Requires improvement

Somerset 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)
RH576	Rydon Wards 1 and 2 and Holford Ward	Adult Acute Mental Health Wards and psychiatric intensive care units	TA2 7AZ
RH572	Rowan Ward	Adult Acute Mental Health Ward	BA20 2BX
RH502	St Andrews Ward	Adult Acute Mental Health Ward	BA5 1TH

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership 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 Somerset Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Somerset 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 Somerset Partnership NHS Foundation Trust acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- Vulnerable patients were not being referred for safeguarding when they needed to be.
- Wards were not managing mixed sex accommodation adequately which meant the dignity and safety of patients was not always protected. Nurses' offices were not ideally positioned to enable nurses to quickly attend to an incident.
- Medical equipment was not being checked and maintained and some medicines were not stored appropriately.
- Patients were not always involved sufficiently in the planning of their care and consent to treatment had not always been asked to consent to their treatment.
- Although there were opportunities for patients to feedback about the service, not all of the wards displayed information about how to complain. When patients did complain there was no clear process for staff to receive feedback and learn from the complaints.

However:

- Wards were clean and were equipped with patient call systems, staff personal protection devices and CCTV was installed in some areas.
- Staff were supervised and appraised and who worked well together in teams. Morale amongst the staff was good.
- Due to the principle of least restrictive practice, patients were given freedom and were only observed closely, restrained or secluded when this was necessary for their welfare and/or the welfare of others.
- Physical health care was monitored while people were in hospital and the medicines they were prescribed were given in line with national guidance.
- Patients were assessed quickly when they were admitted and their risks were carefully considered and planned for. There had not been any recent serious incidents and all patients were being risk assessed effectively.
- There were a range of different activities for patients to get involved in, as well as quiet places and gardens for them to use.

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:

- Referrals for safeguarding were not always being made when they should have been and staff did not know what needed to be reported.
- There were out of hours on-call procedures for medical staff which meant urgent assessments could be completed by a trust psychiatrist on all the wards. However, the acting ward manager for St Andrew's ward told us out of hours cover was provided by the GP who, in turn, could access a psychiatrist. The acting ward manager told us that neither the GP nor the on call psychiatrist attend the ward.
- Ward layouts meant male patients had to enter female only areas to reach the de-escalation room or to use bathrooms. Patients were accompanied by staff when this happened.
- Ward layouts meant nurses' offices were not central which meant they could not observe the ward, when staff were in the office, and there could be delays in nurses reaching incidents.
- Resuscitation equipment was not being checked regularly.
- Emergency medication used to reverse the side effects of rapid tranquillisers could not be located on St Andrews ward, by inspectors, nursing staff or the acting ward manager during our visit.
- Medicines which needed to be kept in the refrigerator were not being stored appropriately on one of the wards.

However:

- Wards were clean and well-staffed.
- All patients were being risk assessed appropriately and there had not been any serious incidents on the wards in the 12 months prior to our inspection.
- Observations were being undertaken to keep patients safe but were not overly intrusive due to the use of the principle of least restrictive practice.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Care plans were not personalised and were not being regularly reviewed.
- Staff were not recording whether they had gained consent from patients in relation to their treatment.

Summary of findings

- Section 17 leave was not always being authorised correctly.
- Not all staff were trained in the Mental Health Act, the Mental Capacity Act or the deprivation of liberty safeguards.

However:

- Physical health checks were being undertaken and medicines were prescribed in line with NICE guidance.
- Care records were comprehensive and assessment was being undertaken in a timely manner.
- Supervision arrangements were in place and being provided regularly and teams were holding comprehensive hand-over meetings.

Are services caring?

Good

We rated caring as **good** because:

- Staff interactions with patients were caring and kind. Staff were attentive and had good understanding of patients difficulties, needs and preferences.
- Patients and carers spoke highly about the service. Carers were able to be involved in supporting patients.
- There were regular opportunities for patients to feedback about their experiences of the service.
- Patients were orientated to the wards on admission and given written information about the ward they were staying on.
- We observed good care on all the wards we visited.

However:

- Patients were not always involved in writing their care plan and were not always given a copy.
- There were some reports of staff not being available to patients
- Patients were not always adequately involved in creating their care plans.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Access to beds was being well managed. The staff actively worked to ensure a bed remained available to patients on short term leave and to ensure new patients could access beds.
- There were a wide range of activities on offer.
- Facilities on the wards promoted recovery.
- There were quiet areas and gardens.
- Patients with disabilities had appropriate facilities.
- Patients enjoyed the food.

However:

Summary of findings

- Some wards did not display information about the Mental Health Act, the Mental Capacity Act and about how to complain.
- There were no clear arrangements for staff to receive feedback from complaints.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- There were poor safeguarding reporting practices and staff lacked knowledge about when to take safeguarding action.
- Staff were not adequately trained or briefed in the Mental Health Act, Mental Capacity Act or new Mental Health Act code of practice.
- There was insufficient monitoring of some safety aspects of the wards including emergency equipment and rapid tranquillisers.
- Although audits of clinical records were taking place, staff were not preparing care plans with adequate involvement from patients and were not reviewing them regularly or providing patients with a copy.
- Staff lacked knowledge about the need to gain patients' consent to their treatment.
- There was a failure to adequately manage gender separation in same sex accommodation.

However:

- Morale amongst the staff was good and teams worked well together.
- Staff were supported by their managers and confident in feeding back and whistleblowing.
- All staff had had good quality appraisals.
- Managers handled staff underperformance effectively.
- Risks were being recorded and managed.
- The policy of least restrictive practice had been implemented to ensure seclusion and restraint was used only when necessary.

Summary of findings

Information about the service

Somerset Partnership NHS Foundation Trust wards for adults of working age provide assessment and treatment for people experiencing acute mental health problems.The wards support patients who require intensive and expert care for illnesses such as severe depression, anxiety, psychosis and personality disorder. The wards admit patients who are detained under the Mental Health Act and voluntary patients, all of whom have complex needs.

The psychiatric intensive care unit (Holford ward - PICU) provides assessment and intensive acute treatment for patients detained under section of the Mental Health Act 1983 (MHA) who cannot be therapeutically managed on a general acute ward. Holford ward includes a seclusion suite, safe care area and a de-escalation room.

All the wards are mixed gender.

There were five wards:

Holford Ward (PICU), a 10 bedded ward.

Rowan Ward, an 18 bedded ward which provides services for people who live in the South Somerset area.

Rydon Ward One, a 15 bedded ward which provides services for people who live in the Taunton area.

Rydon Ward Two, a 15 bedded ward which provides services for people who live in Bridgwater and Somerset Coast areas.

St Andrews, a 14 bedded ward which provides services for people who live in the Mendip area.

Holford and Rydon Wards have had three previous inspections (26/11/2013, 22/06/2011, 21/10/2010). Rowan Ward has had three previous inspections (29/04/2013, 16/01/2012, 15/11/2011). St Andrews Ward has had one recent inspection (03/12/2012).

All areas were compliant at the time of the most recent inspection.

Our inspection team

The comprehensive inspection was led by:

Chair: Kevan Taylor, Chief executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Inspection, Care Quality Commission

The team that inspected this core service comprised two inspectors, a consultant psychiatrist, two Mental Health Act reviewers, an occupational therapist, a psychiatrist, two nurses and two experts by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these service.

Summary of findings

During the inspection visit, the inspection team:

- visited all five of the wards across three hospital sites.
- looked at the quality of the ward environment, including clinic rooms, emergency equipment and ward facilities.
- and observed how staff were caring for patients.
- spoke with 18 patients who were using the service and received 24 comment cards.
- spoke with four carers of patients.
- spoke with five managers.
- spoke with 29 other staff including doctors, nurses and social workers.
- attended and observed four hand-over meetings and four multi-disciplinary meetings.
- checked 49 prescription charts.
- looked at 39 care records, including the legal records of patients detained under the mental health act.
- carried out a check of medication management.
- observed interactions between staff.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients and carers told us they were happy with the service. They liked the staff and said they were caring, kind and helpful. Patients said they felt safe on the wards. Patients said staff listened to them and explained what was happening. Patients liked the ward environment, activities and facilities and they liked the food.

However, some patients said staff spent a lot of time in the office and that they were slow to respond when they knocked on the office door. Some patients said they could not go on leave when they wanted to because staff were not available to take them. Some patients said they had not received information about their rights while detained under the Mental Health Act, or about how to complain.

Good practice

A psychiatrist on Rowan ward was providing a weekly psychotherapy clinic and was trained in eye-movement desensitisation and reprogramming, a NICE recommended treatment for trauma.

Rowan ward had developed a wellbeing practitioner role to meet Commissioning for Quality and Innovation targets for wellbeing. They provided ECG, height, weight and blood pressure and offered advice and help on diet, smoking cessation, exercise and drugs and alcohol.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve:

- The trust must ensure that staff have sufficient knowledge of safeguarding procedure and that all safeguarding incidents are correctly identified and raised. Safeguarding alerts and concerns were not always being made when they should and some staff were not aware of their responsibilities with regard to alerting safeguarding authorities.
- The trust must ensure that consent for treatment is gained, and that this is clearly documented.
- The trust must ensure that all sites where rapid tranquillisation is used hold the appropriate medicines to reverse the effects of benzodiazepine medication.
- The trust must ensure resuscitation equipment and refrigerators are checked and maintained.

Action the provider SHOULD take to improve:

- The trust should ensure mixed sex accommodation is managed to ensure patients' dignity and safety are protected.

Summary of findings

- The trust should ensure patients are being actively informed how to complain.
- The trust should take action to ensure patients have access to appropriate toileting facilities whilst they are in seclusion.
- The trust should ensure that arrangements are in place to provide adequate medical cover at all times on St Andrew's ward and that staff are aware of the arrangements.

Somerset 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
Rydon Ward 1	Wellsprings Hospital
Rydon Ward 2	Wellsprings Hospital
Holford Ward	Wellsprings Hospital
Rowan Ward	Summerland Hospital
St Andrews Ward	Priory Health Park

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 in the Mental Health Act (MHA) was not mandatory but staff were in the process of being trained. Training compliance was 50% for Holford ward, 73% for St Andrews Ward, 80% for both the Rydon wards and 82% for Rowan ward.
- Training in the new MHA code of practice, which was implemented in April 2015, had not been provided for staff working on St Andrews ward, Rydon wards and Holford ward. Trust policies were being updated in line with the new code of practice.
- We found that the recording of capacity and consent to treatment was good on Holford ward. Of the five care records we reviewed at St Andrews ward, there was no evidence that consent to treatment was assessed on admission. We reviewed six care records for Rydon ward

one patients and in all cases there was no record of consent from patients to share information about them. There was also no record of discussions with the patient about their treatments options in all six cases.

- On Rowan ward, there was good recording of the monitoring of capacity to consent to treatment but consent to treatment was missing in one case out of the eight we reviewed.
- Patients had their rights under the Mental Health Act explained to them on. On Holford ward, ward records showed patients were being given information but there was no record of the level of their understanding or when they would have their rights explained again. We reviewed five care records at St Andrews ward and found that according to their records, three of the patients had had their rights read to them on admission but two had not. We found no evidence that staff were repeating rights to patients on an ongoing basis in all of these any cases.
- The trust had a dedicated MHA administration team who would remind managers when detention and consent to treatment procedures needed to be renewed.
- On Holford ward, we reviewed six records and found there were errors and omissions in the recording of section 17 leave rights. One patient's section 17 form did not indicate the date and time the leave was effective from or when leave was to be reviewed. One patient's leave form had expired. On Rydon ward two, section 17 leave conditions were often unclear about the duration of leave permitted. Patients were not always being given a copy of their section 17 leave conditions as required by the new mental health act code of practice.
- We observed a range of useful information for patients and carers displayed on all the wards, including the availability of the Independent Mental Health Advocacy (IMHA) service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act was recommended but not mandatory. 80% of Rydon ward staff had completed the training, 79% of Rowan ward staff, 70% of St Andrews staff and 46% of Holford ward staff.
- There was one deprivation of liberty safeguards application made in the last six months for one patient on Rydon ward one. Managers said they recognised the need for training. Staff could access advice from approved mental health professionals who were on the same site as the Rydon and Holford wards.
- We saw three examples of mental capacity assessments undertaken for patients who needed them. We asked one of the service managers about staff's knowledge of the mental capacity act. They felt staff had not understood it well enough. However, they were telling staff that anyone could make a capacity assessment using the tool on RIO, the trust's electronic patient records system, and that it should not be something only done at admission by a consultant. They were confident capacity issues would be recognised by regular reviews of patients and through ward round discussions.

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

Are acute wards for adults of working age and psychiatric intensive care units 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**

Please refer to earlier summary.

Safe and clean environment

- Ward layouts did not enable all parts of the wards to be observed from a central location. There were a number of blind spots on Rowan ward, particularly in the bedroom corridor, which meant that some rooms were out of sight of the nurses' station. St Andrews ward, Rowan ward and both Rydon wards did not have clear lines of site but staff performed observations at a minimum of hourly intervals to mitigate this. Patients were risk assessed and, where necessary, accompanied during activities. Holford Ward was arranged around a large nursing office with clear views onto the ward. Five minute observations and CCTV supported the observation of patients on Holford ward. Wards were equipped with patient call systems and staff had personal protection devices.
- There were potential ligature anchor points on all the wards but many had been replaced to make them non-weight bearing. Where this had not been possible, risks were noted on risk registers and were being mitigated with patient risk assessments and observations. On Rowan ward, televisions were on the walls but the cables on them had not been concealed and these were a potential ligature. We brought this to the manager's attention but because there had not been any incidents they had elected not to make any changes in favour of presenting an environment that didn't look or feel like a prison. Rowan ward were managing ligature point risks, including the tree in the garden, by carefully risk assessing and appropriately observing patients. On Rydon ward two there were some ligature points in the laundry room and in the disabled patient bedroom but staff were aware of these and mitigating these with appropriate levels of observation. Ligature points were audited annually on each ward. Where ligature points were identified, mitigating factors were also listed. The procedure for action planning for improvements to ligature points was to place them on local risk registers. We reviewed the risk registers and found that ligature risks that had been placed on them were rated and improvements were being planned. There was a ligature management policy which required managers to ensure action plans were executed following ligature audits.
- Accommodation was mixed on all the wards. All the wards had both shared and female only lounges and Rowan and Rydon wards had additional male lounges. All the wards offered en suite accommodation apart from St Andrews ward where there were separate showers and bathrooms for men and women. The bathroom on Rowan ward was communal but all of the bedrooms had their own showers. The female bed area on Rowan ward could be closed to keep the female area inaccessible to male patients. The de-escalation room on St Andrews ward was situated in the female part of the ward which meant both male and female patients were being taken through the female area to de-escalate, sometimes under restraint. In addition, the only immediate toileting facilities near the de-escalation room were for female patients so these were used by anyone in the de-escalation room. There were two female bedrooms directly opposite the de-escalation room door. When the ward was full or if it was necessary to accommodate particular patients near the nurses' station for observation purposes, women would be placed in bedrooms in the male part of the ward. St Andrews ward was accommodating a male patient within the female bedroom corridor during our inspection. Staff were using 15 minute observations to ensure patient safety. As a control measure, staff said they did not leave males and females unsupervised in communal areas, however on St Andrews ward we met a male and female patient in the activity room together unsupervised and we saw no staff in the immediate vicinity. Holford ward patients placed in opposite sex areas were placed on one-to-one observations. This was to safeguard patients from acts of and or allegations of

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abuse. On the day of our visit, Holford ward had reported an incident of a sexual nature between two patients but had not taken appropriate action following the event to safeguard the patients concerned. Records showed that after this event, observations of the patients concerned had not been completed on a regular basis. We spoke to four ward staff and none of them would have considered reporting the incident as a safeguarding alert.

- All wards had fully equipped clinic rooms with resuscitation equipment. We found there were gaps of several weeks in the recording of weekly checks of resuscitation equipment and the resuscitation bag on Holford ward. We found some out of date items in the Rowan ward resuscitation bag and these were removed by the manager. A new checking schedule was implemented just after our visit.
- Managers were reviewing seclusion and restrictive practice on all the wards through a monthly report. Seclusion practices were being used on Holford ward but not on any of the other wards. The seclusion room on Holford ward adjoined the extra care area. This meant it could not be used when the extra care area was in use. One patient on Holford ward was on long term segregation in the extra care area. The patient was nursed by two staff members during the day and monitored by a CCTV monitor in the nurses' office at night. There were two locked doors between the nurses' office and the extra care area, which would have delayed response in the event of an emergency. When staff, due to periods of greater risk, retreated from the extra care suite and used the seclusion procedure, they were required to write an observation record every 15 minutes. We reviewed the observation records for this patient and found 30 occasions during the period 23 August to 8 September 2015 when the 15-minute observations had not been completed when they should have been.
- All the wards were clean, well maintained and had good furnishings. All ward environments were light and spacious. Cleaning records on the wards showed cleaning was being completed regularly. The sluice room on Rydon ward two did not have an extractor fan and there was an unpleasant odour in there. On Rydon ward two we noticed the garden was littered with cigarette butts and that clean stickers had not been placed on equipment. However, most equipment on the wards was well maintained and clean.
- Hand hygiene was being audited monthly at trust level across all the wards and showed compliance in the most recent audit.
- Environmental risk assessments were completed annually and identified risks were listed on local area risk registers. Risk registers included what was being done to mitigate the risk and action plans to resolve each risk.
- During our visit to Rowan ward, a patient from the place of safety who was awaiting assessment was given unaccompanied access to the ward in order to smoke in the patients' garden. The manager told us this was a mistake by staff on the ward who should have accompanied them out into the garden via a fire exit, which would have prevented them being on the main ward.
- The wards had access to appropriate alarms and staff carried personal alarms.

Safe staffing

- There was 180 staff working across the five wards. There had been 26 staff leave in the previous six months. The percentage of permanent staff off sick varied across the wards. The highest sickness rate was for Holford ward at 9%. The lowest sickness rate was on Rowan ward at under 4%. The Rydon wards had the highest number of vacancies at 16% which excluded seconded staff. Holford and Rowan wards had vacancy rates of 11% and St Andrews was 15%. The trust average sickness for the previous year was 4.9%.
- Previous staffing reviews were audited using the `professional judgement tool` to evaluate current skill mix. The Western Australia Model was used to review nursing workload and to calculate the number of hours required to provide patient care.
- Staffing numbers took into account any need to observe particular patients more closely. On Holford ward, extra staff were required on the ward due to a patient on long-term segregation requiring two to one observations. Shifts were rotated and there were three shifts per day.
- Wards used bank staff in preference to agency staff to try to ensure staff were familiar with the ward. Booking of bank and agency staff was done through a centralised

department. Holford ward and Rowan ward had both block booked staff members to enable consistency. Local inductions were being completed before staff went onto the ward.

- Managers were able to adjust staffing levels as dictated by clinical activity to meet the needs of the service.
- Managers told us escorted leave could not always be provided exactly when patients wanted it and would sometimes be delayed until the following day. In order to facilitate Section 17 leave, a daily meeting takes place on St Andrews ward from Monday to Friday to plan all Section 17 leave. Patients we spoke to on St Andrews ward told us section 17 leave was often cancelled due to staff unavailability and the ward manager confirmed that this was the case. On the day of our visit, one patient's leave was cancelled because a member of staff was sent home due to ill health. A patient from Rowan ward told us leave was never cancelled, even when it was escorted leave and the manager confirmed this. Rowan ward patients could say each morning if they wanted to go on leave and this sometimes had to wait until the afternoon but if leave was planned then it was never cancelled.
- The activity organisers were separate to the nursing teams. They worked across the working week and were beginning to provide weekend cover. Activities on Rowan ward were rarely cancelled according to the manager. On Rowan ward, the occupational therapy team covered the working week plus two evenings. At weekends, other ward staff ensured activities were continuing to be provided.
- We saw ward rosters for Rydon, Holford and St Andrews wards and they showed there were enough staff to carry out physical interventions safely.
- We reviewed the medical cover for Rowan, Holford and Rydon wards and they had adequate medical cover day and night. A trust doctor could attend the ward quickly in an emergency. There was a duty manager at band 7 or 8 grade out of hours across all the wards in the inpatient service. St Andrews ward had a different arrangement because of it's rural location. The trust told us there was a contract with the on-call GP service which meant the on call GP acted as the nominated deputy for the responsible clinician on the ward if required for section 5(2) Mental Health Act assessments. Patients could be placed on Section 5(2) to temporarily hold them if there was an increased concern about their mental health. If the on call GP was unavailable, the trust's on call consultant psychiatrist could offer telephone advice or attend if needed to provide senior clinical reviews and assessments of mental/physical health. However, the acting ward manager told us they would contact the on call GP out of hours for health advice. They said the on call GP also had access to a psychiatrist. They said neither the GP nor the psychiatrist would attend the ward in person although the trust disputed this. In addition, St Andrews ward had to be selective about the patients they were able to admit. In an emergency, ward staff would provide immediate life support and call emergency services. Risks associated with admitting to St Andrews ward due to its rural location were mitigated by placing unplanned admissions on wards in Taunton or Yeovil where there was a greater level of Medical and Nursing support. Patients could then return to St Andrews once the clinical risks were clearly identified and they were able to be managed within an isolated ward.
- The average mandatory training rate for staff across the adult acute wards was 94%. St Andrews ward was non-compliant for 'clinical risk assessment & management' with 58% of staff being up to date although there were records to show that staff were booked onto training in the near future.

Assessing and managing risk to patients and staff

- There were 20 episodes of seclusion between 1 April 2014 and 31 March 2015 on Holford ward. Seclusion was only used on Holford ward.
- There were 121 episodes of restraint in the same period. These were highest on Holford ward where there were 50 episodes of restraint involving 24 different patients. 55 of the total number of restraints were in the prone position. These were highest on Holford ward where there were 23 prone restraints but there were also 16 on St Andrews ward. Rowan ward had not undertaken any prone restraint or rapid tranquillisation. The trust had set a target to reduce the use of restraint by 10% in 2015/16 and planned to set a further target in 2016/17 and 2017/18. Ward staff told us restraint was only used after de-escalation had failed. Staff were able to describe correct techniques to restrain patients. On St Andrews ward we observed ward staff emotionally

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supporting a distressed patient without the need for physical intervention. Rowan ward management explained staff had been taught to reduce restraint and to use alternative approaches. If restraint was used then staff were only to use it for the shortest period needed. Staff were confident in the techniques.

- A patient from Rowan ward told us they had been given an injection in the de-escalation room with the door closed for their privacy and that they were free to leave the room. We reviewed one care record on St Andrews with specific focus on the use of de-escalation and restraint. On the two occasions the patient had required restraint, the relevant forms had been completed, and there was a care plan outlining how staff should respond during such an event.
- The trust policy on the use of rapid tranquilisation refers to NICE guidance. Lorazepam may be used to tranquilise patients rapidly and we found prescription records to show that it was in use. Only one staff member out of three we spoke to on Holford ward on the day of our visit knew what the medication Flumazenil was used for and if it was stored on the ward. Flumazenil is a medicine which reverses the effects of Lorazepam, a benzodiazepine medicine that can cause respiratory problems. Although the trust told us Flumazenil was available on all the adult mental health wards, at the time of our visit, Flumazenil could not be located on St Andrews ward by nursing staff or the acting ward manager. We asked that the matter be resolved immediately and the acting ward manager made a request for Flumazenil to be ordered.
- During our visit to Holford ward, one patient was being cared for in the extra care area which is integral to the seclusion suite. As a result, any patient requiring seclusion whilst the extra care area was occupied, had to be secluded elsewhere and staff were using the de-escalation room for this purpose. The de-escalation room did not have immediate access to toilet facilities. This meant patients secluded there would only be allowed access to toilets if it were considered safe for them to leave seclusion. As a result patients were being provided with disposable cardboard bowls for toileting purposes. This practice was confirmed by one patient we spoke to and by the ward manager and the clinical service manager.
- There were no incidents of long-term segregation reported between 1 April 2014 and 31 March 2015 but there was a patient in long-term segregation during our inspection. Rapid tranquillisation had been administered to 22 Holford patients and 16 St Andrews patients whilst in the prone restraint position. Rydon wards had used rapid tranquillisation in eight cases. The trust had set a target to reduce the use of restraint by 10% in 2015/16
- Risk assessments were present and up to date across all the wards. A risk screening tool was being completed which included assessments for self-harm, suicide and for substance misuse. Risk assessments were well linked to care plans. The malnutrition universal screening tool was being used appropriately.
- Blanket restrictions were not in place. Restrictions that apply to all patients in a particular setting should be avoided and where applied should be due to an individual justifiable risk. Several staff complained about the lack of electronic cigarette lighters on Rydon wards one and two where patients were allowed to have their own lighters. Managers told us the lighters had not been installed because the trust was considering a blanket no smoking policy. On Rowan ward there had been a spate of fire setting and the person responsible had not been identified despite attempts to do so. The fires had been lit in areas that were not covered by CCTV and when staff were not present. The ward manager was planning to extend the coverage of the CCTV cameras.
- Informal patients could leave the wards. Before they left, staff would find out how they were feeling, where they were going and for how long, in order to make a brief assessment of the risk of them leaving the ward.
- There was a comprehensive policy for the use of observation and also a policy on searching patients and property. There were four levels of observation and all patients were observed at a minimum rate of random hourly checks. We saw records on St Andrews and Rydon one ward to show that observations were being completed in line with trust policy. However, on Holford ward, we saw nine records where staff had not completed observation paperwork. It was common for patients requiring higher levels of observation to be admitted to Holford ward, as it was a PICU. Observations were flexible and conducted using the concept of least restrictive practice necessary.
- Searches were not routinely undertaken. Patients were asked to adhere to a list of items they should not bring onto the ward. On Rowan ward patients were being

asked to turn out their pockets for sharp implements and the policy was to make individual assessments and arrangements. There were different policies for formal and informal patients. Informal patients were not admitted to the ward without agreeing to a search.

- Staff across the service had three yearly training in safeguarding adults and safeguarding children. All teams were compliant for safeguarding children training but St Andrews ward was 81% compliant for safeguarding adults. Staff had contact numbers for safeguarding agencies on the backs of their identity badges and there were flow charts on the walls. A safeguarding team and a safeguarding lead for the trust supported safeguarding. Staff on Rydon ward two were able to describe the different kinds of abuse. Staff on Rowan ward were encouraged to talk to the nurse in charge about any concerns. Staff on St Andrews and Rydon ward one understood safeguarding procedures and knew how to make safeguarding alerts. In relation to patient on patient assaults the trust told us all incidents of patient on patient assault were reported via the Trust's untoward incident reporting system DATIX. As part of this report a notification was sent to the Trust's safeguarding team where there is felt to be a safeguarding issue. We reviewed three incident records relating to patient on patient assaults on Holford ward, only one of which had been escalated to the safeguard team within the Trust. In addition the trust stated that the decision to identify an incident as requiring safeguarding involvement depended on the nature and degree of the incident and current protective factors. However we were told by one staff member on Holford ward that all patient on patient assaults were automatically escalated to the Trust safeguarding department for consideration. We spoke with four staff on Holford ward, one of which said that they would report all patient on patient assaults as a safeguarding event and one staff member said their reporting is dependent on the degree of threat and harm from one patient to another. However two of the four staff we spoke to said that they would not consider any patient on patient assaults as a safeguarding event and would not report as such.
- Medications for all the wards were supplied by Lloyd's pharmacy. A pharmacy technician checked expiry dates and emergency medicines. The medicines we checked were all in date. The pharmacy technician visited the ward once a week and checked all the medicines charts. This included checking that, when required, the appropriate legal documentation was in place to allow treatment. A report of the pharmacy technician's findings, highlighting any issues, were sent to the unit manager, doctors and nurses on the ward.
- Refrigerator temperatures need to be checked daily in order to ensure the potency and efficacy of medicines stored in them. Overall, medicines were stored securely and refrigerator temperatures were monitored daily and were within safe range. However, on Rydon ward two, refrigerator temperatures were not always recorded and were missing on 14 days of the previous six weeks. On five recorded days the refrigerator temperature exceeded the temperature limit of 8°C with recordings of 16°. This had been reported by the ward but not resolved.
- There were many medicines stored in the clinic room on Rowan ward and this would have made medication reconciliation difficult to carry out. The manager agreed this was causing difficulties and resolved the issue with Lloyds Pharmacy shortly after our visit. The service had begun holding 6- weekly pharmacy liaison meetings to review repeated errors, solve problems and educate staff. An electronic prescribing system was used on Rowan ward. Staff told us they liked the system because prescriptions were much clearer and it reduced the risks of mistakes being made. Paper copies of legal documentation authorising the administration of medicines were available when needed. We saw that staff checked these with the electronic system to make sure patients were prescribed and given the correct medicines.
- We saw two patients being given their lunchtime medicines in a safe way. Patients were able to ask questions about their medicines and staff responded appropriately to these.
- All the wards had safe procedures for children to visit. St Andrews ward had a specific room for child and family visiting. On Rydon and Rowan wards, there were separate family rooms. When it was safe to do so, patients could also go out with their families.

Track record on safety

- There were no serious incidents reported regarding these wards between 15 April 2014 and 24 March 2015.

Requires improvement

Are services safe?

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

However, between 1 July 2014 and 16 July 2015 there had been 139 assaults on trust staff. This is broken down as follows: Holford ward 48, Rowan ward 13, Rydon wards one and two 37 and St Andrews ward 41. The trust were involved in national bench-marking in order to see how these events compared with other trusts but they did not yet have the data on this at the time of our inspection.

Reporting incidents and learning from when things go wrong

- All staff we spoke to knew how to report incidents and what to report. This was covered at corporate and local induction training. Incidents were entered onto the trust Datix system and all staff had access to this. Staff were able to tell us how they would report incidents and the kinds of incidents they would report, such as violence and aggression, patients secreting items and patients being absent without leave. The person who witnessed the incident entered it onto Datix. St Andrews ward had developed a security nurse role. The security nurse was responsible for checking that patients who had taken leave had returned. The nurse in charge signed a document to confirm that a risk assessment had been completed and to document what patients were wearing when they went on leave and the time they left and were expected back to the ward. We saw five examples of incidents reported through the Datix system. However, we found that there was no recorded evidence on RIO of the risk assessment having taken place for any of these five cases.
- Staff understood the importance of being candid when things went wrong including the need to explain errors, to apologise to patients and to keep patients informed.
- Rydon wards one and two were holding proactive care meetings to learn from incidents and to review processes. There was a health and safety and security group for the trust and a trust security manager who visited the wards regularly.
- Ward managers were alerted as soon as an incident was entered onto Datix and they investigated incidents. Incidents were categorised and relevant specialist staff were alerted. Datix forms went to the service manager and incidents were shared in an improving quality of inpatient services (IQIS meeting). Learning was then cascaded to ward managers to be shared in team meetings. Learning from serious incidents was disseminated to trust staff via a monthly section in the 'What's on @ Sompar' staff newsletter. Divisional meetings that the ward managers attended also discussed incidents. An example of learning from an incident was changes to the issuing and returning of cutlery following a patient on patient assault on one of the wards.
- There was a debrief policy and procedure. Staff were debriefed in the event of an incident and offered support. There was a counselling service, an occupational therapy service and a wellness at work service in place to support staff. Patients were also debriefed and supported as appropriate.

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

Are acute wards for adults of working age and psychiatric intensive care units 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.

Please refer to earlier summary.

Assessment of needs and planning of care

- We examined looked at 39 care records. They were comprehensive and showed that assessment was being undertaken in a timely manner. Care plans included summaries, previous history and formulation.
- On Rydon ward one we reviewed six care records for evidence of physical examinations and physical health checks. Physical health checks were being undertaken within 24 hours of admission. Physical health examinations were ongoing and were being monitored based on clinical need. We reviewed five care records on St Andrews ward and all patients had received a physical assessment on admission and annually, where applicable, thereafter. However, in one case, a patient had refused neurological examination but there was no record of it being attempted again. All patients' records showed ECG, smoking status and medical history.
- Most care plans were up to date, personalised and showed holistic recovery orientated care was being offered. Patients' views and preferences were represented in care plans. However, we reviewed five care records on St Andrews ward and found that care plans were not personalised, holistic or recovery-oriented in any cases. We found that there was a library of statements and comments to prompt staff on how to populate care plans. Stock statements and comments had been pasted into a care plan template. Although patients had been given a copy of their care plan on each occasion, there was no evidence to suggest that patients had been consulted in formulating the plan of care. Patients told us at St Andrews ward that they did not understand their care plans. We reviewed six care records on Holford ward and found that consideration had been given to the importance of patients retaining their liberty. The records showed diverse needs were considered and risk assessments had been carried out and reviewed regularly. However, we found an absence of patients' own views regarding their care, treatment and discharge in their care plans.
- All information was stored securely on an electronic records system called RIO, which was available across the trust. There were some paper records such as mental health act assessments, missing persons records and medicine cards. These were stored securely. On Rowan ward all the prescribing was being done electronically.

Best practice in treatment and care

- Psychiatrists were referring to NICE guidance, for example, when prescribing for schizophrenia, bi-polar and personality disorder. The Rydon ward two consultant said the ward were following NICE and Maudsley guidelines for prescribing and that the trust also had their own guidelines for Clozapine. On Holford ward, we reviewed seven medication prescription and administration cards. We spoke with the pharmacy technician who visited Holford ward once a week to audit all the prescription cards, including checking maximum doses of antipsychotic medication, and we saw evidence to show NICE guidance was being followed. The technician had formulated a best practice example prescription card to support nursing and medical staff when prescribing and administering medication to reduce errors. Of the seven prescription cards we reviewed on Holford ward, we found all were completed appropriately. We did find that in the case of one patient they had been prescribed rapid tranquilisation but no information about how to give the medicine had been recorded. We reviewed 14 prescription cards on Rydon ward one and in the case of two patients we found missed signatures relating to administration of medicines, indicating that medicines had not been given.
- Patients could be referred for psychological interventions. Some ward staff had been trained in cognitive behavioural therapy and some staff were being trained in mindfulness. The full time psychiatrist on Rowan ward was a psychotherapist and provided eye-movement desensitisation and reprogramming. Rydon ward staff told us psychological therapies were usually provided following discharge rather than during their admission. If patients were already in therapy the

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ward would facilitate them continuing while they were in hospital. On Rowan ward we were told that on each shift, one-to-one time was offered to each patient with a nurse who was allocated to them for that day and two patients we spoke to confirmed this was the case. We saw a board on the ward which showed which patients were allocated to which member of staff for that day. The board had been created because patients had asked for it in 'have your say' meetings.

- All patients admitted to the wards had their immediate physical health care needs met by the medical or nursing staff. Non urgent physical health care needs arising during admission were assessed and treated by medical staff and highlighted to their GP on discharge from hospital. St Andrews staff had no system in place to monitor when appointments were being made by patients with their GP or to the nature of the appointment, relying solely on patients informing the ward that an appointment had been made. The ward lacking knowledge of GP visits whilst under the care of mental health services was not ensuring the overall wellbeing of the patient concerned. We reviewed three records on Holford ward and found an up to date comprehensive record of physical healthcare checks for one patient. Two patients had refused but the record showed no plans to offer a physical health check again.
- On Rowan ward there was a wellbeing practitioner whose objective was to meet physical health 'Commissioning for Quality and Innovation' targets for wellbeing. The wellbeing practitioner saw all new patients and did a range of tests including ECG, height, weight and blood pressure and provided advice and help on diet, smoking cessation, exercise and drugs and alcohol. Rowan ward had a good relationship with district nurses who came to the ward and provided advice, support and training as required. Rydon wards were receiving visits from a tissue viability nurse and they were developing their practice in relation to wound care. A link nurse for infection prevention and control was working with cooks and cleaners on Rydon wards. Support from diabetic nurses, dieticians and physiotherapy could be accessed by referral. We heard about a patient with mobility issues who was receiving external support from physiotherapy, the equipment service and a disability advisor.
- The wards were using the Health of the Nation Outcome Scale to assess and record the severity of patients' symptoms but they were not using it to review outcomes.
- Clinical staff were actively participating in clinical audits including hand hygiene, infection control, medications management, ward cleanliness, suicide prevention, record keeping, controlled drugs, hand over and care planning. The psychiatrist for the Rydon wards had taken part in audits on lithium initiation and on the use of community treatment orders. Both of these audits had led to improvements in practice including monitoring of liver function and improved decision-making between inpatient and community consultants regarding the use of community treatment orders. An audit meeting was being held every three months where results were presented and discussed.

Skilled staff to deliver care

- The wards had experienced, qualified staff working on them. A range of mental health disciplines and workers were providing input into the wards including occupational therapists, psychiatrists, nurses and social workers.
- St Andrews ward had had six locum consultant psychiatrists since April 2014. The current two ward doctors, who were both locums had been in post for the past six months.
- All professionals had access to appropriate and regular supervision, which was facilitated by appropriate supervisors, some of whom were based in other teams.
- All staff had had an appraisal in the past year. We reviewed a selection of appraisals on Rowan and Rydon wards and found them to be completed to a good standard overall. When we spoke to staff about their appraisals, they said they felt they had had feedback, that their achievements had been appreciated and they were able to set objectives.
- Staff were all receiving statutory and mandatory training. There were a few examples of enhanced training being completed by members of staff. A Healthcare support worker was doing a counselling diploma supported by the trust, a consultant psychiatrist was being supported by the trust to attend psychotherapy conferences and a band five nurse had completed life support training and wound care training recently. On Rowan ward the manager encouraged staff

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to present a case for training they would like to take and that would benefit the ward. They told us some staff on Rowan ward had been on leadership training and two nurses were currently doing mentorship training.

- We saw an example on Holford ward of staff performance being addressed and action plans for improvement in practice were being adhered to. We saw one example of prompt and efficient performance management of staff misconduct on Rowan ward.

Multi-disciplinary and inter-agency team work

- All the wards were holding regular multi-disciplinary meetings. Rowan ward's multi-disciplinary team meetings were also attended by the home treatment team staff and community psychiatric nurses to enable a pathway for patients between inpatient and community treatment. Each patient's nurse would meet weekly with the patient and the community care coordinator nurse where community staffing levels were sufficient to enable this. Crisis teams were attending the Rydon wards and were being invited to the handovers to promote patients being discharged as soon as it was appropriate.
- Rowan ward were having a weekly reflective practice group which all staff were invited to attend. This was enabling them to discuss the emotional impact of work on the staff and to maintain empathy, understanding and compassion for patients.
- At St Andrews ward, ward staff met with medical staff each morning to discuss each patient's risk. Ward rounds were held twice per week to discuss patients' needs and progress. Staff and patients told us they had the opportunity to attend ward rounds. Holford and Rydon wards held weekly ward round meetings but patients were not always sure when they were being discussed and or when these meetings were being held.
- St Andrews and Holford ward were not routinely engaging staff in staff meetings and the last meeting to have taken place on Holford ward was in April 2015. St Andrews ward did not provide us any minutes for any staff meetings.
- All the handover meetings we attended were comprehensive and patient-centred. We attended a handover meeting on Rowan ward which was attended by a variety of disciplines from the multi-disciplinary team. There was a detailed review of all of the patients over the previous 24 hours which included physical and mental health issues and care and activity planning. Patients' medications were discussed and consideration given to the efficacy and side-effects. We observed a handover on St Andrews ward where they discussed each patient's risk, observation levels and mental health issues. We attended a detailed handover on Rydon ward two where the team talked about individual patients' medication and social needs as well as discharges and new admissions to the ward.
- We found effective working relationships with professionals and services in the community. Care was being planned for a patient on Holford ward who was on long term segregation. The team were collaborating with the older people's services, psychological therapies service and independent mental health advocate (IMHA) service to meet the patient's needs.
- Wards said they had effective links with the police and with social services.

Adherence to the MHA and the MHA Code of Practice

- Training in the mental health act was not mandatory but staff were in the process of being trained. Training compliance was 50% for Holford ward, 73.% for St Andrews Ward, 80% for both the Rydon wards and 82% for Rowan ward.
- We spoke with staff on St Andrews ward, Rydon wards and Holford ward and they told us training had not yet been provided in the new MHA code of practice which was implemented in April 2015. Trust policies were being updated in line with the new code of practice.
- We found that the recording of capacity and consent to treatment and best interest assessments was good on Holford ward. Of the five care records we reviewed at St Andrews ward, there was no evidence that consent to treatment was assessed on admission. On Rydon ward one we reviewed six care records and in all cases there was no record of consent from patients to share information about them. There was also no record of discussions with the patient about their treatments options in all six cases.
- On Rowan ward there was good recording of the monitoring of capacity to consent to treatment but consent to treatment was missing in one case out of the eight we reviewed.
- Patients had their rights under the Mental Health Act explained to them. On Holford ward records showed patients were being given information but there was no

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record of the level of their understanding or when they would have their rights explained again. We reviewed five care records at St Andrews ward and found that according to their records, three of the patients had had their rights read to them on admission but two had not. We found no evidence that staff were repeating rights to patients on an ongoing basis in all of these any cases.

- The trust had a dedicated MHA administration team who would remind managers when detention and consent to treatment procedures needed to be renewed.
- On Holford ward, we reviewed six records and found there were errors and omissions in the recording of section 17 leave rights. One patient's section 17 form did not indicate the date and time the leave was effective from or when leave was to be reviewed. One patient's leave form had expired. On St Andrews ward, we came across the record of a patient who had been on leave under section 17 conditions since 1999. On Rydon ward two, section 17 leave conditions were often unclear about the duration of leave permitted. Patients were not always being given a copy of their section 17 leave conditions as required by the new mental health act code of practice.
- We observed a range of useful information for patients and carers displayed on all the wards, including the availability of the Independent Mental Health Advocacy (IMHA) service.

Good practice in applying the MCA

- Training in the Mental Capacity Act was recommended but not mandatory. Staff were in the process of completing the training. 80% of Rydon ward staff had completed the training, 79% of Rowan ward staff, 70% of St Andrews staff and 46% of Holford ward staff.
- There was one deprivation of liberty safeguards application made in the last 6 months for one patient on Rydon ward one. Managers said they recognised the need for training. Staff could access advice from Approved Mental Health Professionals who were on the same site as the Rydon and Holford wards.
- We saw three examples of mental capacity assessments undertaken for patients who needed them. We asked one of the service managers about staff's knowledge of the mental capacity act. They felt staff had not understood it well enough. However, they were telling staff that anyone could do a capacity assessment using the tool on RIO and that it should not be something only done at admission by a consultant. They were confident capacity issues would be recognised by regular reviews of patients and through ward round discussions.

Good

Are services caring?

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

Our findings

Are acute wards for adults of working age and psychiatric intensive care units caring?

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

Please refer to earlier summary.

Kindness, dignity, respect and support

- We observed good care on all the wards we visited. Staff interactions with patients were kind and caring. We overheard interactions that were respectful and supportive. On Rydon ward two we witnessed a patient being comforted because they were upset. They were offered reassurance and escorted to their bedroom where they were offered individual care. Activities co-ordinators demonstrated a good rapport with patients and offered choice to accommodate patients' preferences. On Rowan ward we saw staff being respectful and responsive to patients' needs, for example, during lunchtime, patients were encouraged to choose what they wanted to eat. During the medication round on Rowan ward, staff engaged patients in conversation about morning activities and their plans for the day. Patients were also asked if they were happy for CQC to be present. We saw a patient who was being verbally aggressive calmed by staff using verbal intervention.
- Patients we spoke to on St Andrews ward told us that they felt safe on the ward but that staff spent a lot of time in the ward office. Patients at St Andrews and Holford ward told us that occupational therapy was interesting and good. Patients we spoke to on Holford ward said staff were helpful, listened to their needs and explained what would happen next. One patient on Holford ward said they did not like having to wait to speak to a member of staff and that at times the wait had been longer than necessary. One patient on Rydon ward one said they felt intimidated to knock on the office door and that when they did there was often a long wait for them to answer. One patient on Rydon ward two complained staff spend too much time in the office and said their escorted section 17 leave was often cancelled due to there being insufficient staff to escort them on leave. Another Rydon ward two patient told us their section 17 leave had been cancelled and that staff were often in the office.
- One patient on Holford ward said they had not been given any information, had not had their rights under the mental health act explained, had not been given a choice of treatment and didn't know if they had a care plan. On Rowan ward a patient told us "we like it here". Two other Rowan ward patients told us the care was "very good" and the staff were "nice". Patients spoke of feeling safe on Rowan ward. One patient spoke of being bullied by other patients but said they had spoken to the staff about this. Rowan ward staff were described as kind and helpful and patients said they would listen. Patients on all the wards said staff would not come into their rooms without knocking and waiting to be invited in. A patient on Rowan ward said staff were caring and interested in their well being. Another Rowan ward patient said they had never been restrained, secluded or forcibly medicated and had never experienced any aggression towards them on the ward. They said they had received a leaflet about their medication and discussed the side effects with their doctor. One patient on Rowan ward said "staff are polite, helpful and kind, and do a good job. They all really good." One patient on Rydon ward two said "staff are really good. If it was not for staff here I would not be alive."
- Staff on all the wards were understanding of and had knowledge of the individual needs of patients. We witnessed staff speaking respectfully and knowledgeably about their patients during handover meetings.

The involvement of people in the care they receive

- Admission processes for the wards enabled patients to become orientated with the ward. We saw information or 'welcome' packs on all the wards which gave, for example, information about the wards, how to give feedback and make complaints, information for carers and visitors and items they should not bring onto the ward for everyone's safety. All the wards displayed information for patients on noticeboards on the ward, for example, on Rowan ward information included advocacy, patient advice and liaison services, therapy groups, community support, food and mealtimes, visiting, chaplaincy, staff on duty including a staff photo

Good

Are services caring?

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board. The Rowan ward manager described a sensitive admission procedure which enabled patients to understand the ward and become acclimatised to it. However, one patient on Rowan ward told us they had not been given information on admission about the treatments they were having.

- We saw an information quick reference guide for Rowan ward patients and their families. It gave a description of the ward and included contact telephone numbers, details of the daily routine of the ward and visiting arrangements. There was also information about having belongings on the ward and rules on violence and aggression and smoking. Rydon wards one and two had a ward information booklet which was issued to patients on admission. This was a comprehensive booklet which described the ward and it's routine, the admission assessment and treatment and discharge processes, confidentiality and ward facilities. All of the wards provided facilities for patients to make private phone calls.
- Care plans were mixed in regard to active involvement from patients in the planning of their care. In most cases care plans were personalised to the patient and their views and preferences were represented. On St Andrews ward this was not the case and the staff were using stock phrases in care plans.
- Records showed patients were not always given a copy of their care plan. Of the eight case records we reviewed on Rowan ward and the eight reviewed on Rydon ward 2, none of the patients had been given a copy of their care plan.
- All the wards displayed information about advocacy (provided by Swan Advocacy) and PALS. On Holford ward the citizen's advice bureau attended the ward on a regular basis. At Rowan ward the advocacy service visited the ward most weeks and also on request. On Rydon and Holford wards the advocate would come to the ward and ask people if they wanted any support. The advocate would check with the office if there were new admissions so they could ensure everyone had been offered advocacy. A patient told us they had had a leaflet about the ward, that their treatments had been discussed and that they were awaiting their tribunal.
- On Rowan ward the manager told us carers were involved in the admission process if the patient wanted this. One nurse on Rydon ward told us carers were invited to attend patient reviews and they were recording carers' views in a carers section on Rio. Rydon ward managers showed us a pack they were giving to young people which included a booklet specially written for young carers by the royal college of psychiatrists and Gloucester young carers.
- All wards were holding 'have your say' meetings for patients. This gave them the opportunity to talk about the day to day running of the ward. Patients had been informed about our visit and patients had been encouraged to talk to us and be honest about their experiences. There was a 'you said, we did' board showing improvements made in response to feedback. On Rowan ward there was a 'start the day' meeting every day. We attended the meeting and it was facilitated by four staff. Patients were asked what kinds of activities they would like to do and it was arranged for two of them to attend the gym. The meeting was well facilitated and patients were encouraged to listen to one another and be respectful of each other. On the whole, patients told us they felt able to complain and knew how to do so. A consultant told us that complaints were fed back to the ward staff. We saw minutes of meetings on both Holford ward and Rydon one ward which showed that patient community meetings were occurring on a weekly basis. During our visit to St Andrews we observed a daily meeting between patients and occupational therapy staff where the programme for the day's activities was discussed.
- None of the patients we met had been invited to be involved in decisions about the service and none had been involved in the recruitment of new staff.
- We reviewed six cases on Rowan ward and found advance statements and wishes were recorded in four cases and two had refused to make a statement. An advance statement enables patients to say how they would like to be treated in the future if they ever lost the ability to decide for themselves.

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

Are acute wards for adults of working age and psychiatric intensive care units responsive to people's needs?

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

Please refer to earlier summary.

Access and discharge

- The average bed occupancy across acute and PICU wards between October 2014 and March 2015 was 90%. This was broken down as follows: Rowan ward 94%, Rydon wards one and two 91%, St Andrews ward 91%, Holford Ward 84%.
- The number of out of area placements attributed to this core service in the last six months was three. Two patients had been admitted elsewhere due to bed shortages in this service. The third patient had complex needs.
- One psychiatrist explained beds were generally available but that patients were referred out of area for specialist treatments or services such as mother and baby facilities or care for severe personality disorders. Patients were actively reviewed to see whether they could be managed at home with the help of the home treatment team.
- We spoke to managers about the availability of beds. They told us bed occupancy fluctuated and when there were no beds on Rowan ward or St Andrews ward they would go to one of the Rydon wards. However, those wards would then be under pressure. Rydon and Holford ward managers told us patients might have to go out of area into a private bed for up to a week if there were bed shortages. There had been three episodes of patients transferred out of area due to a lack of appropriate beds in the past six months.
- Wards were aware of the need to ensure patients had a bed on return from leave. At St Andrews ward, access to a bed on return from leave could not be guaranteed and patients were made aware of this prior to leaving. We asked about what happens to patients' beds when they go on leave on Rydon wards. The managers said they try to hold a bed for patients for up to five days. Consultant psychiatrists were aware of the bed pressures and were considering discharge for patients who were well enough to go on leave for longer than five days. On Rowan ward the consultants were working with the ward manager and medical director to ensure leave arrangements were realistic and attainable.
- It was sometimes necessary to move patients between wards but where possible this was done early on in their stay and not once they had become settled. Patients would be moved in order to place them on the ward that covered the geographical area in which they lived. Although the Rydon wards were in the same building, they covered different geographical areas. If a bed was not available on the ward representing the area the patient lived in, then they might be placed on the other ward and then moved when a bed became available to enable them to link with community teams and their GP. While patients resided on a ward outside of their geographic area, staff told us patients would be visited by the teams representing their home geographical area.
- Managers told us it was rare for them not to be able to place a patient on Holford ward if they needed intensive care. When Holford ward was full, patients requiring more intensive care were placed out of area. Holford ward is the only psychiatric intensive care unit (PICU) in Somerset.
- There were a total of 552 days lost to delayed discharge in the six months prior to our inspection. This represented days when patients stayed longer in hospital than they needed to. This was broken down as follows: Rydon wards 209 days, St Andrews ward 284 days, Holford ward 59 days. There were no delayed discharges for Rowan ward. The main reason given for delayed discharge was limited availability of suitable accommodation in the community for patients to move into, especially if they had complex needs. Managers told us there were national problems placing patients with early onset dementia and some difficulties placing patients with learning disabilities but they were actively seeking to place patients and had contacts with a variety of facilities.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had occupational therapy teams and a full range of rooms and equipment to support treatment and care. There were therapy rooms where alternative therapies were delivered and wards were well equipped

Are services responsive to people's needs?

Good

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

for art and music activities. All the wards had computer equipment and well equipped gymnasiums. Patients on Holford ward had access to online banking and shopping. All the wards had lounges where there were games, music and television. Patients could access gardens on all the wards.

- We noticed that on Rowan ward one end of the female patients corridor was overlooked by private residential accommodation. We pointed this out to the ward manager and they ordered a new window. In the meantime it was obscured to ensure privacy.
- All the wards provided areas that could be used as quiet rooms and enabled patients to be visited by their family and for families to attend meetings on the ward. All wards provided places off the main ward for children to visit patients. One patient told us staff encouraged them to have visits with their families.
- Patients were able to make private phone calls on all of the wards. Patients on all the wards were allowed to have their mobile phones with them and they were charged for them by staff.
- Patients on all the wards enjoyed the food and described it as "very good" and "top quality". Patients could also make their own hot and cold drinks and snacks throughout the day. At night, access to the kitchens on St Andrews and Rowan ward was restricted but patients could ask staff to make them a drink and patients confirmed this. This was to enable good sleep hygiene and to stop patients disturbing other patients at night. Holford ward provided access to cold drinks and hot drinks on a schedule and at patients' requests. This was due to the acute nature of their illness which could cause patients to behave in a volatile manner. Patients told us their requests for drinks 0..0.were always met.
- On all the wards patients could personalise their bedrooms. We saw examples of patients using their own bedding and displaying photographs of family members. Due to the nature of Holford ward and the intention to only admit patients for short periods of time, bedrooms were less personalised. On Holford ward, patients did not have keys to their own bedrooms but could access them by asking the nursing staff.
- All wards had somewhere safe where patients could lock and store their personal possessions.
- A wide range of therapeutic activities were available on all the wards and the activity programme also covered evenings and weekends. Rowan ward patients had their own activity care plan in place. On Rydon wards, patients were provided with a list of ward activities and could shortlist the activities they wished to undertake. Activities offered on Rydon ward two included painting, mindfulness activities, computer work, relaxation and cooking. On Rydon wards the occupational therapy service was provided on weekdays but the manager had submitted a bid for additional activities staff to extend the cover. Newly appointed health care assistants were also activity coordinators.
- Records for St Andrews and Holford ward showed they had been the subject of patient-led assessments of the care environment inspection. Records showed that the cleanliness and maintenance of the ward was of a high standard.

Meeting the needs of all people who use the service

- All the wards provided access for people with disabilities and offered facilities such as disabled bedrooms and assisted bathrooms. However, on Rydon ward one, a patient with specific mobility needs was not in the room with disability adaptations. Specialist equipment was hired if it was needed including bariatric equipment and peg feeding equipment.
- All the wards could access information leaflets in foreign languages. These were not on display but staff were able to tell us where they could get them from. On Rydon ward two there was a poster about access to interpreters displayed in different languages. All the wards were able to access interpreters and signers if needed. We witnessed a meeting with a foreign language speaking patient with the aid of an interpreter who was visiting the patient twice per week
- All the wards displayed information on treatments and how to complain. We looked for information for patients on the mental health act and mental capacity act on Rydon ward one and St Andrews ward but there was none on display. On Rowan ward there were leaflets about psychological therapies and community services such as victim support. There were posters about the complaints process.
- There was a trust chaplain who visited the wards regularly. They could provide access to spiritual support

Are services responsive to people's needs?

Good

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

for different denominations. A nurse told us the chaplain had accompanied a patient to church. On Rowan ward a spiritual advisor was also visiting the ward and they were receiving treatments from the Such project, a charity providing a therapeutic service for all mental health wards.The charity worked alongside the medical model to aid recovery from emotional and mental distress through touch therapy. They were providing treatments such as Indian head massage.

Listening to and learning from concerns and complaints

- The total number of complaints in the 12 months from 1 April 2014 to 26 March 2015 for all the wards was 16. Of these, ten were upheld and none were referred to the Ombudsman. Between March 2015 and September 2015 the wards had received 11 complaints and 107 compliments.
- The Rowan ward manager explained how they encourage patients to talk to them in order to resolve issues informally before a complaint is necessary. There were also signs around the ward on how to make formal complaints by phoning or writing to the patient advice and liaison service (PALS). One patient on Rydon ward told us they would not know how to complain and would not feel confident in doing so. Staff clearly explained to us how they would handle complaints on behalf of patients, visitors and family members. One nurse on Rydon ward one said patients were given information on admission and it was repeated later on if they were too unwell to take it in. Ward community meetings provided further opportunities for patients to raise issues. On the Rydon wards, PALS attended 'have your say' meetings on the wards and the minutes were displayed on the ward.
- We reviewed the handling of three recent complaints from Rowan ward patients and they had been handled sensitively and proactively and showed insight into the patient's difficulties. Apologies were issued where appropriate and explanations were offered. On Rydon ward one and Holford ward we saw examples of actions from complaints that had been identified and addressed.
- We did not find any evidence on Holford ward or St Andrews wards to show that staff receive feedback on the outcome of investigation of complaints. Managers told us complaints were discussed during team meetings and individual supervision.

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

Are acute wards for adults of working age and psychiatric intensive care units 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.

Please refer to earlier summary.

Vision and values

- Staff we spoke to knew and agreed with the organisation's values. The trust vision and values were displayed on the wards. The managers for Rydon ward two and Holford ward said the team objectives reflected the trust values and objectives. The Rowan ward manager knew the values of the organisation and was focused on the ward objectives of being caring and compassionate and treating people with dignity. They said they wanted to be a leading ward and were proud of their team. The ten commitments to care were displayed on posters in public areas on the ward. Each ward team were also creating their own mission statement.
- Staff on all the wards told us that they knew who the most senior managers in the organisation were, and said they had received recent visits from the chief executive which they appreciated. Rydon ward managers said the chief executive was approachable and that they had exchanged telephone calls and emails with them. They said they were receiving good practical support from the board and also from senior managers.

Good governance

- Staff across the service were up to date with mandatory training. They were being appropriately supervised and all staff had had an appraisal within the last 12 months. There were sufficient staffing numbers and a good skill mix within multi-disciplinary teams. One patients told us that staff at St Andrews ward spent a lot of time in the office rather than providing direct care.
- Staff were actively participating in clinical audits. One example of audit results which were fed back to managers at 'proactive care business meetings' was the suicide prevention audit and observation level reviews. Incidents were reported appropriately and there had not been any serious incidents within the past 12 months. There was some learning from incidents and complaints but one consultant said incidents were reported and investigated but there was no real structure for feeding back to staff involved.
- Despite safeguarding training and support from the trust safeguarding lead and department, staff were not making safeguarding alerts to the local authority when they should have been. We found examples of staff failing to adequately monitor and protect patients from one another. Patients were not always being adequately monitored when they were together. There was an incident of a sexual nature which was not reported for safeguarding on Holford ward. On St Andrew's ward, staff said they did not leave males and females unsupervised in communal areas, but we witnessed an example of this occurring during our visit. Despite this, managers were confident their staff were aware of their responsibilities in regard to safeguarding.
- Many of the staff had not been trained or adequately briefed in the mental health act, mental capacity act or the new mental health act code of practice. There were errors made in regard to the administration of and record keeping around the mental health act.
- All the teams were keeping local risk registers and there was a system to enable items to be brought to the attention of divisional managers who could, in turn, submit items to the trust risk register based on a scoring system.

Leadership, morale and staff engagement

- Ward managers had sufficient authority to undertake their duties and did so with enthusiasm, autonomy and dedication. Ward managers on all the wards said they felt supported by their senior line managers. Managers could access the administrative support they needed.
- Sickness and absence rates varied across the service and were higher on the psychiatric intensive care unit. The sickness rates for the trust over the past 12 months was 4.9%. For mental health it was slightly higher at 5.3%.
- We were not told of any bullying and harassment cases by any of the managers or staff that we spoke to on any of the wards we visited.

Are services well-led?

Requires improvement

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

- Staff were able to tell us how they could whistle-blow and said they felt able to raise concerns without fear of victimisation. We saw an example of a whistleblowing which had been investigated to good effect. No whistleblowing concerns had been raised with CQC.
- Although morale on the Holford and Rydon wards was described as good at the moment, staff were busy due to staff being off on long term sick leave and the difficulties in recruiting nurses. This was recognised as a national problem. Staff were paid an overtime rate to take on additional shifts. The ward had redesigned the staffing provision and was procuring new staff which aimed to address this difficulty. Some stress was reported on Rydon ward one, linked to a locum consultant psychiatrist, who had been employed to cover the short-term absence of the substantive ward consultant. However, managers told us staff had supported each other well. Morale amongst managers appeared to be good.
- Staff we spoke with on all the wards told us they were happy in their jobs and that although the work could be difficult, morale was high due to the support of their managers and colleagues. Appraisals showed people were empowered to progress in their careers.
- Staff were able to develop as leaders. On St Andrews and Holford ward staff were accessing opportunities for leadership development through promotion into vacant posts. One occupational therapist on Rydon ward was being supported to gain leadership experience as a line manager.
- Staff understood the concepts of the duty of candour and the need to be open with patients and explain when things went wrong.
- Staff were given opportunities to input into service development, for example, the service manager had been involved in the redevelopment and refurbishment of Holford ward and the Rowan ward manager had assisted in the design of major changes to Rowan ward. One health care assistant had been involved in the briefings for 'see something, say something' when it was developed. Another health care assistant had been involved in preparing the induction pack for staff.

Commitment to quality improvement and innovation

- Holford ward was a member of the National Association for Psychiatric Intensive Care Units. This gave them access to best practice guidance. Membership showed a commitment to improving patient experience and the delivery of care.
- We reviewed 'an evaluation of the Rowan ward professional nurse supervision group'. This was a report produced as part of the trust's 'new ways of working' initiative. Nurses introduced a monthly supervision group which was for professional nurses specifically. The group was started in recognition of the fact that nurses were being asked to work in a new autonomous way because of the 'new ways of working' initiative. Staff feedback was positive and they found the group good for seeking advice and support and developing their skills.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 (1)(e) HCSA 2008 (Regulated Activities) Regulations 2014** **The trust was not ensuring resuscitation equipment and refrigerators were being checked and maintained.** **This was a breach of regulations 15 (1)(e)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (2), (3) HSCA 2008 (Regulated Activities) Regulations 2014** **Safeguarding service users from abuse and improper treatment.** **Staff on Holford ward were not always aware of the need to consider making safeguarding referrals in the event of incidents between patients or when patients assaulted one another.** **This was a breach of Regulation 13 (2), (3)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 11(1) HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent Care records showed staff were not always gaining consent to treat patients and they were not treating the consent process as an ongoing one. This was a breach of Regulation 11(1).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(f) HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Appropriate emergency medicines to reverse the effects of Benzodiazepine medication were not available on Holford ward. This was a breach of Regulation 12(2)(f).