 June 2016, the trust placed ten patients in out-of-area beds because of the unavailability of appropriate beds. The average length of stay in the year to 30 August 2016 for discharged patients was 21 days for ward 1, 26 days for ward 2 and 34 days for ward 3.
- The ward admitted new patients to beds of patients on leave. Staff on ward 2 reported a reluctance to give patients long-term or overnight leave because they worried their beds would be filled, which affected discharge planning. Staff advised us of incidents where patients returning from leave early slept on other wards, such as the older people's ward. Staff recorded these as incidents on the trust's electronic patient record system.
- Staff moved patients between wards because of bed pressures and not on clinical grounds. For example, records for two patients on ward 3 showed they were initially admitted to ward 1 because there were no beds available on ward 3. Ward 2 staff told us that in the two weeks prior to our inspection, on two occasions, staff temporarily sent patients to other wards due to bed pressures. We reviewed trust data from 1 March 2016 to 31 August 2016, which showed seven incident reports where patients from ward 2 had been temporarily sent to other wards. Two patients used beds on ward 1, two patients used beds on the Edward Myers Unit (substance misuse ward) and one patient used a bed on ward 7 (older people's ward) on three consecutive occasions.
- The Access team acted as bed managers and gate kept all admissions to the wards as well as supporting early discharge from the wards.
- The trust did not have its own psychiatric intensive care unit (PICU) but had plans to start building a PICU in November 2016. The trust therefore admitted patients whose individual needs required psychiatric intensive care unit (PICU) to out-of-area beds. For male patients, the trust had a service level agreement with a PICU in Staffordshire. The trust purchased out-of-area beds when required for female patients. These were often far away from the local area. At the time of our inspection, there were nine patients in out-of-area PICU beds.
- From March 2016 to August 2016, the trust reported 106 readmissions within 90 days to the acute wards. Ward 1 had 37 re-admissions, ward 2 had 34 and ward 3 had 35.
- From 1 November 2015 to 30 April 2016, trust data showed the acute wards had delayed discharges that amounted to 79 days. At the time of inspection, there were nine patients with delayed discharges, six of whom were on ward 2. The delayed discharges were due to a lack of suitable housing or placements to meet the patients' needs.

### The facilities promote recovery, comfort, dignity and confidentiality

- Each ward had an examination room with a couch. The wards had quiet lounges, laundries and games rooms. The wards had areas for meeting visitors in private. However, there were limited facilities for occupational therapy activities and group sessions. This had an impact on ward-based activities for patients who did not have leave.
- Each ward had direct access to a well-maintained garden area. Patients allowed to leave the wards had free access to the hospital grounds. Patients could smoke outside in the hospital grounds.
- Patient information boards in nurses' offices on wards 1 & 3 were visible to patients and visitors from the corridor. Ward 2 had a roller blind that could be used to cover up their board. The boards held patients' names, detention status, physical health needs and other confidential information. We discussed this with the ward managers who informed us they had ordered new boards with covers to protect patient confidentiality.
- Patients could use their own mobile phones on the wards. Each ward had a pay phone. Staff also gave patients who did not have a mobile phone access to the ward's telephone. Ward 2 had purchased an Ipad that

# Are services responsive to people's needs?

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

patients could use. However, the Ipad was faulty at the time of the inspection and sent off for repair. CQC has since been informed by the trust that the issue is resolved.

- All the patients we spoke with said the food was of good quality. Patients had a choice of menus and catering staff met their dietary requirements and preferences. Staff involved patients in planning the menus.
- Food quality scored 93% for Harplands Hospital in the 2016 patient-led assessment of the care environment (PLACE). This was marginally higher than the trust average of 92.9%, and higher than the national average of 86.6%.
- Facilities were available on all wards for patients to have hot drinks and snacks throughout the day and night.
- Patients could bring posters, family pictures and other personal items to the ward and personalise their rooms, where appropriate. However, the shared facilities on the wards limited the extent to which some patients could personalise their environment. For example, wards 2 and 3 had two four-bedded dormitory bedrooms and ward 1 had a two-bedded dormitory.
- The dormitories did not promote recovery, comfort and dignity. They had curtains between the beds for privacy. Each patient had a wardrobe without doors, which showed their belongings. The bedroom and dormitory doors had viewing panels on the outside that staff operated. All these were open, which compromised patients' privacy and dignity. However, there were curtains on the inside of the doors on wards 2 and 3 but none on ward 1. This meant that patients from wards 2 and 3 could draw the curtains if they needed any privacy. Three patients complained about the noise at night from other patients sharing the dormitories.
- Patients used locked storage areas on the wards to store personal items. They also had their own personal safe with a security code.
- After our previous inspection, the wards had improved their environment with new sofas, comfortable chairs and pictures produced by the patients.
- The wards had access to occupational therapists that facilitated a range of therapy sessions and activities. Each ward had a dedicated activity worker who worked across shifts to ensure their availability throughout the week. Ward 2 had a volunteer who supported staff with some of the activities on the ward. There was an excellent range of recovery-focused activities and groups available to patients on all the wards, and the activities programme covered evenings and weekends. Activities included wellness recovery action plan (WRAP) groups, walking, exercise, art, smoothie making and relaxation.
- Ward 3 had a quiet therapy room, which patients liked. The room was also available to the other wards. The ward manager gave a staff member protected time to offer complementary therapies such as reflexology, hand, feet and Indian head massage once a week. These therapies had positive outcomes. For example, there was a reduction in the use of PRN ('pro re nata' - as needed) medication for those patients who engaged in the sessions. As such, there were plans to increase the availability of this therapy.

### Meeting the needs of all people who use the service

- There were facilities available for patients with mobility difficulties who required disabled access. Occupational therapists carried out assessments for those patients requiring adaptations during their admission. Each ward had an adapted bedroom with toilet and bathing facilities for disabled patients.
- We saw various leaflets displayed on the wards with information about advocacy services, available treatments, ward activities, how to complain and how to contact the Care Quality Commission. Patients' welcome packs also contained this information. Information on patient rights under the Mental Health Act (MHA) was available in various languages. Other information leaflets were available in different languages on request.
- All wards had access to interpreting services when required. Staff had easy access to telephone interpreters when needed. During our inspection, we saw staff using an interpreter with a patient.
- The wards offered a selection of food to patients and met all nutritional needs. A varied menu supported patients with specific dietary needs and preferences ensuring they had access to appropriate meals.

# Are services responsive to people's needs?

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

- There were no designated multi-faith rooms on the wards. We saw patients use an activity room off the wards but on the hospital site for private worship. Staff informed us there were a range of spiritual books and items such as prayer mats available to patients.

### Listening to and learning from concerns and complaints

- During the period of April 2015 to April 2016, the acute wards received 11 formal complaints. Four complaints were fully upheld and one partially upheld. None were referred to the Parliamentary Health Service Ombudsman. Four complaints were about admission, discharge and transfer arrangements. During the period of 1 May 2015 to 30 April 2016, the acute wards received 12 compliments. Ward 2 received the highest number of six compliments.
- All patients we spoke to knew how to make a complaint and felt confident in raising any concerns with the ward managers or staff on the wards. In the first instance, staff tried to work with patients and carers to resolve complaints at a local level.
- We saw a mutual expectations board. This had feedback from patients and carers about the care provided. Wards displayed any compliments and thank you cards received from patients and carers. Staff encouraged patients to raise any concerns they had at weekly patients' meetings and displayed any changes made in response to patients' feedback.
- Ward managers discussed complaints and shared any learning from them with staff at team meetings, in one-to-one sessions, through newsletters and emails. Team meeting minutes noted discussions about complaints, action plans and lessons learnt.

# Are services well-led?

Good

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

- Signs and notices with the trust's values were displayed and visible throughout the wards. Most staff were familiar with the trust's vision of safe, personalised, accessible and recovery-focused services (known as SPAR).Staff attitudes reflected the trust's vision and values, for example, 'proud to care', which staff showed through the person-centred support they offered to patients.
- All wards had local team principles and objectives that were in line with the trust's vision and values. The wards displayed these on notice boards for patients and staff.
- Most staff knew who most of the senior managers were and said that the head of directorate, head of nursing and clinical director visited the wards. Ward managers said they had the confidence to raise any concerns directly to the senior managers if they needed to.

### Good governance

- Staff had received mandatory training and specific training for their roles, such as care planning and risk management, to support them in working with patients. At the time of our inspection, the acute wards had achieved an average mandatory training rate of 90%, in line with the trust's target. Staff received annual appraisals and regular supervision.
- Staffing turnover and vacancy levels had been a challenge for the trust. However, the trust had taken measures to fill the vacancies and had recruited new staff due to start by October 2016. The wards used regular bank staff and booked the same agency staff in advance to fill shifts.
- The trust had addressed the concerns or issues identified in our previous inspection in 2015. The trust had put quality and assurance systems in place to monitor various issues such as serious incidents, and to share lessons learnt and improve practice.
- Staff were aware of the safeguarding lead and there was good awareness of safeguarding procedures. Staff discussed safeguarding in multidisciplinary meetings. The trust had a Mental Health Act (MHA) lead that ensured staff had the right support to enable them to apply the MHA procedures correctly.
- All wards had set key performance indicators to gauge how the service was performing. These monitored the length of patient stay, delayed discharges, readmission rates, GP discharge notifications, patient outcomes and care programme approach reviews.
- The acute wards had robust governance systems, which enabled them to monitor and manage the wards effectively and provide information to senior management in a timely manner. Dashboards in ward corridors displayed data on performance and clinical incidents, staff sickness, length of stay, cleaning schedules and audits.
- Staff participated in a variety of audits on the wards. These included infection control, physical health, medication, MHA compliance, care plans and risk assessment. The frequency of the audits ranged from weekly to yearly.
- All ward managers told us that they were fully committed to making positive changes. They were encouraged and well supported by their head of directorate and head of nursing to operate independently in managing their wards.
- Ward managers confirmed they could submit items to the risk register. Managers displayed copies of the risk registers in staff rooms.

### Leadership, morale and staff engagement

- The average sickness rate for the acute wards was 7.5% as of 31 July 2016, which was higher than the average sickness level for all core services of 5.22%. Most of the absences related to a number of staff on long-term sick leave owing to physical health issues. The average sickness rate for the acute wards during the 12 months to 31 July 2016 was 7.5%,
- Managers assured us that they were managing sickness and absence issues locally in line with the trust's policy.
- At the time of our inspection, there were no bullying and harassment cases reported from this core service.
- Staff were aware of the whistleblowing process and knew how to raise concerns. All staff were aware of the

"Dear Caroline" initiative. This was a forum to address concerns directly and anonymously with the chief executive). Most staff said they would be happy to raise their concerns with their line managers, as they were confident they would be listened to.

- All wards took time out to attend away days that promoted good working relationships and teamwork. Most of the staff we spoke with showed enthusiasm about the developments on the wards since the previous inspection. There was a good sense of team spirit and high morale among staff. All staff said that they were proud of the work they did for patients and were proud to work for the trust.
- Staff on all wards consistently praised their line managers. Staff said they felt valued. All ward managers said they were proud of their staff. They highlighted that staff worked well together and helped create a positive working culture within the acute wards. Managers discussed opportunities for leadership and development with staff.
- Staff had a good understanding of the duty of candour and the need for openness and transparency. During our inspection, we observed a good example of staff sharing information about an incident at a community meeting.
- The trust held its annual 'recognising excellence and achievement in combined healthcare' (REACH) awards just prior to our inspection. Ward 1 received recognition for outstanding practice in providing quality care to meet the needs of patients presenting with behaviour that challenged. The ward 3 manager received the chairman's award for 'leading with compassion'.

**Commitment to quality improvement and innovation**

- All wards had current Royal College of Psychiatry accreditation for inpatient mental health services (AIMS).
- The trust had plans for new services to respond more effectively to local needs and demands. For example, the trust had approved plans to build a psychiatric intensive care unit (PICU) at the Harplands Hospital and building work was scheduled to start in November 2016. There were further plans to build a seclusion suite on ward 2 and a personality disorders ward.
- With an aim to provide a high quality safe inpatient environment, the trust had a five-year ligature reduction programme to reduce ligature risks across the acute wards.
- The acute wards had implemented the 'safe wards initiative'. 'Safe wards' is an international initiative that offers a range of interventions for staff to use to increase patient safety in a ward environment.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>• Patients and visitors could see confidential patient information on the patient information boards in the staff offices.<br>This was a breach of regulation 17(2)(d) |