Requires improvement

Cumbria Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNFG	Furness General Hospital	Dova Unit	LA14 4L
RNNBJ	Carleton Clinic	Hadrian Unit	CA1 3SX
RNNWG	Westmorland General Hospital	Kentmere Ward	LA9 7RG
RNNBJ	Carleton Clinic	Rowanwood	CA1 3SX
RNNBX	West Cumberland Hospital	Yewdale Unit	CA28 8JG

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

Summary of findings

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

Where applicable, we have reported on each core service provided by Cumbria Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cumbria Partnership NHS Foundation 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?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated this core service as requires improvement because:

- There was no psychiatric junior doctor medical cover after 5pm or at weekends on Dova unit, Kentmere ward and Yewdale unit. There was no psychiatric junior doctor medical cover after 12 midnight at Hadrian unit and Rowanwood.
- Privacy, dignity and safety had been compromised on Kentmere ward. A female patient occupied a side room where male patients passed in order to access the bathroom. The female patient needed to pass the male dormitory in order to access the female bathroom and toilet.
- Staff did not always demonstrate application of the mental capacity act in practice.
- There were issues related to recording compliance with the Mental Health Act 1983.
- There was a restrictive practice of locked doors operating across the acute wards without clear justification.
- Overall compliance with mandatory training was low and did not meet the Trust target of 80%.
- All wards used restraint and compliance with basic life support with defibrillator training was below the trust target of 80%

However:

We saw consistently kind and appropriate interactions between staff and patients. Multidisciplinary working was evident across all the wards. Handovers and ward rounds were well-structured and comprehensive, with team members sharing the relevant information.

A daily bed management teleconference call helped to ensure there were sufficient beds available for people requiring acute care or psychiatric intensive care.

There were highly visible, enthusiastic and innovative ward managers on each ward.

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:

- We were told that out of hours' medical cover could be an issue as there was no psychiatric junior doctor medical cover supporting the consultants on call, after 5pm or at weekends on Dova unit, Kentmere ward and Yewdale unit. There was no psychiatric junior doctor medical cover after 12 midnight on week days and weekends at Hadrian unit and Rowanwood.
- Kentmere ward was not compliant with the Department of Health's guidance on eliminating mixed sex accommodation.
- There was a restrictive practice of locked doors operating across the acute wards without clear justification.
- There was no seclusion records on Kentmere ward for an episode which staff described as seclusion.
- The clock in the seclusion room on Rowanwood unit was broken.
- A review of four episodes of restraint on Kentmere ward were not reported on the trust's incident reporting system.
- The temperature of the clinic room on the Hadrian unit was above the recommended maximum of 25c for the storage of medicines.
- Overall mandatory training compliance was poor across all wards.

However:

- Ligature risks across all wards were assessed managed and minimised.
- Staff used evidence based tools and assessments to measure needs and risk
- Risk assessments were up to date.
- Staff understood safeguarding policies and procedures and could apply these in practice.
- There were sufficient staff to meet patient need.
- Wards were clean, well maintained, with safe spaces for patients. There were good hygiene and infection controls in place.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There were issues related to recording compliance with the Mental Health Act 1983.

Summary of findings

- Staff had a variable understanding of the Mental Capacity Act in practice. Staff did not routinely document patients capacity and ability to consent to be involved in the planning, management and review of their care and treatment was not routinely documented.
- Positive behaviour support plans were not in place for patients predicted to be at risk of restrictive interventions.
- Yewdale ward had no dedicated psychology support.
- Electro-convulsive therapy (ECT) was not available as a treatment option within Cumbria as it was not currently commissioned to provide ECT. This meant that patients had to travel out of area to access ECT.
- Compliance with staff annual appraisals was low across the wards.

However:

- Care plans were mostly comprehensive and holistic. Patients' physical health needs were met.
- Patients received regular one to one time with their named nurse.
- A range of activities were offered during weekdays and at weekends. Handovers and ward rounds were well-structured and comprehensive, with team members sharing the relevant information.
- Clinical staff engaged in clinical audit on a regular basis and amended practice accordingly.
- Staff had regular supervision, which was monitored and recorded.

Are services caring?

Good

We rated caring as good because:

- We saw consistently kind and appropriate interactions between staff and patients.
- Staff engaged with patients and showed genuine concern for their well-being.
- There were leaflets and other information available around the wards, giving patients information on treatments and all relevant areas to do with patient care and well-being.
- Carers and relatives felt listened to by staff and were invited to multidisciplinary team meeting to discuss their relatives care.

However:

Summary of findings

- We received mixed feedback from patients about their involvement in the care they received and care plans did not always show patients' comments. Few patients had received a copy of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There were sufficient beds available to people requiring acute care.
- Patients requiring more intensive care could access the PICU.
- Most wards offered an environment conducive for mental health recovery. The environments were spacious, pleasantly decorated and calming.
- Patient activities took place seven days a week.
- Patients had somewhere to store their personal possessions.
- Patients knew how to make a complaint.
- Staff described how complaints were dealt with on the wards and received feedback from compliant investigations.

However:

- Patients going on home leave did not always return to the same bed.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Management had not ensured the trust had robust arrangements for psychiatric medical cover out of hours.
- The procedure for reporting breeches in relation to mixed sex accommodation was not clear.
- Mandatory training compliance was low across all wards.
- Staff annual appraisal compliance was low across wards.

However:

- Ward managers were aware of the wards shortfalls and were working to address them, for example compliance with mandatory training.
- Staff morale was very good.
- Staff felt they were supported by their managers.
- Staff were committed to providing good quality care in line with the trust vision and values. We saw these values demonstrated in their work.
- There were governance systems in place that were understood and shared with staff.

Summary of findings

- Lessons learnt were shared and changes to practice implemented to improve patient care and experience.

Summary of findings

Information about the service

Cumbria Partnership NHS Foundation Trust provides inpatient acute and intensive care services for people of working age with mental health conditions. Services are provided for both patients admitted informally and those compulsorily detained under the Mental Health Act 1983 (MHA).

The trust has four acute wards across four locations for adults who require a hospital admission due to their mental health needs, either for assessment or treatment, or under the Mental Health Act.

The wards are:

- Dova Unit is a ward for both men and women based at Furness General Hospital with 20 beds.
- Hadrian Unit is a ward for both men and women based at Carleton Clinic in Carlisle with 26 beds.
- Kentmere Ward is a ward for both men and women based at Westmorland General Hospital with 12 beds.
- Yewdale Unit is a ward for both men and women based at West Cumberland Hospital with 16 beds.

Cumbria Partnership NHS Foundation Trust also has a ward which provides intensive psychiatric care services for people who present more risks and require increased levels of observation and support:

- Rowanwood is a ward for both men and women based at Carleton Clinic in Carlisle providing psychiatric intensive care and has 10 beds.

In 2014, acute and psychiatric intensive care inpatient services moved from a locality model to a care pathway model called 'acute admission pathway'. The pathway's aim is to provide a consistent approach to care and treatment for patients across all wards.

There have been 22 inspections across 11 locations registered to Cumbria Partnership NHS Foundation Trust. Of these three were at the Dova unit, four were at the Carleton Clinic (which included other services in addition to the Hadrian unit and Rowanwood) and two were at Kentmere ward.

All of the sites were inspected under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At the time of our visit there remained one compliance action on Dova unit with a moderate impact for outcome 21 – Records.

This inspection was the first inspection for the trust under the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. Dova unit was found to have met its compliance action.

During this inspection, an unannounced Mental Health Act review was completed on Kentmere ward and Dova unit.

Our inspection team

Our inspection team was led by: Chair: Paddy Cooney

Team Leader: Jenny Wilkes, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Brian Cranna, mental health hospitals, CQC

The inspection team for this core service consisted of a two CQC inspectors, a CQC inspector in training, a consultant psychiatrist, two mental health nurses, and three Mental Health Act reviewers.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, 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 five of the wards and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 34 patients who were using the service.
- Spoke with 4 carers or relatives of patients.
- Spoke with the managers for each of the wards.
- Spoke with 33 other staff members; including doctors, nurses and social workers.
- Attended and observed four hand-over meetings and nine multi-disciplinary meetings.

We also:

- Collected feedback from 10 patients using comment cards.
- Talked with three patients who attended a focus group.
- Talked with 2 carers who attended a focus group.
- Looked at 49 care records of patients.
- Reviewed 58 medicine charts.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 34 patients across the five wards and received feedback from 10 patients using comment cards. Three patients attended a focus group. We spoke with four carers and a further two carers attended a focus group.

Patients reported that staff were caring, friendly, approachable and polite. Some patients told us that staff dealt with patients who were upset well. Patients felt safe on the wards and commented that staff were always in the corridors. Two patients commented that they did not like the wards being mixed sex.

Two carers felt communication was poor and told us of a delay in their relative receiving care for physical injuries sustained on the ward.

Not all patients had keys to their bedroom. However, they said that staff would open the door for them when they wanted to use it. All patients had access to a lockable area to store possessions.

Most patients felt there were enough staff on the wards for 1:1 meetings. Patients spoke positively about the activities which were available on the wards and said they were rarely cancelled.

Good practice

The Hadrian unit provided a carers group on a Saturday. This was open to all carers and carer's assessments could be undertaken.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must review the out-of-hours medical cover available across the wards to ensure there are sufficient staff to meet the needs of all patients.
- The trust must ensure that arrangements for single sex accommodation are always adhered to in order to ensure the safety, privacy and dignity of patients. Clear signage should be in place at the entrance to each gender area informing patients who could enter. There should be a clear process for staff to report any breaches.
- The trust must ensure all staff understand the application of the Mental Capacity Act in practice. Documentation should contain evidence of recording of any decisions made about a patient's capacity.
- The trust must ensure that mandatory training is completed for all staff to achieve the trust target of 80%.
- The trust must ensure that staff attend basic life support with defibrillator training or intermediate life support.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that medicines are stored safely in rooms that do not exceed the recommended temperature range.
- The trust should ensure that care plans are always personalised and that patients are fully involved in their care planning.
- The trust should ensure that positive behaviour support plans are developed for patients receiving restrictive interventions.
- The trust should ensure that the clock in the seclusion room on Rowanwood is replaced.
- The trust should ensure all staff have an annual performance appraisal.
- The trust should ensure that all episodes of seclusion on Kentmere ward are correctly recorded.
- The trust should ensure all episodes of restraint on Kentmere ward are reported on the incident reporting system.
- The trust should ensure all acute and PICU wards display notices both on the inside and the outside of locked entrance doors to inform informal patients of the reason for the ward being locked and their right to leave at any time.
- The trust should review patients' access to ECT.

Cumbria Partnership 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
Dova Unit	Furness General Hospital
Hadrian Unit	Carlton Clinic
Kentmere Ward	Westmorland General Hospital
Rowanwood Unit	Carlton Clinic
Yewdale Unit	West Cumberland Hospital

Mental Health Act responsibilities

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

Mental Health Act training was part of mandatory training and 41% of staff across the acute wards and PICU had received training in the MHA as at October 2015.

We found that some staff were not very knowledgeable about the MHA and some told us they could not remember if they had received training.

At each of the locations we reviewed the records of people who had been detained under the MHA. An unannounced Mental Health Act review was completed on Kentmere ward and on Dova unit.

We found that systems in place to ensure compliance with the guiding principles of the MHA code of practice were variable. There were a number of areas where compliance with the MHA and MHA code of practice were poor. These included delays in rights being read under the MHA or not filed appropriately. Records showed that there was a delay of up to three days for some patients to be given their

rights. On Kentmere ward staff lacked understanding of the authority to administer medication, correct T2 and T3 forms were not always present and staff seemed unclear which was the most up to date form. We saw inconsistencies with regards to risk assessments prior to section 17 leave and in some records detention documents were missing.

We saw notice boards which displayed relevant information about patient rights and also how to make a complaint. However, we were unable to locate a Care Quality Commission (CQC) detained patient's poster or any CQC detained patient information leaflets displayed for patient reference.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was part of mandatory training and 71% of staff across acute wards and PICU had received training as at October 2015.

Staff we talked to were able to tell us their understanding in relation to consent to treatment and consent to talk to relatives about a patient's care. However, most staff were unable to tell us about other decision focused capacity discussions or assessments. Staff told us that doctors completed capacity assessments yet there was little evidence of this in the care records.

None of the patients receiving care and treatment during our inspection were under Deprivation of Liberty Safeguards (DoLS).

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

Safe and clean environment

All wards were visibly clean with good furnishings and well-maintained decoration. We saw cleaning schedules for the wards and domestic staff were on duty. Cleaning records were up to date. The Yewdale unit and Kentmere ward had both scored below the national average for cleanliness, condition and appearance in the PLACE 2015 assessment. At the time of our visit Yewdale ward had recently had some improvements made to the décor and furnishings of the ward, including replacement of blinds in the conservatory, new artwork for walls and replacement furniture for some rooms had been ordered.

The layout of the wards did not always allow staff to observe all parts of the wards. Risk had been minimised by the use of mirrors to aid observation on most wards. However no mirrors were in the male and female corridors on Hadrian Unit and the female corridor on Rowanwood. Staff told us that regular observations of patients mitigated this and at night staff were seated on these corridors.

Up to date ligature point audits were in place in each ward. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. All wards had ligature points which were referenced on the ligature audits. Mitigations were in place to manage these risks which included locking rooms where ligatures were, for example some bathrooms; observations of staff; and individual patient risk assessments.

All wards provided accommodation for both male and females patients. Kentmere ward was not compliant with Department of Health's guidance on eliminating mixed sex accommodation. At the time of our inspection, we found a female patient using a side room which was opposite the male patient bay. Male patients had to pass by the side room of the female patient to get to the bathroom. The female patient had to pass the male bay, lounge and day room areas to get to the female toilet and bathroom. There were no risk management arrangements in place to minimise the associated risks of this happening.

Clinic rooms were clean, tidy and well arranged. Medicines were stored securely and regular monitoring of fridge temperatures for the storage of medicines was taking place. The fridge in the Hadrian unit had a broken lock which was being repaired during our visit. The clinic room temperature in the Hadrian unit was consistently recorded above 25 C. The ward manager was aware of this and had received advice from the pharmacist to regularly open the window to cool the temperature down which staff were doing. High temperatures in rooms where medicines are stored could compromise the stability of some medicines although we did not see any evidence of this at the time of our visit.

Medicines for emergency use were easily accessible. Appropriate equipment for examinations and monitoring of basic medical observations were available. Daily temperature checks of drug cupboards showed they were within the required range. Weekly cleaning of medical equipment took place.

Rowanwood psychiatric intensive care unit (PICU) was the only unit to have a seclusion room. The room had been subjected to a seclusion review by a Mental Health Act reviewer in August 2015. Actions from that review were still ongoing at the time of our inspection. Window blinds had not been fitted, but had been ordered. These would allow the patient to regulate the daylight. A speaker for the shower room had not been fitted. Engineers had attended on two occasions to fit this, but the room had been in use. A mirror had been fitted to eliminate blind spots. There was not a working clock in the room at the time of our visit as it had recently been broken by a patient.

Staff adhered to infection control principles such as handwashing and there were dispensers at the entrance to all wards with hand sanitizer. Yewdale staff wore uniforms on the ward which helped identify staff to patients. Environmental risk assessments including manual handling hazards and fire risk assessments had been completed.

Nurse call alarms, to attract the attention of staff as required, were present for patients in bathrooms and bedrooms. Security alarms were carried by all staff members working on the wards.

Requires improvement

Are services safe?

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

Safe staffing

The full establishment for the five wards was 67.7 (WTE) qualified nurses and 67.6 WTE nursing assistants. At the time of the inspection, 10.5 and 17.2 qualified nurses and nursing assistant posts respectively were vacant. In order to establish the number of staff required on each shift the trust had completed a review of staffing levels across mental health inpatients. This information had been used to inform staffing levels and skill mix.

All ward managers and staff reported staffing numbers and skill mix was good on the wards. Where there were gaps in staffing due to vacancies or sickness, bank staff or occasionally agency staff were used who were familiar with the ward. Most patients told us that staff were always around for them to talk to and thought there was enough staff. Two patients on Rowanwood said there were too many agency staff used. Ward managers were able to adjust staffing levels depending on the needs of the patients. On Yewdale ward the manager had negotiated the temporary closure of two beds during a period of increased staff sickness. This had helped to ensure patients and staff remained safe.

Staff and patients told us activities on the ward or planned leave was rarely cancelled because there was not enough staff. Two patients did say escorted leave had sometimes been cancelled which they had found frustrating.

All the acute wards had a Section 136 suite attached to them. The units were staffed by

the access and liaison integrated service or existing resources from the adjoining acute admission wards. Each ward allocated a single member of staff to deal with any admission under Section 136. Ward managers reported difficulties at times with staffing due to the high risk nature of the patients being brought to the area by the police. All staff responsible for staffing the 136 suites had received training in the prevention and management of violence and aggression (PMVA). The 136 suites were sometimes used for the purpose of child visits. This practice posed a risk as the dedicated place of safety needed to be available at all times and visits by children would have to be cut short if the room was needed.

An on call consultant psychiatrist for the south of the region and an on call consultant psychiatrist for the north of the region provided psychiatric medical cover out of hours and at weekends. Psychiatric junior doctor cover was provided up to 5pm weekdays on Dova, Kentmere and Yewdale ward and up to 12 midnight, seven days a week at Hadrian unit and Rowanwood. Physical screening examinations on admissions were conducted by nursing staff with the requirement for a full physical examination to be completed within 24 hours during core working hours or when the patient consents. Cumbria Health on Call Limited (CHOC) were contacted for medical queries and prescribing psychiatric medication out of hours (after 5pm weekdays and weekends at Dova, Kentmere and Yewdale ward and after 12 midnight at Hadrian unit and Rowanwood). The Primary Care Assessment Services (PCAS) was also used for any medical emergencies at Kentmere ward. This meant that psychiatric emergencies was dealt with by the on call consultant psychiatrist.

Staff told us that consultants would usually only go to the wards out of hours and at weekends for MHA assessments. Prescribing of medications out of hours was usually done over the telephone. Whilst some staff acknowledged this was manageable, particularly for known patients, some felt it was not ideal for new patients and that access to consultants and psychiatric cover out of hours was not sufficient.

The average mandatory training rate for staff across the acute and PICU wards at October 2015 was 59% which was below the trust target of 80%:-

Dova unit 58%

Hadrian unit 53%

Kentmere Ward 65%

Rowanwood 50%

Yewdale Ward 72%

Records showed levels of compliance were below 75% in all wards in the following areas; informed consent to treatment, mental health legislation update, safeguarding children- working with children and their families, clinical waste management, basic life support with defibrillator, infection prevention and control level 2, hand hygiene, rapid tranquilisation. Basic life support with defibrillator for non qualified staff was very low on Hadrian unit, Rowanwood and Dova unit:-

Dova unit 38%

Hadrian unit 7%

Requires improvement

Are services safe?

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

Kentmere Ward 73%

Rowanwood 33%

Yewdale Ward 71%

Intermediate life support for qualified staff was low on Rowanwood and the Hadrian unit:-

Dova 73%

Hadrian 25%

Kentmere 100%

Rowanwood 50%

Yewdale 92%

Kentmere ward was above the trust target for deprivation of liberties safeguards, intermediate life support and information governance. Yewdale unit was above the trust average for intermediate life support, safeguarding children – working with children and manual handling. Hadrian unit was above the trust target for clinical record keeping.

Managers received monthly emails regarding each staff member's status of their mandatory training which helped them manage attendance. Some staff told us the system was slow to update and was not accurate. Some staff told us they kept their own log of what training they had completed as this was more up to date.

A number of staff reported access to training was a problem. Classroom training tended to be delivered individually and ward managers gave examples of having to free up staff to attend a two hour course in a different part of the trust which may take an hour to travel to. E-Learning courses were hindered by the length of time it took staff to log on to the system and the time it took for the training module to upload.

Ward managers told us they had requested training to be delivered in blocks as that would have been easier to manage in terms of release of staff. All managers had tried to improve their wards compliance with mandatory training including arranging for training to be delivered on the ward.

Assessing and managing risk to patients and staff

We reviewed 49 care records and found that risk assessments had been completed upon admission to the ward using the GRIST risk assessment tool (Galatean Risk and Safety Tool). This complies with the Department of Health Best Practice in Managing Risk guidance (2007) as it covered all the five key areas to risk management that they recommended to be assessed. These were risk of violence, sexual violence, antisocial or offending behaviour, self-harm or suicide and self-neglect or vulnerability. Most risk assessments had been regularly reviewed and were up to date.

Wards had a number of rooms kept locked due to patient safety risks. However, the locking of some rooms, such as bathrooms on Kentmere ward, dining room, visitors lounge and bedrooms on Hadrian unit were not based on current patient risks. This therefore appeared to be a blanket restriction.

The trust had policies for observations of patients and searching of patients. Staff were able to explain these to us. Searching of patients was not routine but if this was felt to be necessary due to risk to self or others this was done in accordance with the trust policy which complied with the MHA code of practice.

There were 115 episodes of restraint in the six months prior to inspection. These were highest on Rowanwood PICU & Kentmere ward with 32 each followed by Dova unit with 22, Yewdale ward with 17 and Hadrian unit with 12. Staff involved in restraint were trained in prevention and management of violence and aggression (PMVA). PMVA training included, full restraint, breakaway skills and de-escalation techniques.

Of these restraints 35 involved prone restraints. This is when the patient is restrained in a face down position. The highest number of prone restraints occurred on Rowanwood with 20 (56% of prone restraints in this core service). There were 22 episodes of patients in the prone restraint position who received rapid tranquilization. A further 14 episodes of rapid tranquilisation was given for patients not in the prone position. Staff informed us that rapid tranquillisation was only used when necessary to prevent violence or aggression in patients.

The manager and deputy managers on Rowanwood told us of a recent restraint incident where the police were used to support staff. It was reported that the episode was a very positive piece of joint working which safeguarded both the patient and staff.

We reviewed five recent records of restraints on Kentmere ward and found that four uses of PMVA were not recorded as incidents.

Requires improvement

Are services safe?

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

There were 17 episodes of seclusion in the six months prior to inspection. These all occurred within Rowanwood PICU. There were no incidents of long-term segregation in the last six months.

Staff on Rowanwood told us that 'seclusion' for female patients was taking place in the female area of the ward. This was due to vulnerability rather than aggression or risk to others. This practice did not meet the seclusion criteria as defined in the MHA code of practice as the patient was free to leave and was not detained in a room. However, the ward was using seclusion recordings as a patient safeguard whist work was ongoing regarding how to manage this.

We were informed on Kentmere ward that a patient had been secluded away from other patients'. There was no seclusion papers or recording of this episode. We did not find any evidence of seclusion on any of the other acute wards.

Staff had a good knowledge and understanding of safeguarding policies and procedures. The number of staff trained in safeguarding adults was Dova unit 74%, Hadrian unit 73%, Kentmere ward 77%, Rowanwood 65% and Yewdale unit 89%.

Staff were able to describe situations that would lead to a safeguarding alert. Managers knew who their safeguarding lead was for support and advice.

There was good medicines management practice on the wards. However, on the Hadrian unit we observed an insulin pen in the fridge which was not labelled. We brought this to staff's attention. A cream was also unlabelled and not dated. We looked at the prescription charts for 58 patients across all the wards and found them to be accurate and up to date. The information on the charts was clear and reflected the pharmaceutical treatments that people received. We also looked at the medicine administration records (MAR) for patients and found these were also completed in a clear way, using appropriate codes and allowing others to easily review medicine that had been given.

Arrangements were in place to ensure wards had the medicines they needed and these were delivered directly to wards usually on the day of request. We were told by staff on the wards that a pharmacist visited regularly to check medicines in stock and ensure that appropriate levels were held on the ward. In addition the pharmacist checked MARs and reported any concerns or discrepancies to the ward manager.

The Dova unit used an electronic drug cupboard which used software to control access and was designed for the safe storage of medication. We were told by the pharmacist that the benefits of the system included reduced medication errors and stock ordering.

Track record on safety

Information provided by the trust prior to our inspection showed there had been four serious incidents that required investigation in the last 12 months. Two were on the Dova Unit and were regarding unexpected deteriorations of patients, one of which resulted in a patient death. The other two incidents were reported by Kentmere ward and concerned a patient who absconded from the ward and another patient who died while on home leave. At the time of our inspection the investigation into these incidents were ongoing.

Reporting incidents and learning from when things go wrong

Wards had access to an online electronic system to report and record incidents and near misses.

Staff were able to describe the electronic system and their role in the reporting process. We saw in one care record staff had documented that an incident fitted the duty of candour requirement and had recorded that the process was being followed.

The majority of staff told us how learning and sharing from incidents took place. This included feedback at staff meetings, in supervision and via email bulletins. Ward managers also ensured that debriefs happened following incidents. This involved discussion of what happened, supporting staff in their emotions and identifying what could have been done differently. Managers also told us that discussions of who would be best suited to debrief the patient would also take place during debrief sessions.

Ward managers attended the trust quality and safety meetings where incidents from across the trust were discussed in order to learn lessons and share learning. This was then fed back to ward teams via team meetings. We reviewed team meeting minutes and saw this was taking place.

Requires improvement

Are services safe?

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

The ward manager on the Dova unit told us the new chief executive had made it clear she had not wanted a blame culture in the organisation. The manager had seen a massive change since the chief executive came in terms of openness and incident reporting.

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

Assessment of needs and planning of care

When patients were admitted to acute and PICU wards, they spent time with a member of staff who would become their named nurse. This person was responsible for ensuring the patient was settled in, oriented and had been given information about their admission.

Staff carried out comprehensive assessments of patients' needs upon admission. This assessment included a review of their clinical needs, mental and physical health and spiritual needs. Outcomes of assessments were recorded and individual needs were appropriately documented in the care records. We saw evidence of regular reviews being carried out and records being updated as needs changed.

We looked closely at 32 care plans and assessments of patients across the acute and PICU wards. We found 27 were detailed, holistic and recovery focussed for patients. Most care plans were up to date and comprehensive. However, only 21care plans were personalised which meant that patient's involvement and their comments were not always completed in the records. We did see some evidence of patients being involved with the writing of care plans and this helped ensure their care was planned in a person centred way.

We did not see positive behaviour support plans for patients who had received restrictive interventions such as restraint or seclusion.

All the wards had daily multi disciplinary team (MDT) handover meetings in which they discussed patient's general health and behaviour over the previous 24 hours and also any issues or concerns that had arisen during that time. In addition to this there were more formal MDT meetings. All wards followed a pathway of initial MDT on admission followed by an MDT meeting after 72 hours. A further MDT meeting took place to plan discharge. In between these times the consultant reviewed the patient with the MDT at daily handover meetings and met with the patient if the patient or staff requested.

All the records we looked at were paper and were held on the wards. Although records were up to date we found information was not always contained in the areas shown on the file index. For example on Hadrian ward we found capacity assessments were recorded on the daily notes and not held within the section for this. This made it difficult to find relevant information when needed.

Best practice in treatment and care

The acute care 'clinical governance group' had dedicated national institute for health and clinical excellence (NICE) leads whose role was to ensure that NICE guidance and quality standards were disseminated across all wards and services. Ward managers or representatives supported the designated NICE lead to review compliance with guidance which was reported back to the 'quality and safety committee'.

We talked to the trust's pharmacist who told us that the trust had not fully implemented the revised NICE guidance on rapid tranquilisation (May 2015). A plan to address this was in place.

Electro-convulsive therapy (ECT) was not available as a treatment option within Cumbria and patients had to travel out of area to access ECT.

Patients had access to psychological therapies with dedicated psychology support available on all wards with the exception of the Yewdale unit. The ward manager on Yewdale told us referrals for psychology support were made to the community teams.

All the wards we visited had systems in place to ensure patient's physical health was appropriately cared for and ongoing assessments meant this was closely monitored. We saw evidence of referrals being made to appropriate specialists and patients being helped to attend these appointments. One patient we spoke with told us they had a rare condition and had been unable to see an appropriate specialist in relation to this. Staff had recorded this condition in the patients' records; however, we saw no evidence of referrals for this condition.

We found, where appropriate, regular medical tests had been carried out to ensure people didn't suffer any negative effects from prescribed medicines. The results of tests were recorded in care records.

The wards used a number of rating tools as part of patients treatment which included the 'the patient health questionnaire 9', 'generalised anxiety disorder assessment 7, 'psychotic symptom rating scale'.

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We found that nationally recognised rating scales to assess and record severity and outcomes, for example, Health of the National Outcome Scales (HoNOS), were being used on the wards we visited.

Outcomes for patients receiving care and treatment on the wards were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation.

We saw evidence of audits being carried out to ensure wards were being run effectively. The trust provided information of the following audits that had been completed over the past 12 months:-

- Homeless housing care plan audit (Hadrian Unit).
- Re-audit of Rowanwood therapeutic writing sessions.
- A re-audit of family and carer involvement on the Hadrian Unit.
- Compliance with guidance on physical examinations and blood investigations prior to starting antipsychotic medication.
- Audit of admission criteria for Rowanwood Psychiatric Intensive Care Unit (PICU).
- Re-audit: prescribing in a hospital kardex (Hadrian unit and Rowanwood).

In addition to this, ward managers told us that staff participated in regular audits of record keeping, care plans, medicine charts, infection control and hand hygiene.

Through speaking with staff and reviewing records we found all wards were delivering care in accordance with the latest and most up to date guidance, standards and legislation.

Skilled staff to deliver care

The wards were staffed by a range of mental health disciplines. All wards had registered mental health nurses and healthcare support workers and a dedicated consultant psychiatrist. Kentmere ward had had a locum consultant for the past 10 months. A permanent consultant was due to take up post later in the month. An occupational therapist was dedicated to each ward. Yewdale ward was in the process of recruiting to their occupational therapist post. There was dedicated psychologist time for each ward with the exception of Yewdale ward. A pharmacy technician visited the wards weekly and pharmacists attended ward rounds.

New permanent staff underwent a formal induction period. This involved attending a corporate induction as well as a local induction learning about the ward and trust policies. New members also shadowed existing staff before working alone.

Staff working on the wards were required to have regular supervision and appraisals. Trust policy was for staff to receive monthly managerial supervision and clinical supervision four times a year. All staff told us they received supervision and we saw examples of completed supervision records on some wards. Staff said they received supervision on a regular basis, however, this did vary with some staff receiving monthly and some eight weekly supervision. Group clinical supervision was also provided by psychologists.

The trust provided us with information of non-medical staff annual performance appraisals for the 12 months prior to our inspection. This showed the rates for each ward to be:- Dova unit 34%, Hadrian unit 54%, Kentmere ward 85%, Rowanwood 36%, Yewdale ward 36%. During our visit we saw evidence that this was being addressed on all wards.

Staff told us they could attend additional training specific to their role including cognitive behavioural therapy.

Multi-disciplinary and inter-agency team work

We observed six MDT meetings across the wards. This gave professionals like nurses, psychologists and occupational therapists the opportunity to discuss with patients the treatment being provided and any possible changes. Without exception, we found these were comprehensive and well planned. Patients were treated in a polite and dignified way and were given the chance to tell staff what their thoughts on their treatment were.

We observed five nursing staff handovers which included everyone coming on duty for that shift. The staff member giving handover referred to the 'acute admissions pathway' (AAP) board and care records to provide all staff with an up to date progress report of each patient. The AAP provided prompts for staff to ensure key actions were completed. These included patients' rights under the MHA, safeguarding concerns and observation levels. Staff were given a full handover for the period of time they had been

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off duty. The handovers were observed to be very positive and focused. Good detail about the patient's mental health act status, level of observations, leave status and any changes in risk were handed over. Staff also discussed the activities patients had participated in, therapy sessions and any visits they had received.

We also observed two MDT handovers. Throughout these handovers we found staff spoke knowledgeably and compassionately about people they cared for.

We reviewed the information held in care records in relation to handovers and admissions. We saw where possible, admissions were planned and there was input from community teams, crisis teams and other medical services. Staff told us they received good handovers from community teams and crisis teams when a patient was admitted. Some staff, however, told us they sometimes experienced problems with communication with community teams or other wards when transferring patients.

We saw evidence of interagency working when people were admitted as urgent cases. Care records contained information about actions or treatments provided by other services. For example, we saw complete records of a transfer from police cells which detailed the reason for detention and details of visits from the police forensic medical examiner.

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

Mental Health Act training was part of mandatory training and 41.4% of staff across the acute wards and PICU had received training in the Mental Health Act (MHA) as at October 2015. By ward this equated to:-

Dova Unit 50%, Hadrian Unit 23%, Kentmere Ward 64%, Rowanwood 8%, Yewdale Unit 5%

We found that some staff working on the wards were not very knowledgeable about the MHA and some told us they couldn't remember if they had received training. Staff received legal advice and support on the implementation of the MHA and code of practice from a central MHA office team. Each ward had administrative support for monitoring of MHA documentation.

At each of the locations we reviewed the records of people who had been detained under the MHA. In total we reviewed 20 records. An unannounced Mental Health Act review was completed on Kentmere ward and on Dova unit.

There was a clear process for scrutinising and checking the receipt of MHA documentation on the wards. However systems in place to ensure compliance with the guiding principles of the MHA code of practice were variable. We found a number of areas where compliance with the MHA and MHA code of practice were poor. These included delays in rights being read under the MHA or not filed appropriately. Records showed that there was a delay of up to three days for some patients to be given their rights. On Kentmere ward staff lacked understanding of the authority to administer medication, correct T2 and T3 forms were not always present and staff seemed unclear which was the most up to date form. We saw inconsistencies with regards to risk assessments prior to section 17 leave and in some records detention documents were missing.

Patients on a section of the MHA were automatically referred to an independent mental health advocate. We saw notice boards which displayed relevant information about patient rights and also how to make a complaint. However, we were unable to locate a Care Quality Commission (CQC) detained patient's poster or any CQC detained patient information leaflets displayed for patient reference.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was part of mandatory training and 71% of staff across acute wards and PICU had received training as at October 2015. By ward this equated to:-

Dova Unit 48%, Hadrian Unit 76%, Kentmere Ward 64%, Rowanwood 77%, Yewdale Unit 74%

Staff we talked to were able to tell us their understanding in relation to consent to treatment and consent to talk to relatives about a patient's care. However, most staff were unable to tell us about other decision focused capacity discussions or assessments. Staff told us that doctors completed capacity assessments yet there was little evidence of this in the notes.

Across all of the wards, we found 19 informal patient records did not have capacity assessments recorded on admission. We found little evidence of capacity assessments being carried out in relation to any other

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decisions. In a multidisciplinary team meeting we saw a patient who was refusing leave and access to her home so they could have some clothes brought to the ward. We would have expected the patient's capacity to be discussed during this meeting but it was not.

None of the patients receiving care and treatment during our inspection were under Deprivation of Liberty Safeguards (DoLS).

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke with 34 patients receiving care and treatment. We observed how staff interacted with patients throughout our inspection. Staff were kind with caring and compassionate attitudes. We observed many examples of staff treating patients with care and compassion. Staff engaged with patients in a kind and respectful manner on all of the wards.

We observed that patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed that staff knocked before entering patients' rooms.

Patients described staff as "very kind", "caring" and said they were "great", "always ask how I am", "most of the staff were very nice" and "I am able to speak with a female doctor". One patient said "they have saved my life". Some patients however, said they were kept "in the dark" and that "staff can be domineering".

Carers told us the "nurses are great" and "always ask how I am".

Most patients told us they felt safe on the ward. Two patients and one carer said they did not like the wards being mixed sex. All patients said they could access their bedroom at any time and had a secure place to store possessions. We observed staff being visible in the communal ward areas and attentive to the needs of the patients they cared for.

The involvement of people in the care that they receive

On admission to acute and PICU wards all patients were provided with an information leaflet explaining about the ward and the service. Staff also told us they explained the layout of the ward and the ward routine to patients, relatives and carers.

Yewdale unit told us of a recent piece of work to improve patients' experience. Feedback from patients revealed they sometimes felt bombarded with information when they were admitted to the ward. In response to this a new patient information pack and patient information board had been developed.

We observed information boards across the wards detailing the staff that were on duty and details of staffing levels. This helped patients and their relatives understand what people's roles were and who to approach.

Care plans were comprehensive but did not always reflect the thoughts of the patient. Most patients did not have a copy of their care plan. We saw only 12 records where the patient had received a copy of their care plan. However, some patients told us they were fully involved in care planning and one patient we spoke with had an advanced decision in place.

Patients had access to a local advocacy service including an independent mental health advocate

(IMHA) and there was information on the notice boards on how to access this service. Patients on a section of the MHA were automatically referred to an IMHA.

Carers told us they were involved in their relative's care and attended MDT meetings. They felt listened to by staff. We found there was a sufficient amount of dedicated space for patients to see their visitors. People under the age of 18 were not allowed on the wards and there were no specific children's visiting areas. In some wards the section 136 suite was used for children visiting. This was not suitable as the room should have been available at all times for use as a place of safety. There was a risk also that childrens visits would have to be cut short if the room was needed.

All wards held weekly community meetings where patients gave feedback about the ward. Staff encouraged patients to complete a questionnaire on discharge.

Ward managers told us that patients helped in the recruitment of staff. All posts at band 6 and higher had a patient representative on the interview panel. This was arranged by the trust's patient experience team.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The average bed occupancy over the past six months was 92%:-

Dova Unit 97%

Hadrian Unit 92%

Kentmere Ward 108%

Rowanwood 90%

Yewdale Unit 80%

All ward managers spoke highly of the new 'acute admission pathway' which included a whiteboard with key milestones which was used during MDT and staff handover discussions. Some managers reported length of stay and patient management had greatly improved with the new pathway.

We saw some patients on the wards were informal and found, in line with the MHA they were free to leave the hospital wards if they wished.

We saw there was a good bed management system in place with daily telephone conferences between wards. We observed one of these conferences which was chaired by the trust's bed manager. All ward managers attended along with the manager from the access and liaison integration service. Each ward discussed clinical pressures and transfers between wards which were required. The conference clarified possible admissions and helped to ensure there were no delays to discharges for current inpatients. The meeting was concise and focused. We observed managers working together to support each other and maintain patient and staff safety.

Managers told us that two to three patients were often admitted to a ward outside of their local area. Transfers to wards nearer their home was always planned with the patient and at an appropriate time of day. The ward manager on Rowanwood PICU told us that patient transfers back to the acute wards would usually be during the day, but sometimes they took place in the early evening if they were planned with the patient.

Staff told us that leave beds were used on all acute wards. This meant that sometimes a patient would return from leave and would not always have the same bed although they would return to the same ward.

There had been a total of 154 readmissions within 98 days across the core services as follows:-

Dova Unit 41

Hadrian Unit 29

Kentmere 21

Rowanwood 8

Yewdale 55

In the period April 2015 – September 2015 Yewdale unit had three delayed discharges and Hadrian unit had two. The reasons for the delayed discharges were due to lack of suitable housing or placements.

We reviewed four records of recent discharges on Dova unit to follow up a non-compliance action from their last CQC inspection. We saw follow up arrangements and discharge summaries had been sent to the GP and community teams. This helped to make sure patients remained safe.

The facilities promote recovery, comfort, dignity and confidentiality

All acute wards and PICU had a full range of rooms and equipment to support treatment and care. These included a clinic room to examine patients, activity rooms and areas which could be used for 1:1 or quiet time. In addition we found all wards offered patients access to outside space. However, on Kentmere ward access to outside was quite a distance from the ward which was on the second floor in a district general hospital.

Most patients had their own mobile phones and they could use the ward phone if they wanted to.

Patients on all wards were able to access drinks and snacks 24 hours a day. Some patients were able to access the kitchen areas and prepared their own meals. This was done as part of their preparation for discharge helping to enable independent living. Most patients told us the quality of the food was good. Patients described it as "tasty" and "nice". One person felt the amount of food was too much.

Patients we spoke with told us they were able to access their bedrooms at any time although some would need to

Are services responsive to people's needs?

Good

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

request a member of staff unlocked the door for them. Patients on all wards were able to secure personal or valuable possessions in either lockers outside of their bedrooms or a security office to which staff had the keys.

All the wards we visited had activities co-ordinators who had a programme of activities available to patients. Some activities were specifically recovery focused and were part of patient's individual therapy. Patient records contained personal activity plans which were discussed and agreed by both patients and staff. These plans were signed by both parties to show this was agreed.

All wards had locks on the main entrances with entry and exit controlled by staff. Signs were displayed on ward doors providing informal patients information about their rights to leave the ward with the exception of the Hadrian unit. The Dova unit did not have a sign on the inside of the door. All ward managers confirmed that patients were informed of their right to leave the ward.

Meeting the needs of all people who use the service

Patients diversity and human rights were respected. We saw staff understood people's differences and supported them in ways that were personal to them. There were facilities available for patients with mobility difficulties who required disabled access with assisted bathroom space, wide corridors and ramped access.

Staff working in the trust were aware of patients individual needs and tried to ensure these were met. This included cultural, religious and language differences with translation services available, leaflets printed in different languages and access to members of religious groups. Multi-faith boxes, which have items relating to different faiths, for example a bible, were available on each ward. Chaplaincy representatives visited each ward.

Patients were given a choice about the meals they ate and staff told us that meals took account of people's cultural, physical and personal needs. For example meals were available for patients who required halal meat, diabetics and vegetarians.

Listening to and learning from concerns and complaints

Patients we spoke with told us they knew how to make a complaint. We saw there was information on all of the wards we visited that told patients how they, or their friends and relatives could raise a concern or complaint.

We interviewed the ward managers on all the wards and asked them about how they would deal with complaints or concerns. We were told there was a complaints policy in place in the trust and any complaints would be investigated and responded to in line with this policy. We were also told that if they became aware of any concerns ward managers discussed these concerns and tried to put people's minds at rest.

There were 46 complaints across the wards with 10 upheld. There were no complaints referred to the ombudsman. Ward managers and staff told us outcomes from complaints were shared through team meetings and 1:1 meetings. We saw feedback recorded in meeting minutes.

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

Vision and values

Staff told us they were aware of the trust's visions and values. We saw the trust's visions and values were displayed around the wards.

Staff told us who the most senior managers in the trust were and these managers had visited the wards. Ward managers reported they felt supported by their senior managers.

Good governance

Care group 'clinical governance committees' and mechanisms were in place which supported the safe delivery of the service. Ward managers told us they attended these meetings and felt they were making improvements in the quality of the service.

Compliance with overall mandatory training was below the trust target on acute and PICU wards. We saw ward managers actively trying to improve this. Appraisal rates were low with the highest being 84.% on Kentmere ward. Ward managers told us they had appraisals booked in for all staff. All staff we spoke with told us they had regular supervisor and said group supervision and informal supervision also took place.

Staff interviews, reviews of staffing data and talking with patients showed that the wards had sufficient numbers of staff of the right grades and experience. However, we were told that out of hours' psychiatric medical cover could be an issue. An on call consultant psychiatrist for the south of the region and an on call consultant psychiatrist for the north of the region provided psychiatric medical cover out of hours and at weekends. Psychiatric junior doctor cover was provided up to 5pm weekdays on Dova, Kentmere and Yewdale ward and up to 12 midnight, seven days a week at Hadrian unit and Rowanwood.

Some staff were engaging in clinical audit on the wards which included record keeping audits, medicine audits and infection control audits. Dova unit had a care plan audit in place which included MHA documents.

Staff knew how to report incidents and records showed they did this in accordance with trust policy. Learning from incidents was cascaded from trust wide clinical governance meetings down to ward team meetings. Staff received email bulletins with key messages and learning.

Staff across acute and PICU wards had a good knowledge and understanding of safeguarding policies and procedures and could apply these in practice.

Ward managers were able to provide us with information on how the wards were performing and had a good understanding of where improvements were required. We observed a dashboard which managers had access to which detailed key performance indicators and audit information. We asked two ward managers or their representative what procedure were in place for reporting breeches in relation to mixed sex accommodation. The managers were unable to tell us this.

All wards had items on the trust risk register which was discussed at monthly care group meetings.

Ward managers confirmed that they had sufficient authority to manage their ward and received administrative support. They told us that they felt well supported by their line manager.

Leadership, morale and staff engagement

The wards appeared to be well managed both on a day to day basis and strategically, for example, the ward managers had future plans of what they wanted to achieve. The sickness rate for acute wards and PICU was 5% which was in line with the national average of 5%.

Staff told us that morale and job satisfaction were high. Staff we spoke with told us that they felt part of a team and received support from each other. We saw evidence that regular staff meetings took place. All staff were aware of the trust whistleblowing policy and felt confident to raise concerns without fear of victimisation..

All staff we spoke with said they felt well supported by their ward manager and felt their work was valued by them. Staff felt listened to and were able to suggest ways to improve services.

The managers were a visible presence on each of the wards and staff spoke highly of them. Staff reported teams worked well together and we observed a positive working culture within the teams.

Ward managers told us a leadership training programme was available to them and some had taken part.

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.

Commitment to quality improvement and innovation

Information provided by the trust confirmed that Hadrian unit and Rowanwood was accredited through the Royal College of Psychiatrists' accreditation for inpatient mental health services programme (AIMS). AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Due to changes in management Dova's accreditation had been postponed, however, the unit was working towards re-accreditation by the end of the year.

Rowanwood was a member of the National Association of Psychiatric Intensive Care units and was participating in benchmarking exercises with other PICUs.

Ward managers detailed ongoing and proposed improvements to patient care with plans to introduce quality improvement and innovation. All wards with the exception of Kentmere ward were part of the' Star Wards' project which provided practical ideas and inspiring examples from and for mental health ward staff. Yewdale ward was also working towards achieving gold status with the 'triangle of care' initiative. The 'triangle of care' project aims to ensure all carers receive consistent information and support to enable them to feel included and better support the person they care for.

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 18 HSCA (RA) Regulations 2014 Staffing The trust did not have robust arrangements for psychiatric medical cover out of hours. This was a breach of Regulation 18 (1).

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 On Kentmere ward a female patient occupied a side room where male patients passed in order to access the bathroom. The female patient needed to pass the male dormitory in order to access the female bathroom and toilet. There was no clear process in place for reporting breaches. This was a breach of Regulation 10(2a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Patient's capacity and ability to consent to be involved in the planning, management and review of their care and treatment was not routinely documented. This was a breach of Regulation 11(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

The overall compliance with mandatory training was below the trust target across all wards. Basic life support with defibrillator training was particularly low on Hadrian unit, Rowanwood and Dova unit.

This was a breach of Regulation 18 (2a)