Requires improvement

Leicestershire Partnership NHS Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
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 Psychiatric Intensive Care Unit (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?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Inadequate** 
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.

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Overall summary

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

- The trust had made improvements to the clinical environments but had not met all the required actions following the previous inspection of March 2015. Improvements to the inpatient wards included updating seclusion rooms, removing some ligature anchor points and replacing garden fencing. However, ligature points remained. Wards had high numbers of hydraulic style patient beds that were a risk to patients with histories of self-harming behaviour. The trust had begun the process of replacing some beds with more suitable options for the patient group. However, we were concerned that ligature risks remained in these bedrooms. Some wards and patient areas had blind spots, where staff could not easily observe patients. We found damaged fixings on one ward; that posed a risk to patients.
- The trust did not have seclusion rooms on all wards. This meant staff transferred patients to wards that had seclusion rooms when needed. This could pose a risk to patients and staff.
- The trust had high numbers of vacancies for registered nurses. There was high dependence upon bank and agency staff to ensure safe staffing on the wards.
- Patients did not have access to psychological therapies, as required by the National Institute for Health and Care Excellence (NICE).
- Staff were not in receipt of regular supervision in order to discuss training needs, developmental opportunities or performance issues. Ward teams did not hold regular team meetings. Ward matrons told us they shared outcomes from incident investigations in team meetings for shared leaning. Therefore, the trust could not be sure staff received information to support best practice and change in a timely manner. The trust had not ensured all staff had received training in immediate life support. The trust could not be sure that all staff
- Staff were not always recording room and fridge temperatures in clinical rooms and out of date nutrional supplement drinks had not been appropriately disposed of.
- The trust experienced high demand for acute inpatient beds. Patients could not always access a bed in their locality when needed and the trust moved patients between wards and services during episodes of care and following return from leave. Staff moved acute patients to the rehabilitation wards when acute beds could not be located. The trust could not ensure continuity of care for these patients.
- The trust had no psychiatric intensive care unit (PICU) for female patients. Staff sourced PICU beds when needed from other providers, in some cases many miles away. The trust was not commissioned to provide a female PICU and have identified the need with their commissioners. The trust admitted male patients to female areas of the mixed wards when male beds were unavailable. This was in breach of the Mental Health Act Code of Practice guidance on mixed sex accommodation. We noted, however, that staff maintained close observation when this occurred and considered this less stressful for patients than sourcing out of area beds.
- The acute service contained large numbers of beds in 'bed bays' accommodating up to four patients. Patients experiencing mental health crisis and distress did not have access to a fully private area in these environments. Curtains separated patients' bed areas and the rooms were not secured to allow free access; meaning that patients could have their property removed by other patients. The provider supplied lockers on the wards; however, these were not large enough to contain all possessions and patients did not hold keys.
- On one ward, female shower rooms did not contain shower curtains. This did not protect the privacy and dignity of patients when staff undertook observations. On many wards, the trust had not

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supplied sufficient numbers of lounge and dining chairs to accommodate all patients and some wards did not have sufficient quiet rooms for care and treatment or for patients to receive visitors.

- Staff completed care plans for patients. However, staff did not consistently record patients' views in their care plan or ensure they had received a copy. Patients did not have access to regular community meetings where they would discuss ward issues and concerns. When community meetings occurred, staff did not include details of outcomes to evidence change.

However:

- Senior managers were aware of the bed pressures in their acute and PICU service and had raised concerns with their commissioners.
- The trust had made improvements to the clinical environments since the last CQC inspection. For example, Ashby, Aston, Bosworth and Thornton Wards had been converted to single sex only accommodation to ensure compliance with the Department of Health and Mental Health Act 1983 guidance on mixed sex accommodation. The trust had begun replacing hydraulic beds on the wards and had agreed plans for the replacement of further hydraulic beds across the site over a four-year period. Improvements had been made to the seclusion facilities, and further improvements were planned across the service to improve patient experience and promote privacy and dignity.
- The trust had completed ligature risk assessments across all wards, detailing where risks were located and how these should be managed. Staff had access to quick guides in their clinical areas to ensure they were aware of how to manage risks. Wards employed additional healthcare support workers to meet patient needs when needed. Staff maintained a presence in clinical areas to observe and support patients.
- Staff received robust and detailed shift handovers, including information on patient risks, observation levels and physical healthcare concerns and how these were to be managed. Staff were provided with relevant information to care for patients safely.
- Staff completed detailed individualised risk assessments for patients on admission and updated these regularly and after incidents. Staff completed Mental Health Act 1983 (MHA) paperwork correctly and systems were in place for secure storage of legal paperwork, advice and regular audits.
- The trust employed registered general nurses (RGN) to assist with assessment and management of physical healthcare needs for patients. Wards had good evidence of multi-disciplinary team working, enabling staff to share information about patients and review their progress
- Staff were caring, compassionate and kind towards patients. 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. Staff were visible in the communal ward areas and attentive to the needs of the patients they cared for. Overall, patients were positive about the care they received and had access to advocacy services on all wards. The trust had a dedicated family room for patients to have visits with children. This environment was pleasant and well equipped. Patients had the use of their mobile phones on the ward. The trust had a patient involvement centre, which was pleasant, well-equipped and supported involvement from friends and family.
- Staff consistently demonstrated good morale. There was highly visible, approachable and supportive leadership.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Wards continued to have ligature points. The trust had not made sufficient changes to ensure a safe environment for patients.
- Wards had blind spots where staff could not easily observe patients.
- Wards had large numbers of hydraulic beds for patient use. The trust had identified hydraulic beds as a risk to patients.
- The trust had breached guidance on mixed sex accommodation on both mixed sex wards.
- The trust had large numbers of vacancies for registered nurses and appropriate skill mix was not always achieved.
- Wards were in need of refurbishment and repair. Some damaged items posed a risk to patient safety.
- The trust had closed some seclusion rooms. However, staff moved patients between wards when seclusion was required. This was a risk to patients and staff and a breach of dignity for patients.
- Staff were not always regularly recording fridge and room temperatures within clinic rooms.
- Not all wards were fitted with working patient call alarms.
- The trust had not ensured all staff had received training in immediate life support.
- Staff were not in receipt of regular team meetings and might not have timely access to outcomes for incident investigations or complaints.

However:

- The trust had completed ligature risk assessments across all wards, detailing where risks were located and how these should be managed.
- Wards employed additional healthcare support workers to meet patient needs and staff maintained a presence in patient areas.
- Staff completed detailed individualised risk assessments for patients on admission and updated these regularly and after incidents.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

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- The trust did not employ sufficient numbers of psychologists for care and treatment for patients. 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.
- Staff were not in receipt of regular clinical supervision, in accordance with the trust policy.

However:

- The trust employed registered general nurses (RGN) to assist with assessment and management of physical healthcare needs for patients.
- Wards had good evidence of multi-disciplinary team working, enabling staff to share information about patients and review their progress.
- Staff received robust and detailed shift handovers to allow them to care for patients.
- Overall, Mental Health Act 1983 (MHA) paperwork was in order.

Are services caring?

Good

We rated caring as good because:

- Staff appeared kind with caring and compassionate attitudes. We observed many examples of staff treating patients with care and compassion.
- Patients were positive about the care they received.
- Patients had access to advocacy services on all wards.
- Patients on the PICU had access to an Iman, trained in the prevention of radicalisation for patient support.

However:

- Not all patients had received a copy of their care plan.
- Patients did not have access to regular community meetings to discuss concerns with staff. Minutes of reviews did not contain details of outcomes.
- Staff did not always include patients' views in care plans.

Are services responsive to people's needs?

Inadequate

We rated responsive as inadequate because:

- Patients could not always access a bed in their locality when needed.
- Wards had large numbers of bed bays where patients could not adequately secure their possessions or have private space away from others.

Summary of findings

- The trust moved patients between wards during admissions and following return from periods of leave. The trust could not ensure continuity of care for these patients.
- The trust was not commissioned to provide psychiatric intensive care unit (PICU) beds for females. Female patients who required treatment in a PICU were moved significant distances to access beds.
- Some wards had insufficient facilities for patients. For example insufficient numbers of lounge and dining chairs. Some wards did not have sufficient numbers of quiet rooms for care and treatment of patients.
- One ward had shower rooms that were not fitted with shower curtains. This was a breach of the privacy and dignity of patients.

However:

- The trust had a dedicated family room for patients to have visits with children. This environment was pleasant and well equipped.
- Patients had the use of their mobile phones on the acute wards.
- The trust had a patient involvement centre, which was pleasant, well-equipped and supported involvement from friends and family.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The trust had not complied with all required actions following the previous inspection of March 2015.
- The trust did not have robust process to ensure staff attended regular supervision or that up to date records were maintained.
- The trust had not ensured all staff had received mandatory training in immediate life support.

However:

- The trust had begun making improvements to the clinical environments and further improvements were planned.
- Senior managers were aware of the pressure on their beds and were raising this with commissioners.
- 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 and the psychiatric intensive care unit (PICU) provided by Leicestershire Partnership NHS Trust are part of the trust's adult mental health and learning disabilities directorate. The wards are situated at the Bradgate Mental Health Unit in Glenfield, Leicestershire.

The Bradgate Mental Health Unit has seven acute wards for adults of working age. The unit has two acute wards admitting both males and females. These are Beaumont ward (22 beds) and Watermead ward (20 beds). Bosworth ward (20 beds) and Thornton ward (24 beds) admit males only. Ashby ward (21 beds), Heather ward (18 beds) and Aston ward (23 beds) admit females only.

The Psychiatric Intensive Care Unit (PICU) is also located at the Bradgate Mental Health Unit and has ten beds. The trust admits patients to the PICU if their needs cannot be safely met within the acute environment. The PICU accepts only male patients. The trust has no PICU facilities for females.

All wards accept patients detained under the Mental Health Act 1983 (MHA).

The trust is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The Care Quality Commission completed a whole trust comprehensive inspection in March 2015. The trust received an overall rating of 'requires improvement' and 'inadequate' for the 'safe' domain. The trust had not ensured all clinical areas were safe for patient use. The trust was required to make improvements to make the clinical environments 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.

During this inspection, we found the trust had made changes to the clinical environments by reducing the number of wards accepting both males and females. The trust had also completed work to some wards to improve the clinical environment, for example, removal of ligatures, improved fencing to garden areas and updates to seclusion rooms to improve patient safety.

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 Manager: Sarah Duncanson, Inspection Manager, mental health hospitals, CQC

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of: one CQC inspection manager, one CQC inspector, four specialist advisors (one nurse, one social worker, one consultant psychiatrist and one psychologist) and one advisor who has experience of using, or caring for someone, who uses services.

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.

Summary of findings

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 trust:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited all eight wards at the hospital site, looked at the quality of the ward environment, and observed how staff were caring for patients
- spoke with 26 patients who were using the service
- spoke with matrons or acting matrons for each of the wards
- spoke with 40 other staff, including consultants, doctors, team managers, senior matrons, nurses, healthcare support workers, housekeepers, occupational therapists, therapy liaison assistants and a patient experience and independent involvement consultant
- interviewed the bed manager for these services
- Attended and observed three handover meetings, two community meetings and a multidisciplinary review.
- collected feedback from 19 patients using comment cards
- looked at 45 treatment records of patients
- looked at 103 medication treatment cards
- carried out a check of the medication management on all wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

We completed an unannounced follow up inspection on 24 November 2016.

What people who use the provider's services say

Patients were mostly positive about the staff, and their experience of care on the wards.

Patients told us staff treated them with kindness, dignity and respect, however, some patients told us that bank staff did not always engage with them or introduce themselves.

Some patients told us they were not involved in their care plan and others said that they had not received copies of care plans.

Patients told us they knew how to complain and that staff were supportive when this happened. 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.

Patients told us staff were always busy and that staff sometimes cancelled leave from the wards, due to staffing levels.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that ligature risks are removed, as far as is practical to promote a safe environment.
- The trust must ensure that blind spots are managed to ensure staff can easily observe patients.
- The trust must replace hydraulic beds with beds more suitable to the clinical environment.
- The trust must ensure there are adequately qualified and experienced staff for care and treatment for patients.
- The trust must ensure all staff are in receipt of regular supervision.
- The trust must review the provision of staffing in the multidisciplinary teams, specifically in relation to psychological input.
- The trust must ensure that all damage to ward equipment or environments are identified and repaired in a timely manner.
- The trust must ensure the privacy and dignity of patients is protected.
- The trust must consistently maintain medication at correct temperatures in all areas.
- The trust must ensure that where patient alarms are fitted, they are in full working order.
- The trust must ensure that all staff are up to date with mandatory training.

Action the provider SHOULD take to improve

- The trust should ensure that all staff have regular access to team meetings
- The trust should ensure that the nutritional supplements that they administer to patients are within their expiry dates.
- The trust should ensure that the prescribing, administration, and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.

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	Bradgate Mental Health Unit
Belvoir Ward Psychiatric Intensive Care Unit (PICU	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 Trust.

The Care Quality Commission completed six Mental Health Act Review (MHAR) visits between 22 August 2015 and 23 October 2016. MHARs found thirty-six issues in six visits to wards in this core service. The most common issues found were 'care, support and treatment in hospital' with nine issues, equating to 25% of the total for this core service, followed by 'protecting patients' rights and autonomy' with seven issues, 19.4% of the total for this core service. MHARs identified ten issues each on visits to Ashby Ward and Ashton Ward.

The trust provided data relating to compliance with staff training in the Mental Health Act 1983 (MHA) and Code of Practice. Data provided showed as of November 2016, the average staff compliance across all acute wards with

training in the MHA was 87%. Staff working in the psychiatric intensive care unit (PICU) were 92% compliant. The trust had ensured that the staff were appropriately trained for their role.

Overall**,** staff completed MHA paperwork correctly. Staff we spoke with were aware of their responsibilities under the MHA and knew where to get further advice. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned MHA onto the electronic record for staff reference.

Staff monitored patients using leave from the ward (section 17) and ensured that patients detained under MHA were read, and understood, their rights. Medical staff completed consent to treatment and capacity requirements. However, they did not always document patients' consent to treatment prior to the first administration of medication, in accordance with the MHA Code of Practice.

Staff had access to the approved mental health professional (AMHP) reports, which detailed the concerns and circumstances identified when patients were assessed and detained. This ensured staff had relevant information to assess and plan care for patients.

The trust provided access to Independent Mental Health Act Advocacy (IMHA) for patients and contact details were contained in admission packs and displayed on wards for patient reference. Staff were clear on how to access the service on behalf of patients. Staff referred all detained patients to the IMHA service. The IMHA service received a list of detained patients on a weekly basis

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust provided data relating to compliance with staff training in the Mental Capacity Act 2005 (MCA). Data provided showed as of November 2016, the average staff compliance across all acute wards with training in the MCA was 89%. Staff working in the Psychiatric Intensive Care Unit (PICU) were 92% compliant. The trust had ensured the majority of staff were appropriately trained for their role. Most staff we spoke with explained how capacity would be assessed for significant decisions. However, staff told us capacity assessments were usually completed by medical staff.

There was one Deprivation of Liberty Safeguards (DoLS) application regarding this core service. At the time of the inspection, no patients were subject to DoLS.

The trust had a Mental Capacity Act and Deprivation of Liberty Safeguards policy for staff reference. Staff we spoke with had varying degrees of knowledge about the MCA and DoLS process.

Requires improvement

Are services safe?

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

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

Our findings

Acute wards for adults of working age

Safe and clean environment

- The trust had not addressed all ligature risks on the wards. A ligature risk is a place to which patients intent on self-harm might tie something to strangle themselves. We found a number of ligature risks remained, for example, door handles and window closers in patient bedrooms and soap and towel dispensers in the bathrooms and shower rooms. The trust reported eight incidents of deliberate self-harm or attempted suicide, across all wards, by patients ligating to a fixed object in the past 12 months.
- The trust continued to use hydraulic (rise and fall) hospital style beds across all wards. The trust had identified these beds on their ligature risk assessment as posing a high risk as ligature anchor points, or a means to barricade bedroom doors. However, the risk register for acute and PICU services did not identify hydraulic beds as a ligature risk to patients and no time frame was included for replacement with beds more suitable to the clinical environment. The trust had updated some rooms with fixed beds, however very few were available and internal door handles remained that posed a ligature risk to patients. The trust later advised us there were plans to replace further beds by March 2017.
- The trust had completed and regularly updated ligature risk assessments on all wards. We found these assessments were robust and included all ligature risks. The trust had included details of previous incidents in their assessments and had appropriately weighted the risks identified. Staff had access to guides to the most significant risks on their wards for quick reference. The trust had taken action to ensure staff were informed of where risks were located and how staff should manage these.
- The ligature risk assessments did not specify actions to remove or replace these items and ward matrons were unaware of whether the trust had plans to complete work. However, the trust had included ligature risks on the older inpatient wards, Ashby, Aston, Bosworth and Thornton, on their trust risk register, with target dates for removal/replacement of doors and door furniture by February 2017 and updating of towel dispensers by January 2017. The trust had plans to complete full ligature works for the Bradgate Mental Health Unit by the end of July 2017.
- The trust had control measures in place to minimise the ligature risk to patients. These included individual patient risk assessments, searching property and the use of increased staff observations of patients who presented as high risk. Staff locked some rooms when not in use and maintained a presence in patient areas.
- Staff locked patient bedroom windows in some areas due to ligature risk. Patients could not easily ventilate their bedrooms without assistance from staff. One patient on Ashby ward was observed wearing anti-ligature clothing and in receipt of anti-ligature bedding. However, we saw a door handle within the bedroom that posed a ligature risk. Staff had assessed that the patient did not require close observations. However, as the patient presented a significant risk, the trust could not be sure the environment was safe for this patient.
- The CQC identified breaches to regulations related to patient safety in the last inspection (March 2015). We were concerned the trust had not fully complied with CQC requirements in relation to removal of ligature points. Despite completion of comprehensive ligature risk assessments, improvement to some patient areas and management plans in place, patients had continued to ligate on the wards. The high numbers of ligature anchor points continued to put patients at risk.
- The trust had converted Ashby, Aston, Bosworth and Thornton Wards to single sex only accommodation to ensure compliance with the Department of Health and Mental Health Act 1983 guidance on mixed sex accommodation.
- The trust had installed mirrors in some areas to aid staff observation of patients. However, wards continued to have blind spots where staff could not easily observe patients. Staff managed this by maintaining a presence in the clinical areas.

Requires improvement

Are services safe?

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

- Staff managed access to high-risk patient areas, for example, patient kitchens, laundry facilities and outside space, with higher staffing observations and supervision.
- Wards consisted of a combination of single bedrooms and bed bays, accommodating between two and four patients. Some single rooms had ensuite facilities but did not contain showers. On Beaumont ward, all rooms had ensuite facilities.
- Staff completed environmental checks of patient areas. However, on Ashby ward we found glass bottles and a lighter within patient bedrooms. This was a risk to both staff and patient safety.
- On Ashby ward we found a shower fitting was broken, exposing screws and sharp plastic edges. This was a risk to staff and patients. We raised this concern during the inspection. We also found a broken toilet roll dispenser with sharp edges exposed. This was also a risk to patients and staff. Staff had reported this damage, but did not know when repairs would be completed. The trust later advised the damaged items had been repaired.
- The trust had addressed previous concerns related to breaches of single sex accommodation. Only Watermead and Beaumont wards continued to admit male and female patients. Watermead and Beaumont wards had designated male and female areas that complied with the Department of Health and Mental Health Act 1983 (MHA) Code of Practice guidelines on mixed sex accommodation. However, staff told us male patients were admitted to female areas of the mixed wards due to bed pressures. This is a breach of the Department of Health and MHA Code of Practice guidelines on eliminating mixed sex accommodation. Male patients could not access their bedrooms without assistance from staff. The bed management team considered the needs of each patient to determine whether this was more appropriate than sourcing a bed out of area. Staff implemented high-level observations when this occurred to ensure patient safety and protect the privacy and dignity of patients.
- Wards had fully equipped clinic rooms with accessible resuscitation equipment, which staff checked regularly. Emergency drugs were available, staff completed regular checks, and recorded these appropriately.
- We found the suitability of clinic rooms varied across the service. For example, clinic rooms on Ashby, Bosworth and Aston wards were small and cluttered. On Bosworth ward, the clinic room was untidy with dirty and cluttered surfaces. No paper roll was available on examination couches and no privacy curtains were in place. Patient privacy was compromised when staff and patients entered the clinic room during examinations. However, the clinic rooms on Beaumont and Watermead wards were spacious and contained a privacy curtain. On Aston ward, staff had left a urine sample on the examination couch. On Beaumont ward, staff had left a urine sample in the medication fridge, which was seven days old. We were concerned that staff had not sent this sample for urinalysis. Therefore, the patient may not have received appropriate treatment for any findings.
- Staff did not always record fridge and clinic room temperatures regularly. For example, on Ashby ward staff had checked room and clinic temperatures on four occasions during November. On Bosworth ward, staff recorded fridge temperatures that were not within the acceptable range (2-8 degrees) from 6 October to 24 October and 12 November to 17 November. Staff did not record actions taken on eight occasions, other than resetting the thermometer. Staff could not be sure that fridge and room temperatures were within acceptable range to maintain the quality of medication. The trust had completed installation of remote temperature monitoring to medicines fridges, linked to the pharmacy, to allow for remote monitoring of fridge temperatures going forward.
- Overall, the seclusion rooms met the guidance in the Mental Health Act 1983 (MHA) Code of Practice. The trust did not have seclusion rooms on all wards. Seclusion is defined as “the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others”. Bosworth, Ashby, Watermead and Aston wards had seclusion rooms. The trust had completed works to update the seclusion rooms, for example, Ashby, Aston and Bosworth wards were fitted with CCTV for observation (reduction of blind spots) and two-way communication to allow patients and staff to communicate more effectively during the seclusion period.

Requires improvement

Are services safe?

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

- On Ashby ward, there were no heavy chairs for staff and patients to sit whilst supporting patients in the de-escalation area of the seclusion facilities. Staff told us they sat with patients on the floor, or on the seclusion room mattress.
- Not all ward areas or bedrooms were clean. For example, two bedrooms on Ashby ward had dirty floors and bed areas, with old food left on bedside cabinets. On Beaumont ward, the garden area was littered with an incontinence pad left on the floor and rubbish accumulating in the shelter.
- On Ashby ward, we found a spare mattress propped up against a wall in a patient's bedroom. Staff could not explain why this was here or what is was used for.
- Ward furniture was in good repair. However, on Aston and Ashby wards we found insufficient chairs for all patients to use. For example, the TV lounges on Aston and Ashby ward had only seven comfortable chairs for patient use and an insufficient number of dining chairs. On Thornton and Bosworth ward, we found insufficient numbers of dining chairs to accommodate all patients.
- Staff kept accurate cleaning records to demonstrate the environment was cleaned regularly.
- The trust supplied data relating to the PLACE scores for cleanliness. Data showed the Bradgate Mental Health Unit scored 93%; against the England average of 98%. PLACE assessments are self-assessments undertaken by NHS and private/ independent health care trusts, and include at least 50% members of the public (known as patient assessors). They focused on different aspects of the environment in which care was provided, as well as supporting non-clinical services.
- Staff had access to protective personal equipment, such as gloves and aprons in accordance with infection control practice.
- Staff had access to personal alarms for use in an emergency. However, on Bosworth ward there were insufficient numbers of personal alarms for all bank staff. The trust could not be sure all staff working with patients had means to summon assistance in an emergency.
- Wards had variable nurse call systems for patient use. For example, on Thornton ward, nurse call bells were available and working in toilets and bathrooms. However, on Ashby ward, a number of nurse call buttons were broken. Senior staff were unsure whether the system was still in working order. We were concerned patients may be at risk when activating broken call bells; resulting in no staff assistance. The trust identified a lack of patient access to call bells on their risk register; scored this as a very low risk and set a review date of February 2017.

Safe staffing

- The trust were unable to meet their required skill mix for safe care and treatment of patients. The trust required a 60-40 split in favour of registered nurses. The trust acknowledged they were unable to meet this ratio and had included ongoing staff vacancies on its risk register for the acute service.
- The trust supplied data related to staff establishment and vacancies for the acute wards between July and September 2016. The total establishment of registered nurses for the service was 120 and there were 26 vacancies. This meant that 20% of the establishment for qualified nursing posts were unfilled. The Watermead ward reported the highest qualified nurse vacancy rates at 37% and Ashby ward the lowest at 17%.
- The total establishment of nursing assistants was 92 with 22 vacancies. This meant that 24% of the establishment for nursing assistant posts were unfilled. Watermead ward reported the highest vacancy rate for nursing assistant posts at 34% and Bosworth ward the lowest at 20%. Bosworth ward reported the highest percentage of staff vacancies overall at 27%.
- The trust employed bank or agency staff to fill vacant shifts. The trust employed regular bank and agency staff, where possible, to ensure continuity of care for patients.
- The trust provided data that showed between July and September 2016, bank staff filled 2067 shifts across the acute service. Agency staff filled 476 vacant shifts over the same period. Trust data showed 426 shifts remained unfilled across all wards. This meant wards worked short of the establishment.
- The trust provided data to show how many shifts were filled over a three-month period (May 2016 to July 2016). Staff fill rates compared the proportion of planned hours worked by staff (nursing and care staff) to actual hours worked by staff (day and night). Mental health

Requires improvement

Are services safe?

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

trusts submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. The fill rate for nursing assistants was above 125% for all wards for both day and night during this period. The trust were employing nursing assistants to meet the needs of patients requiring higher levels of observation.

- The trust did not employ the required numbers of qualified nurses for safe care and treatment for patients. This data showed that while the trust was often able to employ extra nursing assistants when needed, the availability of registered nurses was below that required. The trust data showed that full establishment for qualified nurses for day shifts was only achieved during May 2016, on Beaumont ward. The lowest reported compliance with qualified nursing establishment between May 2016 and July 2016 was on Watermead ward in June 2016 at 69%.
- The trust provided data that showed the number of staff leavers over the past 12 months. The acute wards reported an average of 5%. This was lower that the trust average of 9%. Heather ward reported the highest number of staff leavers with three staff leavers (12.5% of the establishment). Bosworth ward reported no staff leavers over this period.
- The trust provided data that showed the percentage of staff sickness over the past 12 months. The acute wards reported an average staff sickness of 7%. This was higher than the trust average at 5%. Heather ward reported the highest percentage of staff sickness at 17%. Trust data also showed high sickness rates recorded for medical staffing at the Bradgate Mental Health Unit at 13%. Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments.
- Staff completed mandatory training. The trust supplied data related to compliance with training up to November 2016. Overall, the average compliance with fifteen mandatory training
- The trust provided mandatory training for bank staff and advised that bank staff who worked more regularly received a higher priority for training. The trust provided data that showed an average compliance of 71%, the highest compliance being 81% for moving and handling and the lowest 2% for display screen equipment.
- Ward matrons had authority to increase staffing numbers to meet the needs of patients and told us they felt supported when this was needed.
- We observed that staff maintained a constant presence in the communal areas of the wards.
- Patients' views on access to their named nurse for 1-1 sessions were variable. Most patients told us that staff were so busy that 1-1 time was difficult to access. However, some patients told us that staff always made time for them.
- The majority of patients told us that staff facilitated their leave and records confirmed this. Patients and staff told us access to ward activities was rarely cancelled due to lack of staff.
- Wards had staff appropriately trained in the use of physical interventions and staff could access staff assistance from neighbouring wards when required. The trust supplied data that showed at November 2016, 84% of regular staff and 77% of bank staff had received training in the management of actual or potential aggression (MAPA).
- The trust had adequate medical cover day and night. This ensured a doctor could attend the wards quickly in an emergency.

Assessing and managing risk to patients and staff

- The trust provided data between February and July 2016, which confirmed there had been 148 episodes of seclusion across the acute service. Twenty-eight episodes of seclusion had occurred from wards without seclusion facilities. This meant that staff transferred patients from Thornton, Heather and Beaumont wards to alternate wards when seclusion was required. We were concerned this posed a potential risk to patients and staff when transferring through communal areas and corridors and did not promote the dignity and privacy of these patients.

Requires improvement

Are services safe?

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

- Trust data showed an active programme of reducing the need for seclusion of patients, by promoting least restrictive practice and training staff to utilise de-escalation processes effectively.
- The Trust had a "Seclusion and Restrictive Practices Policy" dated December 2015. All staff who participated in seclusion completed seclusion competencies and we saw examples of these. Staff completed accurate records of seclusion, in line with the Mental Health Act (MHA) 1983 Code of Practice and the trust's policy. Ward matrons and the service manager quality checked each record at the conclusion of seclusion.
- Between February and July 2016, there had been 274 incidents of restraint, involving 104 patients. The highest incidents of restraint were on Watermead ward at 51 restraints involving 16 patients. Bosworth reported the lowest number of restraints at 18 restraints involving 15 patients. The trust promoted the use of de-escalation for patients and all staff told us that staff used physical interventions only when necessary.
- Across all wards, the trust reported four incidents of 'prone' (face down) restraint. The Department of Health document, Positive and Proactive Care (2014) and the Mental Health Act Code of Practice state the use of prone restraint should only be used in exceptional circumstances. The trust was compliant with this legislation and had significantly reduced the numbers of prone restraint since the last CQC inspection. Staff we spoke to were aware of the risks of prone restraint for patients.
- We reviewed 39 care and treatment records of patients. Staff completed detailed individualised risk assessments for patients on admission and updated these regularly and after incidents. Staff included the patient's previous history as well as their current mental state in all records reviewed. 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.
- We reviewed the prescription and medicine administration records for 93 patients. The trust had appropriate arrangements in place for recording the administration of medicines. Staff completed accurate records, which showed patients were receiving their medicines when they needed them. Medical staff recorded patient allergies on their electronic prescribing and medication administration record.
- Staff had quick access to medicines and medicines for discharge were readily available with electronic discharge records.
- Overall, patients detained under the Mental Health Act (MHA) received medicines that were duly authorised and administered in line with the MHA Code of Practice. Staff had access to T2 (consent to treatment) and T3 (record of second opinion) for reference when administering medication for patients. However, on Thornton ward we found medical staff had prescribed medication for two patients, detained under the MHA, without completion of the appropriate documentation. Staff were administering medication to these patients without the proper legal authority.
- The trust had pharmacy services across the acute wards. The pharmacist made notes and recommendations on the electronic prescription chart, for both prescribers and nurses administering the medication to be informed. A ward technician visited the wards daily. The pharmacist did not routinely attend ward rounds or MDT meetings. However, an on call pharmacist was available for both dispensing and advice for staff.
- Medical staff prescribed rapid tranquilisation in accordance with the National Institute for Health and Care Excellence (NICE) guidelines (NG10] violence and aggression: short-term management in mental health, health and community settings). The trust had a rapid tranquilisation policy and guidance was visible in clinic rooms for staff reference.
- On Aston ward, one patient had received repeated doses of an oral medication for agitation over ten days. Staff had recorded daily physical monitoring in the notes. However, there was no apparent link to each time the patient was given the medication during the day. Staff were administering twice the British National Formulary (BNF) recommended dose limit. This meant the patient was at risk of developing serious cardiovascular side effects.
- Staff stored controlled drugs appropriately and kept accurate records.

Requires improvement

Are services safe?

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- Staff stored medicines securely. However, we found opened bottles of liquid medication without 'opened on' stickers. Staff advised they did not routinely record when liquid medications were opened. We were concerned that medicines might exceed their 'use by' date and be unsafe for patient use. On Thornton ward, we found nineteen bottles of food supplements in the clinic room with expiry date of between June 2015 and November 2016. Staff had not disposed of this out of date medication appropriately.
- Staff received mandatory training in safeguarding adults and children. Data showed an average of 89% of staff had received training in safeguarding adults and 85% for safeguarding children across six acute wards. However, only 68% of staff on Beaumont ward had received training in safeguarding adults and 59% for safeguarding children. The trust could not be sure that all staff on Beaumont ward had received sufficient training for their role.
- Staff we spoke with were able to describe what actions could amount to abuse. Staff 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. Staff discussed potential safeguarding concerns during team meetings and a safeguarding lead was available to provide advice to staff.
- Staff ensured informal (voluntary) patients were aware of their rights to leave the hospital at will and included information in the patient welcome packs. However, we did not see posters on wards to confirm this.
- The trust had safe procedures for children that visited the wards. A family room was available, within the unit and Watermead ward had a visitor's room with access from the external corridor. This meant that children did not enter the ward when visiting.

Track record on safety

- Between 01 July 2015 and 30 June 2016, the trust reported six serious incidents. Of these, none involved the death of a patient although three were categorised as apparent/actual/suspected self-inflicted harm meeting serious incident (SI) criteria. Trusts must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of the incident. Between 01 October 2015 and 30 September 2016 there were nine incidents reported to STEIS. Of these, six concerned incidents that caused patient harm.
- The trust had made improvements to some clinical environments to reduce risk to patients. For example, CCTV installed in seclusion rooms, removal of some ligature points and robust fencing erected in the ward garden areas.

Reporting incidents and learning from when things go wrong

- Staff described 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 that had occurred within the services. The trust told us that there was a local governance process in place to review incidents. For example the missing persons' violence risk reduction group.
- Ward matrons discussed trust-wide incidents in team meetings and we saw details of incident investigations in team meeting minutes. However, senior staff confirmed, and records showed, team meetings were not taking place regularly and the trust could not be sure all staff were aware of incident investigations and outcomes.
- Staff attended weekly multi-disciplinary team (MDT) meetings that included a discussion of potential risks relating to patients, and how these risks should be managed.
- One ward matron told us that shift handover sheets had been updated to include more detailed information, following the outcome of a serious incident investigation. We observed three shift handovers and found the information shared to be comprehensive and inclusive of detailed information relevant to patients' risks. The trust had processes that ensured staff were informed of relevant information for care and treatment of patients prior to starting their shift.
- Staff signed ward diary entries to detail what actions had been taken and by which member of staff. This ensured staff were aware of outstanding issues for action during each shift.

Requires improvement

Are services safe?

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

- Staff told us they received timely debrief following incidents. We observed staff arranging a debrief, following a serious incident during our inspection. Ward matrons facilitated debriefs for staff and, when needed were supported by senior matrons.

Psychiatric Intensive Care Unit (PICU)

Safe and clean environment

- The Psychiatric Intensive Care Unit (PICU) was a ten bed, purpose built unit, accepting only male patients.
- The unit consisted of large open areas with good visibility for staff. Staff could see patients in communal corridors from the ward office and staff were visible in patient areas to maintain a safe environment. The trust had completed some work to improve the unit since the last inspection, for example, upgrading en-suites, toilets and bathrooms, and removal of ligature points. The trust had fitted new doors and anti-vandal sanitary ware. Seclusion rooms had been updated.
- The trust had completed and regularly updated the ligature risk assessments. We found these assessments were robust and included all ligature risks. The trust had included details of previous incidents in their assessments and had appropriately weighted the risks identified. The trust had ensured staff were informed of the risks present in the clinical environment.
- The trust had control measures in place to minimise the ligature risk to patients. These included individual patient risk assessments, searching property and the use of increased staff observations of patients who presented as high risk. Staff locked some rooms when not in use and maintained a presence in patient areas. The ward had ligature cutters available and accessible in the event of an emergency occurring.
- Staff had access to personal protective equipment, such as aprons and gloves for infection control.
- The environment did not feel homely and the acoustics were loud. However, the unit was generally clean and tidy and staff told us the cleaning services were generally good.
- The unit had a fully equipped clinic room with accessible resuscitation equipment and drugs that were checked regularly. Staff recorded room and fridge temperatures and kept records.
- The unit had two extra care beds within a separated area. Staff nursed patients who required extra support in these rooms. A large de-escalation room was available for staff to support patients in a safe environment
- The unit had two seclusion rooms located within the extra care area. The trust had completed updates to these environments, to include installation of closed circuit television (CCTV), two way communication system and changes to the doors. The seclusion rooms met the guidance in the Mental Health Act (MHA) 1983 Code of Practice. However, we saw one metal lock that was not fitted flush to toilet the door. This posed a risk to patients intent on self-harm. The seclusion rooms were located away from the communal areas to promote privacy and dignity for patients.
- The unit had good furnishings, compliant with the National Institute for Psychiatric Intensive Care Units (NAPICU) guidelines. However, in the dining room, staff used a small wooden chair to prop open the door. We were concerned this could be easily broken and present a risk to patients and staff.
- The trust supplied data relating to the PLACE scores for cleanliness. Data showed the Bradgate Mental Health Unit scored 93%; against the England average of 98%. PLACE assessments are self-assessments undertaken by NHS and private/ independent health care trusts, and include at least 50% members of the public (known as patient assessors). They focused on different aspects of the environment in which care was provided, as well as supporting non-clinical services.
- Staff completed regularly environmental checks and recorded these appropriately.
- Staff had access to personal alarms and extra alarms were available for use by visitors.

Safe staffing

- The trust supplied data related to staff establishment and vacancies for the PICU between July and September 2016. The total establishment of registered nurses was 12 and there were no vacancies. However, during our inspection, the unit had two vacancies for qualified staff. This represented 16% of the total establishment.

Requires improvement

Are services safe?

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

- The total establishment of nursing assistants was 24 with eight vacancies. This meant that 33% of the establishment for nursing assistant posts were unfilled.
- The trust employed bank or agency staff to fill vacant shifts. The trust used regular bank or agency staff for continuity of care for patients. However, senior staff told us they were concerned about the over-reliance on bank or agency staff and the impact on staff morale.
- The trust provided data that showed between July and September 2016, bank staff filled 52 shifts in the PICU. Agency staff filled seven vacant shifts over the same period. Trust data showed no shifts remained unfilled. This meant the PICU ward had sufficient staff for care and treatment for patients.
- The trust provided data to show how many shifts were filled over a three-month period (May 2016 to July 2016). The fill rate for nursing assistants was 100%, for both day and night during the period covered. The trust provided data to show the fill rates for qualified staff over the same period. This data showed an average compliance of 119%. The trust had ensured there were suitable numbers of appropriately qualified staff for care and treatment of patients.
- The trust provided data that showed the number of staff leavers over the past 12 months. The PICU reported one staff leaver over this period (3.2%). This was lower that the trust average of 9%.
- The trust provided data that showed the percentage of staff sickness over the past 12 months. The PICU reported an average staff sickness of 9%. This was higher than the trust average at 5%. Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments.
- Staff completed mandatory training. The trust supplied data related to compliance with training up to November 2016. Overall, the average compliance with fifteen mandatory training
- Staff maintained a constant presence in patient areas. The unit had sufficient numbers of appropriately trained staff to carry out physical interventions safely, when needed and we observed staff responded quickly and appropriately to the needs of patients.
- The unit had one consultant psychiatrist, working three days per week. Doctors were available to respond in emergencies.

Assessing and managing risk to patients and staff

- The trust provided data between February and July 2016, which confirmed there had been 79 episodes of seclusion in the PICU service.
- The Trust had a “Seclusion and Restrictive Practices Policy” dated December 2015. All staff who participated in seclusion completed seclusion competencies and we saw examples of these. Staff completed accurate records of seclusion, in line with the Mental Health Act (MHA) 1983 Code of Practice and the trust’s policy. Ward matrons and the service manager quality checked each record at the conclusion of seclusion.
- Staff utilised physical restraint as a last resort. We observed staff were highly skilled in verbal de-escalation of patients.
- The trust provided data between February and July 2016, which showed there had been 52 incidents of restraint, involving 12 patients. The trust reported five incidents of ‘prone’ (face down) restraint. The Department of Health document, Positive and Proactive Care (2014) and the Mental Health Act (MHA) Code of Practice state the use of prone restraint should only be used in exceptional circumstances. The trust was compliant with this legislation and staff we spoke to were aware of the risks of prone restraint for patients.
- Staff received mandatory training in safeguarding adults and children. The trust provided data that showed 89% of staff had received training in safeguarding adults and 86% for safeguarding children. The trust had ensured staff had received appropriate training to assist in the safeguarding of patients.
- We reviewed the care and treatment records for six patients. Staff completed comprehensive risk assessments on admission and updated records regularly and after incidents. Staff included historical and current risks and assessments contained detailed information for the safe care and treatment of patients.
- The trust had a policy for the observation of patients. Staff assessed observation needs of patients according to known and predicted risks. Staff observed patients discretely and effectively during our inspection.

Requires improvement

Are services safe?

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

- We looked at the prescription and medicine administration records for all patients. The trust had appropriate arrangements in place for recording the administration of medicines. Staff completed accurate records, which showed patients were receiving their medicines when they needed them. Medical staff recorded patient allergies on their electronic prescribing and medication administration record.
- Medical staff prescribed rapid tranquilisation in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. A policy covering rapid tranquilisation, which included the new NICE guidance, dated March 2016, was available on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. However, we found staff did not always document monitoring of patients vital signs post rapid tranquilisation.
- Staff had quick access to medicines and medicines for discharge were readily available with electronic discharge records.
- Overall, patients detained under the Mental Health Act (MHA) received medicines that were authorised and administered in line with the MHA Code of Practice. Staff had access to T2 (consent to treatment) and T3 (record of second opinion) for reference when administering medication for patients.
- The trust had pharmacy services across the acute wards. Pharmacist interventions were located, on the electronic prescription chart, for both prescribers and nurses administering the medication to be informed. A ward technician visited the wards daily. The pharmacist did not routinely attend ward rounds or MDT meetings. However, an on call was pharmacist available for both dispensing and advice for staff.
- Staff stored medicines securely. Controlled drugs were stored appropriately and staff kept accurate records.
- Patients could receive visitors in the quiet room, or dining room. Staff supervised family visits in the dining room and visitors entered via the outside door. This meant visitors did not walk through the patient areas.

Track record on safety

- Between 01 July 2015 and 30 June 2016, trust staff reported one serious incident regarding this core service. The trust had failed to obtain appropriate bed for a child who needed it.
- The trust had made updates to the clinical environment to improve the safety of patients. For example, doors on the seclusion rooms had been re-hung and CCTV and intercoms fitted for observations and communication.

Reporting incident and learning from when things go wrong

- Staff described 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 that had occurred within the services. The trust told us that there was a local governance process in place to review incidents, for example the missing person's violence risk reduction group.
- The ward matron discussed trust-wide incidents in team meetings and we saw details of incident investigations in team meeting minutes. However, senior staff confirmed, and records showed, team meetings were not taking place regularly. The trust could not be sure, therefore, all staff were aware of incident investigations and outcomes. Staff attended weekly multi-disciplinary team (MDT) meetings that included a discussion of potential risks relating to patients, and how these risks should be managed.
- Staff told us they received timely debrief following incidents. Ward matrons facilitated debriefs for staff and, when needed were supported by senior matrons.

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.

Our findings

Acute wards for adults of working age

Assessment of needs and planning of care

- We reviewed 39 care and treatment records for patients.
- Overall, we found staff assessed and planned care for individual patient's needs. Staff completed care plans that gave information about how to best care for the patient. However, the quality of care plans differed in the records we reviewed. For example, we found 37 care plans were holistic, containing a full range of needs and problems, 34 were also recovery orientated, detailing the patients' strengths and goals, 29 contained a physical examination on admission and information of ongoing physical healthcare needs.
- Staff used a combination of electronic patient records and paper records. All staff had access to the electronic patient record system, were able to access, and input patient information. Staff working on other wards, the home treatment and community teams could access patient information to assist with discharge planning and ongoing care needs. Paper records were accessible to staff and stored securely in ward offices.

Best practice in treatment and care

- The trust employed registered general nurses (RGN) to assist with assessment and management of physical healthcare needs for patients. Staff we spoke to confirmed input from the RGNs had been a valuable resource for staff and patients. Staff supported patients to access specialists, as required and escorted patients to appointments, when needed.
- The trust had one psychologist in post. On all wards, staff (doctors and nurses) told us there was an absence of psychology input.No evidence was recorded as to how care was being provided in line with relevant NICE (National Institute for Health and Care Excellence) guidance, particularly relating to the provision of psychological therapies for patients. Nursing staff did not refer patients for psychological input, as no service was available. The trust advised that three staff were completing, or had completed, training in psychological therapies across acute wards.
- Ward staff told us the psychologist facilitated reflective practice sessions for staff every two weeks; however, we were not shown any records of this.
- The trust had identified the lack of psychological therapies for patients, and support and training for staff, on their risk register. The trust detailed plans to advertise for posts with a target date of February 2017. However, the trust was required to address this deficit following the Care Quality Commission inspection in 2015. We were concerned that a significant period had passed and the trust had not improved access to psychology for patients and staff.
- Medical staff completed health of the nation outcomes scales (HoNOS) and assigned patients to specific mental health clusters. These are specific pathways of care, individualised to patient needs.
- The trust monitored and audited outcomes for patients using the service. This included the monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation.
- Staff on wards completed some audits, for example, audits of care records and care planning. We were not shown any records and it was not clear how this information was used for the development or improvement of the service.

Skilled staff to deliver care

- Wards had a range of disciplines to provide care and treatment. The multidisciplinary team (MDT) consisted of consultants, doctors, qualified nurses, healthcare support workers, occupational therapists and therapy liaison workers. Pharmacy staff were available when needed. Wards did not have social workers. However, community psychiatric nurses and social workers would attend care reviews from the community mental health teams when required.
- The trust provided a formal induction period for new permanent staff. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone. Newly registered staff completed a period of preceptorship. Preceptorship is a period in which to guide and support all newly qualified practitioners to make the transition from student to registered nurse.

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 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.
- The trust provided training for health care support workers in the care certificate. The care certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. However, compliance rates were low. On Ashby, Aston, Beaumont and Heather wards, no staff had received this training. The highest compliance was on Watermead ward at 30%, followed by Thornton ward at 22% and Bosworth ward at 14%.
- Staff did not receive regular clinical supervision, in line with trust policy. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice. The trust provided data that showed an average low compliance with supervision at 27%. Watermead ward recorded 40% compliance and Ashby ward recorded 17%.
- The Care Quality Commission last inspected this service in March 2015 and reported the trust was in breach of regulations for supporting staff. The trust was required to improve access to supervision for all staff. The trust had not adequately addressed this issue and could not be sure staff were given the opportunity to discuss their developmental and training needs, or that poor performance had been identified or managed. We found that supervision records contained a mixture of clinical and managerial supervision documentation. However, all staff told us they received informal supervision and guidance regularly from colleagues, ward matrons and senior managers.
- The trust provided data, which showed that 82% of non-medical staff had received an appraisal over the past 12 months. The trust did not supply a target for appraisal compliance. This was slightly below the trust's overall achievement at 83%. Appraisalis a method by which the job performance of an employee is documented and evaluated.
- The Trust had ensured that medical staff received an appraisal in accordance with trust policy, and as required by the General Medical Council (GMC). As at 30th June 2016, 130 doctors had received an appraisal, representing 94%.
- Matrons did not hold regular team meetings. Across all wards, we found team meeting minutes showed sporadic compliance. We were concerned that staff might not receive timely information relating to incident investigations and outcomes.
- The trust had processes for identifying and managing poor staff performance, including involvement from occupational health and the human resources (HR) departments. From August 2015, the trust reported one member of staff placed under supervised practice.

Multidisciplinary and inter-agency team work

- We observed a multidisciplinary meeting on Ashby ward and found staff had prepared well for the discussion. Patients were encouraged to participate and share their views. We found the meeting was 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.
- We observed three ward handovers. We found these to be well structured and informative. Staff provided details including each patient's level of observations, risks, and Mental Health Act status. Staff received information on diagnosis, current presentation, activities for the day and physical health care, as appropriate. Staff had received detailed and relevant information to allow them to care for patients.
- 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.

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

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.

- The Care Quality Commission completed five Mental Health Act (MHA) review visits between 22 August 2015 and 23 October 2016. Mental Health Act reviewers identified thirty-five issues in five visits to wards. The most common issues found were 'care, support and treatment in hospital' with nine issues, equating to 25% of the total, followed by 'protecting patients' rights and autonomy' with eight issues, 22% of the total. The Mental Health Act reviews identified ten issues each on Ashby and Ashton wards.
- The trust provided data relating to compliance with staff training in the MHA and Code of Practice. Data provided showed as of November 2016, the average staff compliance across all wards with training in the MHA was 87%. One hundred percent of staff on Thornton and Ashton wards were up to date with this training. The trust had ensured that the vast majority of staff were appropriately trained for their role.
- Staff we spoke with were aware of their responsibilities under the MHA and knew where to get further advice, if needed.
- Staff completed most MHA paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned MHA onto the electronic record for staff reference.
- Medical staff completed consent to treatment and capacity requirements. Nursing staff had access to T2 (consent to treatment) and T3 (second opinion authorisations) when administering medication for patients.
- However, on Aston ward, one patient had an expired T2 form. Staff had continued to administer medication under an expired authority for eight months. Medical staff corrected this during the inspection. On Heather ward, we found a six-day gap in authorisations for administration of medication for one patient.
- MHA administrators were available to offer support and legal advice to staff on the implementation of the MHA and its Code of Practice. The MHA administration office provided reminders to consultants for section renewals and consent to treatment. Overall, we found this worked well.
- Nursing staff checked and received detention papers. The MHA administrators completed scrutiny of section papers to ensure compliance with the MHA.
- Patients had access to Hospital Managers' Hearings and Mental Health Review Tribunals took place. The trust had ensured patients' right to appeal their detention under the MHA were facilitated.
- Staff did not always document patients' consent to treatment prior to the first administration of medication. The trust was not always recording patients' consent to treatment in accordance with the MHA Code of Practice.
- Staff monitored patient leave from the wards (section 17) by use of paper based 'in/out' recording forms. Staff recorded information such as the time the patient left the ward, expected time of return, actual time of return and escort and description. However, we found staff across wards used the electronic progress notes to record leave differently. For example, staff on Aston, Beaumont and Heather wards did not fully complete the form. Staff on Bosworth, Ashby, Thornton and Watermead wards completed forms in full. Staff told us there was confusion across teams and it was difficult to fully complete forms for short periods of leave due to difficulties in accessing computers.
- Overall, staff read patients their rights under section 132 MHA on admission and regularly thereafter. However, we found two records for patients detained under Section 2 MHA (a 28 day assessment and treatment order) where patients had lacked understanding of their rights and further reminders were set for the following week, significantly reducing the time the patient was able to appeal. One patient had not had a further reminder. Another patient on Section 3 MHA had not understood their rights and there was no evidence of the rights being re-read.
- Staff had access to the approved mental health professional (AMHP) reports, which detailed the concerns and circumstances identified when patient were assessed and detained. This ensured staff had relevant information to assess and plan care for patients.
- The trust provided access to Independent Mental Health Act advocates for patients and contact details were contained in admission packs and displayed on wards for patient reference. Staff were clear on how to access

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.

the service on behalf of patients. Staff referred all detained patients to the Independent Mental Health Advocacy (IMHA) service. The IMHA service received a list of detained patients on a weekly basis.

Good practice in applying the Mental Capacity Act

- The trust provided data relating to compliance with staff training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Data provided showed as of November 2016, the average staff compliance across all wards with training in the MCA was 89%. One hundred percent of staff on Watermead ward were up to date with this training. The trust had ensured that staff were appropriately trained for their role.
- Staff made one DoLS application, relating to an acute patient, between March 2016 and September 2016.
- The trust had a Mental Capacity Act and Deprivation of Liberty Safeguards policy for staff reference.
- Most staff explained how capacity was assessed for significant decisions and told us medical staff completed mental capacity assessments for patients. We saw evidence of good quality mental capacity assessments in some patient care records.
- None of the patients receiving care and treatment during our inspection were under a DoLS.

Psychiatric Intensive Care Unit (PICU)

Assessment of needs and planning of care

- We reviewed six care and treatment records for patients.
- Staff completed care plans for patients and reviewed these regularly. Overall, staff assessed and planned care for individual patient's needs. Staff completed care plans that gave information about how to best care for the patient. However, two care plans did not contain a full range of problems and needs and two were not recovery orientated. Patient records showed only one patient had received a copy of their care plan
- Staff recorded physical health care needs of patients and planned appropriate care to meet identified needs. Staff completed ongoing physical healthcare monitoring and recorded these in the patient records.
- Staff used a combination of electronic patient records and paper records. All staff had access to the electronic patient record system, were able to access, and input patient information. Staff working on other wards, the home treatment and community teams could access patient information to assist with discharge planning and ongoing care needs. Paper records were accessible to staff and stored securely in the ward office.

Best practice in treatment and care

- The trust employed registered general nurses (RGN) to assist with assessment and management of physical healthcare needs for patients. Staff we spoke to confirmed input from the RGNs had been a valuable resource for staff and patients. Staff supported patients to access specialists, as required and escorted patients to appointments, when needed.
- The trust had one psychologist in post. Staff told us there was an absence of psychology input.We saw no evidence of care being provided in line with relevant NICE (National Institute for Health and Care Excellence) guidance, relating to the provision of psychological therapies for patients. Nursing staff did not refer patients for psychological input, as no service was available.
- Ward staff told us the psychologist facilitated reflective practice sessions for staff every two weeks; however, we were not shown any records of this.
- The trust had identified the lack of psychological therapies for patients, and support and training for staff, on their risk register. The trust detailed plans to advertise for posts with a target date of February 2017. However, the trust was required to address this deficit following the Care Quality Commission inspection in 2015. We were concerned that a significant period had passed and the trust had not improved access to psychology for patients and staff.
- Medical staff completed health of the nation outcomes scales (HoNOS) and assigned patients to specific mental health clusters. These are specific pathways of care, individualised to patient needs.
- The trust monitored and audited outcomes for patients. This included the monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation.

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.

- Senior staff told us staff on wards completed some audits, for example, audits of care records and care planning. However, we were not shown any records and it was not clear how this information was used for the development or improvement of the service.

Skilled staff to deliver care

- The unit had a range of disciplines to provide care and treatment. The multidisciplinary team (MDT) consisted of consultants, doctors, qualified nurses, healthcare support workers, occupational therapists and therapy liaison assistants. Pharmacy staff were available when needed. The unit did not have an allocated social worker; however, community psychiatric nurses and social workers would attend care reviews from the community mental health teams when required.
- The trust provided a formal induction period for new permanent staff. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone.
- The trust provided training for health care support workers in the care certificate. The care certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. However, no staff on the PICU had received this training.
- 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.
- The trust had systems for nursing staff to participate in clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice. The trust provided data that showed low compliance with supervision at 37%. The Care Quality Commission last inspected this service in March 2015 and reported the trust were in breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 (supporting staff). The trust was required to improve access to supervision for all staff. The trust had not adequately addressed this issue and could not be sure staff were given the opportunity to discuss their developmental and training needs, or that poor performance had been identified or managed.
- The trust provided data, which showed that 87% of non-medical staff had received an appraisal over the past 12 months. The trust did not supply a target for appraisal compliance. This was above the trust's overall achievement at 83%. Appraisal is a method by which the job performance of an employee is documented and evaluated. The trust could not be sure that performance issues or development opportunities were discussed with all staff working in the PICU service.
- Staff were not in receipt of regular team meetings. The unit aimed to have team meetings every month, however, we reviewed team meeting minutes and found staff had access to six team meetings over a nine-month period. We were concerned that staff might not receive timely information relating to incident investigations and outcomes.
- The trust had processes for identifying and managing poor staff performance, including involvement from occupational health and the human resources (HR) departments.

Multi-disciplinary and inter-agency team work

- Staff attended multidisciplinary team (MDT) meetings. Patients were encouraged to participate and share their views. These meetings were effective in enabling staff to share information about patients and review their progress. Different professionals worked together to assess and plan patients' care and treatment.
- Occupational therapists and therapeutic support workers worked as part of the team and we saw that they worked closely with patients. The patients we talked with spoke positively about the support they received.
- Staff had effective processes for shift handovers. Staff provided details including each patient's level of observations, risks, and Mental Health Act status. Staff received information on diagnosis, current presentation, and activities for the day and physical health care, as appropriate. Staff had received accurate and relevant information to allow them to care for patients.

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.

- Medical staff were a regular presence. Staff spoke highly about the support they received from the consultant and their medical colleagues.
- Community teams were invited to attend MDT and discharge planning meetings.

Adherence to the MHA and the MHA Code of Practice

- All patients on Belvoir ward were detained under the Mental Health Act 1983 (MHA).
- The Care Quality Commission completed one Mental Health Act review visit to the PICU between 22 August 2015 and 23 October 2016. The review identified one issue during the visit, equating to 'protecting patients' rights and autonomy'.
- We reviewed the systems in place to ensure compliance with the MHA and adherence to the guiding principles of the MHA Code of Practice. All patients whose care records we reviewed were lawfully detained and treatment was given under an appropriate legal authority.
- The trust provided data relating to compliance with staff training in the MHA and code of practice. Data provided showed as of November 2016, 92% of staff were up to date with this training. The trust had ensured staff were appropriately trained for their role.
- Staff we spoke with were aware of their responsibilities under the MHA and knew where to get further advice, if needed.
- Staff completed MHA paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned MHA paperwork onto the electronic record for staff reference.
- Medical staff completed consent to treatment and capacity requirements. Nursing staff had access to T2 (consent to treatment) and T3 (second opinion authorisations) when administering medication for patients.
- MHA administrators were available to offer support and legal advice to staff on the implementation of the MHA and its Code of Practice. The MHA administration office provided reminders to consultants for section renewals and consent to treatment. Overall, we found this worked well.
- Nursing staff checked and received detention papers. The Mental Health Act administrators completed scrutiny of section papers to ensure compliance with the MHA.
- Patients had access to Managers' Hearings and Tribunals took place.
- Overall, staff read patients their rights under section 132 MHA on admission and regularly thereafter.
- Staff had access to the approved mental health professional reports, which detailed the concerns and circumstances identified when patient were assessed and detained. This ensured staff had relevant information to assess and plan care for patients.
- The trust provided access to Independent Mental Health Act advocates (IMHA) for patients and contact details were contained in admission packs and displayed on wards for patient reference. Staff were clear on how to access the service on behalf of patients. Staff referred all detained patients to the IMHA service. The IMHA service received a list of detained patients on a weekly basis.

Good practice in applying the MCA

- The trust provided data relating to compliance with staff training in the Mental Capacity Act 2005 (MCA). Data provided showed as of November 2016, staff compliance with training in the MCA was 92%. The trust had ensured staff were appropriately trained for their role.
- The trust had a Mental Capacity Act and Deprivation of Liberty Safeguards policy for staff reference.
- None of the patients receiving care and treatment during our inspection were under a DoLS.
- Staff we spoke with had varying degrees of knowledge about the MCA and DoLS process. Most staff explained how capacity was assessed for significant decisions and told us medical staff completed mental capacity assessments for patients. We saw evidence of a good quality mental capacity assessment in one patient care records.

Good

Are services caring?

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

Our findings

Acute wards for adults of working age

Kindness, dignity, respect and support

- We spoke with twenty-one patients receiving care and treatment in the acute wards.
- We observed how staff interacted with patients throughout the three days of our inspection.
- Staff were 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. Staff were visible in the communal ward areas and attentive to the needs of the patients they cared for.
- Overall, patients told us that staff treated them with respect and were caring in their interactions. However, several patients reported that bank staff were less respectful than regular staff and they did not always introduce themselves. Many patients commented that staff were very busy and often in the office writing notes. Most patients told us they felt safe on the wards; however, some wards were excessively busy and noisy. The majority of patients felt staff were doing their best to meet patient needs but that ward activity levels made this difficult.
- The trust supplied data relating to the PLACE scores for privacy and dignity. Data showed the Bradgate Mental Health Unit scored 82%, which is below the England average of 84% but higher than the trust average of 80%.

The involvement of people in the care that they receive

- Staff had not always ensured patients were involved in the formulation of their care plan. We reviewed 39 care and treatment records for patients and found 34 had evidence of patient involvement. However, 18 of these contained minimal evidence of patient involvement and five contained no evidence of patient involvement.
- From the notes reviewed, 23 patients had received a copy of their care plan. In the records of 16 patients, we could find no evidence that patients had received a copy of their care plan.
- Staff invited patients to attend the multi-disciplinary reviews along with their family where appropriate.
- Patients had access to advocacy services on the wards and information and contact details were contained in patient admission packs and on posters and leaflets available on the wards.
- Wards had information boards detailing the staff on duty and staffing levels. This informed patients of the staff available for care and treatment for that day.
- The trust required community meetings to take place regularly on wards. The trust operated a standard agenda for these meetings, completed by the facilitators. However, we found that records of these meetings were sporadic and actions were not documented as completed. We could not be sure that patients had access to regular community meeting to discuss concerns with staff or that the trust had addressed previous issues.

Psychiatric Intensive Care Unit (PICU)

Kindness, dignity, respect and support

- We spoke with four patients receiving care and treatment in the psychiatric intensive care unit (PICU).
- We observed how staff interacted with patients throughout the 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 and dealing respectfully with challenging and difficult behaviour. Staff were visible in the communal ward areas and attentive to the needs of the patients they cared for.
- Three patients told us that staff treated them with respect and were caring in their interactions and they felt safe on the unit. Two patients told us they felt supported by the high ratios of staff to patients and one patient told us staff did not understand him. The majority of patients felt staff were doing their best to meet patient needs but that ward activity levels made this difficult.
- All staff spoken todetailed knowledge 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.

- The trust supplied data relating to the PLACE scores for privacy and dignity. Data showed the Mental Health Unit scored 82%, which is below the England average of 84% but higher than the trust average of 80%.

The involvement of people in the care they receive

- Staff had not always ensured patients were involved in the formulation of their care plan. We reviewed six care and treatment records for patients and found only one contained evidence of patient involvement.
- From the notes reviewed, one patient had received a copy of their care plan and one patient record showed the patient had refused. This meant there was no evidence of patient involvement in their care for four of the patients whose records we reviewed.
- Staff invited patients to attend the multi-disciplinary reviews along with their family where appropriate.
- Patients had access to advocacy services on the unit and information and contact details were contained in patient admission packs and on posters and leaflets available on the unit.
- The trust required community meetings to take place regularly on wards. The trust operated a standard agenda for these meetings, completed by the facilitators. However, we found that records of these meetings were sporadic and staff had not documented that actions were completed. We could not be sure that patients had access to regular community meeting to discuss concerns with staff or that the trust had addressed previous issues. However, the trust had re-employed an external facilitator, with experience of using services, to facilitate community meetings going forward. We observed a community meeting during the inspection and found this was well organised. Patients had sufficient time to express their views and staff maintained a discreet presence throughout. Patients responded positively to the meeting, stating that it had been very useful and a good opportunity to share views on services they received.

Are services responsive to people's needs?

Inadequate

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

Our findings

Acute wards for adults of working age

Access and discharge

- The trust had a crisis resolution home treatment team, responsible for requesting inpatient treatment for patients. The trust's proportion of admissions to acute wards gate kept by the crisis resolution home treatment (CHRT) team was above the England average for seven of the 12 quarters reported. The trust reported particularly low achievement between January and March 2016 at 59%. The trust did not achieve the national 95% target in all quarters.
- The trust provided data to show their average bed occupancy between May 2016 and October 2016 or all acute wards. The average bed occupancy for this period was 110%. The highest bed occupancy rate was Beaumont ward at 125%, meaning that the trust were utilising beds of patients on leave for new admissions. Aston ward recorded the lowest bed occupancy at 82%.
- The trust experienced pressure on their acute beds to admit patients and to find beds for patients returning from leave. The trust had a bed management team, working 24 hours, seven days per week that managed all inpatient beds. The bed management team maintained records to show patient needs and barriers to discharge, for example, housing needs and requirements for allocation to care co-ordinators.
- Staff attended regular bed management meetings to discuss patient needs and bed availability. However, staff reported feeling pressured into admitting patients into leave beds.
- Due to pressure on beds, staff often transferred patients from one ward to another during their admission. This disrupted the continuity of their care because it meant that patients came under the care of a different team of nurses each time they changed ward. During our inspection, we observed on a number of wards patients were using leave beds of other patients. During our unannounced visit on 23 November, one staff member told us on Beaumont ward that patients were "frightened to go on leave" in case they had no bed to return to.
- On Thornton Ward, 24 beds were available and accommodated by 24 patients. Additionally, four further patients were on leave with no bed was available on their ward, should they need to return. A further patient was receiving care at Stewart House (a long stay rehabilitation ward) as no beds were available within the acute service. However, staff were trying to locate a bed on Thornton ward for their return.
- Staff moved patients to the rehabilitation wards, during periods of acute care, to free beds for admissions. Since May 2016, staff transferred 39 patients between acute wards and rehabilitation wards during episodes of care. The trust advised 18 patients were transferred back to acute beds and 17 were assessed and found suitable to remain within the rehabilitation service. Staff transferred eight patients back to the acute wards within three days and ten remained on rehabilitation wards for between five and 57 days. The trust was not ensuring continuity of care for these patients.
- Between 1 February 2016 and 31 July 2016, the trust reported 53 out of area placements for the acute wards and psychiatric intensive care unit (that is, beds that are not within the trust's catchment area). The bed management team sourced out of area beds for patients requiring admission when no local beds were available
- The trust provided data to show the average length of stay for patients. Across the acute wards, the average length of stay was 51 days. The longest average length of stay was on Beaumont ward at 72 and the lowest on Aston ward at 37. The trust reported no incidents of re-admission of patients within 90 days from August 2015 to August 2016.
- The trust reported 48 delayed discharges between August 2015 and July 2016. The highest number was on Beaumont ward at 15 and the lowest on Aston ward at one. Patients' discharges were delayed for a variety of reasons, the most common being lack of suitable housing and difficulties with finding suitable ongoing placements.
- The trust did not have psychiatric intensive care (PICU) facilities for females. The trust was not commissioned to provide a female PICU and have identified the need for this provision with their commissioners. The bed management team made individual referrals to

Are services responsive to people's needs?

Inadequate

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

alternate PICU services for females as needed. The provider told us this resulted in patients having to travel long distances to access PICU beds, for example, hospitals in Essex (110 miles) and Blackheath (124 miles). Bed management staff also sought access to alternate male PICU beds, when the trust's PICU facility was at capacity.Patients requiring an acute bed were also placed out of area when no beds were available; sometimes considerable distances, for example to Bristol (117 miles) and Surrey (116 miles) Patients might experience difficulties maintaining contact with family, community support, and friends during these placements.

The facilities promote recovery, comfort, dignity and confidentiality

- The accommodation and facilities for patients at the Bradgate Mental Health Unit varied between wards. For example, on Ashby, Bosworth and Thornton wards, we found inadequate numbers of rooms for care and treatment of patients. Wards did not have sufficient rooms for patient to access 1-1 time with nursing staff, to receive visitors or to participate in ward based activities. Patients had difficulty having confidential and private conversations with staff and visitors.
- Patients accommodated in shared bed bays had no access to a private space. Curtains separated the beds and up to four patients were accommodated in each bay. Patients experiencing mental health crisis or distress had limited personal space in these environments. However, on Heather, Beaumont and Watermead we found quiet rooms available and on Aston ward a quiet room was available, however staff could not easily observe patients using this area.
- Patients had access to a family room on site. Patients could use this area to meet with children. Watermead ward had a visitor's room, accessible from the main corridor. This meant that visitors did not need to enter the ward to access the visitor's room.
- On Ashby ward, the shower rooms did not have curtains fitted. This was a breach of the privacy and dignity to patients as staff might be required to enter the shower rooms to check patients were safe. One shower room did not have any area for patients to place clean clothing. Patients placed their clean clothing on the bin and as there was no shower curtain, patients clothing would get damp whilst they showered.
- Patients had use of their mobile phones across all wards. Wards had payphones for patient use in communal areas and staff facilitated private phone calls in ward offices or by use of cordless telephones when needed. The trust provided information on accessing telephone calls and the internet in patient welcome packs.
- All wards had good access to outside space. Patients could access the garden areas between 06:00 am and midnight. Staff would facilitate access to the garden during the night, when needed. However, we found some blind spots within garden areas where staff could not easily observe patients, for example on Aston and Bosworth wards. The garden on Thornton ward was not accessible to patients due to damage to the entrance door. Patients were using a small walkway in the interim. However, staff had reported the damage and the trust told us the door has since been replaced.
- The trust supplied data relating to the PLACE scores for food. Data showed the Bradgate Mental Health Unit scored 94%; this is above the England average of 88% and higher than the trust average at 85%.
- Patients had access to ward kitchens to make hot and cold drinks and access fresh fruit. Staff closed access to these rooms after midnight. Staff would provide patients with drinks when kitchens were closed, on request.
- Patients were able to personalise their bedrooms, for example with artwork and photographs. Patients accommodated in bed bays had less space; however, we observed personal items in these areas.
- Patients did not have lockable spaces in bedrooms or bed bays. The trust provided lockers on each ward for patients to store their valuables. However, patients did not hold their own keys. Staff would access lockers on behalf of patients. Patients accommodated in bed bays could not protect any personal items as room doors were left open. Wards also had lockable cupboards for items considered to pose risk to patients, for example,

Are services responsive to people's needs?

Inadequate

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

razors and hair straighteners. Patients could access these items on request from staff and access was subject to risk assessment and staff observation, when needed.

- Wards had a range of activities available for patients. Occupational therapy staff facilitated activities on the wards, for example, art, pampering and relaxation, and pool tournaments. Patients had access to activities off the ward, for example anxiety management, art and pottery, and walking groups. Patients also had access to a gym. The trust provided an involvement centre within the site. Patients could access a computer and attend a variety of activities for which there was a separate timetable. Staff escorted patients according to risk assessment and observation levels. Friends and families were welcome to attend with patients.
- Patients received information on the involvement centre in patient admission packs. Staff provided some activities at weekends, although these were more limited and varied between wards. For example, on Thornton and Bosworth ward, we saw baking and games were facilitated at weekends and on Beaumont ward, no activities were included in the timetable for patients over the weekend.

Meeting the needs of all people who use the service

- The trust did not have facilities for disabled patients on all wards. However, the trust had disabled facilities for patients on some wards. For example on Heather ward, an assisted bathroom was available. Staff told us the trust could access mobility aids and equipment when needed. We reviewed the equipment provided for one patient who was wheelchair bound and found all necessary equipment was available.
- Staff could access information leaflets in a variety of languages for patients whose first language was not English. The trust had a specific email address and contact telephone number to ensure information was available quickly when needed. We found these details contained in patient admission packs.
- Patients had access to a wide range of information leaflets in ward areas. For example, information of advocacy, patients' rights, how to complain and local services.
- Staff had access to interpreters to ease communication with patients, as needed. Staff had access to contact telephone numbers in ward offices.
- The trust provided a choice of food to meet differing dietary needs and choices. However, patients told us that vegetarian options were sometimes limited when patients not restricted to a vegetarian diet selected these choices.
- The trust provided a chaplaincy service that provided patients with access to support from a variety of religions and faiths.

Listening to and learning from concerns and complaints

- Patients had access to information on how to make a complaint. Wards had information on the complaints process available to patients on ward notice boards and in leaflets. Staff supported patients to raise concerns when needed.
- The trust had systems for the recording and management of complaints. We saw it evidenced how the trust investigated complaints and included outcomes and learning for staff. However, we reviewed the minutes of team meetings across all wards and found staff did not have access to regular team meetings. Therefore, the trust could not be sure staff received feedback in a timely manner.
- Between August 2015 and July 2016, the trust received 37 complaints for acute services, of which 20 were upheld (54%). Two complaints were referred to the ombudsman, neither of which were upheld.
- The trust recorded 33 compliments from patients and carers who were pleased with the services they received. Beaumont ward received the highest amount of compliments at 21.

Psychiatric Intensive Care Unit (PICU)

Access and discharge

- The trust provided data to show their average bed occupancy between May 2016 and October 2016. The average bed occupancy for this period was 98%. The trust had beds available for care and treatment for patients.

Are services responsive to people's needs?

Inadequate

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

- The trust provided data to show the average length of stay for patients. The average length of stay on the PICU was 28 days.
- The trust reported 53 out of area placements between 1 February 2016 and 31 July 2016. However, the trust did not advise how many related specifically to the PICU service
- The trust reported one delayed discharge between August 2015 and July 2016.
- The trust experienced pressure on their PICU beds to admit patients. The trust had a bed management team, working 24 hours, seven days per week that managed all inpatient beds. The bed management team maintained records to show patient needs and barriers to discharge, for example, housing needs and requirements for allocation to care co-ordinators. Staff attended regular bed management meetings to discuss patient needs and bed availability.
- The trust did not have psychiatric intensive care (PICU) facilities for females. PICU staff assessed patient need for PICU beds and the bed management team made individual referrals to alternate PICU services for females as needed. Staff told us this resulted in patients having to travel long distances to access PICU beds, for example, hospitals in Essex (110 miles) and Blackheath (124 miles). Patients might experience difficulties maintaining contact with family, community support, and friends during these placements. Bed management staff also sought access to alternate male PICU beds, when the trust's PICU facility was at capacity.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients were accommodated in single rooms, with en-suite facilities. The trust supplied furniture that met the National Institute for Psychiatric Intensive Care Units (NAPICU) standards. Patient bedrooms did not contain showers; however, the unit provided access to two bathrooms and three showers for patient use.
- The unit had a range of rooms and equipment to support treatment and care of patients. For example, two lounges, a games room, dining room and quiet rooms. Patients had access to a gym and staff supervised patients to ensure the equipment was used safely.
- Patients could receive visitors in the quiet room and staff facilitated visits, under supervision, in the dining room when needed. Visitors could access the dining room via an outside entrance, meaning they did not have to enter to main ward environment.
- Patients could make telephone calls in private. The unit had a telephone room with a heavy chair for patient use. Staff maintained observations while patients used the telephone room due to an identified ligature risk.
- Patients had access to outside space. Staff facilitated access to the garden every one to two hours and supervised patients when outside. The garden had adequate seating and patients could participate in games, for example basketball, in this area. There was no closed circuit television (CCTV) in this area; however, patients were supervised by two staff when using the garden.
- The trust supplied data relating to the PLACE scores for food. Data showed the Bradgate Mental Health Unit scored 94%; this is above the England average of 88% and higher than the trust average at 85%. Overall, patients told us the food was of good quality with plenty of variety.
- Staff facilitated access to hot drinks for patients and cold drinks were readily available. The cold-water dispenser was broken during our inspection; which meant patients had to request cold drinks from staff. Patients had access to snacks and fruit on request.
- We saw patients were able to personalise their bedrooms, for example with pictures, personal items and art work.
- Patients could store their valuable in lockers. Staff accessed valuables on behalf of patients, subject to risk assessment, when requested.
- The unit did not have a full time occupational therapist. The occupational therapists worked within clusters covering the Bradgate Mental Health Unit. The occupational therapist visited the unit two or three times a week. However, the therapeutic liaison worker attended the unit daily to facilitate activities. Activities included a newspaper group, pool, basketball and access to the gym. Patients and staff told us there were fewer activities available during the weekends.

Are services responsive to people's needs?

Inadequate

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

Meeting the needs of all people who use the service

- The unit could accommodate a disabled patient and had a profiling bed. A profiling bed is specifically designed to be adjusted to reposition and support the disabled user. The unit had no assisted bathrooms; however, wet rooms were available and suitable for use by a patient with disabilities. The unit could access other equipment as needed to support the needs of a disabled patient.
- Staff could access information leaflets in a variety of languages for patients whose first language was not English. The trust had a specific email address and contact telephone number to ensure information was available quickly when needed. We found these details contained in patient admission packs.
- Patients had access to a wide range of information leaflets in ward areas. For example, information of advocacy, patients' rights, how to complain and local services.
- Staff had access to interpreters to ease communication with patients, as needed. Staff had access to contact telephone numbers in ward offices.
- The trust provided a choice of food to meet differing dietary needs and choices.
- The trust provided a chaplaincy service that provided patients with access to support from a variety of religions and faiths. The unit had used the services of an Imam trained in the Government's anti-terrorism strategy (Prevent) designed to safeguard vulnerable people at risk of radicalisation. The trust had acknowledged the need to protect and support vulnerable patients under such circumstances.

Listening to and learning from concerns and complaints

- Patients had access to information on how to make a complaint. The unit had information on the complaints process available to patients on posters and in leaflets. Staff supported patients to raise concerns when needed.
- The trust had systems for the recording and management of complaints. We saw it evidenced how the trust investigated complaints and included outcomes and learning for staff. However, we reviewed the minutes of team meetings and found staff did not have access to regular team meetings. The trust expects teams to have monthly meetings. Between March and October 2016 there had been six team meetings. Therefore, the trust could not be sure staff received feedback in a timely manner.
- Between August 2015 and July 2016, the trust received one complaint for the PICU, which was upheld (100%).No complaints were referred to the ombudsman.
- The trust recorded three compliments from patients and carers who were pleased with the services they received.

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.

Our findings

Acute wards for adults of working age

Vision and values

- Staff we spoke with were aware of the organisation's values. Staff identified that these were available on the trust's intranet system and were regularly highlighted in meetings and training.
- Staff we spoke with knew who the most senior managers in the organisation were. Staff told us that senior staff within the trust had visited the wards. These included the chief executive and various executive directors. Overall, staff spoke highly about support offered at the senior executive level.
- Staff felt well supported by ward matrons and local senior managers.

Good governance

- The trust had systems to monitor staff compliance with mandatory training. Overall compliance up to November 2016 with all training was 83%. The trust did not identify a target for staff to achieve. However, the CQC identified low compliance with staff training in immediate life support following its inspection in March 2015. Trust data showed compliance with ILS training had not achieved a satisfactory level of compliance. The average compliance with ILS training was 70%; however, Ashby ward recorded compliance at 54% and Bosworth ward 58%.
- The trust did not have robust process for ensuring all staff had access to clinical supervision. The trust had not achieved its 85% target for compliance with clinical supervision of staff. Data provided showed an average compliance across acute wards of 27%. The Care Quality Commission last inspected this service in March 2015 and found the trust was in breach of Regulations related to supporting staff. The trust was required to improve access to supervision for all staff. The trust had not adequately addressed this issue and could not sure staff were given the opportunity to discuss their developmental and training needs, or that poor performance had been identified or managed. The trust was non-compliant with their clinical supervision policy.
- The trust had systems for monitoring compliance with annual appraisal of staff. Data provided showed 82% of non-medical staff had received an appraisal over the past 12 months.
- The trust had an overall vacancy rate for registered nurses of 20%. Bosworth and Watermead wards reported qualified nursing vacancies of 37%. Wards employed temporary staff to maintain a safe environment. However, there were insufficient numbers of registered staff across the service. The trust had ongoing recruitment and retention processes to address this.
- Patients did not have access to a psychologist or adequate psychological therapies, in accordance with NICE guidelines. The CQC highlighted this as a concern and a breach of regulations following its inspection in March 2015. The trust was required to address this deficit in care provision. The trust provided data that showed, at the time of the inspection, psychology posts had been identified but not advertised. Therefore, the trust had not addressed this concern for over two years and psychology posts remained unfilled.
- The trust had processes for the recording and investigation of incidents and complaints. However, staff were not in receipt of regular staff meetings. The trust could not be sure staff were in receipt of investigation outcomes in a timely manner.
- The trust had processes for the identification and reporting of safeguarding alerts and concerns. Staff spoken to demonstrated a good understanding of processes. With the exception of Heather ward, data showed good compliance with safeguarding training across wards.
- Overall, we found Mental Health Act (MHA) paperwork to be in order and accessible to staff for reference. Staff had received training in MHA across all wards. The trust completed regular audits to ensure MHA paperwork was in order and provided regular reminders for updates to medical staff. Staff received training in the Mental Capacity Act and had varying degrees of knowledge about processes.
- Ward matrons had access to administrative support and had sufficient authority to manage their wards. Ward matrons told us senior managers supported them in their role.

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.

- Staff were supported to submit to the trust risk register. We saw examples of where this had been actioned.

Leadership, morale and staff engagement

- The trust had systems for monitoring staff sickness and absence rates and reviewed these regularly. Support was available from the occupational health and human resources department when needed. Sickness rates varied across wards. Heather ward reported the highest rate of sickness at 17% over a 12 month period and Bosworth ward the lowest at 0.3%.
- No staff spoken to reported concerns with bullying or harassment.
- The trust had a whistleblowing policy and all staff told us they felt able to raise concerns with managers without fear of victimisation.
- Overall, morale amongst staff across the acute service was good. All staff we spoke with said they felt well supported by their immediate matron and the inpatient nurse manager and felt they valued their work. Generally, we saw a positive working culture within the teams.
- Staff reported good team working and told us they felt supported by their colleagues in their work. 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.
- Ward matrons had access to leadership courses. Several managers were undertaking the 'leading differently' course during our inspection.

Commitment to quality improvement and innovation

- The trust had made improvements to the clinical environments, but had not complied with all required actions from the last CQC report.
- Senior managers were aware of the bed pressures in their acute service and had raised concerns with their commissioners.
- The acute wards did not participate in AIMS (accreditation for inpatient mental health services). AIMS-WA engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised and services are supported to identify and address areas for improvement. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided.
- Staff collected data on performance. Ward matrons completed a database that recorded their performance against a range of indicators, for example agency use and staff sickness. Ward matrons reported this monthly to the senior managers.
- 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.
- The trust had a bed management team in operation 24 hours a day, seven days per week. The bed management team found beds for new admissions and patients returning from leave and arranged out of area placements for patients when needed. The bed management team had good oversight of the needs of all patients across the wards and assisted teams with discharge planning, including liaison with the crisis team for patients discharged under home treatment. Ward staff received support to locate beds, which otherwise would take up valuable clinical time best used for patient care.

Psychiatric Intensive Care Unit (PICU)

Vision and values

- Staff we spoke with were aware of the organisation's values. Staff identified that these were available on the trust's intranet system and were regularly highlighted in meetings and training.
- Staff we spoke with knew who the most senior managers in the organisation were. Staff told us that senior staff within the trust had visited the wards. These included the chief executive and various executive directors. Overall, staff spoke highly about support offered at the senior executive level.
- Staff felt well supported by ward matrons and local senior managers.

Good governance

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 provider had systems for monitoring staff compliance with mandatory training. The average compliance with mandatory training for staff across fifteen subjects was 89%. The trust did not supply a trust target.
- The trust did not have robust process for ensuring all staff had access to clinical supervision. The trust had not achieved its 85% target for compliance with clinical supervision of staff. Data provided showed compliance on the PICU of 37%. The Care Quality Commission last inspected this service in March 2015 and found the trust in breach of Regulations related to supporting staff. The trust was required to improve access to supervision for all staff. The trust had not adequately addressed this issue and could not be sure staff were given the opportunity to discuss their developmental and training needs, or that poor performance had been identified or managed. The trust was non-compliant with their clinical supervision policy.
- The trust had systems for monitoring compliance with annual appraisal of staff. Data provided showed 87% of non-medical staff had received an appraisal over the past 12 months.
- The trust reported no vacancies within the PICU for registered nurses and 32% vacancy rate for healthcare support workers. The trust employed regular bank or agency staff to ensure safe staffing levels for care and treatment for patients.
- Patients did not have access to a psychologist or adequate psychological therapies, in accordance with NICE guidelines. The CQC highlighted this as a concern and a breach of regulations following its inspection in March 2015. The trust was required to address this deficit in care provision. The trust provided data that showed, at the time of the inspection, psychology posts had been identified but not advertised. Therefore, the trust had not addressed this concern for over two years and psychology posts remained unfilled.
- The trust had processes for the recording and investigation of incidents and complaints. However, staff were not in receipt of regular staff meetings. The trust could not be sure staff were in receipt of investigation outcomes in a timely manner.
- The trust had processes for the identification and reporting of safeguarding alerts and concerns. Staff had received safeguarding training and demonstrated a good understanding of processes.
- Overall, we found Mental Health Act (MHA) paperwork to be in order and accessible to staff for reference. All staff had received training in the MHA and Code of Practice. The trust completed regular audits to ensure MHA paperwork was in order and provided regular reminders for updates to medical staff. All staff received training in the Mental Capacity Act and had varying degrees of knowledge about processes.
- Ward matrons had access to administrative support and had sufficient authority to manage their wards. Ward matrons told us senior managers supported them in their role.
- Staff were supported to submit to the trust risk register. We saw examples of where this had been actioned.

Leadership, morale and staff engagement

- The trust had systems for monitoring staff sickness and absence rates and reviewed these regularly. Support was available from the occupational health and human resources department when needed. The PICU reported sickness over the past 12 months of 9%.
- No staff spoken to reported concerns with bullying or harassment.
- The trust had a whistleblowing policy and all staff told us they felt able to raise concerns with managers without fear of victimisation.
- Overall, morale amongst staff across the PICU was good. All staff we spoke with said they felt well supported by their immediate matron and felt they valued their work. Generally, we saw a positive working culture within the team.
- Staff reported good team working and told us they felt supported by their colleagues in their work. We were impressed with the morale of the staff we spoke with during our inspection and found that the team was cohesive and enthusiastic.

Commitment to quality improvement and innovation

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 trust had made improvements to the clinical environments, but had not complied with all required actions from the last CQC report.
- Senior managers were aware of the bed pressures in their PICU service and had raised concerns with their commissioners.
- The PICU did not participate in AIMS (accreditation for inpatient mental health services). AIMS-WA engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised and services are supported to identify and address areas for improvement. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided.
- Staff collected data on performance. The ward matron completed a database that recorded performance against a range of indicators, for example agency use and staff sickness, and reported this to senior managers.
- The ward matron, 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.
- The trust had a bed management team in operation 24 hours a day, seven days per week. The bed management team found beds for new admissions and patients returning from leave and arranged out of area placements for patients when needed. The bed management team had good oversight of the needs of all patients across the wards and assisted teams with discharge planning, including liaison with the crisis team for patients discharged under home treatment. Ward staff received support to locate beds, which otherwise would take up valuable clinical time best used for patient care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The trust had not ensured the privacy and dignity of patients was protected at all times. • Shower rooms on one ward did not have shower curtains for the privacy and dignity of patients. • The trust admitted males to female areas. The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation This was in breach of regulation 10

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not completed work to remove ligature risks on acute wards. The trust must ensure that ligature risks are removed, as far as is practical to ensure a safe environment for patient care. • Wards continued to have ligature risks, including door handles, soap and towel dispensers and window closers. • The trust had hydraulic beds in use. These beds posed a risk of ligature and barricade for patients. • Wards had areas where staff could not easily observe patients. • One ward had nurse call alarms that were not in working order.

This section is primarily information for the provider

Requirement notices

- Staff were not always recording room and fridge temperatures in clinical rooms. The trust must consistently maintain medication at correct temperatures in all areas
- Staff had not ensured that out of date medication was disposed of appropriately.

This was in breach of Regulation 12

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 15 HSCA (RA) Regulations 2014 Premises and equipment The trust had not ensured that all equipment within the patient area was free from damage and suitable for use. • One ward had a damaged shower fitting and toilet roll holder that posed a risk to patient safety This was in breach of Regulation 15

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 18 HSCA (RA) Regulations 2014 Staffing The trust did not deploy sufficient numbers of suitably qualified staff, competent, skilled and experienced persons. • The trust had not ensured there were sufficient registered nurses for safe care and treatment. • The trust had not ensured all staff were in receipt of regular supervision. The trust could not be sure staff were appropriately supported for their role. • The trust had not ensured that patients could access psychological input, in accordance with National Institute for Health and Care Excellence (NICE) guidelines.

This section is primarily information for the provider

Requirement notices

- The trust had not ensured all staff were up to date with mandatory training requirements. The trust reported low levels of compliance with immediate life support training. The trust was required to address this following the CQC inspection in 2015.

This was in breach of Regulation 18