

# Nottinghamshire Healthcare NHS Foundation Trust

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

### Quality Report

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### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RHANM	Highbury Hospital	Rowan 1 Rowan 2	NG6 9DR
RHANM	Highbury Hospital	Rowan 2	NG6 9DR
RHABW	Millbrook Mental Health Unit	Lucy Wade Ward	NG17 4JL
RHABW	Millbrook Mental Health Unit	Orchid Ward	NG17 4JL

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

# Summary of findings

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 Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Foundation Trust.

## **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 wards were clean and had a good range of rooms and facilities to meet patient needs. The staff teams had a good range of professionals and understood the individual needs of patients. Staff used national guidance and outcome measures to support their practice.
- Staff interactions we observed were caring, warm, and respectful. Generally, patients were positive about staff and how staff treated them, they said staff were available. Patients knew how to complain and had opportunities for feedback.
- Staff received the necessary training to do their jobs. They received appraisals and supervision. Staff received feedback from incidents and complaints, staff we met with were aware of recent changes to policies. Staff were happy in their roles and felt supported.

However,

- There was on-going pressure on the beds available. All wards we visited had in excess of 100% bed occupancy for the three months prior to inspection. The trust had admitted patients to out of area placements, locally patients had 'slept out' on other wards. The trust had taken actions to address this but it remained an issue.
- The trust was in the process of reviewing all ligature points on the wards we inspected and rolling out a new risk assessment and observation policy. During the inspection, we highlighted a concern, which could have increased ligature risk; the trust confirmed this would be included in future risk assessments.

# Summary of findings

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

### Are services safe?

- The wards we visited were visibly clean and pleasant. We saw evidence of regular audits taking place. Each ward had an environmental risk assessment.
- Staff received mandatory training, helping to keep patients safe. Staff we spoke with were familiar with changes to policies and practice. A new observation policy had recently been introduced staff knew about this and were implementing the new standards.
- Patients confirmed staff were a visible presence on the wards. Staff completed individual patient and group based activities. Staff were available to support patients taking their leave entitlements.
- Staff knew what constituted an incident and how to report it. Staff received feedback and debriefs following incidents. The trust produced a regular bulletin of lessons learnt that staff could access.
- There were initiatives to reduce the use of restraint and restrictive practices. Staff we spoke with confirmed that they primarily used de-escalation techniques to manage potentially difficult situations. Staff assessed restrictions on an individual patient basis. All records we checked contained a risk assessment.

However,

- Each of the wards had known ligature risks. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. The trust were rolling out new ligature risk assessments that were more comprehensive and sharing this with staff on the wards. Staff knew where the ligature points were and could describe to us actions they would take to minimise the risks. This was an on-going piece of work. During Highbury inspection, we identified areas, which potentially increased the likelihood of successful ligatures to the trust. The trust confirmed they would add this to the ligature risk assessments at the Highbury site.
- Staffing levels were a concern to eight staff we spoke with during this inspection. The wards in the previous three months had unfilled shifts. To manage staffing issues the trust had an on-going recruitment programme and a regular bank of staff they used. The use of agency staff was low. Previously this had

# Summary of findings

been a concern on Rowan 2 Ward, we found this was no longer an issue. Although staffing remained a challenge the use of bank staff was not negatively affecting the experiences of patients.

- Lucy Wade Ward was without a blood pressure machine as it had loaned it to Lucy Wade PICU. This could have put patients at risk if a patient had suddenly become unwell and the team did not have ready access to the monitoring equipment needed.

## Are services effective?

- The National Institute for Health and Care Excellence (NICE) guidance informed care provided. The trust based its policies on NICE guidance, where available. Staff were familiar with how NICE guidance supported their practice. Staff completed outcome measures of patients' progress.
- The wards had a good range of disciplines within the teams. Good relationships existed with other trust teams and teams outside of the trust. The relationships meant patients had wider opportunities to get appropriate support. Comprehensive handovers took place between each change of shifts, which were patient focussed.
- Annual staff appraisals took place. Generally, supervision took place. Appraisals and supervision help to keep services safe, and support staff to provide effective care to patients.
- Staff received specialist training for their roles. Staff completed safeguarding training to keep patients safe. Training in psychological therapies such as behavioural family therapy was available. Managers received leadership training to enable them to complete their roles. New staff received an induction to both the trust and their roles. Preceptorship programmes were in place to support newly qualified nurses.
- Staff received training in the Mental Health Act (MHA) and Mental Capacity Act (MCA). Staff had a good working knowledge and understood their responsibilities in these areas. The implementation of the MHA, MCA, and DoLS helped patients to receive effective care.
- Records we checked contained patient care plans. We found that the quality of these varied some were comprehensive and detailed. Others lacked detail or were not holistic in covering a range of patient needs. Ward teams completed clinical notes audits each month to ensure that the necessary information was present. Where scores were consistently low over a three-month period, the trust put actions in place to address this.

However,

# Summary of findings

- Lucy Wade Ward was moving from paper-based records to electronic records we found that the notes were difficult to follow and that several copies of some records were present. We found that staff had not discontinued old copies of Mental Health Act paperwork. There was a risk that during this period of transition that staff may not know where to look for information or that they may inadvertently access old information. This could put both staff and patients at risk.

## Are services caring?

- The majority of patients reported positive staff attitudes. We observed warm, caring, and considerate interactions between staff and patients. We noted staff to be polite and to listen to patients. Recent audits on each of the wards had scored 100% for areas including privacy and dignity.
- The wards had clear processes in place to orientate new patients to the wards. Staff showed each patient around the ward and gave basic information, such as mealtimes. An introduction leaflet was available which staff gave to patients.
- Patients had opportunities to feedback and be involved in service decisions. Regular community meetings took place; patients said they received feedback on issues raised. You said, we did, boards were present in the wards we visited, indicating what had changed in response to feedback. Two staff confirmed patients had been part of their interview panels.
- Staff had a good understanding of individual patient needs. We observed good staff knowledge at handovers and a patient review we attended.

However,

- Advocacy services were available although the advocate did not visit the wards at set times and relied on staff making referrals for the patients. This could have disadvantaged patients.
- Five patients on Rowan 1 Ward and Rowan 2 Ward told us they did not always feel safe. Patients said they felt unsafe due other patients who were unwell. Patients on these wards also raised concerns about the safety of their possessions.

## Are services responsive to people's needs?

- The wards had a good range of spaces to support patients. Quiet areas, rooms for activities and outside space were accessible. Patients generally reported the food was of a good quality and they had a choice.

# Summary of findings

- Patients knew how to complain and said they would be confident to do so. Staff knew how to deal with complaints and received feedback from complaints so that they could learn.
- The wards were accessible to disabled people, including wheelchair users. The trust had a system, which could translate written information into other languages. The trust used interpreters; staff knew how to access these services.
- A pastor who offered support to patients visited each ward. This was not a religion specific service. Patients had access to multi-faith rooms. If assessed as safe, staff supported patients to access community facilities.

However,

- The bed occupancy of the wards was in excess of 100%. This resulted in the trust admitting patients to out of area placements when local beds were unavailable. Patients also had to 'sleep out' on other wards when beds were under pressure. If patients took leave they could not guarantee returning to the bed, they left. Staff made us aware of two instances where this had preventing patients taking leave.

## Are services well-led?

- Staff were familiar with the vision and values of the trust as these fed into their annual appraisals. Staff knew who senior managers were and confirmed they had visited the wards.
- Staff were happy in their roles and felt supported to develop. Staff felt confident to raise any concerns they had.
- Staff knew the processes for reporting incidents and complaints. Staff confirmed if the trust or ward identified learning, they received feedback so that practice could improve. If mistakes happened, staff apologised to patients.
- The wards carried out internal audits on a regular basis. There were plans put in place to make improvements if needed. We saw action plans in relation to improving record keeping on Rowan 1 Ward. Ward managers completed reports on their ward's performance. The managers used reports to continually monitor and improve the service provided.



# Summary of findings

## Information about the service

The four wards we visited were on two hospital sites run by Nottinghamshire Healthcare NHS Foundation Trust. All of the wards were acute adult working age admission wards.

Rowan 1 Ward and Rowan 2 Ward were situated at Highbury Hospital site. Rowan 1 is a male only ward and can accommodate between 12 and 20 patients. Rowan 2 is the female equivalent ward and can accommodate between 12 and 20 patients. The wards were situated next to each other and there were a series of doors that could be locked to either increase or decrease the bed numbers for each ward, up to a total of 32 patients depending on the current need for either male or female beds. On the day of inspection both Rowan 1 Ward and Rowan 2 Ward had 16 occupied beds each.

Lucy Wade Ward and Orchid Ward are part of Millbrook Mental Health Unit. Lucy Wade Ward and Orchid Ward admit both male and female patients. Lucy Wade Ward has 11 beds. Orchid Ward has 25 beds. On the day of inspection, Lucy Wade Ward had 11 patients admitted.

We briefly visited Orchid Ward to check if they had made necessary improvements. We completed the last comprehensive inspection in June 2014. There were requirements that the trust needed to make in relation to gender separation at Bassetlaw hospital (B2 Ward) and Millbrook Mental Health Unit (Orchid Ward). We checked Orchid Ward at Millbrook Mental Health Unit and found that the ward now met guidance in relation to gender separation, which upheld patient's privacy and dignity.

## Our inspection team

The team was comprised of: Team leader: Lynne Pulley

An inspection manager, four further CQC inspectors, and an assistant inspector.

## Why we carried out this inspection

We inspected this core service in response to information we had received and to check if the trust had met previously identified issues.

We completed the last focussed inspection of the service on Rowan 2 Ward in February 2015. At this time, we found that improvements were required. We issued two requirement notices in relation to the care and welfare of people who use services and in relation to staffing. The ward was using high levels of bank staff who were unfamiliar with the ward and patients, which could have put patients at risk. We found this was no longer an issue. Although staffing remained a challenge the use of bank staff was not negatively affecting the experiences of patients. Rowan 2 Ward was no longer in breach of regulations.

We completed a comprehensive inspection in June 2014. There were requirements that needed to be made in relation to gender separation at Bassetlaw hospital (B2 Ward) and

Millbrook Mental Health Unit (Orchid Ward). We did not inspect Bassetlaw hospital (B2 Ward). We visited Orchid Ward and found that there were now clear segregated areas that met the needs of both male and female patients. The actions taken meant that the service had responded to and met the requirement notice. Orchid Ward was no longer in breach of this regulation.

# Summary of findings

## 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.

During the inspection visit, the inspection team:

- visited four wards at two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with nine patients who were using the service
- spoke with the managers for each of the wards
- spoke with 14 other staff members; including a doctor, a pharmacist, a modern matron, nurses, healthcare assistants and a domestic.
- attended and observed three hand-over meetings and one multi-disciplinary meetings.

We also:

- collected feedback from three patients using comment cards
- looked at 15 treatment records of patients
- reviewed 37 prescription 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

We spoke with nine patients and received two positive comment cards, which said staff were kind. The majority of patients felt that all staff were genuinely interested in their well-being. Three patients although generally positive in their feedback said that not all staff members were interested in them.

Patients confirmed that nurses were always a visible presence on the wards. Seven patients said that staff had not cancelled their leave and that activities took place.

Two patients said that staff had cancelled their leave and activities due to low staffing numbers.

Five patients at Highbury Hospital stated that at times they felt unsafe if other patients were unwell. One patient said they would feel safer if CCTV was present in communal areas. Four patients reported feeling safe. Five patients at Highbury Hospital felt their possessions were not safe from other patients and spoke about patients wandering into their bedrooms.

## Good practice

The manager at Lucy Wade Ward had a well-being plan in place for each staff member. This proactive approach to support staff members was an example of good practice.

# Summary of findings

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that ligature risk assessments are fully completed and that consideration is given to actions that could mitigate the risks further.
- The provider must continue to monitor and review bed usage and to take steps to improve the experience of patients.

### Action the provider **SHOULD** take to improve

- The provider should continue with their on-going staff recruitment programme.

- The provider should take actions to ensure patients feel safe and their belongings are safe on Rowan 1 Ward and Rowan 2 Ward.
- The provider should ensure that a blood pressure monitor is present on Lucy Wade Ward.
- The provider should ensure that during the transition from paper-based records to electronic records current information is accessible and clear.
- The provider should review if the current referral process for advocacy fully engages patients as only one patient we spoke with had used advocacy services.

# Nottinghamshire Healthcare NHS Foundation Trust

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

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)

Name of CQC registered location

#### Mental Health Act responsibilities

#### Mental Capacity Act and Deprivation of Liberty Safeguards

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- The layout of the wards did not allow staff to have clear vision of all areas to observe patients. Staff positioning and the use of mirrors helped to mitigate the risk. We saw during inspection that staff were present in the main patient areas of the wards. Rowan 2 Ward had identified further areas that were difficult to observe and were waiting for the trust to install additional mirrors.
- Each of the wards had ligature points. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. Staff knew where the ligature points were. Staff showed us photographs of the ligature points, which were, used as part of staff member inductions. This was a new initiative to managing the risks following a serious incident. The ligature risks were contained within the divisional risk register. Each ward was developing a floor plan, which highlighted known risks. Ligature points were present within the bedrooms of Rowan 1 and Rowan 2 Wards as the windows had metal closures. Below some windows, boxing was present that patients could step onto to access the ligature points and could have increased the likelihood of patients successfully ligating. We highlighted this risk to the trust. The trust confirmed post inspection that they had highlighted this increased risk to staff across the Highbury site and staff would add this to the ligature risk assessments. Staff told us if a patient was high risk of self-harm then staff would lock the windows to prevent access to the ligature point. Ligature points were also present on the bathroom doors on all of the wards we visited. Staff told us the trust was considering the introduction of sensors, which would alert staff if pressure was applied to the bathroom door. The trust was completing a scoping exercise to look at the feasibility of fitting sensors to doors. Once this was completed, staff would present a formal paper to the senior management team for consideration. The service was working to update all ligature risk assessments onto a new ligature risk assessment that the trust had formulated following a serious incident. Once ward staff completed all ligature risk assessments, the division would present the findings and information to the trust executive leadership team to allow the team to make decisions regarding capital investment to further mitigate identified risks.
- Rowan 1 Ward admitted only male patients. Rowan 2 Ward admitted only female patients. Both Lucy Wade Ward and Orchid Ward admitted both male and female patients. At Lucy Wade Ward and Orchid Ward, there were appropriate measure in place to uphold the privacy and dignity of both male and female patients. All bedrooms had en-suite facilities meaning that no females had to pass by male bedrooms at night to access toilet facilities. Female only lounges were available. Patients at Lucy Wade Ward told us they felt safe.
- Each ward had a clinic room, which was clean and tidy. They contained couches so that staff could examine patients. The necessary equipment to carry out physical observations was present. Staff checked equipment as safe to use. However, Lucy Wade Ward had lent their blood pressure monitor to the adjoining ward. Staff said they had been without a blood pressure monitor for several days. Grab bags were present within the wards should a medical emergency occur. Staff checked emergency equipment daily to ensure it was present and safe to use.
- The wards visited did not have seclusion facilities. Seclusion did not take place on these wards.
- The wards visited were visibly clean. The furniture was in a good state of repair and appeared comfortable for patients to use. Staff completed the monitoring of infection, cleanliness, and environment audits on the wards. In October 2016 Rowan 1 Ward scored 91%, Rowan 2 Ward scored 88%, which are good scores. Lucy Wade Ward scored 97%, which is an excellent score in September 2016. Patient led assessments of the care environment (PLACE) last completed in April 2016 scored positively. Rowan 1 and Rowan 2 Wards had a

# Are services safe?

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rating of being very confident in the ward at both initial and lasting impression. Lucy Wade Ward had a rating of confidence in the ward both initially and following the assessment.

- The trust displayed correct handwashing procedure notices in clinic rooms. The trust had sited hand gel dispensers at the entrance to the wards. Staff used hand gel during the inspection.
- We saw that electrical testing stickers were present on items within the clinic room that confirmed equipment was checked and up to date.
- Cleaning records were present on each of the wards we visited. Records showed that cleaning took place in accordance with the cleaning schedule. If this was not possible reasons staff documented reasons for example, bedroom not cleaned as patient was in bed. On a weekly basis, a team leader checked and signed off records.
- Each ward had an environmental risk assessment completed. Staff completed audits at Rowan 1 and Rowan 2 Wards within the previous 12 months prior to our inspection. Staff last completed Lucy Wade Ward audit in August 2015, so this was overdue.
- Nurse call systems were in place for patients to seek assistance from staff. Nursing staff carried alarms that they could activate if they needed support from other staff members.

## Safe staffing

- The trust had identified staffing establishments for each ward. Each ward had a staffing establishment for qualified and unqualified staff. Staff worked a mixture of early, mid and late shifts, long days and nights.
- Rowan 1 Ward had 10.4 qualified nursing posts and 14.14 unqualified posts. At the time of inspection, there were 1.6 vacancies for unqualified staff. The trust had advertised the posts and they were due to be short-listed. Rowan 1 Ward worked on two qualified nurses and 2 healthcare assistants (HCAs) during the day and one qualified and two HCAs at night.
- Rowan 2 Ward had 12.8 qualified nursing posts and 11 unqualified posts. At the time of inspection, all posts were full. Rowan 2 Ward worked on two qualified nurses day and night and two HCAs during the day and one HCA at night.
- Lucy Wade Ward had a shared staffing establishment with Lucie Wade PICU. This consisted of 20.4 qualified nursing posts and 20.4 unqualified posts. At the time of inspection, there were vacancies for 2.6 qualified nurses, with one nurse due to start and the other 1.6 posts advertised. There were vacancies for 4.6 unqualified nurses with four staff appointed and due to take up employment. Lucy Wade Ward worked on two qualified nurses and two HCAs during the day and one qualified nurse and two HCAs at night.
- We reviewed duty rotas for 4 weeks until the 6th November and found that gaps were present in either the total staff numbers or the skill mix. During the three months leading up to, the inspection 11th August until 11th November 2016 each of the wards used bank and agency staff to fill shift vacancies. Bank staff the trust used were familiar with the wards. Eight staff told us low staffing numbers were an issue. Rowan 1 Ward filled 306 shifts with bank and agency. The majority of the shifts were filled by bank staff (296) with agency staff filling 10 shifts. Rowan 2 Ward filled 277 shifts with bank or agency staff. Bank staff filled 267 agency staff filled 10 shifts. Lucy Wade Ward and PICU filled 747 shifts with either bank or agency staff. Bank staff covered 708 shifts agency staff filled 39 shifts. Staff did not fully fill shifts on each of the wards. Rowan 1 Ward had 36 shifts unfilled, meaning that staff filled 89% of shifts. Rowan 2 Ward had 55 shifts unfilled, meaning that staff filled 83% of shifts. Lucy Wade Ward and PICU had 84 shifts unfilled, meaning that 90% of shifts were filled. Ward managers had the authority to adjust staffing levels to meet patient needs. The trust held a daily demand meeting to scrutinise staffing needs and had developed a flexible workforce to try to address staffing needs. When the trust could not meet safe staffing levels, an incident form was completed and the deficit escalated to senior managers.
- A qualified or experienced nurse was present within the main ward areas. Patients we spoke with confirmed this.
- Staff were available for patients to have one to one time patients confirmed this. Escorted leave took place. Patients told us occasionally they had to wait but that their leave took place.

# Are services safe?

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

- Medical staff were part of the ward teams. An on-call rota system was in place to provide medical cover to the wards out of hours. Staff said accessing a doctor throughout the 24-hour period was not a problem.
- The staff received mandatory training. The trust target for mandatory training was 85%. Rowan 1 Ward had 87% of staff who had completed mandatory training, Rowan 2 Ward 91% and Lucy Wade Ward 88% therefore meeting the target.
- The trust had a target rate of 4% for sickness. Each of the wards for the 12-month period up until October 2016 were above this target. Lucy Wade Ward was slightly above the target at 4.6 %. Rowan 1 Ward was 5.6% and Rowan 2 Ward was 8%. Both Rowan wards had experienced staff with long-term sickness. The human resources department assisted managers to monitor and manage sickness.
- The trust had a staff turnover rate target of 11%. Rowan 1 Ward was well below this target with an annual staff turnover of 5.7%. Both Lucy Wade Ward (13.6%) and Rowan 2 Ward (12.1%) were above this target. Rowan 2 Ward figures were consistently reducing over the 12-month period with a turnover rate of less than 4% in the last two months. The trust told us Lucy Wade Ward had a high turnover rate as staff left following securing promotions or moved to posts elsewhere in the trust.
- Although prone restraint (face down) was included within the training staff received to manage violence and aggression staff informed us that this was a rare event. Lucy Wade Ward had recorded seven incidents of prone restraint, Rowan 2 Ward had two incidents of prone restraint, between April and September 2016.
- The trust used rapid tranquilisation. We saw that staff completed the additional monitoring required following the administration of rapid tranquilisation in one of the records we checked. Pharmacy staff had completed a recent audit on rapid tranquilisation. Following this pharmacy had reminded medical staff of the guidelines and policy on the use of rapid tranquilisation.
- Sign up to Safety is a national campaign that has a reduction in restrictive practices as one of its core aims. The trust was using this to try to improve patient safety. Other initiatives the trust were considering were the Ideal Ward Round, a local initiative and Safer Wards model, a nationally recognised initiative to improve patient involvement and help staff to understand why wards can be unsafe at times and how they can manage this in a person-centred way.
- We reviewed 15 patient care records of across the three wards. We found that all records contained a risk assessment. Staff completed patient risk assessments within the first 24 to 36 hours from the point of admission. Thirteen records were complete and up to date. Staff had not reviewed two risk assessments at the agreed time. The staff used a trust wide risk assessment

## Assessing and managing risk to patients and staff

- Seclusion did not take place on the wards we visited.
- Staff reported using restraint infrequently and that staff used other techniques to manage aggression. The trust had an initiative, a de-escalation model “no force first” which emphasised verbal de-escalation. Techniques used included distraction, using different areas of the wards and staff actively engaging with patients. Staff were familiar with this approach. There had been 72 incidents of restraint across the three wards we inspected between April and September 2016. The highest incidence was on Lucy Wade Ward where 50 of the restraints had taken place. We contacted the trust who were aware of this high figure and had started to review all restraints on a monthly basis. The trust had nominated a staff member to lead on this work and feedback directly to managers as part of the sign up to safety initiative.
- Staff only placed restrictions on patients to manage risks. Where restrictions were in place for example, in relation to bedroom access this was care planned for individual patients. Wards had items that were restricted to patients such as cigarettes, lighters, and aerosol cans. We saw staff kept these securely locked in individual boxes for individual patients on Rowan 1 Ward. The trust had recently become a smoke free trust. The trust did not allow patients to smoke on site and staff could not escort patients to smoke off site. Choices of nicotine replacement therapies were available to patients. We received mixed feedback regarding this change during inspection from both staff and patients.
- Informal patients could leave at will. We saw notices by the ward doors advising informal patients of this. We spoke with informal patients who were aware of their



# Are services safe?

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right to leave should they choose to. Staff at Rowan 1 Ward told us that if they had concerns for an informal patient's safety they would ask them to remain to see to a doctor prior to leaving.

- The trust had recently introduced a new policy on the observation of patients. Staff we spoke with were familiar with the new policy. Staff had received training in the new policy, which included watching a video. Staff read and signed to say they understood the new policy. We saw staff members completing observations and records throughout the inspection to try to minimise the risk to patients.
- If staff had concerns patients may have brought restricted items into the building staff completed 'pat down' searches of patients. Staff sought patient consent prior to completing searches. Staff received training how to complete these searches. If a patient did not consent staff would increase their observations of patients temporarily to try to keep all patients safe.
- Staff received training in safeguarding and knew what constituted a safeguarding concern. Staff knew how to raise concerns and reported good relationships with local safeguarding teams.
- Policies were in place for medicines management. Staff understood the requirements for the ordering, transportation and storage of drugs, including controlled drugs. We checked controlled drug records and found these were correct and up to date. The staff contacted patient's GPs following admission to make sure they had a complete record of medications prescribed. The pharmacy team aimed to review patient prescriptions within 24 hours of admission on weekdays to check for any contra-indications of the medications.
- Procedures were in place for children to visit patients. All visits, which included children, took place in a designated visiting room off the wards.

## Track record on safety

- In the 12 months prior to November 2016, there had been five serious incidents in relation to the three wards we inspected.
- Following two recent serious incidents, the trust had introduced a new ligature risk assessment. The trust was in the process of completing this across the wards. Staff we met with were aware of the changes in the

assessment of ligatures and could identify ligature points within the wards. If staff assessed patients as high risk staff took measures to prevent access to ligature points within bedrooms by closing and locking the windows. The trust provided additional staff training in patient observations.

- Improvements were underway to the service following recent incidents. There was a new missing person's policy in draft following an incident of absconding. Staff were reviewing how they observed patients who returned to the ward under the influence of alcohol or illicit substances following leave. The trust was developing guidelines for staff who offered support to families following incidents.

## Reporting incidents and learning from when things go wrong

- Staff knew what constituted an incident and how to report it. On the wards inspected staff reported incidents that took place. For the 12 months prior to the date of inspection, staff reported 846 incidents. Of the reported incidents, the majority fell within the category of no harm or low harm to patients. Figures were Lucy Wade Ward 98%, Rowan 1 Ward 95%, and Rowan 2 Ward 94% of incidents, which were categorised as no harm or low harm to patients.
- Staff were familiar with the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers to notify people who used services (or other relevant persons) of certain safety incidents and then provide reasonable support. Staff gave examples where they had offered support to families in relation to recent incidents. Staff said that when things went wrong they offered an explanation and apology to the patients.
- Staff confirmed receiving feedback from incidents. Feedback was via team meetings, e-mails, or as part of the handover process. We reviewed team meeting minutes available to us and saw that managers provided some feedback from incidents to the teams with changes to practice identified. One example was the new observation policy that the trust had introduced. The trust produced a lessons learnt bulletin that staff could access.
- Staff were aware of changes that the trust had introduced in relation to incidents at ward level and in



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other parts of the service. Examples were the new observation policy, and the re-auditing of ligature risks. There was more robust recording of ligature risks now including photographs. The trust had made changes following recent incidents and following the outcomes of investigations.

- Debrief occurred following serious incidents. Debrief was conducted by either senior ward staff or a specific trust debrief team. Most staff confirmed being offered and accepting debrief following serious incidents. One staff member reported a potentially serious incident and not receiving any debrief from the management team or feedback from the incident form submitted.

# Are services effective?

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

## Our findings

### Assessment of needs and planning of care

- Fifteen records reviewed contained a care plan, we found one care plan on Rowan 1 ward had not been reviewed when due. Another care plan on Rowan 1 ward did not contain a review date. The quality of the care plans varied, we found seven plans were detailed, comprehensive, and holistic. Other care plans were either lacking in detail or did not cover a range of issues. Five care plans clearly demonstrated patient involvement and were personal to that patient. Staff had given care plans to four patients on Rowan 1 ward. Within the remaining records (11), we could not see evidence that staff had given patients copies of their care plans.
- Staff clearly assessed physical healthcare needs of patients in 13 of the records we reviewed. We saw that body maps were completed and that staff completed a physical examination as part of the admission process. There was evidence of on-going physical health monitoring within most records. At Lucy Wade Ward, we did not find a physical health care plan for a patient who had diabetes and had not been taking their diabetic medication prior to admission, this could have been a risk to the patients' health.
- Rowan 1 and Rowan 2 Wards securely stored all clinical information electronically, apart from patient checklists and Mental Health Act paperwork. Once completed staff scanned this into the electronic system to complete the patient record. There were lockable cabinets where staff kept paper records securely. Lucy Wade Ward was in the process of transferring from a paper-based patient record system to the electronic system. In one set of records, we struggled to ascertain current Mental Health Act paperwork. Staff had not discontinued outdated paperwork and the notes contained several copies of forms. Duplication of paperwork and the transition from paper to electronic records could have meant that staff were not clear regarding current patient needs and Mental Health Act parameters.

### Best practice in treatment and care

- Trust policies took account of NICE guidance, an example being, rapid tranquilisation, violence, and aggression: short-term management in mental health

in-patient and community settings. Staff received training in behavioural family therapy as recommended in psychosis and schizophrenia in adults: prevention and management, and bipolar disorder: assessment and management NICE guidance. Psychologists were part of the ward teams and offered psychological interventions.

- Staff completed an initial physical health assessment when patients were admitted. Physical health care plans were present in all but one patient record where there was an identified physical health need. Staff offered physical health monitoring on a weekly basis to patients via clinics they ran.
- Staff used Health of the Nation Outcome Scales to monitor patient progress. The occupational therapy staff within the teams completed outcome-rating scales to initially assess and monitor progress.
- Staff members completed audits at ward level. Recent audits were a daily audit of the completion of patient observations. The trust had introduced this as the observation policy had very recently changed to ascertain that staff understood and carried out observations correctly. Monthly note keeping audits took place they were comprehensive. Post inspection the trust supplied us with an action plan following a recent audit that detailed how the trust would make improvements, with indicative timescales. The pharmacist and ward managers completed annual medication management audits jointly. An audit of patient discharges took place and covered a wide range of areas completed in discharge summaries, completion figures were all in excess of 80%.

### Skilled staff to deliver care

- The teams consisted of a good range of disciplines. The wards had dedicated medical consultants and junior doctors who completed patient reviews. Nurses, healthcare assistants, occupational therapists and occupational therapy assistants were part of the teams. Each ward had a half-time psychologist. Wards had daily input from either a pharmacist or pharmacy technician Monday to Friday who completed medication reconciliation. Each ward had an activity worker to

# Are services effective?

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support patient activities taking place. The trust introduced activity workers to the wards as part of the trust becoming smoke free to offer patients increased activity. Social workers were not integral to the teams.

- The staff teams had a mixture of staff who had worked for a number of years and staff who were new to post. We met two ward managers who had been in post less than 12 months. There were a number of preceptorship nurses who existing staff were supporting to develop. This was their first post since qualifying as a nurse. We spoke with two preceptorship nurses who felt supported. Staff received an induction to both the trust and to the post they took up. As part of the induction, they completed mandatory training. Staff told us they felt supported when new to post and that they had received additional support at this time from more senior staff.
- Staff confirmed receiving annual appraisals and monthly supervision. Ward managers monitored the percentage of staff who received appraisals and supervision monthly. Appraisal figures for the previous six months up until October 2016 were 88% (Rowan 1), 100% (Rowan 2), and 91% (Lucy Wade Ward). Figures for completed supervisions for the previous six months up until October 2016 were generally in excess of 84% across the three wards. In the past two months, Lucy Wade Ward figures had dropped to 68% and 69%. The service manager and ward manager were addressing this. There was a plan in place.
- Staff stated regular team meetings took place. We requested information regarding team meetings post the inspection. Rowan 1 Ward had five team meetings documented to have taken place between June and November 2016. Rowan 2 Ward and Lucy Wade Ward had two team meetings documented during the same timeframe. The trust had recently started acute locality meetings, which ward managers (or representatives), attended, and took essential information back to teams. However, we did not see this referenced in team meetings we reviewed.
- Staff received specialist training for their roles. Staff completed training in safeguarding adults and children. Figures varied across the wards the only figure, which was below 85%, was on Rowan 1 Ward for safeguarding children, which was at 83%. Previously staff had completed level two safeguarding. Now the trust

expected staff to complete level three safeguarding training by the end of November 2016. Staff had completed training in behavioural family therapy, dialectical behavioural therapy, Recovery College and training in managing distress. Ward managers had completed Vision 21 training, which focussed on management and leadership.

- Managers addressed poor performance initially via supervision sessions. If things did not improve, managers' formally escalated this as per policy. There was a disciplinary procedure in progress on one of the wards and the trust was completing an investigation on another ward at the time of our visit.

## Multi-disciplinary and inter-agency team work

- Multidisciplinary team reviews of patients took place on a weekly basis. We attended one patient review, which had medical, nursing staff and a social worker present. The staff team had a discussion prior to the patient joining the review but staff made the patient aware of this when they arrived. We witnessed an open discussion between disciplines and the patient. Areas considered were current risks, discharge planning, mental, and physical health, and the patient's capacity to consent. Staff provided the patient with information and options to move forward. Staff and patients developed a plan during the review.
- Handovers between staff occurred between night staff and day staff and between changes of staff during the day. We attended three handovers we found these to be comprehensive and patient focussed. Staff discussed each patient individually, general ward issues were covered, and any outstanding jobs that needed to be completed were highlighted and allocated. As part of the handover, the wards used handover sheets which highlighted individual staff roles such as completing physical observations and who would respond to emergency alarms. The handover nurse made staff aware of who senior nurses and fire officers were for the shift.
- The wards reported good working relationships with other teams within the organisation. We saw a staff member from another team on one of the wards ensuring that information about a newly admitted patient was available to the ward team. The crisis team assisted the wards to facilitate discharges. The

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community mental health teams were not always able to attend in person but the wards did maintain regular contact with care co-ordinators via phone or e-mail and staff shared patient plans.

- Relationships existed with teams external to the trust. As part of the admission process, the wards contacted GPs to request an up to date list of a patient's medication prescribed. Social workers attended the weekly bed management meeting. Staff reported good relationships existed.

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

- Ward staff were aware of which staff members were able to accept and examine Mental Health Act paperwork on the admission of detained patients. We witnessed a staff member accept and scrutinise Mental Health Act documentation for a newly admitted patient.
- The trust had a centralised Mental Health Act office with administrators. Staff knew who to contact for advice should they need it.
- We saw within patient records that staff kept records in relation to detained patients having leave. There were clear parameters of the leave, including whether or not it was escorted and for what period.
- Staff received training in the Mental Health Act. Staff training figures across the three wards were Rowan 1 Ward 88%, Rowan 2 Ward 85%, and Lucy Wade Ward 81%. Staff we spoke with understood their responsibilities in relation to the Mental Health Act.
- Medication cards we checked had the appropriate consent to treatment forms attached to them, if needed. This meant that staff knew they were legally administering medication to detained patients.
- We saw evidence within the records we reviewed that patients detained under the Mental Health Act had their rights explained to them on admission. We saw that periodically staff re-read patients their rights, this was documented. Six patients told us staff had explained their rights to them. Rowan 1 Ward carried out audits of staff reading patients their rights to ensure it was consistently happening.

- Each month as part of the records audits completed the wards reviewed the Mental Health Act paperwork they held for patients to ensure it was present and up to date.
- An advocacy service was available to patients detained under the Mental Health Act. We saw posters and leaflets displayed advising of this. However, the advocate did not visit the wards at a regular time and staff made referrals to the service. Staff knew how to make referrals but only three patients we spoke with were aware of advocacy, and only one patient had accessed advocacy. The reliance on staff making referrals for advocacy could have disadvantaged patients.

## Good practice in applying the Mental Capacity Act

- The trust had a policy on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the policy and knew they could access it via the intranet. If unsure staff would seek advice from the central trust team.
- Staff received training in the Mental Capacity Act. Staff figures trained in MCA were Rowan 1 Ward 83%, Rowan 2 Ward 85%, and Lucy Wade Ward 81%. Staff we spoke with understood that capacity was decision specific and had an awareness of the underlying principles.
- In the previous six months, the wards had made two applications under Deprivation of Liberty Safeguards, one on Lucy Wade Ward, and one on Rowan 2 Ward.
- Staff routinely assessed patient capacity as part of the admission process. During the ward round we attended we witnessed staff discussing a patient's capacity to consent to treatment. Staff used a checklist in relation to capacity within ward rounds if the staff team had reason to doubt a patient's capacity.
- Staff spoke about sometimes delaying making decisions if a patient's capacity was impaired due to their mental ill health and if the decision could wait until the patient regained capacity.
- Two wards had patients where the multidisciplinary team were considering making Deprivation of Liberty Safeguard applications to protect the individual patients.

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- Rowan 1 Ward had received a recent Mental Health Act Review report, which highlighted that although the

multidisciplinary team had discussions regarding patient capacity staff did not accurately record this. The team were working to address this and to complete a plan of how staff could demonstrate this in the future.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- During the inspection we observed, warm, caring, and considerate staff interactions with patients. We noted staff to be polite, listen, and be respectful.
- We spoke with nine patients and received three comment cards, which said staff were kind towards them. The majority felt that staff were genuinely interested in their well-being. Three patients although generally positive said that not all staff members were interested in them.
- Four patients told us they felt safe. Other patients felt unsafe if the ward was unsettled or if unwell patients were present. One patient told us having CCTV in communal areas would make them feel safer. Five patients were concerned that their belongings were not safe due to other patients wandering into their bedrooms. We raised this with the trust following the inspection.
- We witnessed during handovers and during a multidisciplinary review that staff were familiar with the individual needs of patients. Staff spoke about patients in a respectful and positive manner.
- Recent monitoring of infection, cleanliness, and environment audits completed during September and August scored 100% for each ward in relation to Privacy and Dignity, Outside Spaces and Documentation. The last patient led assessments of the care environment (PLACE) completed April 2016 overall were positive for patient privacy, dignity and wellbeing.
- The wards had processes in place to orientate patients to the ward on admission. Staff could explain to us how they would physically show new patients around and how they would ensure they provided basic information, such as mealtimes. The wards had a welcome leaflet that re-enforced the information that staff gave to patients. Five patients recalled staff showing them around the ward.
- We observed at a multidisciplinary patient review that staff listened to the patient and allowed them time to express themselves. Patients we spoke with varied in whether they felt involved in their care. Some patients felt very involved, whilst others felt that they had not been involved in decisions regarding their care. Four patients recalled staff offering copies of their care plans, one patient confirmed having their own copy of their care plan.
- A local advocacy service was available to patients. Recently the service offered had changed to meet the needs of informal patients as well as patients detained under the Mental Health Act. The advocacy service did not visit the wards routinely. The ward staff or the patient referred himself or herself to advocacy, the service then attended the ward.
- Each of the wards held community meeting on a weekly basis. Five of the patients we spoke with had attended community meetings and felt they were positive and an opportunity to give feedback on the service. Two patients said that staff gave feedback to issues raised in the following meeting. We saw wards had 'you said, we did' boards present displaying actions that staff had taken in response to patient feedback.
- Two staff members we spoke with who were new in post confirmed that a patient had been part of their interview panel demonstrating that the trust valued the involvement of patients.

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



# Are services responsive to people's needs?

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

## Our findings

### Access and discharge

- Average bed occupancy across the three wards we visited was consistently in excess of 100% between April and September 2016. Lucy Wade Ward had average bed occupancy of 114%. Rowan 1 Ward had average bed occupancy of 123%. Rowan 2 Ward had average bed occupancy of 119%. The trust had over a six-week period up until the 23rd of October 2016, used health based place of safety facilities to admit 12 patients due to bed pressures. Health based place of safety beds are to assess individuals who the police have detained because they were concerned they were mentally unwell. Following assessment if deemed necessary trusts admit patients to a ward, these facilities are not admission beds. The trust was aware of these high bed occupancy figures and had introduced new initiatives to try to alleviate the pressure on the beds available. The trust had developed a centralised bed management team to oversee admissions and discharges. In early October 2016, a new facility was opened Beacon Lodge transitions unit. This unit was to improve the patients pathway by offering patients an alternative to acute inpatient stay when they are deemed no longer requiring acute stay but not ready for discharge to independent living. Eight staff we spoke with highlighted the pressure on acute beds. Two staff felt that the bed management team not the ward team made decisions regarding admission and discharge.
- Between the 3rd May until 11th November 2016, the trust admitted 59 into out of area placements due to local acute beds not being available. This figure was not for the three acute wards we visited but for the whole of the acute division. This equates to 1068 days that the trust admitted patients to acute beds out of their local area.
- Due to the high bed occupancy figures and the number of patients admitted to out of area placements beds were not always available to patients from the local area when they needed one.
- Patients and four staff told us that when patients went on leave they could not guarantee returning to the bed they left. Staff told us during inspection that two patients declined to go on leave for fear of losing their bed or being placed elsewhere on their return. Four staff members told us this was a concern.
- Seven patients had slept out on other wards due to the pressure on acute beds. This had been for 119 nights. Processes were in place where the bed management team reviewed patients prior to them being asked to move beds. This included consideration of physical need, risk, and acuity. Staff asked patients if they were willing to move. The bed management team reviewed patients sleeping out in other wards daily. Six of the seven patients moved to older peoples mental health wards.
- There were 23 recorded instances of delays to patient discharges across the three wards between May and October 2016. Rowan 1 Ward had the highest number of delayed discharges, 14 during this period. Staff told us delays did occasionally occur but this was usually whilst waiting for an appropriate placement or support package to be available. A weekly delayed transfer of care meeting took place attended by the modern matron, service manager, and ward representatives to review if there was any other action they could take.
- Between April and September 2016 there were 12 patients re-admitted to acute wards within 28 days of their discharges. This figure was highest for Rowan 2 Ward. Seven patients had been re-admitted within 28 days of being discharged.

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

- There was a range of rooms and facilities to support patients. All wards had well equipped clinic rooms. Activity rooms and lounges were available which had games and games equipment within them. Each ward had a designated quiet room, which patients could access.
- Visiting could take place in the quiet room, ward communal areas, ward gardens or in the visiting room located just off from the wards.
- Patients had access to a private phone to make phone calls. We witnessed a patient making a phone call during our visit.

# Are services responsive to people's needs?

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- Each ward had direct access to outside space. We saw that sports equipment was available to patients on Rowan 2 Ward outside. Access to outside space was restricted due to the patient mix and risks but staff facilitated access when requested.
  - Seven of the nine patients we spoke with said that the food was good and that there was a choice at mealtimes. Two patients said the food was not good and the choice was limited. Recent monitoring of infection, cleanliness, and environment audits rated food as 100% on Rowan 1 Ward and Lucy Wade Ward. Rowan 2 Ward rated food as good or 88%, this was because a bottle of sauce in the dining room was out of date. Patients had unrestricted access to both hot and cold drinks throughout the 24-hour period. Snacks were not readily available on the wards but staff would provide biscuits, make toast or reheat microwave meals if requested.
  - Patients were able to personalise their bedrooms. When we toured the wards, we saw that patients had personal belongings within their bedrooms.
  - Patients did not have keys to their bedrooms. Patients could lock bedrooms when they were in them or they could ask staff to lock them when they were on the main ward. Five patients on Rowan 1 and Rowan 2 Wards were concerned that their possessions were not safe. Patients told us that other patients went into their bedrooms and took things.
  - The trust employed activity co-ordinators on each ward to provide activities. There was a weekly timetable of activities displayed on all wards. Activities offered were a mix of structured groups such as anxiety management and social activities. Occupational therapy activities included gardening, relaxation and a recovery group. One staff member told us that occupational therapy services were stretched as they served several wards. Highbury live was another project which offered patients at Highbury Hospital access to further activities. When we visited Lucy Wade Ward, the activity worker and an occupational therapist were on annual leave for a week so the patients were in the main lounge either watching TV or sleeping. One staff member told us they were concerned that patients were bored. At weekends, staff facilitated games and social activities. Three staff members told us they had other priorities, which affected their ability to provide activities with patients.
  - Between May and October 2016 Rowan 2 Ward and Lucy Wade Ward had offered 100% of patients at least 25 hours activity per week. Rowan 1 Ward had figures between 50% and 100% of offering at least 25 hours of activity per week. The average for the six-month period was 68% of patients offered at least 25 hours of activities per week. The trust could not provide the activity levels that patients took up.
- ## Meeting the needs of all people who use the service
- The wards were accessible to people with disabilities including wheelchair users. Each ward had an assisted bathroom and bedroom, en-suites had wet room type shower facilities. Staff said that they could make reasonable adjustments to meet the needs of all patients.
  - We saw a range of information leaflets available including information on smoking cessation (the trust had recently become a no smoking trust), recovery, social events, and advocacy. All information displayed was in English but staff were confident they could get information translated into other languages. The trust computer system had the ability to translate information into other languages. Easy read information was available.
  - Staff were aware of how to access interpreters. During the inspection, we witnessed staff offer an interpreter to a patient although they could speak some English. Staff knew how to gain support for patients who used sign language.
  - Although the menu provided had limited choices staff could order special diets to meet patient cultural or spiritual needs.
  - The trust provided a pastoral service for all faiths. Staff had facilitated patients accessing external places of worship if the risks in facilitating this were manageable. Multi-faith rooms were accessible on the hospital sites.
- ## Listening to and learning from concerns and complaints
- The service had received six compliments. The service collected data from patients by asking them to complete a survey. Between January and November



# Are services responsive to people's needs?

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2016, they had received 28 survey responses for the wards inspected. They collected information under the 'what did we do well heading', 21 responses were positive in this area.

- In the previous 12 months up until the date of inspection, the three wards inspected had received 17 formal complaints. On investigation, no complaints were fully upheld, although 10 were in part upheld. Four complaints were not upheld, two were on going, and one was withdrawn. Ten of the complaints related to Lucy Wade Ward. Patients had referred none of the

complaints to the Ombudsman. Patients we spoke with knew how to complain and said they would feel confident to do so. They said they would go to the office to fill out a complaints form.

- The staff knew how to manage complaints. Staff tried to address and resolve complaints informally if possible. If patients remained dissatisfied, staff assisted them to complain and offered the opportunity to speak with ward managers. If patients escalated complaints beyond this staff directed patients to the patient advice and liaison services (PALS). Staff recorded complaints electronically, including informal complaints that were resolved. Staff received feedback from complaints either through handovers, e-mails or via team meetings.

# Are services well-led?

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

## Our findings

### Vision and values

- Staff were aware of the trust vision and values. Staff translated vision and values into the team's aims and values, which formed the basis of staff annual appraisals.
- Staff knew who the senior managers of the organisation were and confirmed that these individuals had visited the wards in recent months. Staff on all the wards we inspected confirmed modern matrons and divisional leads visited on a regular basis.

### Good governance

- Staff received mandatory training. Figures for completion were in excess of 85%. Staff received regular appraisals and supervision. There was on-going monitoring of staff appraisals and supervision. If figures dropped, managers put plans in place to address this.
- There were gaps in the number of staff required on shift against the number of staff on shift. The wards used regular bank staff and agency staff to try to manage this. The figures for the six months from May until October 2016 indicated that Rowan 1 Ward had a full complement of staff 89% of the time. Rowan 2 Ward had a full complement of staff 83% of the time and Lucy Wade Ward 90% of the time. The acute services directorate had an on-going rolling recruitment programme. The trust allowed each ward to recruit one member of staff above establishment numbers to try to ensure that sufficient staff remained available if other staff left. The trust had recruited a number of newly qualified preceptorship nurses. Eight of the 14 staff we spoke with raised low staffing numbers as an issue.
- Staff reported incidents. We saw evidence of the trust making changes to policies and practice following incidents. Each of the wards carried out community meetings. We saw boards that gave feedback on changes made, 'you said, we did' on the wards we inspected.
- The ward staff received training and had a good understanding of their responsibilities in relation to

safeguarding patients. Staff received training in the Mental Health Act and Mental Capacity Act helping them to protect the patients and their rights. Staff knew how to follow the processes to protect patients and did this.

- Ward managers completed weekly returns on the performance of their wards. They had easy access to this information. We saw within team meeting minutes we reviewed that senior staff shared this information with team members to inform and improve practice. Ward managers felt they had sufficient authority to manage the wards. They felt more senior were available to support them if needed.
- Audits took place at ward level. Adult mental health governance meetings took place, which reviewed, and monitored results, which ward managers, attended. Matrons and service managers worked with ward managers to identify necessary actions and monitor progress. The daily demand management meeting also had an overview of staffing levels and patient observations.
- Ward managers were able to submit items to the divisional directorate risk register. Divisional leads presented items to the trust executive team for consideration of inclusion on the Trust risk register.

### Leadership, morale and staff engagement

- Sickness and absence rates were above the trust target of 4% on all of the wards we inspected. The service manager reviewed sickness and absence rates within the one to ones of the ward managers. The trust implemented health and wellbeing plans to try to support staff back into work or to remain at work. The human resources department supported this process.
- Staff we spoke with said they would raise concerns they had without the fear of recriminations. Staff knew about the whistleblowing policy but said they would be confident to raise concerns locally, at ward level.
- Staff were happy in their roles, felt supported by their teams, and ward managers. Staff had an appreciation of other team member's skills and expertise. Several staff identified team working as one of the best things about their jobs.
- Staff were able to access development opportunities. Staff told us about taking on additional roles and receiving training to develop. The trust provided

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preceptorship nurses with a development pack to work through over a six to 12 month period. They had six days identified for learning sets during this time. One preceptorship nurse we spoke with had recently attended a day on communication.

- Staff explained to patients if things went wrong. All staff told us they would apologise to patients and help them to complain if they wanted to. Staff knew how to support patients to complain.
- There were team meetings so staff had an opportunity to give feedback on their services. Qualified nursing staff felt that they could influence service development. Health care staff were less confident that senior staff would fully listen to their ideas.

## **Commitment to quality improvement and innovation**

- The service took part in Prescribing Observatory for Mental Health (POMH-UK) audits. The most recent audits completed were in relation to the use of rapid tranquilisation and the use of lithium, a medication prescribed as a mood stabiliser. Results of these most recent audits were at the time of inspection not yet available to the trust.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**The provider must ensure that ligature risk assessments are fully completed and that consideration is given to actions that could mitigate the risks further.**

**The provider must continue to monitor and review bed usage and to take steps to improve the experience of patients.**

Regulation 17(2) (a)