North Essex Partnership University NHS Foundation Trust

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

Quality Report

The Lakes
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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)
RRDX1	The Lakes Mental Health Wards	Gosfield Ward Ardleigh Ward	CO4 5JL

This report describes our judgement of the quality of care provided within this core service by North Essex Partnership University NHS Foundation 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 North Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of North Essex Partnership University NHS Foundation Trust.

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- We found environmental risks around the ward; however, significant action had been taken to address these. The Trust had an annual programme of audit conducted by a joint audit team including clinical staff, risk management and estates. All risks were rated and where action was required this is highlighted. The layout of the ward offered poor lines of sight to assist staff in monitoring patients. We saw high level ligature points around the ward which had not been adequately addressed through the trust's ligature risk assessment. However, we saw that the trust had implemented some mitigating factors. These included the creation of high dependency bedrooms based on individual risk assessments of patient need.
- We identified concerns with the seclusion room on Ardleigh ward. Staff told us the only method of communication was to talk/shout through a door. The window on the seclusion door had a plastic safety window which was marked and it would be difficult to clearly observe patients. There was no clock in the room for patients to see the time. The seclusion room did not have direct access to a shower/bathroom/toilet; staff had to bring in washing/toilet equipment or carefully manage access to facilities which affected patients' privacy and dignity. These issues meant that this facility did not meet the standards required by the Mental Health Act code of practise. However for the period January to April 2015 seclusion was used on seven occasions, four of which were the same two patients.
- The ward did not comply with the code of practise guidance on same-sex accommodation.
- Following a serious incident some initial actions were taken to reduce the risk of reoccurrence. However a serious incident investigation was taking place and we noted that staff had identified some learning prior to the event.
- We received concerning information regarding discharge medication planning. We found examples of insufficient medication being ordered when patients went on leave and delays in medication being sent to the wards.
- Detention paperwork regarding MHA 1983 was not always filled in correctly and there was un-scrutinised paperwork on files. In one instance we found treatment being administered without the proper legal authority in place. We were unable to find evidence of second opinion approved doctors (SOAD) report or entries relating to SOAD's consultations. We did not see evidence that responsible clinicians were providing people with the decision of the second opinion doctor. We found some MHA forms unsigned and incomplete.
- Patient records were held on electronic and paper records and this made it difficult to locate where information was held about patient care. We found that some care plans had not been updated regularly and that information was missing.
- Managers told us that bed occupancy could be above 100%. Patients privacy and dignity was compromised due to emergency bedrooms being created in side rooms which were not appropriately furnished. For example mattresses were used on the floor instead of beds.
- Three patients alleged that they had been injured during a restraint. We did not find evidence of this. However we reported the allegations to senior managers during the inspection who said they would investigate these concerns. Subsequently the Care Quality Commission received the results of this investigation. There was no independent evidence to corroborate these allegations.

However

- Most patients felt safe on the wards and told us that staff reacted promptly to any concerns. We found that some actions had been taken by the trust to mitigate risks to patients through relational security such as enhanced staff observation levels.
- We found care plans had interventions identified to support patients with complex behaviours.
- Patient records evidenced restrictions to people were assessed and appropriately reviewed.

Summary of findings

- Most patients told us staff treated them with dignity and respect and felt staff were approachable and supportive. We observed interactions with staff and patients and found that staff communicated in a calm and professional way.
- Staff reported good morale and being supported by their colleagues.
- Governance systems were in place and managers had access to trust data to gauge the performance of the team and compare against others. A range of audits took place to assess the quality of the service.

Summary of findings

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

Are services safe?

- We found environmental risks around the ward; however, significant action had been taken to address these. The Trust had an annual programme of audit conducted by a joint audit team including clinical staff, risk management and estates. All risks were rated and where action was required this is highlighted. The layout of the ward offered poor lines of sight to assist staff in monitoring patients. We saw high level ligature points around the ward which had not been adequately addressed through the trust's ligature risk assessment. However, we saw that the trust had implemented some mitigating factors. These included the creation of high dependency bedrooms based on individual risk assessments of patient need.
- The ward did not comply with the code of practise guidance on same-sex accommodation.
- No patient acuity tool was used to assess and plan staffing levels
- Staff told us that the treatment room on Ardleigh ward was relocated to another room on the ward. It held relevant equipment. However the bed was too high for staff to examine the patient and no stool was provided. There was also no hand washing facilities in the room so staff had to use hand sanitizer.
- We had concerns about the seclusion room on Ardleigh ward. It was of adequate size and clean. Staff told us the only method of communication is to talk/shout through a door. The window on the seclusion door had a plastic safety window which was marked and it would be difficult to clearly observe patients. There was no clock in the room for patients to see the time. The seclusion room was not ensuite. However for the period January to April 2015 seclusion was used on seven occasions, four of which were the same two patients.
- We received concerning information regarding discharge medication planning. We found examples of insufficient medication being ordered when patients went on leave and delays in medication being sent to the wards.
- We received concerning information regarding discharge medication planning with the trusts in house pharmacy service. We found challenges with ordering prescription only medicines when patients were due for discharge.

Summary of findings

- Following a serious incident some initial actions were taken to reduce the risk of reoccurrence. However an investigation was taking place and we noted that staff had identified some risks prior to the event.

However:

- Most patients felt safe on the wards and told us that staff reacted promptly to any identified concerns. We found that actions had been taken by the trust to mitigate risks to patients through relational security such as enhanced staff observation levels.
- Patients had access to room keys unless a risk assessment identified they should not. We saw that bedroom doors had vision panels which staff could use to carry out observations. This minimised the intrusion for patients.
- Staff had received safeguarding training and were aware of their responsibilities for reporting concerns. Staff knew how to report incidents and these were reviewed through the trust's clinical governance structure.
- There was use of bank and agency staff and recruitment was on-going.

Are services effective?

- Detention paperwork regarding MHA 1983 was not always filled in correctly and there was un-scrutinised paperwork on files. In one instance we found treatment being administered without the proper legal authority in place. We were unable to find evidence of second opinion approved doctors (SOAD) report or entries relating to SOAD's consultations. We did not see evidence that responsible clinicians were providing people with the decision of the second opinion doctor. We found some MHA forms unsigned and incomplete..
- We found that some care plans had not been updated regularly and some information was missing.
- Patient records were held on electronic and paper records and this made it difficult to locate where information was held and to look at patients care.
- Training records showed not all staff were trained in MHA.
- Some patient records had copies of care plans, however they did not contain treatment plans which met the standard required by the MHA code of practice.

However:

Summary of findings

- We found care plans had interventions identified to support patients with complex behaviours.
- Ward managers had systems in place for monitoring supervision attendance and staff appraisals. The staff exceeded the trust standard of six weekly supervision by attending monthly supervision.
- Patient records showed restrictions in place were assessed and appropriately reviewed. We saw evidence of patients detention being renewed appropriately. Manager review hearings would then take place. We saw evidence of patients being referred to tribunals.

Are services caring?

- Most patients told us staff treated them with dignity and respect and felt staff were approachable and supportive. We observed interactions with staff and patients and found that staff communicated in a calm and professional way. Staff showed an understanding of the individual needs of the patient.

However:

- Staff reported that sometimes patients had to sleep in side rooms on a mattress on the floor due to increased demand on inpatient beds. This meant patients privacy and dignity was compromised.
- Seven patients told us they were not involved in their care planning. However when patients had signed their care plans, the care plans demonstrated evidence of patient involvement.

Are services responsive to people's needs?

- Managers told us that bed occupancy could be above 100%. Side rooms were used to increase the admissions to the wards and meant some patients had to sleep on mattresses on the floor.
- We were informed that a bed needs analysis had been undertaken across the trust. A meeting was scheduled with commissioners to discuss the increased demand on acute admission beds.

However:

Summary of findings

- Wards were newly decorated, bright, clean and airy. There were separate lounges for female patients. There was a family room for visits and a gym. We saw assisted bathrooms/toilets were available for patients with mobility difficulties.
- Patient records on Gosfield and Ardleigh wards evidenced staff supporting patients to general hospital appointments and regular health checks were in place for people.

Are services well-led?

- Staff explained governance systems in place and managers had access to trust data to gauge the performance of the team and compare against others. Staff reported good morale and being supported by their colleagues. A range of audits took place to assess the quality of the service.

Summary of findings

Information about the service

The Lakes Mental Health wards for adults of working age are provided by North Essex Partnership University NHS Foundation Trust and are part of the trust's acute division.

The Lakes Mental Health wards have two acute admission wards for adults of working age: Ardleigh and Gosfield. They have 18 beds each. Both wards are mixed sex.

The Harbour Suite is a place of safety where patients detained under Section 136 MHA 1983 were brought for assessment.

The location was last inspected by the Care Quality Commission on 13 June 2013 and there were no regulatory breaches identified.

Our inspection team

The team that inspected the Lakes Mental Health wards consisted of six people: one expert by experience, three CQC inspectors and two Mental Health Act reviewers.

Why we carried out this inspection

We carried out an unannounced focused inspection of this core service following concerns identified by the Care Quality Commission.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

During the inspection visit, the inspection team:

- Visited both wards, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with nine patients.
- Spoke with the managers for each ward.
- Reviewed all medication records.
- Reviewed 13 patients' treatment and care records.
- Spoke with eight staff members; including doctors and nurses.

We also:

- Carried out a specific check of the medication management on both wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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

Summary of findings

What people who use the provider's services say

- Most patients told us staff treated them with dignity and respect and felt staff were approachable and supportive. Patients had a choice of food at meal times and could make or request drinks throughout the day. Inpatient discharge questionnaires collected in March 2015 showed results that staff were friendly and supportive and that the staff always had time for individual sessions.

However:

- Three patients alleged that they had been injured during a restraint. This was not supported by those incident reports examined. This was reported to senior managers during the inspection who said they would investigate this. Subsequently the Care Quality Commission received the results of this investigation. There was no independent evidence to corroborate these allegations.

Good practice

- Ward Managers had systems for monitoring supervision attendance and staff appraisals. The staff on both wards exceeded the Trust standard of six weekly supervision by attending monthly supervision sessions.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that they have adequate systems in place to ensure that Mental Health Act paper work is accurate and properly scrutinised.
- The provider must ensure that seclusion rooms and recording of seclusion meet the requirements of the Mental Health Act code of practise.
- The trust must ensure that they meet the requirements for mixed sex accommodation.
- The trust must ensure that actions are taken to minimise identified high risk ligature points around the wards.

Action the provider SHOULD take to improve

- The trust should ensure that all patients are involved in the planning of their care
- The trust should consider using a patient acuity tool to assess and plan staffing levels.

North Essex Partnership University NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Gosfield Ward	The Lakes Mental Health Wards
Ardleigh Ward	The Lakes Mental Health Wards

Mental Health Act responsibilities

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

- Training records showed that not all staff had attended training in MHA.
- We were unable to find evidence of second approved doctors (SOAD) reports or entries relating to SOAD's consultations or that responsible clinicians were providing patients with the decision of the second opinion doctor. Detention paperwork was not always filled in correctly and there were omission of names from detention paper work.
- Some patient records showed that patients had copies of care plans, however they did not contain treatment plans to a standard required by the MHA code of practice.
- Patients were aware of how to access an independent mental health advocate (IMHA). The trust had robust procedures in place for automatically referring patients. However, it was not clear within care records how patient's mental capacity to understand rights and information regarding to the IMHA were being assessed.
- Access to the seclusion room did not respect patients' privacy or dignity. Access was from the male bedroom corridor at the end of ward. This meant that male and female patients from Ardleigh and Gosfield would be

walked through communal areas to access the room. The seclusion room environment does not meet the current guidelines set out in the Mental Health Act Code of Practice (April 2015) as there were no furnishings, no clock and no toilet or shower facilities.

However

- Patient records showed restrictions on people were assessed and appropriately reviewed. Section 20 MHA renewals of patient detentions were in place, followed by timely managers review hearings. We found good examples of section 17 leave planning and leave being facilitated. Processes were in place to remind staff to read patients their legal rights of appeal and to remind responsible clinicians when consent to treatment was due for review.
- Patients were referred to the Mental Health first tier tribunal and were provided with information on appeal process.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training records they showed that 39 staff across both wards had been trained in MCA.
- Mental capacity assessments were not found in eight out of the nine records examined.
- No patients were subject to deprivation of liberty (DOLs). Informal patients had received a leaflet informing them of their rights whilst in hospital.
- Both wards were locked and there was signage in place informing informal patients of how they could leave the ward.

Are services safe?

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

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

Summary of findings

- We found environmental risks around the ward; however, significant action had been taken to address these. The Trust had an annual programme of audit conducted by a joint audit team including clinical staff, risk management and estates. All risks were rated and where action was required this is highlighted. The layout of the ward offered poor lines of sight to assist staff in monitoring patients. We saw high level ligature points around the ward which had not been adequately addressed through the trust's ligature risk assessment. However, we saw that the trust had implemented some mitigating factors. These included the creation of high dependency bedrooms based on individual risk assessments of patient need.
- The ward did not comply with the code of practise guidance on same-sex accommodation.
- No patient acuity tool was used to assess and plan staffing levels
- Staff told us that the treatment room on Ardleigh ward was relocated to another room on the ward. It held relevant equipment. However the bed was too high for staff to examine the patient and no stool was provided. There was also no hand washing facilities in the room so staff had to use hand sanitizer.
- We had concerns about the seclusion room on Ardleigh ward. It was of adequate size and clean. Staff told us the only method of communication is to talk/shout through a door. The window on the seclusion door had a plastic safety window which was marked and it would be difficult to clearly observe patients. There was no clock in the room for patients to see the time. The seclusion room was not ensuite. However for the period January to April 2015 seclusion was used on seven occasions, four of which were the same two patients.
- We received concerning information regarding discharge medication planning. We found examples of insufficient medication being ordered when patients went on leave and delays in medication being sent to the wards.
- We received concerning information regarding discharge medication planning with the trusts in house pharmacy service. We found challenges with ordering prescription only medicines when patients were due for discharge.
- Following a serious incident some initial actions were taken to reduce the risk of reoccurrence. However an investigation was taking place and we noted that staff had identified some risks prior to the event.

However:

- Most patients felt safe on the wards and told us that staff reacted promptly to any identified concerns. We found that actions had been taken by the trust to mitigate risks to patients through relational security such as enhanced staff observation levels.
- Patients had access to room keys unless a risk assessment identified they should not. We saw that bedroom doors had vision panels which staff could use to carry out observations. This minimised the intrusion for patients.
- Staff had received safeguarding training and were aware of their responsibilities for reporting concerns. Staff knew how to report incidents and these were reviewed through the trust's clinical governance structure.
- There was use of bank and agency staff and recruitment was on-going.

Our findings

Safe and clean environment

- The layout of the wards offered poor lines of sight to assist staff in monitoring patients. For example on both

wards there were areas of corridors which were difficult to observe. Staff told us that they used nursing observations to observe patients routinely throughout the day and night.

- We saw the ligature risk assessment audit for both wards dated March 2015. This identified a number of concerns and listed the control measures used by the trust to manage these. However, we had concerns as these control measures did not follow the trust's own policy on patient safety environmental standards dated 2014.
- A number of potential high risk ligature points were identified in both wards and these were brought to the attention of staff. The trust had undertaken some work to reduce ligature risks on both wards. This included the creation of high dependency bedrooms based on individual risk assessments of patient need.
- Wards were mixed sex. There were male and female identified areas and gender designated facilities. However at times patients had to walk through an area occupied by the other sex to use bathroom facilities. The ward manager told us staff would ensure increased observations. Senior managers told us that the trust were considering making both wards gender specific but a timeframe was not given.
- The seclusion room on Ardleigh was used when required for patients on Ardleigh and Gosfield wards. It was situated in the male bedroom corridor. It was of adequate size and clean. There was no clock in the room for patients to see the time. The seclusion room was not ensuite. The nearest available toilet was situated outside the seclusion room in the male bedroom area. Staff told us they communicate by talking/shouting through a door. The window on the seclusion door had a plastic safety window re-enforcing the door panel which was very marked and difficult to see through. The seclusion room did not meet the current guidelines set out in the Mental Health Act Code of Practice (April 2015). However for the period January to April 2015 seclusion was used on seven occasions, four of which were the same two patients.
- Staff on Gosfield ward reported some challenges with transferring patients to the seclusion room on Ardleigh. They preferred to de-escalate patients on the ward whenever possible.
- The clinics were clean and bright. The clinic on Ardleigh ward had recently been re-designed and painted. There was a private area for patients to discuss any issues with a nurse. We noted good storage of medication and good adherence to clinical waste management and disposal of sharps. We found gaps in the recording of fridge temperatures in the clinics on both wards. There were processes in place for ordering stocks of medication and a regular auditing process to ensure that medications were stored and administered safely and effectively. Staff reported issues with delays in the trust pharmacy. The pharmacy providing medication was not onsite, there were two deliveries to the pharmacy daily but if medication was ordered outside of these times then this could cause a delay in medication being in stock and administered. We received concerning information regarding discharge medication planning with the trusts in house pharmacy service. We were told by staff that there were challenges with ordering prescription only medicines when patients were due for discharge. Examples of insufficient medication being ordered when patients went on leave and delays in medication being sent to the wards were identified during the inspection.
- Staff told us that environmental checks were completed daily. We saw that an environmental check was carried out daily by staff however this did not include checking the safety and security of windows, doors, locks or ligature points. The check list was a tick box with actions taken. There were no actions recorded on any of the forms indicating that either no environmental issues have been found or no issues had been reported for repair.
- Some patients had perishable food items and milk in their rooms, which could pose a health risk. We brought to this to staff's attention. Staff told us that they were aware of the issues and were discussing ways to manage it.
- The entrance door to the unit was damaged. Staff told us it had been reported for repair.

However

- Significant action had been taken to address environmental risk around the ward. The Trust had an

Are services safe?

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annual programme of audit conducted by a joint audit team including clinical staff, risk management and estates. All risks were rated and where action was required this is highlighted.

- Staff informed us that there were identified bedrooms allocated near the nursing office to those patients assessed as being at high risk of self-ligature. If these rooms were not available then other bedrooms were adapted in accordance with individual risk assessments. Security measures were noted to be in use for higher risk patients; for example enhanced staff observation levels and information about risk being exchanged during staff handovers.
- Alarms were available in bedrooms for patients to use. Staff told us that they carry a personal alarm and that when activated staff responded from other areas.
- Doors were locked which meant that patients did not have access to leave without consulting staff. We saw that all patients were risk assessed prior to leave and a paper record was completed. We saw that a poster was on display near the door advising informal patients of their rights to leave.
- We saw that a report to the trust's 'Risk and Governance Executive', dated October 2014 referred to replacements of doors and windows following a review of the latest developments in anti-ligature furniture.
- Both wards were clean and there were dedicated cleaners employed. Cleaning schedules were available on the unit. Hand hygiene audits and health and safety checks such as fire alarm testing took place. A monthly maintenance audit on Gosfield had achieved 95% compliance.
- A monthly suicide prevention audit took place.

Safe staffing

- Core staffing levels had been set by the trust. This included having two trained nurses on shift at all times including the night shift. The ward managers confirmed that they could book additional staff if required by patient dependency. Ward managers were aware of the need to constantly review staffing levels based on assessed patient need. The trust's own staff bank staff were used if needed to ensure staffing consistency. A senior manager told us that staff reported using the 'safer staffing' data. However, safer staffing information was not seen on the wards.
- Managers told us that a staff skill mix audit was previously undertaken at the end of 2014 by senior trust staff. This meant that some staffing posts were reduced across wards with plans for use of bank/agency staff as needed. This had been reviewed to ensure that staffing levels were adequate as staff had identified some challenges with getting bank/agency cover. In December 2014 the substantive staffing levels were 84% for Ardleigh and 72% for Gosfield.
- We found evidence of high use of bank/agency staff. For example between December 2014 and 25 January 2015 six shifts on Gosfield and Ardleigh wards had more than 50% bank/agency staffing. On Ardleigh ward for six shifts staffing levels were below requirement between 23 March 2015 and 19 April 2015. Records shown that there has been an improvement in the levels of permanent staff on the wards**.** Whilst the trust acknowledged that the agreed skill mix was not met on all occasions, staffing numbers were being met. Risk of using temporary staff were mitigated by filling shifts with regular Lakes staff and bank staff who worked the majority of their shifts on the ward and therefore knew patients, policies and procedures, and the ward environment.
- Staff told us that at times there was only one qualified nurse on duty and the second nurse was replaced by a healthcare assistant. We found that staffing would be an issue if someone required seclusion. A "floating" member of staff worked across the two wards if they were not required to staff the 136 harbour suite increasing staffing levels.
- The Gosfield manager reported two healthcare assistant vacancies. One had just been appointed to and the other post was being advertised. Ardleigh had no vacancies.
- The trust had introduced the 'Journeys Programme' intended to maximise skills and knowledge of staff and how the trust want to make their services fit for the future as part of a modern NHS.
- Medical cover was available throughout the day immediately. However at night, staff told us there could be long delays as the on call doctor covered two hospitals. This could affect patient access to medical care at night.
- There was no evidence of a patient acuity tool being used to plan staffing levels.

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- Three staff and three patients told us that they felt staffing levels had been affected by the increased level of bed occupancy.
- A manager told us there could be delays in getting staff, for example to cover increased patient observations due to agency/bank unavailability.

Assessing and managing risk to patients and staff

- One patient's care record did not detail how staff had managed their increased risk following a self-harm episode.
- We received concerning information regarding discharge medication planning with the trusts in house pharmacy service. We found evidence that there were issues with ordering prescription only medicines when patients were due for discharge. Examples of insufficient medication being ordered when patients went on leave and delays in medication being sent to the wards were identified during the inspection.
- Risk assessments gave guidance for staff to follow. We found examples of multi-disciplinary teams regularly reviewing risks.
- Staff had received safeguarding training. Training records they showed that 39 staff across both wards had been trained in safeguarding level one to three; 18 on Gosfield and 21 on Ardleigh. Staff were able to tell us of their individual responsibility in identifying safeguarding concerns and reporting these promptly. Staff knew who the trust's safeguarding lead was and the ward safeguarding lead. Gosfields manager told us there was a safeguarding trust audit visit due the next day.
- Staff on both wards had a whiteboard in the office with key patient details for ease of reference.
- A nurse was identified to complete physical healthcare checks for patients who needed monitoring for medication side effects.
- Post incident debriefings were offered routinely to staff and patients. Staff told us that they found this process supportive.
- Staff explained search procedures and that high risk patients would have some items restricted. Staff reported receiving training in control and restraint, however this was limited.

Track record on safety

- There had been several serious incidents (SI) within this service in the last year. Some of these remained under investigation by the trust.
- We saw minutes from the 'Quarter report for serious incidents' dated 20th February 2015. The trust received 100% in meeting targets for serious incident reporting. 55% were submitted before the 45 day deadline with two being closed at the seven day reporting stage. However compliance with seven day reporting targets was not being met. 12 out of 19 reports were not submitted within the seven day timeframe.

Reporting incidents and learning from when things go wrong

- An electronic system was used by staff to report and monitor incidents. Email notifications were sent to managers and senior management teams for review. The manager was then required to investigate and give feedback. Ward staff knew how to report any incidents using the system.
- Senior staff were aware of incidents and these had been discussed daily and escalated appropriately for action. All serious untoward incidents were reviewed through the trust's clinical governance structure. Staff received feedback about the outcome of incidents at fortnightly business team meetings. Staff told us that they received the right level of support following the incident from management and the team. Meetings took place jointly across wards to ensure shared learning.
- Following a serious incident, actions had been taken to ensure that loft hatches were secure. This was supported by maintenance records we reviewed.

Are services effective?

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

Summary of findings

- Detention paperwork regarding MHA 1983 was not always filled in correctly and there was un-scrutinised paperwork on files. In one instance we found treatment being administered without the proper legal authority in place. We were unable to find evidence of second opinion approved doctors (SOAD) report or entries relating to SOAD's consultations. We did not see evidence that responsible clinicians were providing people with the decision of the second opinion doctor. We found some MHA forms unsigned and incomplete..
- We found that some care plans had not been updated regularly and some information was missing.
- Patient records were held on electronic and paper records and this made it difficult to locate where information was held and to look at patients care.
- Training records showed not all staff were trained in MHA.
- Some patient records had copies of care plans, however they did not contain treatment plans which met the standard required by the MHA code of practice.

However:

- We found care plans had interventions identified to support patients with complex behaviours.
- Ward managers had systems in place for monitoring supervision attendance and staff appraisals. The staff exceeded the trust standard of six weekly supervision by attending monthly supervision.
- Patient records showed restrictions in place were assessed and appropriately reviewed. We saw evidence of patients detention being renewed appropriately. Manager review hearings would then take place. We saw evidence of patients being referred to tribunals.

Our findings

Assessment of needs and planning of care

- Care plans had interventions identified to support patients with complex behaviours. Individual needs were being assessed and reviewed regularly. We saw that some care plans expressed views of the patients, however care plans were often left unsigned by patients.
- 13 files examined all had risk assessments in place. However some assessments lacked detail. One person's care plan and risk assessment had not been updated to show their change in legal status.
- Nine of 13 files showed physical health examinations were routinely completed. We found that physical healthcare assessments were held in paper and electronic records making it difficult to track how the patient's needs were being met.
- Two staff reported challenges with recording information on the trust electronic patient record system. We saw that some records were not on the system and patients who had long stays could have multiple files. We saw that staff found it difficult to locate where records were held.
- Post admission assessments were timely. We saw good evidence of discharge planning in the care records.
- All care plans gave sufficient detail to enable staff to provide informed interventions.
- Staff were aware of how to meet patients individual care needs. For example by ensuring patients drank enough.
- A healthcare assistant had recently been appointed and was going to be trained to audit and improve the physical healthcare assessment process by conducting regular physical healthcare clinics.

Best practice in treatment and care

- Staff referred to relaxation, emotional coping skills and drug and alcohol groups being available. We saw the therapeutic timetable on display on both wards, with timetabled morning and afternoon sessions. Some session were offered as individual sessions.
- The Health of the Nation Outcome Scales (HONOS).

Are services effective?

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

Skilled staff to deliver care

- Staff told us that they had access to mandatory training. This was confirmed by records examined. However, training records showed that 11 staff were out of date in clinical risk management and 14 staff had not received training in basic life support. Staff had opportunities to attend specialist training and were required to apply for funding approval via their managers.
- Five staff across wards told us they received supervision, support and training. For example a healthcare assistant told us the trust had paid for them to develop their skills through a local university course.
- The trust had systems for monitoring supervision attendance and staff appraisals. We saw records for March 2015 for the attendance at supervision and appraisals. On Gosfield ward 14 out of 18 staff had received supervision in March 2015. 16 out of 18 appraisals were completed.16 out of 20 staff on Ardleigh ward had attended supervision. All 20 staff had completed their appraisals. The staff on both wards exceeded the trust standard of six weekly supervision by attending monthly.

Multi-disciplinary and inter-agency team work

- Care programme approach (CPA) meetings were scheduled and attendance was encouraged by all involved in the patient's care and treatment. Both wards held clinical meetings three times per week. We saw that meeting records were very detailed, linked into patients' care plan reviews, discharge planning and physical health.
- Handovers took place between staff shifts with systems for communicating areas of improvement or risks.
- Staff reported examples of effective team working and joint working across units and other trust services.
- Both wards had access to a psychologist and occupational therapist. Both wards shared a gym with an instructor allowing the patients to have access to physical exercise.
- Managers reported strong working relationships with the local police.

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

- Staff training was in place for the MHA 1983 and MCA 2005. However the training records seen identified not all staff were trained in MHA.
- Patients were aware of how to access an IMHA. The trust has robust procedure in place for automatically referring patients. However, it was not clear within care records how patient's mental capacity to understand rights and information regarding to the IMHA were being assessed.
- Detention paperwork was not always completed correctly. There was un-scrutinised paperwork on files. One example we found was treatment being administered without the proper legal authority in place. We saw on Gosfield ward a medication was not authorised on the documentation. The same patient had the wrong treatment certificate attached to their medication chart. We found that current treatment certificates were not always attached to the medication charts.
- There was no evidence of second opinion appointed doctors reports or entries relating to SOAD's consultations or that responsible clinicians were providing people with the decision following the consultation.
- A patients name was missing from one MHA document. Initials were used instead of full names. We raised this for senior manager's attention during the inspection.
- Staff we spoke to, including a MHA Administrator, could not confirm that mental health act paper work was audited.
- Staff were clear on the process to access IMHAs for patients.
- Patient records evidenced restrictions on patients were assessed and appropriately reviewed. We saw good examples of section 17 leave planning and leave being facilitated. We noted a patient on Gosfield ward had their section 17 leave rescinded due to the risk they posed. We found their care plan and risk assessments were regularly reviewed. Although some of the paperwork had "empty boxes" where information should have been added, for example, entries on how the leave went.

Are services effective?

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

- We saw evidence of section 20 renewal of detentions, followed by timely managers review hearings. Patients were referred to a tribunal and provided with information on the appeals process. Processes were in place to remind staff to read patients their section 132 legal rights and clinicians when consent to treatment was due for review.
- Staff and patients told us that advocates regularly visited the wards and would assist with explaining rights, complaints and general information. Rights and information leaflets were available for detained and informal patients.

Good practice in applying the Mental Capacity Act

- Training records they showed that 39 staff across both wards had been trained in MCA.
- Mental capacity assessments were not found in eight out of the nine care and treatment records we reviewed. Informal patients had received a leaflet informing them of their rights whilst in hospital.
- Both wards were locked and there was signage in place informing informal patients of how they could leave the ward.

Are services caring?

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

Summary of findings

- Most patients told us staff treated them with dignity and respect and felt staff were approachable and supportive. We observed interactions with staff and patients and found that staff communicated in a calm and professional way. Staff showed an understanding of the individual needs of the patient.

However:

- Staff reported that sometimes patients had to sleep in side rooms on a mattress on the floor due to increased demand on inpatient beds. This meant patients privacy and dignity was compromised.
- Seven patients told us they were not involved in their care planning. However when patients had signed their care plans, the care plans demonstrated evidence of patient involvement.

Our findings

Kindness, dignity, respect and support

- We observed that staff spoke about patients in a caring and compassionate manner and had an understanding of individual need. We saw staff communicating in a calm manner, allowing patients to express their needs. Staff we spoke with were knowledgeable of individual patient care needs.
- Staff had a flexible approach when supporting patients. For example they had supported a patient to buy a bed, as this was delaying their discharge. They supported a patient to continue with dying their hair whilst in hospital as this was important part of their identity and hair colour was usually a restricted item.
- Patients told us that all the staff treated them with respect and encouraged them to become more independent.
- Patients had a choice of food at meal times and could make or request drinks throughout the day.
- Inpatient discharge questionnaires collected in March 2015 showed that staff were friendly and supportive and always had time for individual sessions. However, it reported that patients wanted more time with doctors, more activities at the weekends and that the toilets and bathrooms were often not working.
- Patients told us there were issues with meeting specific dietary needs and choice. This was being addressed through the trust complaints procedure.

The involvement of people in the care that they receive

- Managers told us a unit welcome pack was developed with patient and carer involvement as a pilot with plans to develop this across the trust. The pack was given to all new admissions to the wards.
- Carers support group details were displayed in the reception.
- Patients told us that they enjoyed the group sessions that took place on the ward and that they looked forward to them.
- We found minimal evidence on all nine files of patients' involvement with care planning. Two patients told us they had been involved in their care plan. Seven patients told us that they had not been involved and were not asked about their likes and dislikes.
- Care plans were not always signed, we found no reasons recorded as to why they were not signed. However when patients had signed their care plans, the care plans demonstrated evidence of patient involvement.
- Three patients told us that they did not have their medication explained to them.

Are services responsive to people's needs?

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

Summary of findings

- Managers told us that bed occupancy could be above 100%. Side rooms were used to increase the admissions to the wards and meant some patients had to sleep on mattresses on the floor.
- We were informed that a bed needs analysis had been undertaken across the trust. A meeting was scheduled with commissioners to discuss the increased demand on acute admission beds.

However:

- Wards were newly decorated, bright, clean and airy. There were separate lounges for female patients. There was a family room for visits and a gym. We saw assisted bathrooms/toilets were available for patients with mobility difficulties.
- Patient records on Gosfield and Ardleigh wards evidenced staff supporting patients to general hospital appointments and regular health checks were in place for people.

Our findings

Access and discharge

- Staff on Gosfield ward told us that in response to a need for beds, they were admitting patients above the identified number for their ward. Emergency bedrooms were created to increase bed occupancy. Staff were recording these occasions on the trust incident log. An example was in April 2015 when a patient had gone on leave and returned with no bed available.
- At the time of our visit there were two available beds on Gosfield ward, however seven patients were on leave. Staff reported a high turnover of admissions particularly during the Easter holiday period.
- Discharge arrangements took into account existing and potential risks of patients and this was evidenced on files.
- Staff reported taking patients outside their usual catchment area such as from Chelmsford.
- Staff reported challenges when a bed was needed out of hours.
- Three patients were identified as delayed discharge with reasons such as awaiting specialist placements (inpatient and community).
- A manager told us daily meetings were held to review patients placed out of area in independent healthcare beds to consider if they could be repatriated.
- A manager told us that home treatment team workers were based on site and liaised with staff when planning patients discharge. A discharge and admission coordinator had just started in post and managers reported it was alleviating the pressure of having to find inpatient beds within the trust and independent sector.

The facilities promote recovery, comfort, dignity and confidentiality

- Wards had a fresh feel and had been newly decorated. The wards were clean. There were two lounges, a family room for visits and a gym. Bedrooms were furnished with a fixed bed, shelving and chair. There were some with ensuite washrooms. Outside areas were landscaped. There was a designated smoking area. There were rooms used for clinical meetings and activities.
- Patients had access to room keys unless a risk assessment identified they should not. Bedroom doors had vision panels which staff could access to carry out observations. This minimised the intrusion for patients.
- Patients had access to a kitchen to make hot/cold drinks. Cold drinks were available on the ward.
- Closed circuit television (CCTV) was present on the unit and wards. Signage informing people of this was not visible.
- An (ECT) electroconvulsive therapy suite was adjacent to the unit and could be accessed for inpatients as appropriate.
- Information for patients was available. We saw a therapeutic day programme for patients and there was access to an identified day service. Leaflets included information about the care programme approach (CPA), the mental health charter and responsibilities. Voluntary agency information about social inclusion and recovery was on display.

Are services responsive to people's needs?

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

- Staff told us that the treatment room on Ardleigh had been relocated to another room on the ward. We saw relevant equipment was in the room and an examination couch, however the bed was too high for staff to examine the patient and no stool was provided. This was a manual handling risk to staff and could cause injury. There were also no hand washing facilities in the room which meant staff had to use hand sanitizer. This was a risk of cross infection as hand sanitizer is only suitable for three uses and then hands had to be washed.

Meeting the needs of all people who use the service

- Assisted bathrooms/toilets were available for patients with mobility difficulties. Patient records on Gosfield and Ardleigh evidenced staff supporting patients to general hospital appointments and regular health checks were being facilitated.
- Staff told us they had access to interpreters and translation services as and when this service was required.
- We found letters on file informing relatives of information regarding their rights. Information leaflets were available in languages other than English. The advocacy and chaplaincy services were displayed on the ward. Gosfield ward had information displayed about how the trust could meet patients specific dietary needs.
- Staff referred to the 'Veterans First' service which was commissioned to meet the needs of Colchester's military community for specialist assessment and support.

Listening to and learning from concerns and complaints

- We saw, 'We listen, we learn' leaflets which gave details on the trust comments, compliments, concerns and complaints policy. Patient advice and liaison services (PALS) information was displayed.
- A manager told us that any complaints were discussed via team meetings for managers and cascaded via team meetings. We reviewed complaints details; we found the trust had responded. We did not see specific details of their investigation.
- Patients were able to raise issues on both wards at daily morning 'start up' meetings. Community meetings were not regularly taking place and a plan was in place to start them weekly.
- All patients were aware of how to complain. We saw posters around the wards explaining the process to them.
- A compliments and feedback board was available on Gosfield ward, with patient discharge questionnaire 2015 information. This included 'what we could have done better' information. Managers reported that actions from these were discussed at team meetings.

Are services well-led?

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

Summary of findings

- Staff explained governance systems in place and managers had access to trust data to gauge the performance of the team and compare against others. Staff reported good morale and being supported by their colleagues. A range of audits took place to assess the quality of the service.

Our findings

Good governance

- Staff told us about trust governance systems, such as the senior staff 'band seven' monthly meetings.
- Managers had access to trust data such as monthly 'barometers' to gauge the performance of the team and compare against others. This included information on care documentation completion and other staff performance indicators. We reviewed barometers dated from July 2014 to December 2014 for both wards. The overall rating for July was amber. From August to December the overall rating was green. This showed there had been an improvement from partial compliance to full compliance.

Leadership, morale and staff engagement

- Staff reported good morale and being supported by their colleagues.
- Staff approached their manager if they had any concerns about clinical practice and were aware of the trust whistleblowing policy.
- The trust had a human resources department and an occupational health service was available to staff.

Commitment to quality improvement and innovation

- A range of audits took place, for example equipment and infection control.
- Managers confirmed that actions were taken as a result of these findings. Gosfields infection control audit showed that the ward was 90% and Ardleigh was 80%. Both audits had a clear plan of action to improve. A cleaning audit reported an overall functional score was 98% for Ardleigh and 97% for Gosfield. Hand hygiene audits was 98% for Ardleigh and 96% for Gosfield.
- Managers told us a Patient-Led Assessment of the Care Environment (PLACE) had taken place that week and they were awaiting the report.
- Managers reported that following an identified need for staff training a team away day was planned for June 2015. This would include reviewing practice, considering 'STORM' a self-harm risk assessment training and physical health care needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the trust had did not have systems or processes in place to ensure that there have adequate systems in place to ensure that Mental Health Act paper work are accurate and properly scrutinised. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems or processes must be established and operated effectively to ensure compliance with the requirements. Such systems or processes must enable the registered person, in particular, to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17(1)(2)(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises We found that the seclusion room on Ardleigh ward was not fit for purpose. And that the trust had not protected patients by taking action to fully address high risk ligature points around the wards. This was in breach of Regulation15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

All premises and equipment used by the service provider must be suitable for the purpose for which they are being used.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,15(1)(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found that the trust had not protected the privacy of the patients as Ardleigh and Gosfield ward do not adhere to gender separation guidelines. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Service users must be treated with dignity and respect. The things which a registered person is required to do include in particular ensuring the privacy of the service user.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 10 (1)(2)(a).