Kent and Medway NHS and Social Care Partnership Trust

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

Quality Report

Trust Headquarters, Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Tel: 01622 724100
Website: www.kmpt.nhs.uk

Date of inspection visit: 17 - 20 March 2015
Date of publication: 30/07/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXY3P	Littlebrook Hospital	Amberwood Ward	DA2 6PB
RXY3P	Littlebrook Hospital	Cherrywood Ward	DA2 6PB
RXY3P	Littlebrook Hospital	Woodlands Ward	DA2 6PB
RXY3P	Littlebrook Hospital	Willow Suite	DA2 6PB
RXY2X	Medway Maritime Hospital	Emerald Ward	ME7 5NY
RXY3P	Littlebrook Hospital	Amherst Ward	ME16 9PH
RXY3P	Littlebrook Hospital	Brocklehurst Ward	ME16 9PH

Summary of findings

RXY03	St Martins Hospital	Bluebell Ward	CT1 1TD
RXY03	St Martins Hospital	Fern Ward	CT1 1TD
RXY03	St Martins Hospital	Foxglove Ward	CT1 1TD
RXY03	St Martins Hospital	Samphire Ward	CT1 1TD

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Overall summary

We found significant differences in the quality of care provided at the four main hospitals where acute wards were situated. For example, we found most areas of concern regarding the care provided in the wards at Littlebrook Hospital in Dartford. There were some areas of concern on some of the wards at St Martin's Hospital in Canterbury and Medway Maritime Hospital in Gillingham. While, we found there were no significantly serious concerns at Priority House in Maidstone.

We gave an overall rating for acute wards for adults of working age and psychiatric intensive care units of **requires improvement** because:

- The trust did not have a system to maintain the privacy and dignity of women who were secluded on Willow suite (psychiatric intensive care unit).
- Cherrywood ward and Amberwood ward (in Dartford), Emerald ward (in Gillingham), and Samphire ward (in Canterbury) did not have all their emergency equipment and medication accessible and/or in date, or have effective systems for regularly checking that this was the case.
- Patients who had behaved aggressively, or who had been restrained, had not had their care plans updated to describe how to prevent, manage and de-escalate potential future incidents.
- The storage and recording of medication, including controlled drugs, was not safe and secure on Cherrywood ward (in Dartford). We raised this immediately and this was rectified on the day of our inspection.
- The seclusion room on Willow suite was not equipped in accordance with the Mental Health Act Code of Practice. The trust had policies about the management of violence and aggression, and monitored their usage, but had significant levels of prone restraint which is contrary to the Department of Health guidance.
- The Mental Health Act was not consistently implemented in accordance with the Code of Practice. For example, on Amberwood ward (in Dartford), patients were not informed of their rights in accordance with the Mental Health Act and Code of Practice; medication had been administered without the proper consent, and there was poor documentation of the treatment plan when a patient had a second opinion from a second opinion appointed doctor (SOAD).
- There were delays in finding psychiatric intensive care unit (PICU) beds for patients.
- There was pressure on beds, which meant that patients might be moved for non-clinical reasons.
- The monitoring processes had not identified gaps and problems in the services. For example, there were gaps in updating risks assessments and care plans; we found out of date and missing resuscitation equipment; and the reasons behind high levels of restraint, including prone (face down) restraint had not been identified. There were also problems with medication storage and recording, including the recording of consent to treatment provisions under the Mental Health Act and Code of Practice.

However, patients were mostly positive about the care they received on the wards and found most of the staff approachable and caring. Patients had 1-1s with staff, although this could be difficult when staff were busy. Patients had access to advocacy on the ward. Patients' relatives were involved in their care where appropriate. There were community meetings on most of the wards.

There were environmental risks on many of the wards, but the trust had an extensive programme of refurbishment and was managing the risks until building works were completed. Most of the wards were satisfactorily managing medication. Most of the wards had adequate emergency procedures. There were staff vacancies on most of the wards, particularly for band five nurses, but this was being managed at a local and corporate level, and the trust had a recruitment strategy. The trust had safeguarding policies and staff knew how to identify and report safeguarding concerns. Staff knew how to report incidents, and there were policies for reporting and managing this. There was a bulletin for sharing information including learning from incidents that was circulated to staff.

Priority House in Maidstone had introduced a number of initiatives which included the recovery clinic. Research

Summary of findings

into the effectiveness of the clinic was being undertaken by a member of staff as part of their PhD. We were told that recovery clinics had also been rolled out on all other acute wards.

Peer support workers, who were people employed by the trust who had experience of mental health services, were a positive addition to the wards, and helped reinforce the patients' perspective.

Summary of findings

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

Are services safe?

Requires improvement

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

- The trust did not have a system to maintain the privacy and dignity of women who were secluded on Willow suite (psychiatric intensive care unit).
- Cherrywood ward and Amberwood ward (in Dartford), Emerald ward (in Gillingham), and Samphire ward (in Canterbury) did not have all their emergency equipment and medication accessible and/or in date, or have effective systems for regularly checking that this was the case.
- Patients who had behaved aggressively, or who had been restrained, had not had their care plans updated to describe how to prevent, manage and de-escalate potential future incidents.
- The storage and recording of medication, including controlled drugs, was not safe and secure on Cherrywood ward (in Dartford). We raised this immediately and this was rectified on the day of our inspection.
- The seclusion room on Willow suite was not equipped in accordance with the Mental Health Act Code of Practice. The trust had policies about the management of violence and aggression, and monitored their usage, but had significant levels of prone restraint which is contrary to the Department of Health guidance.

There were environmental risks on many of the wards, but the trust had an extensive programme of refurbishment and was managing the risks until building works were completed. Most of the wards were satisfactorily managing medication. Most of the wards had adequate emergency procedures. There were staff vacancies on most of the wards, particularly for Band five nurses, but this was being managed at a local and corporate level, and the trust had a recruitment strategy. The trust had safeguarding policies and staff knew how to identify and report safeguarding concerns. Staff knew how to report incidents, and there were policies for reporting and managing this. There was a bulletin for sharing information including learning from incidents that was circulated to staff.

Are services effective?

Requires improvement

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

- The Mental Health Act was not consistently implemented in accordance with the Code of Practice. For example, on

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Amberwood ward (in Dartford), patients were not informed of their rights in accordance with the Mental Health Act and Code of Practice; medication had been administered without the proper consent, and there was poor documentation of the treatment plan when a patient had a second opinion from a second opionn appointed doctor (SOAD).

Staff did not have a clear understanding of the Mental Health Act and Code of Practice. Records and patients' feedback identified repeated instances of patients being told, or care records documenting, that although they were informal (voluntary patients), if they wanted to leave they would be detained under the Mental Health Act. On Amberwood ward (in Dartford) and Emerald ward (in Gillingham), staff had not checked that drugs they had administered were included on the formal consent to treatment and emergency treatment forms. Thus the lawfulness of the administration of this medication could be under question.

Patients were assessed by the crisis team prior to admission, and were assessed on admission to the ward. Patients had their physical healthcare needs monitored and responded to. All patients had a risk assessment and care plan, although this was not always patient or recovery focused, and reviewed when the patient's situation changed. Patient information was stored securely and, as it was electronic, could be shared between the wards, crisis and community teams. The wards followed NICE (National Institute for Health and Care Excellence) prescribing guidance, and completed health of the nation outcome scales (HONOS). Care was provided by a multidisciplinary team of staff. Most staff received supervision and appraisal, and had completed most of their mandatory training. There were regular multidisciplinary team meetings and handovers where patient care was discussed.

Are services caring?

Good

We rated caring as **good** because:

Patients were mostly positive about the care they received on the wards and found most of the staff approachable and caring. Patients had 1-1s with staff, although this could be difficult when staff were busy. Patients had access to advocacy on the ward. Patients' relatives were involved in their care where appropriate. There were community meetings on most of the wards.

Are services responsive to people's needs?

Requires improvement

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

- There were delays in finding psychiatric intensive care unit (PICU) beds for patients.

Summary of findings

- There was pressure on beds, which meant that patients might be moved for non-clinical reasons.

There was an activity programme and/or an occupational therapy suite for all of the wards. Patients had access to phones on the wards. Patients had free access to drinks and snacks until midnight. There were disabled facilities available across the trust. There were posters and information leaflets which included how to complain, how to access advocacy and local facilities and support services. There was access to interpreting services, and a choice of food for people with special dietary requirements. The trust managed and responded to complaints.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The monitoring processes had not identified gaps and problems in the services. For example, there were gaps in updating risks assessments and care plans; we found out of date and missing resuscitation equipment; and the reasons behind high levels of restraint, including prone (face down) restraint had not been identified. There were also problems with medication storage and recording, including the recording of consent to treatment provisions under the Mental Health Act and Code of Practice.

There were local and corporate governance systems that monitored the quality of care. The trust had a risk register which identified risks and the actions to reduce or mitigate them. Sickness and absence were monitored by the local teams with support from human resources. Staff had a 'green button' on the trust's website for raising concerns or making suggestions.

Summary of findings

Background to the service

The acute wards for adults of working age and psychiatric intensive care units (PICU) provided by Kent and Medway NHS and Social Care Partnership Trust are part of the trust's acute service line.

Acute wards for adults of working age and psychiatric intensive care units are provided across four sites: Littlebrook Hospital in Dartford, Medway Maritime Hospital in Gillingham, Priority House in Maidstone and St Martins Hospital in Canterbury.

Littlebrook Hospital has three acute wards for adults of working age: Amberwood ward, Cherrywood ward and Woodlands ward. Amberwood ward and Cherrywood ward both have 16 beds. Woodlands has 12 beds and is temporarily based in the former Rosewood Lodge during refurbishment. Amberwood and Woodlands wards admit both men and women, and Cherrywood ward is for women only. There is one PICU called the Willow suite, which also provides a PICU outreach service to the acute wards in the trust. Willow suite has 12 beds and admits men and women.

Medway Maritime Hospital has one acute ward for adults of working age: Emerald ward. Emerald ward has 16 beds and is for men only.

Priority House has two acute wards for adults of working age: Amherst ward and Brocklehurst ward. Both wards have 18 beds and admit men and women.

St Martins Hospital has four acute wards for adults of working age: Bluebell ward, Fern ward, Foxglove ward and Samphire ward. Bluebell, Fern and Foxglove wards have 18 beds, and Samphire ward has 15 beds. Bluebell and Foxglove wards admit both men and women. Fern ward only admits women and Samphire ward only admits men.

We have inspected the services provided by Kent and Medway NHS and Social Care Partnership Trust 38 times between 2011 and 2015. At the time of the last inspections, all services at these locations had met the essential standards inspected.

Our inspection team

The teams that inspected the acute wards for adults of working age and psychiatric intensive care units consisted of 17 people: an expert by experience, three inspectors, three Mental Health Act reviewers, six nurses, two consultant psychiatrists, a social worker, and a pharmacist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of findings

- Visited all 11 of the wards at the four hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients;
- Spoke with 34 patients who were using the service;
- Spoke with the managers for each of the wards;
- Spoke with 55 staff members including doctors, nurses, healthcare assistants, therapists, psychologists and social workers;
- Spoke with five relatives;
- Interviewed the senior management team with responsibility for these services;
- Attended and observed 15 multi-disciplinary clinical meetings or handover meetings.

We also:

- Looked at 46 treatment records of patients;
- Carried out a specific check of the medication management on one ward and observed medication rounds on three wards;
- Carried out a detailed and specific check of the Mental Health Act on two wards;
- Looked at records of seclusion and medication charts;
- 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

- Patients were mostly positive about the staff on most of the wards, and said they were approachable and caring, treated them with respect, and were able to meet their needs. However, some of the patients on the acute wards at Littlebrook Hospital in Dartford told us that the staff could be unhelpful, and some said they would not approach staff for help. Some informal patients told us that they had been “threatened” with detention under the Mental Health Act, or had been prevented from leaving whilst they were informal.
- Patients told us that they had 1-1s with staff, but this didn’t always happen as staff were too busy.
- We saw positive interactions between staff and patients when on most of the wards. We observed some positive interactions on the acute wards at Littlebrook Hospital in Darford. However, on some of the wards at Littlebrook Hospital we observed some staff being dismissive towards patients and the culture was not patient focused. For example, in one staff handover meeting patients were referred to by their bed number and some staff did not know the actual names of some of their patients, only their bed number.

Good practice

- Priority House in Maidstone had introduced a number of initiatives which included the recovery clinic. Research into the effectiveness of the clinic was being undertaken by a member of staff as part of their PhD. We were told that recovery clinics had also been rolled out on all other acute wards.
- Peer support workers, who were people employed by the trust who had experience of mental health services, were a positive addition to the wards, and helped reinforce the patients’ perspective.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- The trust must ensure it has a system to maintain the privacy and dignity of women who are secluded on Willow Suite (psychiatric intensive care unit (PICU)).
- Trust managers must ensure that emergency equipment and medication are accessible and in date and ensure that effective systems are put in place for regularly checking emergency equipment and medication.

Summary of findings

- Systems must be put in place to ensure that, following incidents of aggressive behaviour or restraint, the care plans for the patients involved are updated to describe how to prevent, manage and de-escalate potential future incidents.
- Trust managers must ensure that the Mental Health Act is consistently implemented in accordance with the Code of Practice; and that staff working on the acute and PICU wards have sufficient understanding of the Mental Health Act and its Code of Practice to ensure patients are given correct information about their rights and to ensure medication is administered lawfully under the Act.
- Trust managers must ensure that delays in finding PICU beds for patients are minimised.
- The trust must ensure that its monitoring processes identify gaps and problems in the services, and identify the reasons behind such issues.

Action the provider SHOULD take to improve

- The provider should review the seclusion room to ensure it is equipped in accordance with the Mental Health Act Code of Practice.
- The provider should make sure staff have access to a reliable emergency alarm system.
- The provider should ensure there are robust processes in place for assessing and managing environmental risks, and that these are followed.
- The provider should ensure there are adequate numbers of appropriately qualified and experienced staff.
- The provider should ensure that all patients have a risk assessment which is reviewed regularly and updated in response to changes.
- The provider should ensure that staff understand the circumstances and limitations within which de-escalation rooms can be used to nurse patients who are violent or aggressive.
- The provider should ensure that all incidents of restraint are recorded correctly, and ensure any use of prone restraint is consistent with Department of Health guidelines.
- All patients should have care plans that are individualised, incorporate their views, and are recovery focused.
- All staff should have an understanding of the Mental Capacity Act and DoLS.
- The provider should make suitable sleeping arrangements for patients who return from leave, and reduce the need for patients to change bedrooms for non-clinical reasons.

Kent and Medway NHS and Social Care Partnership 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
Amberwood Ward, Cherrywood Ward, Woodlands Ward, Willow Suite	Littlebrook Hospital
Emerald Ward	Medway Maritime Hospital
Amherst Ward, Brocklehurst Ward	Priority House
Bluebell Ward, Fern Ward, Foxglove Ward, Samphire Ward	St Martins Hospital

Mental Health Act responsibilities

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

- Most nurses and healthcare assistants had received training about the Mental Health Act. However, we saw examples on Emerald ward (in Gillingham), Samphire ward (in Canterbury), Amberwood ward (in Darford) and the Willow suite (psychiatric intensive care unit in Dartford) that showed that staff were not always clear in their understanding of the Act and its Code of Practice. For example, records and feedback identified repeated instances of patients being told, or care records documenting, that although they were informal if they wanted to leave they would be detained under the Mental Health Act. This is potentially unlawful and contrary to the Code of Practice. There were instances on Amberwood ward where informal patients were described as being on section 17 leave. Where patients

were being seen by a second opinion appointed doctor (SOAD) there was either no, or a very limited, treatment plan recorded. On Amberwood ward a patient had been taking medication for over 30 days but it was not specified on their consent to treatment form (T3). Another patient had, on nine occasions, been given a drug that was not included on their emergency treatment form. This meant that staff had potentially been administering the medication unlawfully. The consent to treatment forms were attached to the medication charts, but they had not been taken account of when administering medication. We asked the trust to address this and it responded immediately, rectifying the situation.

- The completion of capacity assessments in accordance with the Mental Health Act Code of Practice varied across the wards. Capacity assessments had not always been completed at Littlebrook Hospital (in Dartford), but they had been at Priority House (in Maidstone). On Emerald ward (in Gillingham) patients had not all had their capacity to consent to treatment recorded in accordance with the Mental Health Act Code of Practice.
- Most detained patients were informed of their rights and this was documented accordingly for most patients. However, on Amberwood ward (in Dartford) patients were not fully informed of their rights as required by the Code of Practice.
- There was a Mental Health Act administrator on the hospital sites who staff could contact for advice.
- An Independent Mental Health Advocate (IMHA) regularly visited all the wards. Information including contact details of the IMHA were on display on the wards. Staff knew how to make a referral to the IMHA service and the days each week that the IMHA visited their wards. Patients also knew how to contact an IMHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for the implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Most staff had completed mandatory training on MCA and DoLS. The staff we spoke with had an understanding of some of the fundamental aspects of the Act, such as acting in a person's best interest and in the least restrictive way. Staff had less understanding of when a DoLS application should be made. There was no one subject to DoLS at the time of our inspection.
- The implementation of the MCA and DoLS was monitored through the Mental Health Act office.

Requires improvement

Are services safe?

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

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

Summary of findings

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

- The trust did not have a system to maintain the privacy and dignity of women who were secluded on Willow suite (psychiatric intensive care unit).
- Cherrywood ward and Amberwood ward (in Dartford), Emerald ward (in Gillingham), and Samphire ward (in Canterbury) did not have all their emergency equipment and medication accessible and/or in date, or have effective systems for regularly checking that this was the case.
- Patients who had behaved aggressively, or who had been restrained, had not had their care plans updated to describe how to prevent, manage and de-escalate potential future incidents.
- The storage and recording of medication, including controlled drugs, was not safe and secure on Cherrywood ward (in Dartford). We raised this immediately and this was rectified on the day of our inspection.

The seclusion room on Willow suite was not equipped in accordance with the Mental Health Act Code of Practice. The trust had policies about the management of violence and aggression, and monitored their usage, but had significant levels of prone restraint which is contrary to the Department of Health guidance.

There were environmental risks on many of the wards, but the trust had an extensive programme of refurbishment and was managing the risks until building works were completed. Most of the wards were satisfactorily managing medication. Most of the wards had adequate emergency procedures. There were staff vacancies on most of the wards, particularly for band five nurses, but this was being managed at a local and corporate level, and the trust had a recruitment strategy. The trust had safeguarding policies and staff knew how to identify and report safeguarding concerns.

Staff knew how to report incidents, and there were policies for reporting and managing this. There was a bulletin for sharing information including learning from incidents that was circulated to staff.

Our findings

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

Safe and clean ward environment

- The trust had an ongoing programme to rebuild and refurbish the wards within the trust. The acute wards were a mixture of new, refurbished and awaiting refurbishment, so there were differences in the quality and safety of the environment across the wards. The new and refurbished wards had fewer ligatures and environmental risks, and better lines of sight around the wards. The unrefurbished wards had some reduced risks, but had poor lines of sight, and there were ligature risks in bedrooms and bathrooms where patients could be unsupervised. The nursing station on Amberwood ward (in Dartford) had a solid wooden door and no internal windows, so staff in the office could not see the ward or who was outside the door. All the wards had an environmental risk assessment, but the quality of this was variable and we found gaps between the risks presented on the wards and those identified in the assessment. Where risks were identified there were actions for how these were to be managed. For example, by assessing patient suitability to go into bedrooms that contained more risks, and the use of observation.
- Most of the wards were compliant with guidance about separation of male and female accommodation. There were some single sex wards and other wards had dedicated corridors. However, the bedroom corridors were mixed on Cherrywood ward (in Dartford), but bedrooms had ensuite shower rooms. Woodlands ward (also in Dartford) had recently moved to a new building, and there was a woman in a bedroom at the end of the

Requires improvement

Are services safe?

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

male corridor. The wards had female lounges, although the female lounge on Woodlands ward was in the middle of the male corridor. The manager told us that they planned to move the female lounge.

- Willow suite (in Dartford) was the trust's only psychiatric intensive care unit (PICU) and was for both men and women, although most patients admitted there are male. The seclusion room at Willow Suite was used by all the wards at Littlebrook Hospital in Dartford. The seclusion room was in an open corridor surrounded by bedrooms, which were all male at the time of our inspection. We saw a female patient being secluded. Staff took her to the seclusion room through the male corridors, and men approached and tried to talk to her. Whilst she was in the seclusion room, male patients had to walk past the room to get to their own bedrooms and looked into the room. This did not promote the privacy and dignity of the woman being secluded.
- Willow suite had the only seclusion room. This was not equipped to the standards recommended in the Mental Health Act Code of Practice. There was no clock, no intercom to allow staff and patients to communicate with each other through the closed door, and there were ligatures in the bathroom. The seclusion room was on an open corridor with four bedrooms. This did not support privacy for patients in the seclusion room.
- All the wards had equipment and medication for use in the event of a medical or psychiatric emergency. Most of the wards regularly checked the equipment, and ensured it was accessible and in working condition. However, some of the wards had items missing or out of date, and some wards had not regularly checked the emergency equipment. For example, on Cherrywood ward (in Darford) the staff could not find the emergency drugs, but they were later discovered in a domestic plastic box at the back of a cupboard, which would not have made them easily accessible in the event of a medical emergency. The equipment and drugs were recorded as being checked daily. The emergency drugs were in date but there were some items missing; and some of the emergency equipment was out of date. On Amberwood ward (in Dartford) the oxygen cylinder was nearly empty. Staff told us they had been aware of this for four days, but it was not reordered until the day after we had pointed this out. The ward did have emergency drugs and equipment which were in order, but there were only records of them being checked on two occasions. On Emerald ward (in Gillingham) the equipment had not been signed as checked for three months, and there were items missing.
- There were emergency alarms on all the wards, and we saw these being used and responded to correctly on some of the wards. However, this was not the case on all the wards. On Samphire and Fern wards (in Canterbury) there were 15 alarms for each ward but they needed 20. This issue had been on the risk register since June 2012, but had not been rectified. On wards at St Martins Hospital (in Canterbury) there was sometimes a delay between an alarm being activated and it sounding. Staff told us there could be a 10 second delay. This raised safety concerns as staff did not know if their alarm would sound immediately when activated. This issue was being addressed with the contractor. On Amberwood ward (in Dartford) we observed staff responding when an individual alarm was activated. However, staff could not find who had activated the alarm so the response was cancelled without knowing the cause.
- Most of the wards were clean and well maintained. However, Amberwood ward (in Dartford) had a broken television and the 'sanctuary' room was out of use because of damage. The damage had happened over two weeks previously and had yet to be repaired.

Safe staffing

- All the wards had established staffing levels, and the ward managers were clear about vacancy levels and local and trust strategies to address them. All the wards had nursing and healthcare assistant vacancies. Staff told us that the recruitment of band five qualified nurses was a particular challenge, and we saw that most of the wards had a number of vacancies at this level. For example, Foxglove, Samphire and Fern wards (in Canterbury) and Woodlands ward (in Dartford) all had five vacancies at this level at the time of our inspection. The trust had a recruitment strategy to address the vacancy rate, and service directors met regularly with human resources to review this. There was a rolling advert for nursing staff, and there were staff going through the recruitment process across the service.
- The vacancies were filled by bank and agency staff, who were used regularly on all the wards. Staff told us they tried to book agency staff who were familiar with the

ward, but this was not always possible. On some wards agency staff were routinely used. For example, on Amberwood and Cherrywood wards (in Dartford) the night staff were mostly regular agency staff.

- All the ward managers told us they were able to vary their staffing levels depending on the needs of people on the ward. Feedback from staff and patients said that leave and activities usually went ahead, but there were some occasions when these were cancelled. Feedback from patients was that if the wards were short staffed, or staff were busy, then they would not be able to have 1-1 time with them.
- There was adequate medical cover both during the day and on call out of hours.
- All four wards at Littlebrook Hospital (in Dartford) had sickness rates above the trust average of 3.9%, with one ward over 17%. The trust had policies for managing sickness and absence, which involved human resources and occupational health.

Assessing and managing risks to patients and staff

- All wards use a standard risk assessment tool that is recorded in RIO, the electronic records system. Patients had a risk assessment carried out when they were admitted to the service. However, the risk assessments were not always reviewed, or updated following incidents or changes in risk behaviour. The risks identified were not always identified and included in a care plan, and it was not always clear what action staff should take to manage risk. For example, we observed that an informal patient had threatened to harm themselves and had left the ward, and was later returned by the police. They had been assessed by a doctor who found that the patient did not meet the criteria to be detained under the Mental Health Act (MHA) but said that they should be detained if they wanted to leave, which is poor practice under the MHA Code of Practice.
- All the wards were locked, and there were notices on most of the ward doors stating that informal patients should speak with staff if they wished to leave. We observed that informal patients did come and go from the wards. However, some patients described occasions where they had been prevented by leaving from staff, but had not been detained under the Mental Health Act. Other patients gave examples of when they had been told they would be detained if they asked to leave the ward.
- The trust had clear policies on the use of observation which were accessible to staff. These included a small quick guide for staff to refer to. Records were maintained of the observations, and levels were increased in response to concerns about a person, and reviewed in the multidisciplinary team meetings.
- The trust had policies on the management of violence and aggressive behaviour, and the use of de-escalation and restraint. Most staff were trained in techniques to use physical restraint safely. Restraint was used on all the wards. Emerald ward had not used restraint recently, and did not admit patients to the ward who were at risk of aggressive behaviour because of the ward's isolation from other mental health wards. The restraint records at St Martins Hospital (in Canterbury) were completed correctly, and included full details of the restraint which included the staff involved and the holds used. At Littlebrook Hospital (in Dartford) the forms were not always completed fully so it was difficult to analyse if patients had been restrained correctly. Prone restraint was regularly used. For example, on Samphire ward (in Canterbury) 35 restraints had happened since 5 January 2015, and of these 20 involved the use of prone restraint; on Foxglove ward (also in Canterbury) 64 restraints had happened since 2 January 2015 and 19 of these had involved prone restraint. This was not planned in advance, and was for the shortest possible time. The records at Littlebrook (in Dartford) were unclear; they identified that prone restraint was used but the rationale was not identified.
- Staff had fortnightly reflective practice sessions with the psychologist where they were able to discuss incidents, and how to work with patients who presented with aggressive behaviour. Details of incidents of restraint were recorded on RIO, but the lead up to the incident or what attempts were made to de-escalate a situation were not always recorded. Some of the records included detailed behaviour support plans for patients. However, we saw at least two records where patients had been restrained on multiple occasions but the care plan had not been updated to include how to manage or prevent these situations.
- The trust had a policy for the use of rapid tranquilisation which followed NICE guidance. Most of the wards used rapid tranquilisation and this was in accordance with the trust policy.
- There was a seclusion room in the Willow suite at Littlebrook Hospital (in Dartford), which was also used

by the acute wards on the site. Records were completed appropriately. A patient at St Martins Hospital (in Canterbury) had been nursed in a de-escalation room for several days whilst awaiting a bed elsewhere. Staff gave us conflicting messages about whether the person had been allowed to leave the room or not, and it was not clear from the incident forms or the patient's records. Not all staff understood that 'de facto' seclusion is when a patient is nursed in a room they cannot leave, but without the safeguards of a designated seclusion room and its related policies.

- The trust had safeguarding policies that were accessible to staff. Staff had completed safeguarding training, and knew which concerns could be considered as safeguarding concern and how to make a referral. Staff described examples of safeguarding concerns that had been identified, referred to the safeguarding team, and action taken. The records confirmed that safeguarding issues were being recorded and referred appropriately.
- The trust had policies for the management of medication. Prescribing was in line with NICE guidance. The trust pharmacist visited regularly to check the prescription charts and medication, and an external pharmacist also visited some sites. There were some gaps on medication charts on most of the wards, so it was not clear if a patient had taken a medication at the prescribed time. For example, on Cherrywood ward (in Dartford) of the current 18 patients, there were 36 gaps over the last month.
- Medication was not stored securely on Cherrywood ward (in Dartford). The medication cupboard in the clinic room was of an approved design, but it had bowed. When locked, it was possible to reach into the cupboard and take out medication, so medic ation was not stored securely. Legislation and polices for the handling and storage of controlled drugs were not being followed on Cherrywood ward. The controlled drugs register stated that a bottle of Oramorph (a controlled drug) had been returned to a patient. However, the bottle was still in the cupboard. It was in the main part of the cupboard, not the designated part for controlled substances, and was accessible due to the poor condition of the cupboard. The ward had corrected this error by the end of our inspection.
- The medication fridge temperatures on most of the wards were within the acceptable range (2-8 degrees Celsius), and were checked regularly. However, on Amberwood ward (in Dartford) the checks had last been completed a month prior to our visit, and at that time had been just above the acceptable range at 10 degrees. There was no record of any action that was taken, but the fridge was in range on the day of our inspection. On Cherrywood ward (in Dartford) the fridge temperature was recorded as 17 degrees, well above the acceptable range, for several weeks but no action had been taken.
- Children were not allowed onto the wards. There was a family room on each of the main hospital sites that all the wards used for child visitors. Emerald ward (in Gillingham) had limited facilities, so child visits had to be agreed in advance and staff arranged to use the family room in the onsite general hospital.

Track record on safety

- The trust published a bulletin for staff working in the acute service line, which shared information and learning from incidents. Staff were able to describe examples of learning from incidents in their own and other wards. For example, a person had modified an item and used it to harm themselves severely, so this item was now highlighted as a risk across the trust. This information had been circulated to all wards shortly after the incident so immediate action could be taken.
- The trust had identified that many of its buildings, including its acute wards, were not up to modern standards of safety. In response the trust had identified the risks from its current premises and the actions needed to manage and mitigate against them in the short to medium term. To remove or significantly reduce the risks the trust had an ongoing programme of rebuilding and refurbishment to make its wards safer and more therapeutic and attractive for patients. For example, the new wards at St Martins Hospital (in Canterbury) had ligature free fittings in bedrooms and bathrooms, and all patients had a swipe card which limited access to their rooms, and to male/female areas. The other wards will be moved or refurbished as part of the programme.

Reporting incidents and learning from when things go wrong

- The trust had policies for the reporting and management of incidents. Most staff were familiar with this policy and knew how and to whom to report incidents. The trust currently had a paper-based incident reporting system. The paper forms were completed by staff, and reviewed and approved by the

Requires improvement

Are services safe?

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

ward and service managers. The forms were then sent to a central team for review. The trust collated this information but not all staff knew what happened to this information. Staff told us that the paper-based system was due to be replaced by an electronic system in April, which they thought would make the process quicker and easier to audit.

- Incidents were recorded, feedback was given to staff and information shared. For example, plastic bags were contraband in the service but they were available on a cleaning trolley. This had been identified following an incident, and the information shared across the trust. Incidents were discussed with staff in team meetings, through individual supervision where appropriate, and through the acute service line learning bulletin.
- Staff were offered debriefing following serious incidents.

Are services effective?

Requires improvement

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

Summary of findings

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

- The Mental Health Act was not consistently implemented in accordance with the Code of Practice. For example, on Amberwood ward (in Dartford), patients were not informed of their rights in accordance with the Mental Health Act and Code of Practice; medication had been administered without the proper consent, and there was poor documentation of the treatment plan when a patient had a second opinion from a second opionn appointed doctor (SOAD).

Staff did not have a clear understanding of the Mental Health Act and Code of Practice. Records and patients' feedback identified repeated instances of patients being told, or care records documenting, that although they were informal (voluntary patients), if they wanted to leave they would be detained under the Mental Health Act. On Amberwood ward (in Dartford) and Emerald ward (in Gillingham), staff had not checked that drugs they had administered were included on the formal consent to treatment and emergency treatment forms. Thus the lawfulness of the administration of this medication could be under question.

Patients were assessed by the crisis team prior to admission, and were assessed on admission to the ward. Patients had their physical healthcare needs monitored and responded to. All patients had a risk assessment and care plan, although this was not always patient or recovery focused, and reviewed when the patient's situation changed. Patient information was stored securely and, as it was electronic, could be shared between the wards, crisis and community teams. The wards followed NICE (National Institute for Health and Care Excellence) prescribing guidance, and completed health of the nation outcome scales (HONOS). Care was provided by a multidisciplinary team of staff. Most staff received supervision and appraisal, and had completed most of their mandatory training. There were regular multidisciplinary team meetings and handovers where patient care was discussed.

Our findings

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

Assessment of needs and planning of care

- The local crisis teams were the 'gatekeepers' for the inpatient beds, and assessed patients to decide if they required admission. At admission, patients received a nursing and medical assessment which included a physical examination. Patients had care plans developed within 72 hours of their admission to hospital.
- A patient had been admitted to Littlebrook Hospital (in Dartford) to restart medication. However, after eight days they had still not been given the medication despite asking for it. The medication was prescribed for 10pm, but the patient was usually asleep by then so it had not been administered and alternative arrangements to administer the medication had not been made. The patient was discharged without having had the medication and was due to start it at home. When we discussed this issue with the ward they identified it as an incident that required investigation into the rationale behind the admission, and why it was not picked up sooner that the medication was not being administered.
- Patients had their physical observations taken as part of their initial assessment, and then had this monitored as/if necessary on a medical early warning system (MEWS) chart. This chart highlights if a person's observations are outside the normal range, so that this can be quickly picked up and reviewed by a doctor. The observations include blood pressure and pulse. The MEWS records were not always completed as regularly as prescribed. For example we saw that a person was due to have their observations taken four times a day, but they had not been done at all. However, we did see that physical healthcare was discussed in the multidisciplinary ward round meetings, and that there were detailed individualised care plans for a person who had complex physical healthcare problems. The trust had commenced recruitment of a physical healthcare nurse to improve the monitoring and management of patients' physical health.
- All patients had care plans. However, the quality of these varied across the wards. For example, most

Are services effective?

Requires improvement

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

patients at Priority House (in Maidstone) had copies of their care plans which were responsive, patient-focused and recovery orientated. However, many of the care plans for patients at Littlebrook Hospital (in Dartford) were not patient-focused, contained limited information that was specific to individual patients, and were not recovery focused.

- The trust used an electronic care records system called RIO. This was accessible to all employed staff, which included those in the community and crisis teams. This means staff were able to access information about patients when and before they moved between services. RIO was the primary care record and should contain all the information about a patient. However, paper records were still used for some information, such as the MEWS charts, and these were stored in lockable filing cabinets in lockable staff offices. Staff logged into RIO with a smart card and password, so information was stored securely. Staff told us that RIO could break down, and access to the internet was not always reliable, which could cause frustration and made it difficult to access information.

Best practice in treatment and care

- Staff followed NICE guidance when prescribing medication. The psychologists provided group work and limited 1-1 work with patients. Their primary role was to assess patients and if they determined they would benefit from, and were suitable for psychological therapies they would signpost or refer them to community based psychology services. The psychologists offered reflective sessions with staff, and had provided training to support staff to work with patients in a therapeutic way.
- The wards completed health of the nation outcome scales (HONOS), a recognised outcome scale, and other audits required by the trust such as the nursing matrix. The nursing matrix was an audit generated through RIO, which included checking if physical healthcare checks had been carried out and care plans reviewed. There were some local audits being carried out, but this varied between the wards. For example, some wards carried out regular infection control, care plan, prescription chart and Mental Health Act audits.

Skilled staff to deliver care

- There was a multidisciplinary team of staff providing care to patients on all the wards. This included consultant psychiatrists, nurses and healthcare assistants, occupational therapists, and psychologists.
- The trust had policies to ensure staff received appraisal, supervision and training. Most staff had completed most of their mandatory training. For example, uptake was above 90% for all wards at Littlebrook Hospital (in Dartford) and Priority House (in Maidstone), except Amherst ward (in Maidstone) at 78%. Uptake of training was monitored locally and by the central training team. Most staff received supervision, though not always as frequently as stated in the trust's policy. Many staff told us that they were able to access additional training. For example some staff had completed masters degrees or nurse training. A central team monitored the completion of appraisals. Staff had to confirm that they had completed their appraisal before they could receive their annual pay increment. Most staff had received an appraisal within the last year.
- We saw examples of where poor staff performance had been addressed.

Multi-disciplinary and inter-agency team work

- There were regular multidisciplinary team (MDT) meetings and care programme approach (CPA) or discharge planning meetings for each patient.
- There was a meeting each weekday morning that was attended by the ward-based MDT, plus the crisis team and other staff such as the pharmacist. The purpose of these meetings was to briefly review any specific issues with patients which included care and social needs, including discharge planning. The crisis teams could also access information on RIO about patients on the wards, so information was easily shared.
- The quality of handovers/daily meetings varied across the wards. For example, at the nursing handover on Fern ward (in Canterbury) each patient was discussed, the relevant information was handed over, and staff demonstrated that they had a good understanding of individual patients' needs. However, a staff handover at Littlebrook Hospital (in Dartford) referred to patients by their bed number rather than their name, the information was not patient focused, and contained limited information.

Are services effective?

Requires improvement

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

Adherence to the MHA and MHA Code of Practice

- Most nurses and healthcare assistants had received training about the Mental Health Act. However, we saw examples on Emerald ward (in Gillingham), Samphire ward (in Canterbury), and Amberwood ward and the Willow suite (in Dartford) that showed that staff were not always clear in their understanding of the Act and its Code of Practice. For example, records and feedback identified repeated instances of patients being told, or care records documenting, that although they were informal (voluntary patients), if they wanted to leave they would be detained under the Mental Health Act. This was potentially unlawful and contrary to the Code of Practice. There were instances on Amberwood ward where informal patients were described as being on section 17 leave. Where patients were being seen by a second opinion appointed doctor (SOAD) there was either no or a very limited treatment plan recorded. On Amberwood ward (in Dartford) a patient had been taking medication for over 30 days but it was not specified on their consent to treatment form (T3). Another patient had been administered another drug on nine occasions that was not included on their emergency treatment form. This meant that staff had potentially been administering the medication unlawfully. The consent to treatment forms were attached to the medication charts, but they had not been taken account of when administering medication. We asked the trust to address this.
- The completion of capacity assessments in accordance with the Mental Health Act Code of Practice varied across the wards. Capacity assessments had not always been completed at Littlebrook Hospital (in Dartford), but they had been at Priority House (in Maidstone). On Emerald ward (in Gillingham) patients had not all had their capacity to consent to treatment recorded in accordance with the Mental Health Act Code of Practice.
- Detained patients had been informed of their rights, and this was documented accordingly for most patients. However, on Amberwood ward (in Dartford) patients had not been fully informed of their rights as required by the Code of Practice.
- There was a Mental Health Act administrator on the hospital sites, who staff could contact for advice.
- An independent Mental Health Advocate (IMHA) regularly visited all the wards. Information, including contact details of the IMHA, were on display on the wards. Staff knew how to make a referral to the IMHA service and the days each week that the IMHA visited their wards. Patients also knew how to contact an IMHA.

Good practice in applying the MCA

- The trust had a policy for the implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Most staff had completed mandatory training on MCA and DoLS. The staff we spoke with had an understanding of some of the fundamental aspects of the Act, such as best interest and acting in the least restrictive way. Staff had less understanding of when DoLS applied, and when it should be used. There was no one subject to DoLS at the time of our inspection.
- The implementation of the MCA and DoLS was monitored through the Mental Health Act office.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

Patients were mostly positive about the care they received on the wards and found most of the staff approachable and caring. Patients had 1-1s with staff, although this could be difficult when staff were busy. Patients had access to advocacy on the ward. Patients' relatives were involved in their care where appropriate. There were community meetings on most of the wards.

Our findings

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

Kindness, dignity, respect and support

- Patients were mostly positive about the staff on most of the wards and said they were approachable and caring, treated them with respect, and were able to meet their needs. However, some of the patients on the wards at Littlebrook Hospital (in Dartford) told us that the staff could be unhelpful and some patients said they would not approach staff for help.
- Patients told us that they had 1-1s with staff, but they did not always happen as staff were too busy.
- We saw positive interactions between staff and patients when on most of the wards. We observed some positive interactions on the acute wards at Littlebrook Hospital (in Dartford). However, on some of the wards we observed some staff being dismissive towards patients and the culture was not patient focused. For example, in a staff handover patients were referred to by their bed number and some staff did not know the actual name of some of their patients only their bed number.

The involvement of people in the care they receive

- Patients on most of the wards told us that they had been orientated to the ward on admission. For example on Willow suite (in Dartford) staff ensured that on admission all patients were given a good introduction of the ward, including the patient handbook that allowed them to understand their rights, their treatment, make a complaint, and gave feedback and details of how to access the advocacy service. However, patients on Samphire ward (in Canterbury), and Amberwood and Woodlands wards (in Dartford) told us they had had no orientation or welcome pack when they were admitted to the ward.
- Some of the patients we spoke with felt involved in their care planning. For example, we saw patients' views recorded in their records and care plans on the Willow suite (in Dartford), and on the wards at Priority House (in Maidstone). However, this was not the case on all the wards. We found limited evidence of patients being involved in their care planning, or their views recorded, on the acute wards at Littlebrook Hospital (in Dartford) and on Samphire ward (in Canterbury).
- There was information on display about general advocacy services, and specific Independent Mental Health Advocacy (IMHA) for patients detained under the Mental Health Act. Some of the patients we spoke with had used the advocacy services and found them helpful. Some of the wards had IMHAs who regularly visited. Staff were familiar with the role of the advocates, particularly the IMHAs, and knew how to contact them for patients.
- Patients' families were involved in their relatives' care where appropriate. Relatives were invited to and attended multidisciplinary meetings.
- Community meetings took place on all the wards and patients could raise any concerns or suggestions at these meetings. Most were scheduled to take place weekly, but these did not always happen. The availability and detail of the minutes of these meetings varied so it was not possible to see what action had been taken as a result. On some of the wards, for example at St Martins Hospital (in Canterbury), the minutes were displayed along with 'you said, we did' so that patients could see any changes that had been made as a result of their feedback.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

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

- There were delays in finding psychiatric intensive care unit (PICU) beds for patients.
- There was pressure on beds, which meant that patients might be moved for non-clinical reasons.

There was an activity programme and/or an occupational therapy suite for all of the wards. Patients had access to phones on the wards. Patients had free access to drinks and snacks until midnight. There were disabled facilities available across the trust. There were posters and information leaflets which included how to complain, how to access advocacy and local facilities and support services. There was access to interpreting services, and a choice of food for people with special dietary requirements. The trust managed and responded to complaints.

Our findings

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

Access, discharge and bed management

- Crisis teams were the 'gatekeepers' for the inpatient services, and decided who needed to be admitted. There was a daily bed management conference call across the trust, so beds were managed across the trust, not at a local level. There was a discharge co-ordinator who approved and reviewed patients in out of area placements, and co-ordinated their return to the service, though this was due to change. Staff told us there was a lot of pressure on beds, and this was exacerbated by taking patients from out of the ward's locality. There was also pressure to discharge patients as soon as possible. The crisis teams worked with the wards to facilitate discharges.
- Staff told us that they only moved people to a different bed if absolutely necessary but patients were moved for bed management rather than clinical reasons. Emerald ward (in Gillingham) and Woodlands ward (in Dartford) were not admitting patients who might present a risk of violence and aggression, due to their isolation from other services. This meant that patients may be transferred to these wards, to create beds elsewhere.
- There was usually a bed available for patients when they returned from leave. However, in February, a patient returned from leave and as there was no bed available they spent two nights in the room of another patient who did not use their room. The patient who had returned from leave spent the first night sleeping on a bean bag and the second in the bed, until they were subsequently found a room of their own.
- There was one psychiatric intensive care unit (PICU) ward for the trust – the Willow suite - based at Littlebrook Hospital (in Dartford). The number of PICU beds had reduced. The PICU ward was supplemented by a PICU outreach service that assessed patients to determine if they required psychiatric intensive care and, if not, provide advice on their management to enable care to be provided in the least restrictive environment. This could result in very unwell patients being nursed on the acute wards. There had been at least three occasions (at Priority House (in Maidstone), Samphire ward and Fern ward (in Canterbury)) where patients were nursed in the section 136 suite (health based place of safety) or in a quiet room/lounge as they were not suitable to be cared for in the main patient area of an acute ward. Some staff were very positive about the PICU outreach service and found them supportive, but they felt that a very disturbed patient on the ward impacted on the patients and staff as the environment was fundamentally unsuitable. The PICU outreach service currently assessed patients, was responsible for gatekeeping the PICU beds, and gave recommendations on how to manage aggressive behaviour. The service manager said they had requested additional funding so that the outreach staff could provide more direct support. There were four staff who provided assessment and advice as part of the outreach team. There was an on-call system, with a limited service at weekends.
- Most of the wards had one or two people who no longer needed to be on the ward but were waiting for a suitable placement. One patient was waiting several weeks for a local bed but most patients were awaiting

Are services responsive to people's needs?

Requires improvement

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

confirmation of funding, housing, or specialist placements. There were two patients in the PICU who were 'delayed discharges' because they were waiting for beds to become available in another service.

The ward optimises recovery, comfort and dignity

- There were occupational therapy (OT) and activities provided on the wards or in dedicated areas. For example, Littlebrook Hospital (in Dartford) had a dedicated OT suite where most activities were provided. Patients could access the OT department if they were well enough to leave the ward but there were limited activities on the ward. For those too unwell, OT staff worked to support ward staff to provide a specific program with specially designed activity boxes.
- There were clinic rooms on some of the wards, or alternatively patients were examined in their bedrooms.
- All the wards had a quiet room and/or a place where patients could meet visitors.
- There were ward phones for patients to use and patients could use their own mobile phones.
- All the wards had outdoor space.
- Patients gave mixed feedback about the quality of the food but most patients thought it was ok or good.
- There was access to tea, coffee and snacks in the kitchen on the wards until midnight.
- Patients had storage for personal items or had their own room they could lock or access with a swipe card or key. However, the bedrooms at Littlebrook Hospital (in Dartford) were either unlocked (Woodlands ward) or could only be locked and unlocked by staff (Amberwood ward). Patients had lockers on the ward, but these were accessible only with staff and were primarily for risk items should as razors and some toiletries.
- Patients had access to activities during office hours, but this was limited at weekends and evenings. Activity boxes were being introduced across the wards. These included jigsaws, colouring books and anagrams. Most patients were positive about the activities that were available, but some patients thought some of the activities, such as colouring, were "babyish".

Meeting the needs of all people who use the service

- There were disabled facilities across the service, though this was limited on some of the wards such as Emerald ward (in Gillingham). Disabled facilities were incorporated into the trust's refurbishment plans.
- Information leaflets were not on display in different languages. However, staff told us that some of the leaflets were in different languages on the internet and they would print them if necessary.
- There were leaflets and posters on display on all of the wards. These included how to complain, how to access advocacy services, the activity programme and details of local helplines and services.
- Patients had access to an interpreting service if English was not their first language.
- Patients had some choice of food at mealtimes. They were able to order food to meet their dietary requirements, such as vegetarian, halal or for patients with diabetes.
- Information was available on how to contact local religious groups. A chaplain visited the wards and could be contacted if required.

Listening to and learning from concerns and complaints

- The trust had policies for receiving, managing and responding to complaints. There was information about how to complain on display on the wards. Patients knew how to make a complaint and the service investigated and responded appropriately. A manager tried to meet with the complainant to discuss their complaint before they responded to it. The complaints process was coordinated by a central patient experience team and reviewed by a senior manager before a response was sent. We looked at a sample of complaints submitted to Amberwood ward (in Dartford), and Amherst and Brocklehurst wards (in Maidstone) and saw that they had been responded to appropriately. There was no means of monitoring or identifying themes from low level or verbal complaints.
- Staff were familiar with the complaints procedure and knew what to do if a patient wanted to make a complaint. Staff told us that when complaints were investigated the findings were shared appropriately with staff, as was any broader learning.

Are services well-led?

Requires improvement

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

Summary of findings

We rated well-led as **requires improvement** because:

- The monitoring processes had not identified gaps and problems in the services. For example, there were gaps in updating risks assessments and care plans; we found out of date and missing resuscitation equipment; and the reasons behind high levels of restraint, including prone (face down) restraint had not been identified. There were also problems with medication storage and recording, including the recording of consent to treatment provisions under the Mental Health Act and Code of Practice.

There were local and corporate governance systems that monitored the quality of care. The trust had a risk register which identified risks and the actions to reduce or mitigate them. Sickness and absence were monitored by the local teams with support from human resources. Staff had a 'green button' on the trust's website for raising concerns or making suggestions.

Our findings

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

Vision and values

- The organisation's values were on display around the trust's services and staff were familiar with them. Staff on the wards knew who their service manager was, but did not necessarily staff above the level of service manager. Staff at Priority House (in Maidstone) told us they knew who the chief executive was as she had recently visited the unit.

Good governance

- There were local and corporate governance arrangements in place. The local arrangements included monthly health and safety and governance meetings, and staff meetings on the wards. The minutes showed that the meetings included highlighting developments; monitoring information; and reviewing incidents, complaints and safeguarding. There was an acute service line which incorporated the acute wards, psychiatric intensive care unit (PICU) and crisis teams. Each hospital had a service manager who held regular meetings with their teams, the service line director and their deputy held regular meetings with all the service. However, there were still inconsistencies of practice across the hospitals.
- It was of concern that gaps in updating risk assessments and care records, gaps in checking resuscitation equipment and problems identified with poor medication storage and recording, including in relation to consent to treatment and the Mental Health Act had not been identified through the existing governance processes.
- The trust had identified that the highest use of physical restraint was on Foxglove, Bluebell, Fern and Samphire wards (all in Canterbury), and the highest number of prone restraints on Foxglove ward. However, there was no rationale for why this was. Managers had discussed the introduction of a 'safer wards' initiative to address the number of restraints.
- Managers had access to the trust's risk register and incident management system, on which risks in the service were rated, and actions and plans recorded to mitigate or remove the risks. There were risk registers for the acute service line, and risk registers for each of the wards. The highest risks included bed management, staffing (recruitment), and others such as demand on beds (acute and PICU), access to acute hospital beds when required, and bank and agency staff not trained in promoting safer and therapeutic services (PSTS). Staff could access and add items to the risk register.
- Ward managers had authority to carry out their role and had support from senior managers. Training and appraisal management were monitored through a central team and this information was shared with local managers. Staffing levels and recruitment were monitored locally and fed into the corporate recruitment strategy.

Leadership, morale and staff engagement

- Sickness and absence rates were monitored locally and centrally. Managers told us the trust had strategies to manage sickness and absence, whilst being supportive of staff, which involved an absence manager and occupational health. There were policies for managing sickness and absence in the trust. A central team in human resources provided a monthly sickness report to the service manager, who discussed it with the ward

Are services well-led?

Requires improvement

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

manager. The trust monitored the absence centrally and locally. If a person had three episodes of absence in a year they automatically met with the ward manager to set a target for future absence. If they did not meet the absence target, or had enduring health problems, then staff from the human resources department supported the process.

- The trust target for sickness was 3.9% but many of the acute wards were above this. For example, at Littlebrook Hospital (in Dartford), Woodlands ward had the lowest rate at 6.75% (from most recent data in January 2015), and Cherrywood ward had the highest rate at 17.23%. At Priority House (in Maidstone), Brocklehurst ward was below average at 2%, but Amherst was well above average at 15%. The service managers were aware of these issues and were able to give a broad rationale for the levels.
- Staff told us they knew how to raise concerns. The trust had a 'green button' on the internal website that staff could use to ask questions, raise concerns, or make suggestions. Some staff said they were unsure about confidentiality, as they had to be logged in to raise the concern. However, other staff said they had raised issues and they had been dealt with appropriately.
- We received mixed feedback from staff about their view of staff morale, job satisfaction and how much influence they had in the service. Staff thought the recruitment problems put pressure on staff and impacted on the effectiveness of the teams. Some staff thought they had been listened to, for example regarding the improvement in physical health care. In other areas staff did not feel they were involved. For example, regarding the psychiatric intensive care unit service – they felt the acute wards were having to care for patients who needed to be in a PICU. They did not know if, or how, the effectiveness of the PICU outreach service was being monitored and had not had this information fed back to them.
- There was information in the January 2015 'acute service line lessons bulletin' about the 'duty of candour' requirement placed on trusts, and what this meant for staff. There were posters around the trust giving basic information about the duty of candour for patients. For example, in the reception area of Littlebrook Hospital (in Dartford).

Commitment to quality improvement and innovation

- Two of the acute wards at Littlebrook Hospital (in Dartford) had been accredited by the Royal College of Psychiatry using their accreditation for inpatient mental health services (AIMS) programme in 2007, and were last assessed in 2011. Staff at Priority House told us they had been participating in the AIMS accreditation scheme but had stopped as it was too time consuming.
- Priority House (in Maidstone) had introduced a number of initiatives which included the recovery clinic. Research into the effectiveness of the clinic was being undertaken by a member of staff as part of their doctorate studies. We were told that recovery clinics had been rolled out on all wards.
- Peer support workers, who were people who had experience of mental health services, were employed by the trust. They were a positive addition to the wards and helped reinforce the patients' perspective.

This section is primarily information for the provider

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	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found that Kent and Medway NHS and Social Care Partnership Trust did not have a system to maintain the privacy and dignity of women who were secluded on Willow suite (in Dartford). This was in breach of regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that Kent and Medway NHS and Social Care Partnership Trust did not always have available and adequately maintained equipment in the event of a medical emergency. This included on Cherrywood ward and Amberwood ward (in Dartford), Emerald ward (in Gillngham), and Samphire ward (in Canterbury) which did not have all their emergency equipment and medication accessible and in date, or have effective systems for regularly checking that this was the case. This was in breach of regulation 9(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that Kent and Medway NHS and Social Care Partnership Trust did not always have up to date care plans for patients that reflected their needs. Patients who had behaved aggressively, or who had been restrained, had not always had their care plans updated to describe how to prevent, manage and de-escalate potential future incidents. This was in breach of regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that Kent and Medway NHS and Social Care Partnership Trust did not always consistently implement the Mental Health Act in accordance with the Code of Practice. This included on Amberwood ward (in Dartford) and Emerald Ward (in Gillingham) where patients had not been informed of their rights, informal patients had been told they would not be allowed to leave, medication had been administered without the proper consent, and there was poor documentation of the treatment plan when a patient had a second opinion from a second opinion appointed doctor (SOAD). This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Compliance actions

We found that Kent and Medway NHS and Social Care Partnership Trust did not always have psychiatric intensive care unit (PICU) beds available, which led to delays in finding a suitable bed for unwell patients.

This was in breach of regulation 9(1)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that Kent and Medway NHS and Social Care Partnership Trust had monitoring processes that did not always identify gaps and problems in their services. This included gaps in updating risk assessments and care plans, out of date and missing resuscitation equipment, problems with medication storage and recording which included in relation to consent to treatment and the Mental Health Act, and identifying the reasons behind physical restraint including prone restraint on some incident forms. This was in breach of regulation 10(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement 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.