Good

Nottinghamshire Healthcare NHS Trust

Psychiatric intensive care units and health-based places of safety

Quality Report

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Date of inspection visit: 29 April - 1 May 2014
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Millbrook Mental Health Unit	RHABW	Lucy Wade PICU	NG17 4JL
Millbrook Mental Health Unit	RHABW	Jasmine Suite Place of Safety	NG17 4JL
Highbury Hospital	RHANM	Willows PICU	NG6 9DR

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire 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.

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire 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 Psychiatric intensive care units (PICU) and health-based places of safety	Good 
Are Psychiatric intensive care units (PICU) and health-based places of safety safe?	Good 
Are Psychiatric intensive care units (PICU) and health-based places of safety caring?	Requires Improvement 
Are Psychiatric intensive care units (PICU) and health-based places of safety effective?	Good 
Are Psychiatric intensive care units (PICU) and health-based places of safety responsive?	Good 
Are Psychiatric intensive care units (PICU) and health-based places of safety 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

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Summary of findings

Overall summary

The psychiatric intensive care units (PICUs) and health based place of safety are based on two hospital sites at Millbrook Mental Health Unit and Highbury Hospital. They provide inpatient mental health services for adults aged 18 to 65.

We found the intensive care units and place of safety service provided by Nottinghamshire Healthcare Trust provided people with a safe place to have their mental health needs assessed. There were also good systems for transferring people to the right areas for care. Staff were skilled to work with the service users and were trained to keep people safe during disturbances. The trust also ensured that they worked within the Mental Health Act Code of Practice. There were good systems in place to monitor care provided, but seclusion facilities did not protect people from the risk of infections.

People's physical health was regularly assessed; however, we saw examples where their privacy and dignity was not always protected.

The different services involved in the place of safety, including Crisis Resolution Home Treatment teams, worked well together. Services were planned and delivered to meet the needs of vulnerable people and risk assessments were completed.

Staff understood how to follow the local multi-agency operational policy for safeguarding adults and children. This governed the use of the place of safety and the transfer of patients.

Staff told us they were well supported by their managers and regularly received supervision and appraisals.

Summary of findings

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

Are services safe?
People received safe care and treatment in the PICUs and place of safety. There were clear systems for capturing and reporting incidents and notifying the appropriate external bodies.

All staff we spoke to understood and followed the safeguarding procedures, and were clear about the extent of their professional responsibilities. The number of staff in the place of safety was not always consistent and this had caused the unit to close, affecting the people who needed the service.

People were not always protected against the risk of infection when placed in seclusion.

Good

Are services effective?
There were good systems and forms in place to ensure that people's rights were adhered to under the Mental Health Act.

People's physical health needs were assessed and monitored to ensure that they received the best possible care while on the wards.

Good

Are services caring?
All of the staff we spoke with were caring, responsive and supportive of the people using the service.

Requires Improvement

Are services responsive to people's needs?
Care was planned and delivered to meet people's needs however, we found that some people's privacy and dignity was not always protected. Individual risk assessments were completed so there were not 'blanket rules' on the wards. The different services involved in the place of safety worked well together.

Good

Are services well-led?
Leadership in the PICUs was supportive and helped staff to do their jobs. There was also a good operational policy for the place of safety that had been developed through a multi-agency group. However, people using the services did not always have their privacy and dignity protected.

Good

Summary of findings

Background to the service

The PICUs and place of safety are based on two hospital sites at Millbrook Mental Health Unit and Highbury Hospital. They provide inpatient mental health services for adults aged 18 to 65.

Services

- A Place of Safety
- Psychiatric Intensive Care Unit (PICU)
- Adult Mental Health Inpatient Service
- Assessment and Treatment Service

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector for Hospitals (Mental Health)

Team Leader: Jenny Wilkes, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Two specialist nurses, a Mental Health Act commissioner, an occupational therapist, and one expert by experience who had experience of care.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

We visited Nottinghamshire Healthcare NHS Trust psychiatric intensive care units (PICU) and health-based places of safety on 29 April to 1 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff, including nurses, doctors and therapists, and talked to people who use services, their carers and/or families. We also observed how people were cared for and reviewed their care or treatment records.

What people who use the provider's services say

We used focus groups to speak to previous users of the service, and also spoke to people on the wards during our inspection. People told us that they were very happy with the service and that staff were helpful in resolving issues. One person, however, said that they were unhappy about the attitude of staff and felt that there had been a lack of response when they made a complaint.

Summary of findings

Good practice

The employment of peer support workers in the PICUs.

The use of additional staff to ensure that PICUs had the right number of staff when dependency levels rose.

Excellent working arrangements with the police in the place of safety.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

The environment in the Lucy Wade women's PICU must be improved to protect people's privacy and dignity.

Action the provider SHOULD take to improve:

The trust should consider how access to the place of safety ensures that people's privacy and dignity is protected.

Care Quality Commission

Nottinghamshire Healthcare NHS Trust

Psychiatric intensive care units and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Lucy Wade PICU	**Millbrook Mental Health Unit**
Jasmine Suite Health Based Place of Safety	**Millbrook Mental Health Unit**
Willows PICU	Highbury Hospital

Mental Health Act responsibilities

We reviewed people's records and found that there were systems and forms in place to ensure that people's rights were adhered to under the Mental Health Act. We saw that there were good systems in place for administration under the Mental Health Act (MHA) including good checklists. Compliance with the statutory requirements of the Mental Health Act was well supported by experienced and committed MHA administrative staff and managers.

We found there were arrangements in place to contact an Approved Mental Health Professional (AMHP), and access to section 12 approved doctors. A section 12 approved doctor is a medically qualified with an expertise in mental disorder and has been recognised under section 12(2) of the Act.

We found that staff worked in accordance with the Mental Health Act (MHA) Code of Practice in relation to the place of safety. There were appropriate proformas and systems to ensure staff worked within the MHA Code of Practice, for example to record key demographic details, issues such as transfers between the police and place of safety and the outcome of the use of the place of safety.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff were trained in the use and understanding of the Mental Capacity Act (MCA) and the Depravation of Liberty safeguards.

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

Summary of findings

People received safe care and treatment in the PICUs and place of safety. There were clear systems for capturing and reporting incidents and notifying the appropriate external bodies.

All staff we spoke to understood and followed the safeguarding procedures, and were clear about the extent of their professional responsibilities. The number of staff in the place of safety was not always consistent and this had caused the unit to close, affecting the people who needed the service.

People were not always protected against the risk of infection when placed in seclusion.

Our findings

Jasmine Suite

We found that the unit staff had access to the 'Learning lessons' information sent out by the trust. Staff demonstrated how they were able to apply learning from incidents across the trust in the day to day management of the unit. The unit was always contacted by either the police or the 'Street Triage' team prior to bringing a patient to the unit. The street triage scheme allows mental health nurses accompany police officers to incidents where it was indicated that people required immediate mental health support.

We saw that the unit was always staffed in readiness for people to be brought in for assessment.

The unit had robust processes in place to ensure safe operation of the unit. Good arrangements were in place to transfer people to the unit and when staff were concerned about people they were able to request support from the police. The unit had good arrangements to contact an Approved Mental Health Professional (AMHP), good contact arrangements with doctors from Children and Adolescent Mental Health Services (CAMHS) and good access to section 12 approved doctors. (A section 12 approved doctor is a medically qualified with an expertise in mental disorder and has been recognised under section 12(2) of the Act.)

All the staff we spoke with had completed training in safeguarding vulnerable adults and were able to describe the different types of abuse they may see. They were clear about the action they would take to report any abuse they saw. They unit had a flow chart detailing the steps to take in reporting abuse. We found that staff checked with people coming into the unit if there were children and assessed if there were any safeguarding issues that might impact on them and required the unit staff to alert the local safeguarding team.

New admissions to the unit always had details of the reasons for admission. The team were able to access RIO (patient information system) and paper notes if the person's information was not updated on to the RIO system. This ensured the staff had the most up to date information about the person being admitted and any risk that may need to be actively managed.

Information was gathered from a variety of sources to inform the assessment of people admitted. If a person was known to services, their community team were contacted for details about their care and risk assessments. General practitioners were contacted for any relevant information relating to people's risk and care.

The suite had a number of measures to prevent incidents and was monitored by Close Circuit Television (CCTV). We found the unit has good arrangements with the police to access support if a person brought to the Jasmine suite's behaviour was unpredictable and difficult to manage.

We found that people brought to the unit and suspected of being under the influence of drugs or alcohol, were searched by the police and breathalysed by the staff. Urine samples were requested as part of the physical health checks and for drug testing. Where confirmation of medication was needed contact with the person's general practitioner was made.

Before people arrived on the suite, information was gathered about risk, people's physical health profile and the previous baseline observation levels.

Good

Are services safe?

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

Lucy Wade PICU

The Lucy Wade unit was a five bedded women's Psychiatric Intensive Care Unit, (PICU). We saw five single bedrooms with fixed furniture all with ensuites. The unit had a very small communal space with no separate dining area for people to use.

On the day of our inspection we found three people detained under the Mental Health Act. The unit was staffed by four staff, two qualified nurses and two unqualified staff. In addition to the four staff was an unqualified worker whose role was to provide and lead activities for people on the PICU three days per week.

The trust distributed a learning lessons information sheet that the unit was able to use to improve practice in the unit to reduce risk. We found that the environmental risk assessments had been completed to ensure people were kept safe in the ward environment.

Staff had received training in Managing Violence and Aggression (MVA). All the staff we spoke with confirmed their training was up to date and they attended each year a two day update course in MVA. We were told that staff that missed the update course had to attend the full week long training course to be able to participate in restraints. The unit did not have a seclusion room and the shared space was very small. This meant that when there were disturbances, people were restrained in full view of others and had to be taken to their bedrooms to be managed.

One person we spoke with raised concerns about having to observe someone being restrained in full view and how upsetting that had been to them.

All the staff we spoke with had completed training in safeguarding vulnerable adults and were able to describe the various types of abuse that they might encounter during their work on the ward. The staff were able to tell us how they would deal with any incident of abuse they came across. This meant that staff were trained to spot the potential signs of abuse and knew what action to take to protect people in their care.

We found that people who used the unit did not know how to report abuse or concerns. We were told by one person that when they had made a complaint, they had not received any response to their concerns leaving them feeling unsafe.

We found that doors to two ensuites were missing. Staff told us the doors had been removed 12 months ago because two people had attempted self-harm using the doors. Following risk assessments at the time the doors had been removed and that situation had continued following their discharge. When the viewing panes were left open or the bedroom doors opened people using the shower could be seen by anyone passing or standing outside their rooms. This did not protect people's privacy and dignity.

From the reviews of case files we found that individual risk assessments had been completed for everyone admitted. We saw that people's care plans reflected the risks that had been identified and were regularly updated in response to changing circumstances.

We saw that people were supported to maintain and develop their independence through care planning and their engagement in various activities available. On the day of our visit we saw people participating in beauty therapy and one to one time with staff.

Willows PICU

Willows is a 10 bedded male Psychiatric Intensive Care Unit (PICU) serving Nottingham City and South areas. On the day of our inspection the unit had seven people detained under the Mental Health Act. There were 10 single bedrooms with ensuite facilities. We saw the viewing panes into each bedroom had a curtain on the inside of the bedroom door. This meant that staff had to physically enter people's bedrooms to carry out observational checks at all times. This practice could be detrimental to people trying to sleep at night with regular entry and exit by staff to carry out observations checks.

We saw that when incidents happened the staff completed incident reporting forms that were reviewed by the manager and sent to the appropriate monitoring department. The incident was shared with staff on the ward through handovers, staff meetings, weekly reflective practice meetings and one to one supervision.

We saw the minutes of staff meetings that took place every two months. The minutes provided staff with information on training, service needs and staffing issues. We saw that weekly reflective practice meetings were used to discuss ongoing issues and concerns from staff.

There were clearly defined and embedded systems, processes and operating procedure that reflected national

Good

Are services safe?

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

guidance and professional guidance, such as monitoring of infection control and patient led assessments of the care environment (PLACE). Prevention of violence and aggression was through training their staff in Managing Violence and Aggression (MVA). We saw that there were low levels of disturbances on the ward and low use of seclusion. The seclusion record showed that there were four episodes of seclusion since January 2014 to April 2014.

The ward had an adjacent seclusion room, which was a de-escalation room with toilet and washing facilities. Staff were trained on how to enter and exit the seclusion room, MVA and general observation. There was no training given to staff on how to manage people once in the seclusion room. The seclusion door had a 'post' hole where food or urine bottles could be passed through. We were told that staff were aware of the risk of infection therefore did not pass urine bottles and food at the same time and that wipes were available to clean the area.

People in seclusion were on continuous observation through the window in the door to the seclusion room. There was a ceiling mirror in the seclusion room but this did not help with observation because of its position. People could be observed from the window in the door. There was a separate toilet and shower that was not accessible from the seclusion room. We were told that people were only allowed out of the seclusion room to use the toileting facilities if there was a minimum of three staff. This could delay people's access to toilet facilities.

The unit was spacious, well lit with quiet areas for people to use. There was easy access to a secure courtyard for people who needed to smoke or wanted to go outside. We observed staff responding to people's request to go outside quickly.

Management of medication was good and we saw evidence of safe administration. An audit of omitted or missed doses of medicines undertaken in February 2014 showed that there were no omitted or missed doses.

Staffing levels were consistent and managed to keep people safe. The manager told us that additional staff would always be added to the planned rota if the level of dependency increased and this reflected the low levels of incidents occurring on the unit.

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.

Summary of findings

There were good systems and forms in place to ensure that people's rights were adhered to under the Mental Health Act.

People's physical health needs were assessed and monitored to ensure that they received the best possible care while on the wards.

Our findings

Jasmine Suite

Assessment and delivery of care and treatment

We looked at the hospital-based place of safety (Jasmine Suite) managed by the trust. We spoke with staff that regularly assessed people in the suite and the managers who oversee the area. We looked at the environment of the unit, considered the policies for the use of the area and reviewed records relating to the use of the facility.

We found that staff worked in accordance with the Mental Health Act (MHA) Code of Practice in relation to the place of safety. There were appropriate proformas and systems to ensure staff worked within the MHA Code of Practice – for example to record key demographic details, issues such as transfers between the police and place of safety and the outcome of the use of the place of safety.

We saw that the unit was staffed twenty-four hours and would receive support from staff on the ward next to the unit. The manager was based close to the suite with on call management support out of hours if advice or support is needed. We found that the unit was closed twice in the previous five weeks due to lack of staff meaning that people on section 136 had to be taken to the accident and emergency department to be seen by the mental health team based there.

Under the MHA, people brought in to the hospital-based place of safety, under police powers, must be informed about their rights whilst they were there. By the nature of the police power and the short time allowed to keep people in the place of safety, people's rights are limited.

On this inspection, we saw that the hospital had leaflets and pro-forma to record that these rights had been given. We heard that staff attempted to assist patients to understand their rights.

Lucy Wade PICU

On the day of our inspection there were three women on the unit. We saw two of them participating in beauty sessions, one person was having a face pack session and the second person was having their nails painted.

We did not see in the main ward area any information leaflets about how to make complaints displayed on the unit. Staff told us this was because people had destroyed information and notices that had been displayed. We did see a rack with leaflets and information in a small lounge but the room was kept locked when not in use so people did not have access to them. We were told that lockable notice boards had been ordered to display the required information.

We found there were four members of staff during our inspection. Two were qualified nurses and two were health care assistants. There was an additional health care assistant responsible for leading and coordinating activities three days per week on the unit.

Willows PICU

We found that the unit had good systems for assessing the physical health care needs of people on the unit. We saw that staff had received training from the trust's mental health physical health training team in basic observations such as taking blood pressures and undertaking Electro Cardio Graphs (ECG).

We saw that regular monitoring of people's weight was completed; however the link between people's weight loss and diet was not always made or reflected in their care planning. The access to junior doctors had resulted in delayed checking and medical provision for some people.

We looked at the training matrix for the unit and saw that 90% of staff on the unit had completed their mandatory training.

The unit had a good staffing ratio for the ten beds it has. There were five staff for early and late shifts with four staff at night. We saw that when dependency levels increase the staffing levels are increased accordingly.

We saw a good mix of qualified and unqualified staff on the unit. The unit had Peer Support Workers (PSW) who had

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.

used services in the past and now supported people on their journey through the PICU. The unit had a consultant psychiatrist and junior medical staff. There had been recent difficulties recruiting junior doctors with posts covered by a series of locum doctors. This had meant that systems of care had not always been completed, such as documentation and writing up of prescriptions for people's medication. We saw that the unit now had recruited junior medical staff who worked regularly on the Willows.

Requires Improvement

Are services caring?

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

Summary of findings

All of the staff we spoke to were caring, responsive and supportive of the people using the service. However, we found that some people's privacy and dignity was not always protected.

Our findings

Lucy Wade PICU

Kindness, dignity and respect

One person asked to speak to us and told us about their experience of the unit. They said they felt 'invisible' on the unit and not listened to by staff. They told us they had made a complaint, but they had not received a response. We spoke to the ward manager who confirmed that they had received a letter from the person that morning and would ensure that all the concerns in the letter would be investigated. They agreed to contact Patient Advice and Liaison service (PALs) on the person's behalf to come and see them.

The unit had limited communal space for people and no separate dining area. People we spoke to told us that the unit is very small and when any incident happened in it often took place in their view.

Willows PICU

During our inspection we saw positive interventions between people and staff. Staff responded to people's requests promptly and appropriately. The unit had a weekly community meeting where people were able to raise issues and have a discussion with the staff.

We spoke to seven people on the unit. We heard how the staff supported people's choice and ensured they had money to meet their personal needs. All the people we spoke to told us they had a care plan and had participated in writing them. People told us the peer support workers had supported them to write their recovery plans. We saw people engaging and participating in different activities around the ward with staff.

The unit did not have a pay phone for people to use, and had to take incoming calls on the unit's office telephone. This meant that people had to have private conversations in front of staff. We saw that confidential information is stored in the office and potential breaches of that information could happen when people are in the office taking or making calls.

We observed a staff member taking a call from a family member who was calling to complain about something relating to their relative. The staff member managed and dealt with the situation with skill and tact despite being in the centre of a very busy and noisy office.

We reviewed the seclusion records and found them satisfactory and correctly completed. We saw that the trust's seclusion policy and seclusion pack of papers was held in a file for staff to access.

Jasmine Suite

On the day of our inspection there were no people admitted to the unit so we did not see any interactions between staff and people. We saw that staff working on the suite had completed and were up to date with their mandatory training.

We saw that access to the suite was through a public area that could potentially breach people's privacy and dignity when being brought onto the suite by the police.

Are services responsive to people's needs?

Good

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

Summary of findings

Care was planned and delivered to meet people's needs. Individual risk assessments were completed so there were not 'blanket rules' on the wards. The different services involved in the place of safety worked well together.

Our findings

Lucy Wade PICU

We saw that there were regular planned activities organised for people to take part in. The ward had an activity coordinator who worked with people to undertake different activities. The activity coordinator worked on the unit three days per week.

People had single bedrooms with en-suite facilities where they could go when they wanted to have some private time. People were aware they were under observation and this meant that staff regularly checked them whilst they were in their bedrooms. We saw that doors were missing from ensuites in two of the five rooms on the unit. When the door to their bedroom was opened if they were using the shower they would be in full view of anyone outside their room. Staff told us that the doors had been removed 12 months ago following two other people self-harming and a risk assessment had been completed. This meant that people's privacy and dignity was not always maintained.

The unit was small with limited circulation space for people staying on the unit. There was no separate dining space, therefore anyone wishing to eat away from other people had to use their bedrooms.

Willows PICU

People told us that there were regular activities organised that stopped them being bored. The different staff on the ward told us about the activity programme that ran most days. We saw that ward staff facilitated activities such as quizzes, smoothie making and gardening groups. The peer support workers worked one to one with people staying on the ward who did not want or could not cope with participating in group activities.

We found the ward did not have blanket rules and restrictions about people having their own mobile phones with chargers or items that could be considered a ligature risk. Any restriction that was placed on people was supported by individual risk assessments.

One person did express concern about the diet they received and we found there had not been any recorded assessment of their particular dietary requirements.

Jasmine Suite

There was evidence of good working relationships between the many parties involved in the place of safety, including Crisis Resolution Home Treatment teams, the Approved Mental Health Professionals (AMHPs), the Doctors, the Police service and Accident and Emergency departments.

The arrangements to ensure people could be conveyed to a hospital-based place of safety were in place, including working arrangements for the police phoning in advance to ensure that the suite was available and to assist staff to co-ordinate a speedy assessment. There was a continued lack of delay during the assessment process both between arrest and the Mental Health Act assessment, and following the assessment and admission/discharge.

Information we saw showed people were able to access an inpatient bed in the relevant acute psychiatric service in their local area in most circumstances, when a decision was reached to admit to hospital. Where people were not deemed to require hospital stays we saw them offered follow up by the crisis resolution and home treatment service with the level of support determined by the levels of assessed and manageable risk.

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.

Summary of findings

Leadership in the PICUs was supportive and helped staff to do their jobs. There was also a good operational policy for the place of safety that had been developed through a multi-agency group. However, people using the services did not always have their privacy and dignity protected.

Our findings

Lucy Wade PICU

We found that the leadership of the ward was not robust. This was because there was no recognition that people's privacy and dignity had not been protected. We saw that previous risk assessments meant that new patients were subject to controls that did not reflect their current risk levels.

Information to inform people of their rights was not available in the main areas of the ward and where there were leaflets, they were in a room that was kept locked when not in use and therefore not available to people staying on the unit.

We did not see regular audits had been undertaken on the ward. We found the ward used rapid tranquilisation and requires resuscitation equipment. The equipment is checked and reported; we found checks for February 2014 but none for January 2014 or March 2014.

All the staff we talked with told us the unit was small and cramped; however, they were working to visually improve the look of the ward.

Willows PICU

There was a clear governance framework in place and all trained staff spoken to were aware of the systems in place to effectively monitor standards on the Ward. There were systems in place to carry out routine quality audits and equipment checks. Systems to monitor infection control on Willows Ward such as food handling, cleanliness and environmental audits had been implemented.

Community meetings occurred on the ward on a regular basis providing patients with a means to express their needs and wishes. We saw that regular staff meetings took place where staff were able to discuss issues relating to the ward and their personal development needs. Staff were consistent in their views about the support they received. They said supervision was helpful and regular. We were told that there were debriefs available after serious incidents and that these were helpful.

Staff were very supportive of each other and offered peer support. The team manager was very supportive of his staff.

Jasmine Suite

We saw that there were good systems in place for administration under the Mental Health Act (MHA) including good checklists. Compliance with the statutory requirements of the Mental Health Act was well supported by experienced and committed MHA administrative staff and managers.

We saw that the trust had in place a multi-agency operational policy that governs the use of the place of safety and transfer of patients.

The unit had clear local leadership through a clinical lead and manager. Staff working on the unit had received regular supervision and support. All staff had Personal Appraisal and Development (PADs) plans that had been completed in the last year. The unit had been visited and supported by members of the executive team.

All the staff we spoke with told us they felt part of the trust and were able to raise concerns that would be listened to and acted on. There were staff shortages, but senior managers were aware of them and were working to employ staff into the vacancies.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not ensured that suitable arrangements were made to ensure the dignity, privacy and independence of service users. **How the regulation was not being met:** At the Millbrook mental health unit (Lucy Wade) doors were missing from the ensuite in two rooms leaving people in full view from the viewing pane or when the bedroom door was open. Regulation 17(1)(a)