Requires improvement

Leicestershire Partnership NHS Trust

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

Quality Report

Trust Headquarters
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester
LE19 1SX
Tel:Tel: 0116 295 0816
Website: www.leicspt.nhs.uk

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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)
RT5KF	The Bradgate Mental Health Unit	Aston ward Ashby ward Beaumont ward Bosworth ward Heather ward Thornton ward Watermead ward	LE3 9EJ
RT5KF	The Bradgate Mental Health Unit	Belvoir ward (PICU)	LE3 9EJ

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement
Are services safe?	**Inadequate**
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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Summary of findings

Overall summary

Overall we rated this core service as 'requires improvement' because:

- Whilst staff were working hard to identify and manage individual risks, some ward environments were unacceptable. Improvements were needed to make them safer, including reducing ligatures, improving lines of sight and ensuring the safety and dignity of patients.
- Some wards did not meet the Department of Health and Mental Health Act Code of Practice requirements in relation to the arrangements for mixed sex accommodation.
- The acute wards for adults of working age had not complied with all of the required actions following the previous inspection of September 2013.

However:

- We found that staff across the service were committed to providing good quality care to the patients and showed care and compassion. We found positive multidisciplinary work and observed staff were supporting patients.

Summary of findings

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

Are services safe?

Inadequate

We rated this domain as 'inadequate' because:

- We found numerous ligature risks within most of the ward environments which were not effectively managed.
- Some wards had a layout which did not allow staff to observe all areas with a clear line of sight.
- There were concerns about privacy and dignity and arrangements for mixed sex accommodation.
- There was poor attendance at some mandatory training, for example the life support courses.
- Safer staffing levels, as defined by the trust, were not being met. There was an over-reliance on bank staff.

However:

- There were clear systems in place for reporting incidents and learning from incidents had taken place within the acute service.

Are services effective?

Requires improvement

We rated this domain as 'requires improvement' because:

- Patient care plans were of a variable quality across the wards**.**
- There was an absence of dedicated psychological input which meant guidance from the National Institute for Health and Care Excellence (NICE) was not being met.
- Not all staff had up to date formal supervision or a personal development plan/appraisal.
- There were discrepancies in some aspects of the administration of the Mental Health Act**.**
- Mental capacity was not always assessed on admission or on an ongoing basis.

However:

- There was good evidence of multi-disciplinary team working, enabling staff to share information about patients and review their progress.

Are services caring?

Good

We rated this domain as 'good' because:

- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner on all of the wards.

Summary of findings

- Patients we spoke with were mainly positive about the staff, and felt they made a beneficial impact on their experience on the wards.

Are services responsive to people's needs?

Requires improvement

We rated this domain as 'requires improvement' because:

- Patients were unable to access beds in their local acute wards in a timely manner due to shortages of beds.
- Not all ward environments optimised patients' privacy and dignity.
- The arrangements, on many of the wards, for single sex accommodation did not meet the guidance set by the Department of Health or within the Mental Health Act Code of Practice.
- We were concerned that some practices may be restrictive, for example, times at which patients can access the garden.

However:

- We saw that spiritual care and chaplaincy was provided when requested.
- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs.

Are services well-led?

Requires improvement

We rated this domain as 'requires improvement' because:;-

- We were concerned about governance systems relating, particularly, to the maintenance of the wards, and to the administration of the Mental Health Act.
- There was a lack of strategic direction on the wards.
- The acute wards for adults of working age had not complied with all required actions following the previous inspection of September 2013.

However:

- Staff consistently demonstrated good morale.
- There was highly visible, approachable and supportive leadership.

Summary of findings

Information about the service

The acute wards for adults of working age are based on one hospital site in Glenfield, Leicestershire. All acute wards provide inpatient mental health assessment and admission services for adults aged 18 and over.

The trust also provides a psychiatric intensive care unit (PICU) for adults aged 18 and over. This is also based in Glenfield, Leicestershire.

Leicestershire Partnership NHS Trust has been inspected 26 times since registration in April 2010. Of these, six inspections looked at the acute wards for adults of working age and psychiatric intensive care unit.

At the time of our inspection, there were five of compliance actions in place, from September 2013, at the Bradgate Mental Health Unit. These were in relation to:

- Care and welfare of people who use services.
- Co-operating with other providers.
- Management of medicines.
- Staffing.
- Assessing and monitoring the quality of service provision.

During this inspection we reviewed all of these areas of previous non-compliance.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

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 visiting, we reviewed a range of information we hold about Leicestershire Partnership NHS Trust and asked other organisations to share what they knew. We carried out an announced visit from 10 to 12 March 2015. An unannounced inspection was also carried out throughout the night commencing 23 March 2015.

During the inspection visit, the inspection team:

Summary of findings

- Visited all wards (eight) and looked at the quality of the ward environment and observed how staff were caring for patients.
- Visited the involvement centre and occupational therapy department.
- Spoke with 47 patients who were using the service.
- Spoke with the matrons or acting matrons for each of the wards.
- Spoke with 37 other staff members, including doctors, nurses and occupational therapists.
- Spoke with the head of psychology.
- Interviewed the inpatient team manager, inpatient lead nurse and two senior matrons with responsibility for these services.
- Interviewed the clinical audit lead for the Bradgate Mental Health Unit.
- Attended and observed seven hand-over meetings and one multi-disciplinary meeting.

We also:

- Collected feedback from two patients using comment cards.
- Looked at the medication charts of 58 patients.
- Carried out a specific check of the medication management on five wards.
- Looked at the care records of 46 patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients we spoke with were mostly positive about the staff, and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care.

Patients were admitted to hospital when required, but there could be delays in finding a suitable bed within their home catchment area because of the ongoing demand.

There was information about the trust available for people who used the service. People could access the advocacy and the Patient Advocacy and Liaison Service (PALS) to get information and give feedback about the trust's services.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight.
- The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation.
- The trust must ensure there are sufficient, experienced, staff on duty at all times to provide care to meet patients' needs.
- The trust must ensure appropriate arrangements are in place for the safe keeping of medicines.
- The trust must review the use of current sharps (for example, needles) in light of Health and Safety Executive regulations.
- The trust must review the provision of staffing in the multidisciplinary teams, specifically in relation to psychological input.
- The trust must adhere to the requirements of the Mental Health Act and Mental Health Act Code of Practice.
- The trust must carry out assessments of each patient's capacity and record these in the care records.
- The trust must review governance systems relating to the buildings management and maintenance.
- The trust must review governance systems relating to the monitoring of the administration of, and adherence with, the Mental Health Act.

Action the provider SHOULD take to improve

- The trust should ensure that all staff, providing direct patient care, receive training in basic or intermediate life support.
- The trust should formally review any restraint involving the prone position.

Summary of findings

- The trust should review the meaningful activities programme for patients.
- The trust should review any practices which could be considered restrictive, for example, times at which patients can access the garden.
- The trust should ensure that patients who are detained under the Mental Health Act have information on how to contact the CQC.

Leicestershire Partnership NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Aston ward Ashby ward Beaumont ward Bosworth ward Heather ward Thornton ward Watermead ward	The Bradgate Mental Health Unit
Belvoir ward (PICU)	The Bradgate Mental Health Unit

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.

Systems in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice were variable.

We found a number of issues where compliance with the MHA and MHA Code of Practice were poor. These included issues relating consent to treatment, informing patients detained under the MHA of their legal rights, and patients not being given a copy of their section 17 leave forms.

The standard of the administration of the MHA across the wards was variable. On some wards, it appeared that all

detained patients, whose care records we reviewed, were being appropriately detained and treated under the MHA. However, on Ashby ward, Heather ward and Watermead ward, we had concerns about this.

Staff could not recall when they had last received training in the MHA. Some staff had a better knowledge of the Act than others. The trust did not offer specific training in the MHA.

There was not a clear process for scrutinising and checking the receipt of MHA documentation. We found overall that the MHA record keeping and scrutiny was poor.

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw that 87% of staff members working within this core service had received training in the Mental Capacity Act 2005 (MCA). This was as part of the annual training programme. When we spoke with staff they demonstrated varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).

None of the patients receiving care and treatment during our inspection were under a DOLS.

Records we sampled showed that patients' mental capacity to consent to their care and treatment was not always assessed on their admission or an ongoing basis.

Inadequate

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 this domain as 'inadequate' because:

- We found numerous ligature risks within most of the ward environments which were not effectively managed.
- Some wards had a layout which did not allow staff to observe all areas with a clear line of sight.
- There were concerns about privacy and dignity and arrangements for mixed sex accommodation.
- There was poor attendance at some mandatory training, for example the life support courses.
- Safer staffing levels, as defined by the trust, were not being met. There was an over-reliance on bank staff.

However:

- There were clear systems in place for reporting incidents and learning from incidents that had taken place within the trust.

Our findings

Acute wards

Safe and clean ward environment

- Each ward had undertaken, and updated when necessary, ligature risk assessments. Control measures in place, to minimise the risk to patients, included patient risk assessments and use of observations, increased staff supervision of environmental areas and locking of relevant room when not in use. However, an unacceptable number of ligature risks remained on some of the wards. Ward matrons were unaware of when work would be undertaken to remove these risks. Staff were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed. Each ward had ligature cutters available and accessible in the event of an emergency occurring.
- On Ashby ward we saw a number of ligature risks in the bath/shower rooms and bedrooms. We found numerous blind spots throughout the ward, making observation of patients difficult for staff.
- On Aston ward we saw a number of ligature risks in the lounge, bath/shower rooms and bedrooms. We found numerous blind spots throughout the ward, making observation of patients difficult for staff.
- On Beaumont ward we were able to access an electrical cupboard, the contents of which presented a ligature risk to patients and electrical shock. We drew this to the immediate attention of the ward matron, who took swift and appropriate action. We saw further ligature risks in the bedrooms and in the communal areas.
- On Bosworth ward we saw a number of ligature risks in the bathrooms, bedrooms and corridors.
- On Heather ward we saw ligature risks in the bedrooms.
- On Thornton ward we saw a number of ligature risks in the bath/shower rooms, bedrooms, and corridors. We drew our concerns about the risks, particularly a specific risk in a corridor, to the inpatient lead nurse at the time of our inspection. We found numerous blind spots throughout the ward, making observation of patients difficult for staff.
- On Watermead ward we saw ligature risks in the bedrooms.
- We found that Ashby ward, Aston ward and Bosworth ward did not meet the Department of Health's guidance on eliminating mixed sex accommodation. This compromised the safety, privacy and dignity of patients using these wards.
- Ashby ward did not have availability of same-sex day space particularly for female patients. Additionally, due to one shower being out of order, the remaining bath and shower rooms were used by both male and female patients.
- On Aston ward, we saw that a day space particularly for female patients was available. However, we observed that the toilet/shower room used by male patients was located in the corridor used by female patients.
- On Bosworth ward, the bath and showers were used by both male and female patients.
- Beaumont ward, Heather ward, Thornton ward and Watermead ward were compliant with the Department of Health's guidance on eliminating mixed sex

Inadequate

Are services safe?

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

accommodation. Heather ward accommodated female patients only whereas Thornton ward accommodated male patients only. Beaumont ward and Watermead ward provided mixed sex accommodation however had suitable arrangements in place to meet the guidance.

- Most wards had accommodation consisting of dormitory sleeping areas, with a few single rooms. We found a two bed dormitory on Thornton ward appeared cramped for two patients to use. There was little space between the beds.
- On three of wards, we found bath/shower rooms out of order and awaiting repair. We were told that they had been reported and repairs were awaited.
- We saw that patients had lockers to place valuables in. However, patients did not have a key to their lockers, so had to approach a member of staff. This was for all patients and not based on risk.
- Practices were in place to ensure infection control and staff had access to protective personal equipment such as gloves and aprons. All of the wards were generally clean and tidy and we were told by staff the cleaning services were generally good. However, we observed on Watermead ward that the seclusion room wall had been defaced with excrement. Whilst this had been cleaned, we could still see evidence of the stain on the wall.
- On Bosworth ward, we found possible mould spores starting to grow around one shower unit on the wall. In another shower room, we saw the flooring was lifting, due to water damage. This could present a trip hazard.
- On Thornton ward we saw one shower room, which was still in use, with damaged skirting board, flooring and ceiling. On the unannounced inspection, we observed that refurbishment of this room had commenced.
- On Ashby ward, we observed a burn mark on the flooring of the seclusion room. A bathroom on Ashby ward, Bosworth ward and Thornton ward was out of order. These had been reported to the independent contractor responsible for the maintenance contract and a response was awaited.
- Overall, we found the environments of, particularly, Aston ward, Bosworth ward and Thornton ward to be in need of refurbishment. This was due to the wards being in a poor state of repair, appearing dated and not appearing to offer an environment conducive for mental health recovery.
- An electronic prescribing and medication administration record system for patients was in operation and facilitated the safe administration of medicines. A pharmacist reviewed the prescription charts each weekday. This review was conducted remotely from the pharmacy department. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the system to help guide staff in the safe administration of medicines.
- Medicines were stored securely. However, on Bosworth ward we found a patient's emollient medication in a communal shower room. Records showed that fridge temperatures were recorded daily. However, during our unannounced inspection, we found on Ashby ward and Heather ward that the fridge temperatures were higher than the required range. We immediately drew this to the attention of the nurse in charge, due to the effect such a high temperature could have on the medicines stored in the fridge. On Bosworth ward, the medicines fridge was out of order, however arrangements were in place for the medications to be stored in a fridge on another ward. On the remaining wards, we observed the fridge temperatures to be within the acceptable range.
- We looked at the prescription and medicine administration records for 56 patients. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were receiving their medicines when they needed them. If patients were allergic to any medicines this was recorded on their electronic prescribing and medication administration record.
- Staff had access to up to date information about medications through the electronic BNF (the British National Formulary, a book providing comprehensive information about all medications).
- We found that staff did not have access to safer sharps, as defined in recent guidance from the Health and Safety Executive. For example, a range of syringes and needles are available with a shield or cover that slides or pivots to cover the needle after use, however we saw no evidence of these during our inspection.
- All the wards had resuscitation trolleys that were clean and checked on a daily basis. However, none of the trolleys were sealed and so could be tampered with. On Heather ward, we found that one item was missing from

the emergency drug box. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.

- We saw the gardens leading from each ward. They provided a spacious area for patients to be able to access fresh air. However, we noted that they were littered with cigarette ends, appeared generally unmaintained and garden furniture was limited. There was no shelter available for patients to use whilst, for example, smoking outside during inclement weather. The access to the gardens was locked at midnight, though patients could request to go for a cigarette after this time, but were accompanied by a member of staff.

Safe staffing

- The staff we spoke with told us that there was a heavy reliance on the use of bank and, sometimes, agency staff. One member of staff told us that they often worked a night shift as the only permanent member of staff on the ward. Another member of staff told us they sometimes were asked to move to another ward at night, to take charge without being given sufficient information to support patients. This presented a risk as the member of staff taking charge of the ward was not aware, other than at a superficial level, of the patients' individual care needs and risks.
- Most patients told us that there were not always enough staff on duty and they did not always receive one-to-one time with their nurse because of this.
- We were told by a senior manager, and information requested from the trust by the CQC prior to the inspection stated, that the safe staffing nursing levels for each ward was three qualified with two unqualified members of staff per shift (early and late shifts), and two qualified with one unqualified members of staff per night shift. The senior manager was unclear how these safe staffing nursing levels had been calculated. During our unannounced night inspection, whilst we saw the correct numbers of staff were working on each ward, the skill mix was not meeting safe staffing levels on Ashby ward, Beaumont ward and Thornton ward because only one qualified member of staff was on duty on these wards, with unqualified members of staff. This meant that the qualified member of staff worked the entire night shift with no break.
- We observed a total of 16 permanent staff on duty across the seven wards and the supernumerary night co-ordinator. A total of 17 bank staff were on duty, of which five staff were covering due to a shortage of staff, whilst 12 staff were covering due to the increased needs of the patients. We found each ward had at least one qualified and one unqualified permanent member of staff on duty.
- When we checked each wards duty rota for the week commencing 23 March 2015, we found that the safe staffing levels were not being met as there was generally not three qualified members of staff on duty for each day shift. We saw that a combination of permanent and bank staff were covering the day shifts to ensure that the correct number of staff were on duty. However, we were concerned to note at the time of our inspection that Ashby ward, Beaumont ward, and Watermead ward that staffing rotas detailed wards would be short staffed during the latter part of the week, though we were assured by the nurse in charge that efforts were being made to cover the relevant shifts.
- We were informed by various members of staff and ward matrons that the staffing difficulties arose from a combination of staff sickness, along with staff recruitment and retention. From the information we saw, the staff sickness average was 9% for February 2015.
- Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments. We were told that recruitment to vacant positions was ongoing and a number of newly qualified nurses had recently been appointed.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff told us that where particular risks were identified, such as a risk to self or to others, measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. The individualised risk assessments we reviewed had taken into account the patient's previous history as well as their current mental state, and were detailed.
- Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, CPA meetings or after an incident.

Inadequate

Are services safe?

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

- The majority of staff (88%), working within this core service, had completed safeguarding vulnerable adults training and 87% of staff had safeguarding vulnerable children training.
- Staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns. Potential safeguarding concerns were discussed at the team meeting and we saw posters giving contact details of the trust's safeguarding lead.
- The trust provided information stating there had been 89 incidents of the use of seclusion within the last six months. Ashby ward, Aston ward, Bosworth ward and Watermead ward had seclusion facilities. The other wards did not.
- We observed that part of the flooring had been burned in the seclusion room on Ashby ward and were informed of an incident that had taken place in the room. We were concerned that the full staff response to this incident may not have been as swift as it could have been.
- The seclusion rooms did not have intercoms, therefore patients being nursed within the seclusion room needed to communicate with staff through a thick wooden door, and visa-versa. A toilet was available within the seclusion area of the ward.
- We found that 78% of the staff working within this core service had received training in MAPA (management of aggression or potential aggression).

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to describe the electronic system to report incidents and their role in the reporting process. We saw each ward had access to an online electronic system to report and record incidents and near misses.
- Staff were able to describe the various examples of serious incidents which had occurred within the services. The trust told us that there was a local governance process in place to review incidents.
- Discussions had occurred locally at monthly team meetings about trust-wide incidents. There were weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients, and how these risks should be managed.
- Each of the ward matrons we spoke with told us how they provided feedback in relation to learning from incidents to their teams. Staff showed us emails from ward matrons which provided the serious incident report, along with any learning points.
- The trust provided information stating there had been 129 incidents of use of restraint within the last six months. Of these, 20 patients (representing 15.5% of incidents) were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Each incident of restraint was recorded using the trust's incident reporting system.

Psychiatric intensive care unit

Safe and clean ward environment

- We saw the ward had undertaken, and updated when necessary, ligature risk assessments.
- We saw that control measures in place, to minimise the risk to patients included patient risk assessments and observations, increased staff supervision of environmental areas and locking the relevant room when not in use.
- This included locking bathrooms to reduce the risks which impacted on patients' privacy when they wanted to use the bathroom.
- Staff we spoke with were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed.
- We were informed that significant ligature risks had been identified on the ward for at least the past two years, however only recently had builders began work on minimising the number of ligature risks on the ward.
- The ward had ligature cutters available and accessible in the event of an emergency occurring.
- We found that Belvoir ward did not meet the Department of Health's guidance on eliminating mixed sex accommodation. This compromised the safety, privacy and dignity of patients using this ward.

Inadequate

Are services safe?

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

We saw a female only sitting area, however this was being used by a male patient during our inspection. Female patients had to pass through male areas of the ward to access the female only area.

- Practices were in place to ensure infection control and staff had access to protective personal equipment such as gloves and aprons. The ward was generally clean and tidy and we were told by staff the cleaning services were generally good. However, we observed paint flaking off the wall in the seclusion room shower and other areas of the ward where painting was required to be finished off (for example, where a cupboard had been removed).
- An electronic prescribing and medication administration record system for patients was in operation and facilitated the safe administration of medicines. A pharmacist reviewed the prescription charts each weekday. This review was conducted remotely from the pharmacy department. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the system to help guide staff in the safe administration of medicines.
- Medicines were stored securely. Fridge temperatures were recorded daily. We found the fridge temperature was above the acceptable range for six of the last ten entries with no action taken. However, during our unannounced inspection, we saw the fridge temperature was within the acceptable range.
- We looked at the prescription and medicine administration records for two patients. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them. If patients were allergic to any medicines this was recorded on their electronic prescribing and medication administration record. Patients, who were detained under the Mental Health Act (MHA) received medicines that were duly authorise and administered in line with the MHA Code of Practice.
- Staff had access to up to date information about medications through the electronic BNF (the British National Formulary, a book providing comprehensive information about all medications).
- We found that staff did not have access to safer sharps, as defined in recent regulations from the Health and Safety Executive. For example, a range of syringes and needles are available with a shield or cover that slides or pivots to cover the needle after use, however we saw no evidence of these during our inspection.
- The ward had a resuscitation trolley which was clean and checked on a daily basis. However, the trolley was not sealed and so could be tampered with. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.
- We saw the garden leading from the ward. It provided a spacious area for patients to be able to access fresh air. The garden was tidy and well maintained. However, we noted that there was no shelter available for patients to use whilst, for example, smoking outside during inclement weather. The access to the gardens was locked, though patients could request to go into the garden, but were accompanied by a member of staff.

Safe staffing

- The staff we spoke with told us that there was not an over-reliance on the use of bank to cover the safe staffing levels of two qualified with three unqualified members of staff per day shift (early and late shifts), and one qualified with three unqualified members of staff per night shift. When we spoke with a senior manager they were unclear how these safe staffing nursing levels had been calculated. The ward matron explained that they were able to increase the staffing levels to meet the clinical needs of the patients. The staff duty rotas confirmed this.
- On our unannounced night inspection, we saw the correct numbers of staff were working on Belvoir ward. We found one qualified member of staff and three unqualified members of staff were all permanent members of staff. Additionally, two unqualified bank members of staff were working to provide care for patients with higher levels of clinical needs and observation. However, because only one qualified member of staff was on duty, this meant they worked the entire night shift with no break.
- From the information we saw, the staff sickness average was 0% for February 2015. Processes were in available to manage staff sickness, which included the involvement of the human resources and occupational health departments.

Assessing and managing risk to patients and staff

Inadequate

Are services safe?

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

- Patients had individualised risk assessments. Staff told us where particular risks were identified, such as a risk to self or to others, measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. The individualised risk assessments we reviewed had taken into account the patient's previous history as well as their current mental state, and were detailed.
- Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, CPA meetings or after an incident.
- The majority of staff (88%), working within this core service, had completed safeguarding vulnerable adults training and 87% of staff had safeguarding vulnerable children training.
- Staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns. Potential safeguarding concerns were discussed at the team meeting and we saw posters giving contact details of the trust's safeguarding lead.
- The trust provided information stating there had been 45 incidents of the use of seclusion within the last six months on Belvoir ward.
- The trust provided information stating there had been 47 incidents of use of restraint within the last six months. Of these, 8 patients (representing 17% of incidents) were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible.
- Each incident of restraint was recorded using the trust's incident reporting system. We saw that 78% of the staff, working within this core service, had received training in MAPA (management of aggression or potential aggression).
- In relation to this core service, we noted that only 65% of staff had received training in intermediate life support and 76% of staff in basic life support. This meant that some staff were not up to date with life support training, thus increasing the risk to the safety of patients.

Track record on safety

- The trust provided information stating there had been 47 incidents of use of restraint within the last six months. Of these, 8 patients (representing 17% of incidents) were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to describe the electronic system to report incidents and their role in the reporting process. The ward had access to an online electronic system to report and record incidents and near misses.
- Staff were able to describe the various examples of serious incidents which had occurred within the services. The trust told us that there was a local governance process in place to review incidents.
- Discussions had occurred locally at monthly team meetings about trust-wide incidents. There were weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients, and how these risks should be managed.
- The ward matron we spoke with told us how they provided feedback in relation to learning from incidents to their team. Staff confirmed that they received emails from their ward matron which provided the serious incident report, along with any learning points.

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 this domain as 'requires improvement' because:

- Patient care plans were of a variable quality across the wards.
- There was an absence of dedicated psychological input which meant guidance from the National Institute for Health and Care Excellence (NICE) was not being met.
- All staff did not have up to date formal supervision or a personal development plan/appraisal.
- There were discrepancies in the some aspects of the administration of the Mental Health Act.
- Mental capacity was not always assessed on admission or on an ongoing basis.

However:

- There was good evidence of multi-disciplinary team working, enabling staff to share information about patients and review their progress

Our findings

Acute wards

Assessment of needs and planning of care

- The crisis team acted as the gatekeeper for admissions to the inpatient wards. On most occasions detailed assessments were carried out for each patient and care plans were developed from this initial assessment.
- Patients' needs were assessed and care and treatment was planned to meet identified needs. We looked at over 40 care records for patients receiving care and treatment in the acute wards and saw that these usually contained up to date care plans that gave information to staff about how best to care for the person. However, the quality of care plans differed on Aston ward, Bosworth ward, Thornton ward and Watermead ward. We found some care plans to be detailed, individualised to the patients' needs and showing the patients' involvement in the care planning process, whereas other care plans did not have this level of expected detail.
- An electronic record system had been recently introduced across the trust. Information, contained within this system, could be shared between the wards, home treatment teams and other community teams. However some paper records still existed. We were informed that staff working within social services (for example, approved mental health practitioners) could not access the electronic system. Such staff had to rely on paper-based information.
- Patients' physical health needs were identified. Patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were met. Physical health examinations and assessments were usually documented by medical staff following the patient's admission to the ward. Ongoing monitoring of physical health problems was usually taking place. All records we sampled included a care plan that showed staff how to meet patients' physical needs.
- A senior manager informed us that a physical healthcare nurse had been appointed to the Bradgate Mental Health Unit since our inspection of September 2013. However, this nurse had recently retired. Recruitment had taken place and a successful candidate was due to commence employment into this role imminently. The senior manager was hoping to be able to create a second physical healthcare nurse position and had produced a business case to support this proposal.

Best practice in treatment and care

- We saw multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the care plan was achieving the desired outcome for patients.
- On all wards, we were consistently told by staff (doctors and nurses) that there was an absence of psychology input. We were told that referrals for psychology input were made to the community mental health teams, and the patient would be placed on a waiting list. There was not a clinical psychologist within the adult mental health's divisional management team. We saw little evidence of care being provided in line with relevant NICE (National Institute for Health and Care Excellence) guidance, particularly relating to the absence of psychology.
- Outcomes for patients using the services were monitored and audited by the service. This included the

Are services effective?

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monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation. We received mixed feedback from the patients we spoke with about the quality of the care and treatment they had received. Overall, the feedback was positive. However, some patients we spoke with commented about the lack of one to one time with their nurse and lack of activities within the wards.

- Some wards we inspected had a range of on-the-ward activities. For example, on Thornton ward we saw a selection of activities offered during the day of our inspection: window board painting, "get up and go", board games and pool, and relaxation. We observed the window board painting activity and saw a calm and happy atmosphere, with patients engaging in and enjoying the activity. However, on Bosworth ward, we saw only one on-the-ward activity offered, "get up and go" for the day. We were told, and saw, a range of games available, though the football table was broken. Patients told us that they felt there were a lack of activities available on the wards and activities were sometimes cancelled due to a shortage of staff.
- A separate occupational therapy department was located within the premises, which operated seven days a week, between 8.30am to 8.45pm. We were informed that priority screening takes place for patients receiving care and treatment on the acute wards. This involved assessing patients' needs and capacity to engage with a structured occupational therapy programme. On admission, patients could partake in ward based groups where offered**.** Once the patients' observation level changed, they could attend the occupational therapy department. A number of individual and group activities were offered, including activities of daily living, art, photography and walking.
- There is also an involvement centre located within the premises which provided an information, information technology and social resource for patients, their carers, family, friends and staff, which is open Monday to Friday 10am to 4pm (except bank holidays). We saw six laptops with internet access, plus a large range of leaflets covering a variety of informative topics, such as medications, advocacy, complaints and infection control. Patients could attend the involvement centre following a period of assessment on the wards. We observed a friendly, relaxed atmosphere, with friendly supportive staff.

Skilled staff to deliver care

- The majority of permanent staff had been trained in de-escalation techniques and the use of physical interventions. We saw that 78% of staff, working within this core service, had received training in MAPA (management of aggression or potential aggression). We were informed that bank staff received mandatory training, which included MAPA training.
- We found that there was a variety of mandatory training available for staff. This included courses in, for example, information governance, basic and intermediate life support, safeguarding vulnerable adults and children, mental capacity act, record keeping and medicines management. We noted that there was no specific training in relation to the Mental Health Act. However, we saw that 87% of staff had attended training in the Mental Capacity Act.
- A senior manager explained to us that a new electronic learning system had recently been introduced. The senior manager rigorously monitored the system and provided monthly feedback to the ward matron about the progress relating to training.
- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone. A number of newly qualified nurses told us of a well-structured and in-depth preceptorship programme. Preceptorship is a period of time in which to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.
- We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. This was signed off by the nurse in charge of the shift. We saw some examples of these completed forms.
- Staff had access to supervision. A senior manager explained to us that a new electronic learning system had recently been introduced. Information about supervision and appraisals was being introduced on this system.
- In relation to this core service, we saw 71% of staff had an up to date personal development plan in place at the time of our inspection. This compared to 83% in December 2014. The senior manager explained that the decrease may relate to recording on the new system.

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.

- We sampled supervision records on some wards and noted, overall, that supervisions occurred less frequency than the trust's standard of every three months. Both ward matrons and staff told us that informal supervision took place regularly, though this was not documented. Staff felt supported by their peers and immediate matrons.
- Staff described receiving support and debriefing from within their team following any serious incidents. Additionally, we were informed that a psychologist lead a debrief following a serious incident.
- Staff told us there were regular team meetings and staff felt well supported by their immediate matrons and colleagues on the wards. Staff also told us they enjoyed good team working as a positive aspect of their work on the wards.

Multi-disciplinary and inter-agency team work

- We observed some multi-disciplinary meetings during our inspection and found these effective in enabling staff to share information about patients and review their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- Occupational therapists and therapeutic support workers worked as part of each team and we saw that they worked closely with patients in forming their wellness and recovery action plans. The patients we talked with spoke positively about this.
- There was an absence of psychology input on the wards. We were told that referrals for psychology input were made to the community mental health teams, and the patient would be placed on a waiting list.
- The consultant and medical staff were a regular presence on the wards and were present at times during our inspection. We observed good interaction between the ward staff and medical teams on the wards.
- We saw how community teams were invited and attended discharge planning meetings, and patients we spoke with told us these were supportive.
- Throughout our inspection, we observed well-structured and detailed handovers from one day shift to another.

Adherence to the MHA and MHA Code of Practice

- We checked whether systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. We found examples of discrepancies in relation to this.
- On Ashby ward, when we reviewed medication charts, we found one T2 form (the certificate to consent to treatment, under section 58 of the Mental Health Act) contained an error. The form stated one oral antipsychotic medication, whereas the patient had been prescribed an oral antipsychotic and a prn (only as needed) antipsychotic medication. One patient we spoke with, who was informal, could not understand why they required an escort if they wanted to leave the ward. This told us that the patient had not been given, or understood, their rights as an informal patient.
- On Aston ward we found, in two of the three care records of detained patients, that there was no evidence of discussions about rights and an assessment of the patient's understanding of their rights (under section 132 of the Mental Health Act). In two care records, we could not locate a copy of the report from the approved mental health practitioner (AMHP).
- On Beaumont ward, we found two patients where treated under section 58 provisions however medication prescribed on their treatment charts was not listed on the T2/T3 forms.
- On Bosworth ward we found, in three of the four care records of detained patients, that there was evidence of discussions about rights and an assessment of the patient's understanding of their rights. However, one care record did not contain this information. We found no evidence that a copy of the section 17 leave form was given to patients, when such leave was approved.
- On Heather ward, staff told us that one patient had been admitted under a section of the Mental Health Act, however three months later the section was found, by the trust, to be unlawful. Once the error was realised, the patient was placed on a section again, however no T3 form (the certificate of second opinion, under section 58 of the Mental Health Act) had been completed, as this was being judged on the date of the second section. We could find no obvious records about the mistake and staff were unsure if the patient had been informed.
- On Watermead ward, we were concerned that one patient was potentially being unlawfully treated, due to their legal status. There was confusion, on the ward, about this as the patient had been recalled on a

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community treatment order. We drew this serious concern to the immediate attention of the responsible clinician and a senior manager. We were assured that swift action was being taken to review the situation.

- We saw posters were displayed informing patients of how to contact the independent mental health advocate (IMHA). However, we did not see any information for patients who were detained under the Mental Health Act about how they could contact the CQC.
- With the exception of the examples relating to Ashby ward, Heather ward and Watermead ward, all treatment appeared to have been given under an appropriate legal authority. However improvement was needed in the recording of the person's capacity to consent and their consent or refusal of treatment at their first administration, and any subsequent authorisation, of treatment for mental disorder.
- Staff could not recall when they had last received training in the Mental Health Act. Some staff had a better knowledge of the Act than others. One member of staff told us that they were going to specifically ask for Mental Health Act training in the forthcoming appraisal. The trust did not offer specific training in the Mental Health Act.
- Concerningly, on one ward, a member of staff told us that if an informal patient wanted to leave the ward, the member of staff would be directed to detain the patient (using section 5 of the Mental Health Act). Other informal patients we spoke with were aware of their right to leave the ward. We saw that information, displayed on ward doors, was provided for patients who were not detained as to their right to leave the ward when they wanted to.
- There was not a clear process for scrutinising and checking the receipt of MHA documentation. We found overall that the MHA record keeping and scrutiny was poor.

Good practice in applying the MCA

- We saw that 87% of staff members working within this core service had received training in the Mental Capacity Act (MCA). This was as part of the annual training programme.
- However, when we spoke with staff there was varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).
- None of the patients receiving care and treatment during our inspection were under a DOLS.
- Records we sampled showed that patients' mental capacity to consent to their care and treatment was not always assessed on their admission or an ongoing basis

Psychiatric intensive care unit

Assessment of needs and planning of care

- Referrals of patients for admission to the psychiatric intensive care unit (PICU) were made from the acute wards. It was explained that there was sometimes a delay in admitting patients due to the bed occupancy levels in the PICU.
- We found patients' needs were assessed and care and treatment was planned to meet identified needs. We looked at over six care records for patients receiving care and treatment in the PICU and saw that these contained up to date care plans that gave information to staff about how best to care for the person. We found the care plans to be detailed, individualised to the patients' needs and showing the patients' involvement in the care planning process.
- An electronic record system had been recently introduced across the trust. Information, contained within this system, could be shared between the wards, home treatment teams and other community teams. However some paper records still existed. We were informed that staff working within social services (for example, approved mental health practitioners) could not access the electronic system. Such staff had to rely on paper-based information.
- We saw that patients' physical health needs were identified. Patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were met. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward. Ongoing monitoring of physical health problems was usually taking place. All records we sampled included a care plan that showed staff how to meet patient's physical needs.
- A senior manager informed us that a physical healthcare nurse had been appointed to the Bradgate Mental Health Unit since our inspection of September 2013. However, this nurse had recently retired. Recruitment had taken place and a successful candidate was due to

Are services effective?

Requires improvement

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commence employment into this role imminently. The senior manager was hoping to be able to create a second physical healthcare nurse position and had produced a business case to support this proposal.

Best practice in treatment and care

- We saw multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the care plan was achieving the desired outcome for patients.
- We were told by staff (doctors and nurses) that there was an absence of psychology input. We were told that referrals for psychology input were made to the community mental health teams, and the patient would be placed on a waiting list. There was not a clinical psychologist within the aprovided in line with relevant NICE (National Institute for Health and Care Excellence) guidance, particularly relating to the absence of psychology.
- Outcomes for patients using the services were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation. We received positive feedback from the patients we spoke with about the quality of the care and treatment they had received.
- We saw from care records that physical health was monitored and there were specific care plans for patients with complex physical health concerns.
- We did not observe a specific programme of therapeutic activities on the ward. We were informed that the occupational therapy service was part-time on Belvoir ward. We did however observe patients enjoying a game of basketball with staff.

Skilled staff to deliver care

- The majority of permanent staff had been trained in de-escalation techniques and the use of physical interventions. We saw that 78% of staff, working within this core service, had received training in MAPA (management of aggression or potential aggression). We were informed that bank staff received mandatory training, which included MAPA training.
- We found that there was a variety of mandatory training available for staff. This included courses in, for example, information governance, basic and intermediate life support, safeguarding vulnerable adults and children, mental capacity act, record keeping and medicines management.
- A senior manager explained to us that a new electronic learning system had recently been introduced. The senior manager rigorously monitored the system and provided monthly feedback to the ward matron about the progress relating to training. In relation to this core service, we noted that only 65% of staff had received training in intermediate life support and 76% of staff in basic life support. This meant that some staff were not up to date with life support training, thus increasing the risk to the safety of patients. We further noted that there was no specific training in relation to the Mental Health Act. However, we saw that 87% of staff had attended training in the Mental Capacity Act.
- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning the ward and trust policies and a period of shadowing existing staff before working alone.
- We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. This was signed off by the nurse in charge of the shift. We saw some examples of these completed forms. Belvoir ward generally used bank staff who had previously worked on the ward.
- Staff had access to supervision. A senior manager explained to us that a new electronic learning system had recently been introduced. Information about supervision and appraisals was being introduced on this system. In relation to this core service, we saw 71% of staff had an up to date personal development plan in place at the time of our inspection. This compared to 83.6% in December 2014. The senior manager explained that the decrease may relate to recording on the new system. Staff felt supported by their peers and immediate matrons.
- Staff described receiving support and debriefing from within their team following any serious incidents.
- Staff told us there were regular team meetings and staff felt well supported by their immediate matrons and colleagues on the ward. Staff also told us they enjoyed good team working as a positive aspect of their work on the ward.

Multi-disciplinary and inter-agency team work

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.

- We were informed, by the ward matron, that the multi-disciplinary meetings are attended by the doctors, nurses and, occasionally, occupational therapists. These meetings were found to be effective in enabling staff to share information about patients and review their progress.
- Occupational therapists and therapeutic support workers worked as part of the team and we saw that they worked closely with patients in forming their wellness and recovery action plans. The patients we talked with spoke positively about this.
- There was an absence of psychology input on the ward. We were told that referrals for psychology input were made to the community mental health teams, and the patient would be placed on a waiting list.
- The consultant and medical staff were a regular presence on the ward and were present at times during our inspection. We observed good interaction between the ward staff and medical teams on the ward. The permanent consultant psychiatrist had recently retired and a locum was currently working. However, a substantive consultant had been appointed and was due to commence on 01 April 2015.

Adherence to the MHA and MHA Code of Practice

- Each patient on Belvoir ward was detained under the Mental Health Act.
- We checked whether systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. All patients in Belvoir ward were detained under the MHA.
- It appeared that all detained patients, whose care records we reviewed, were being lawfully detained. All treatment appeared to have been given under an appropriate legal authority.
- We did not see posters displayed informing patients of how to contact the Independent Mental Health Advocate (IMHA) or how patients could contact the CQC. We were told that these had been removed by patients.
- During our unannounced inspection, we reviewed the records of a patient who was being nursed in the seclusion area. A contemporaneous record of the behaviour of the patient in seclusion was documented. However, the records lacked any details as the amount of food and fluid that the patient had taken. We drew this to the attention of the nurse in charge at the time of our inspection.
- Staff could not recall when they had last received training in the Mental Health Act. The trust did not offer specific training in the Mental Health Act.

Good practice in applying the MCA

- We saw that 87% of staff members working within this core service had received training in the Mental Capacity Act. This was as part of the annual training programme. When we spoke with staff they demonstrated a good of knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards.
- None of the patients receiving care and treatment were under a Deprivation of Liberty Safeguards (DOLS).
- Records we sampled showed that patients' mental capacity to consent to their care and treatment was assessed on their admission and on an ongoing basis.

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 this domain as good because:

- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner on all of the wards.
- Patients we spoke with were mainly positive about the staff, and felt they made a beneficial impact on their experience on the wards.

Our findings

Acute wards

Kindness, dignity, respect and support

- We spoke with forty-two patients receiving care and treatment in the acute wards. We observed how staff interacted with patients throughout the three days of our inspection.
- Staff appeared kind with caring and compassionate attitudes. We observed many examples of staff treating patients with care and compassion. We saw staff engaging with patients in a kind and respectful manner on all of the wards.
- For example, we observed an activity group on Thornton ward where there was a calm and happy atmosphere, with patients appearing engaged in and enjoying the activity. We also saw patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed staff knocked before entering patients' rooms, and speaking positively with patients.
- We observed staff treating patients with respect and communicating effectively with them. Staff were visible in the communal ward areas and attentive to the needs of the patients they cared for. Patients we spoke with were mainly positive about the staff in relation to the respect and kindness they showed to them.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.

The involvement of patients in the care they receive

- Patients told us, and forty care records we sampled showed, that they were involved in their care planning and reviews to varying degrees.
- The majority of patients told us they had been actively involved in planning their care. However, two patients on Aston ward told us that they had not been. We saw that patients' views were clearly evident in their care plans. Patients were invited to the multi-disciplinary reviews along with their family where appropriate.
- We observed information boards across the wards detailing the staff that were on duty and what staffing levels the wards should be on, to highlight to the patients receiving services what staffing resources were available that day. This helped everyone on the wards to understand how best to facilitate each patients plans for the day.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were in operation. On some wards there was a lack of dedicated space for patients to see their visitors.
- There was a specific children's visiting area within the Bradgate Mental Health Unit. This was based off the wards in one of the corridors. There were two separate rooms: one for patients to see younger children and one for patients to see older children.
- Patients had access to a local advocacy service including an independent mental health advocate (IMHA) and there was information on the notice boards on how to access this service. However, two patients on Aston ward and one patient on Ashby ward were unaware of the advocacy services available.

Psychiatric intensive care unit

Kindness, dignity, respect and support

- We spoke with five patients receiving care and treatment in the Belvoir ward. We observed how staff interacted with patients.
- Staff appeared kind with caring and compassionate attitudes. We observed staff treating patients with respect and communicating effectively with them. Staff were visible in the communal ward areas and attentive to the needs of the patients they cared for.

Good

Are services caring?

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

- Patients we spoke with were positive about the staff in relation to the respect and kindness they showed to them. One patient told us that staff were sympathetic, gentle and thoughtful, and the doctors were helpful and good doctors.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.

The involvement of patients in the care they receive

- Patients told us, and six care records we sampled showed, that they were involved in their care planning and reviews. Patients' views were clearly evident in their care plans. Patients were invited to the multi-disciplinary reviews along with their family where appropriate.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate.
- Visiting hours were in operation, though there was a lack of dedicated space for patients to see their visitors. Visits usually occurred in communal areas.
- There were no specific children's visiting areas. The ward matron explained that, if it was proposed that a child was to visit the ward, a full risk assessment would be undertaken. We were told that children making visits to the ward was rare.
- Patients had access to a local advocacy service including an independent mental health advocate (IMHA). We were informed that an advocate visited the ward on a weekly basis.

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 this domain as requires improvement because:

- Patients were unable to access beds in their local acute wards in a timely manner due to shortages of local beds.
- Not all ward environments optimised patients' safety, privacy and dignity.
- The arrangements, on many of the wards, for single sex accommodation did not meet the guidance set by the Department of Health or within the MHA Code of Practice.
- We were concerned that some practices may be restrictive.

However:

- We saw that spiritual care and chaplaincy was provided when requested.
- We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

Our findings

Acute wards

Access, discharge and bed management

- Staff told us that there was often a problem finding beds for patients who needed an admission. We were shown supporting data which gave the bed occupancy on the wards as very often above 100% capacity. It was frequently necessary to admit other patients into the beds of patients who were on short term leave.
- During our unannounced inspection, we observed on a number of wards patients were using leave beds of other patients. For example, one patient was using a leave bed on Aston ward, three patients on Beaumont ward and Bosworth ward, four patients on Thornton ward and two patients on Watermead ward.
- On 10 March 2015, we observed that one patient had returned from leave on Bosworth ward. However, a bed was not immediately available for this patient, so they had been asked to wait in the lounge until a bed became available.
- Staff told us there could be delays if patients needed to be transferred to more appropriate care facilities, such as a psychiatric intensive care unit (PICU) if there were no beds available there.
- The trust had a bed management system. During day, a bed management team co-ordinated the admissions. However, at night, this responsibility fell to the night co-ordinator.
- During our unannounced visit, the night co-ordinator explained that a patient was being admitted to a detoxification bed usually used for patients with substance misuse problems. The patient did not require this type of facility, however there was no other bed available within the Bradgate Mental Health Unit. The alternative was to find a bed out of area, for example, in an out of area bed. The night co-ordinator explained that a discussion had taken place with the on-call manager and on-call director about this and permission had been given for this patient to be admitted to the Bradgate Mental Health Unit.
- We were informed that there were currently, at the time of our inspection, 19 patients in out of area beds (that is, beds which are not within the trust's catchment area). Of these patients, we noted that one patient had been out of area for 144 days, though the overall average was 38 days.

The ward environment optimises recovery, comfort and dignity

- With the exception of Watermead ward, patients told us they were unable to lock their room. This was because much of the accommodation within the Bradgate Mental Health Unit was dormitory style, with up to four patients sleeping in one dormitory. Curtains were provided between the beds but this did not provide the privacy required. Whilst patients had access to lockable storage space, they did not have the keys for such storage and had to approach a member of staff and this was not based on assessed risk. On Watermead ward, patients were able to lock their rooms.
- We saw in each ward how the main sleeping areas for male and female patients were segregated. However we had concerns that arrangements did not promote people's dignity or adequately protect people's safety. Some arrangements did not meet guidance set by the Department of Health. On Watermead ward, patients had single bedrooms with en-suite facilities.

Are services responsive to people's needs?

Requires improvement

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

- We saw no female lounge on Ashby ward, Aston ward and Bosworth ward. This meant that if female patients receiving care who wanted to avoid spending time with male patients had no separate facility which impacted on their dignity. This does not meet guidance from the Department of Health and the Mental Health Act Code of Practice. Both Heather ward and Thornton ward provided single sex accommodation which ensured guidance from the Department of Health and the Mental Health Act Code of Practice was met. We saw female only lounges in Beaumont ward and Watermead ward.
- Wards had locks on the main entrances with entry and exit controlled by staff. Staff carried personal alarms. During our inspection, we were offered personal alarms on some wards, but not on other wards.
- We did not see call bells throughout any of the wards to enable patients to request assistance when required. We were particularly concerned that some bathrooms did not have call bells.
- Payphones were provided on each ward where people could make a phone call. However, the payphones were generally located in communal areas where conversations could be overheard. We were told that, upon request, a telephone call could be facilitated in a quiet area, however there were no visible signs informing patients of this. The payphone on Thornton ward was out of order. One patient told us that telephone was frequently out of order. Patients could also use their own mobile phones, following a risk assessment.
- All the wards had access to garden areas in which patients could smoke. However, there were no smoking shelters (particularly for use in inclement weather).
- Patients told us the food on the wards was generally good. Each ward had laundry facilities and patients were supported to use these when required.

Meeting the needs of all patients who use the service

- We saw that spiritual care and chaplaincy was provided when requested. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Staff told us that interpreters were available using a local interpreting service or language line. These services had been used previously to assist in assessing patients' needs and explaining their care and treatment.
- There were some blanket restrictions. For example, there was a rule that access to the garden was only permitted after midnight, on a one patient basis with an escorting member of staff.
- Patients had access to drinks and snacks at any time.

Listening to and learning from concerns and complaints

- All the wards accessed the trust's complaints system. Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint.
- Complaints were recorded using the trust's computerised incident reporting system. We saw it evidenced how the issues were investigated, what outcomes and any learning were. The ward matrons told us they shared learning amongst their staff via staff meetings and communications.
- Feedback from patients was obtained, prior to their multi-disciplinary meeting, using the 'inpatient survey' on a weekly basis . We saw examples of this.

Psychiatric intensive care unit

Access, discharge and bed management

- Staff told us that there was sometimes a problem finding beds for patients who needed an admission.
- We were informed that there was currently, at the time of our inspection, one patient in out of area beds (that is a bed which is not within the trust's catchment area). We noted that this patient had been out of area for 16 days.

The ward environment optimises recovery, comfort and dignity

- We saw each patient had their own sleeping accommodation. We saw that patients' bedrooms were unlocked, meaning patients could access their bedroom at any time. We saw an example where one patient had personalised their bedroom to meet their own taste and preferences.
- We saw there was lounge for female patients on Belvoir ward, however a male patient was using it at the time of our inspection. This does not meet guidance from the Department of Health and the Mental Health Act Code of Practice.

Are services responsive to people's needs?

Requires improvement

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

- We were informed that female patients receiving care on Belvoir ward were nursed on a high level of observation. We found this was, potentially, not the least restrictive option of nursing female patients.
- The ward had locks on the main entrances with entry and exit controlled by staff. An air lock system operated, where one door could not be opened, whilst the other door was open. Staff carried personal alarms.
- We saw no call bells throughout the ward to enable patients to request assistance when required. We were particularly concerned that bathrooms did not have call bells.
- A cordless telephone was available, upon request to staff, for patients to make a private telephone call. Additionally, a payphone was available in the corridor. The use of mobile telephones was not permitted on Belvoir ward.
- The ward had access to a garden area in which patients could smoke. However, there was no smoking shelter (particularly for use in inclement weather).
- Patients told us the food on the ward was generally good. The ward had laundry facilities and patients were supported to use these when required.

Meeting the needs of all patients who use the service

- We saw that spiritual care and chaplaincy was provided when requested. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Staff told us that interpreters were available using a local interpreting service or language line. These services had been used previously to assist in assessing patients' needs and explaining their care and treatment.
- There were some blanket restrictions. For example, smoking was only permitted in the garden at designated times.
- Patients had access to drinks and snacks at any time. However, they had to ask for these. We saw that water was available in the communal areas, though patients had to ask for the cups.

Listening to and learning from concerns and complaints

- The ward accessed the trust's complaints system. Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint.
- Complaints were recorded using the trust's computerised incident reporting system. We saw it evidenced how the issues were investigated, what outcomes and any learning were. The ward matron told us they shared learning amongst their staff via staff meetings and communications.

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 this domain as requires improvement because:

- We were concerned about governance systems relating, particularly, to the maintenance of the wards, and to the administration of the Mental Health Act.
- There was a lack of strategic direction on the wards.
- The acute wards for adults of working age had not complied with all required actions following the previous inspection of September 2013.

However:

- Staff consistently demonstrated good morale.
- There was highly visible, approachable and supportive leadership.

Our findings

Acute wards

Vision and values

- Staff we spoke with told us were aware of the trust vision and values. We were told staff that these, in addition to being available on the trust's intranet system, had been distributed with staff pay slips.
- We saw the values and visions were available in a credit card size format, which some staff had attached to their identity badge holder.
- Staff told us that senior staff within the trust had visited the wards. These included the trust chairman, the chief executive and various executive directors.

Good Governance

- Governance committees and mechanisms were in place which had supported the safe delivery of the service. Lines of communication, from the board and senior managers, to the frontline services were clear at a local level.
- We were given an example of where the chief executive had been approached by staff. Staff told us that the chief executive's intervention in the specific issue was very helpful.
- We saw evidence of trust wide learning from incidents and complaints being shared with staff in order to change to practice.
- On some wards, we had concerns about the governance in relation to the maintenance of the ward. For example, we pointed out a number of minor repair issues, which we would have expected staff to be aware of, however they were not. We had further concerns relating to the governance of the administration of the Mental Health Act.
- We found there was a general lack of strategic direction on the wards. Senior ward staff were invariably dealing with bed management issues, whilst the more junior staff were dealing with the patients. One member of staff described this as "fire-fighting". Dealing with immediate issues, with the current staffing levels, meant that staff could not plan for the future development of the wards.
- The acute wards for adults of working age had not complied with all required actions following the previous inspection of September 2013.

Leadership, morale and staff engagement

- On a day to day basis, the wards appeared to be well managed. Many staff told us that morale in the past across the service had been very low. However, staff considered that morale was improving and the trust was heading in the right direction. We were impressed with the morale of the staff we spoke with during our inspection and found that the local teams were cohesive and enthusiastic.
- Staff spoke of a number of changes since the last CQC inspection in September 2013. One of these changes was the introduction of two senior matrons covering the Bradgate Mental Health Unit (and more recently, the inpatient forensic service). We were told that the senior matrons were highly visible on the wards, approachable and supportive. The senior matrons reported directly to the lead nurse for inpatients.
- Changes in the local management structure were due to take place imminently. A new head of service had been appointed; the current inpatient team manager was due to 'act up' into the inpatient service manager position. An existing inpatient team manager would then provide management cover for the unit. Most staff we spoke with were aware of the current and proposed management structure. They confirmed that the current inpatient team manager regularly visited the wards.

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.

- All staff we spoke with said they felt well supported by their immediate matron and felt their work was valued by them. Generally we saw a positive working culture within the teams which we inspected.

Commitment to quality improvement and innovation

- We saw patients views were gathered through feedback from questionnaires upon discharge. We saw in some services how these results were analysed by the individual ward matrons to provide an overview of the service.
- Data was collected regularly on performance. Each ward matron completed a database, which recorded their performance against a range of indicators such as staff sickness, agency use, and level of CPA meetings. This was reported on every month to the inpatient team manager. Where performance had caused some concerns, we were told action plans would be agreed between the managers and implemented to improve performance.
- The ward matrons, inpatient team manager and senior matrons were able to provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required. They were making improvements in the quality of the service.

Psychiatric intensive care unit

Vision and values

- Staff we spoke with told us were aware of the trust vision and values. We were told staff that these, in addition to being available on the trust's intranet system, had been distributed with staff pay slips.
- We saw the values and visions where available in a credit card size format, which some staff had attached to their identity badge holder.
- Staff told us that senior staff within the trust had not visited the ward.

Good Governance

- Governance committees and mechanisms were in place which had supported the safe delivery of the service. Lines of communication, from the board and senior managers, to the frontline services were clear at a local level.
- We saw evidence of trust wide learning from incidents and complaints being shared with staff in order to change to practice.
- We found there was a clear strategic direction on the ward. We were told that the ward was seeking accreditation through the Royal College of Psychiatrist's Accreditation for Inpatient Mental Health Services (AIMS) programme.

Leadership, morale and staff engagement

- On a day to day basis, the ward appeared to be well managed. Staff considered that morale was good and the trust was heading in the right direction. We were impressed with the morale of the staff we spoke with during our inspection and found that the team were cohesive and enthusiastic.
- Changes in the local management structure were due to take place imminently. A new head of service had been appointed; the current inpatient team manager was due to 'act up' into the inpatient service manager position. An existing inpatient team manager would then provide management cover for the unit. Most staff we spoke with were aware of the current and proposed management structure. They confirmed that the current inpatient team manager regularly visited the wards.
- All staff we spoke with said they felt well supported by their immediate matron and felt their work was valued by them. Staff spoke extremely positively about the management team of Belvoir ward. We saw a positive working culture within this team.

Commitment to quality improvement and innovation

- We saw patients views were gathered through feedback from questionnaires upon discharge. We saw how these results were analysed by the ward matrons to provide an overview of the service.
- Data was collected regularly on performance. The ward matron completed a database, which recorded their performance against a range of indicators such as staff sickness, agency use, and level of CPA meetings. This was reported on every month to the inpatient team manager. Where performance had caused some concerns, we were told action plans would be agreed between the managers and implemented to improve performance.

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.

- The ward matron, inpatient team manager and senior matrons were able to provide us with an up to date picture of how the ward was performing and had a good understanding of where improvements were required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout. · Not all wards at the acute service at the Bradgate unit, and the PICU complied with guidance on same sex accommodation. · Some wards at the acute services, and the PICU had potential ligature points that had not been fully managed or mitigated. · Observation was not clear within some of the acute wards. · Not all seclusion facilities had safe and appropriate environments. · Repairs had not always been completed in a timely way. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 10 and 12 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Requirement notices

The trust did not take appropriate steps to ensure there were sufficient numbers of staff.

· Not all wards had sufficient staffing to safely meet patient need.

This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider did not protect patients against the risks associated with the unsafe management of medicines.

· The rapid tranquilisation policy did not cover oral treatment.

· Fridge temperatures were not monitored meaning medicines may not be safe.

· The trust had not implemented the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Requirement notices

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care to meet individual service user's needs.

· There was limited and delayed access to psychological therapy.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The trust did not make appropriate arrangements to ensure the consent to care and treatment of all services users.

· Not all patients had recorded assessments of capacity.

· Procedures required under the Mental Capacity Act were not always followed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Requirement notices

The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment due to a lack of accurate records being made and held securely.

· Procedures were not always followed for detention under the Mental Health Act and records relating to patient's detention were not always in order.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment through availability of accurate information and documents in relation to the care and treatment provided.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The trust did not protect people, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.