Good

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

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

Quality Report

Tel: 0300 790 7000
Website:
http://www.sssft.nhs.uk/

Date of inspection visit: 21-24 March 2016
Date of publication: 12/07/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RREX9	Redwoods Centre	Laurel Ward	SY3 8DS
RREX9	Redwoods Centre	Pine Ward	SY3 8DS
RRE13	St George's Hospital	Chebsey Ward	ST16 3AG
RRE13	St George's Hospital	Brocton Ward	ST16 3AG
RRE13	St George's Hospital	Norbury Ward PICU	ST16 3AG
RRE58	George Bryan Centre	West Wing	B78 3NG

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

Summary of findings

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

Where applicable, we have reported on each core service provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of South Staffordshire and Shropshire Healthcare 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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

Contents

Summary of findings

Overall summary

We rated South Staffordshire and Shropshire NHS Foundation Trust as good because:

- Across the service, there was evidence of comprehensive and holistic care planning that demonstrated patient involvement and set clear goals for admissions.
- The multidisciplinary team worked cohesively to determine and meet immediate patient need and were very responsive to change.
- All of the wards shared a common philosophy and model of care that was focused on recovery
- There were robust systems in place to manage the recording of incidents and learning from them.
- There were strong and motivated clinical teams offering each other mutual respect and support.

However:

- Staff did not consistently follow trust policy concerning seclusion or rapid tranquilisation. This meant that patient safety was compromised on occasions
- On some wards, guidance around same sex accommodation was not being consistently followed

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:

- On some of the wards, staff did not follow or record the safeguards to protect patients who had been given sedating medicines in emergency situations (rapid tranquilisation)
- Staff did not follow local policy or the Mental Health Act Code of Practice that supported safe practice when documenting the observations and decision-making in the use of seclusion.
- We found that new works on one ward had resulted in ligature risks that staff had not recognised and risk assessed.
- Staff regularly placed female patients in rooms on 'male' corridors or amongst male bedrooms on all five acute wards. Staff/the service/the trust did not always consider (or take into account) the female patients' concerns, or obtain their consent.

However:

- Risk assessments were comprehensive, completed on admission and reviewed daily by the multidisciplinary team
- All the hospitals were clean, well equipped and staff maintained the clinical areas and equipment to a high standard.
- Staff ensured medicines were safely stored and well managed and followed best practice to reduce errors.
- Staff knew how to record incidents and learned lessons that improved the future safety of patients.
- Ward managers and support services responded immediately when we raised safety concerns with them.

Are services effective?

Good

We rated effective as good because:

- The purposeful inpatient admissions (PIPA) model of care was working well to focus the resources of the team on patients' immediate needs and work towards planned discharge.
- The introduction of the Vona du Toit Model of Creative Ability '(Vdt MOCA) approach was a positive attempt to work with patients on their readiness and ability to engage in the therapeutic process.
- The service's introduction of 'safe wards' had improved relationships between patients and staff and reduced the risk of

Summary of findings

incidents caused by misunderstandings. Safewards is an approach to nursing care that focuses improving communication between staff and patients by developing a common understanding of problems.
- Staff had a good understanding of the Mental Health Act. Patients knew their rights and advocacy services had a visible presence on all of the wards.

However:

- Staff on west wing at the George Bryan centre produced care plans from generic templates that did not reflect the levels of patient involvement evident in the notes.
- Supervision levels for nursing staff were below the trust target

Are services caring? Good

We rated caring as good because:

- Information was available to patients on all aspects of their care and staff gave a comprehensive information pack to patients on admission. Carers received information about the service on their first visit to the ward.
- Patients gave regular feedback on the quality of care on the wards through surveys and participation in weekly community meetings.
- The 2015 Patient Led Assessment of the Care Environment (PLACE) scores for privacy, dignity and wellbeing were above the national average for NHS trusts.
- Care records demonstrated that staff involved patients in regular discussions about their care.
- Advocacy services were accessible to patients and had a regular presence on the wards.

Are services responsive to people's needs? Good

We rated responsive as good because:

- Ward managers effectively managed bed occupancy. The average length of stay was short; there were few delays in discharges across the service and beds available to patients in crisis.
- The wards offered patients a good range of activities and space for therapeutic and social activity.
- To overcome difficulties in visitors accessing Redwoods from rural areas with poor transport links, staff used SKYPE to facilitate family contact with patients.

Summary of findings

- Patients told us they knew how to complain formally and said they were happy to raise issues at community meetings or directly with individual staff.

However:

- Staff, patients and visitors found the acoustics of the wards at St George's hospital very noisy and distracting.
- Some carers told us that they were not always invited to care reviews or were denied information despite having the consent of the patients involved.

Are services well-led?

Good

We rated well led as good because:

- All staff knew of the trust's values and could relate them to their practice.
- Senior managers had a recognisable presence on the wards.
- The trust had developed strong teams of professional leaders.
- Local and clinical audits took place that were informed by the relevant national institute for health and care excellence (NICE) guidance.
- Clinical teams were strongly motivated. Team members supported one another and respected the knowledge and skills of other professional groups.

Summary of findings

Information about the service

The service comprises five acute inpatient wards across three sites and a psychiatric intensive care unit (PICU), based on Norbury ward at St George's Hospital. All the wards are mixed sex admitting both men and women from locality based community teams. The clinical management system across all six wards consists of a dedicated multidisciplinary team including a full-time consultant psychiatrist.

At the Redwoods Centre in Shrewsbury, there are two adult acute admissions wards; Pine and Laurel; each providing 16 beds.

At St George's Hospital in Stafford, there are two adult acute admission wards; Chebsey and Brocton; each providing 20 beds. Norbury ward PICU is part of St George's Hospital and offers 13 beds for those patients requiring additional support to that offered on the acute wards.

West Wing is an adult acute admission ward providing 20 beds and is situated at the George Bryan Centre in Tamworth.

This was the first comprehensive inspection of the trust and core service as part of our new approach to inspection.

We last inspected the Redwoods Centre in May/June 2013 and found it to be fully compliant with all the standards considered.

St George's Hospital was met all the essential standards of quality and safety inspected when we last visited in August 2012.

We last inspected the George Bryan Centre in July/August 2013 visiting West Wing alongside East Wing (an older adult acute psychiatric ward). We inspected the two wards together and made judgements made about the hospital as a whole. We found that the safety and suitability of premises to be below the required standard. The concerns were that the ward did not provide suitably segregated accommodation for men and women. We also found the hospital to be failing to safeguard people who used services from abuse due to restrictions in accessing bedrooms and outside spaces that we considered to be unreasonable. The trust submitted action plans showing how they would address these issues.

Our inspection team

Our inspection team was led by:

Chair: Vanessa Ford, Director of Nursing Standards and Governance, West London Mental Health

NHS Trust

Team Leader: James Mullins, Head of Hospital Inspection (Mental Health), CQC

Inspection Manager: Kendrick Jackson, Inspection Manager (Mental Health), CQC

The team was comprised of: one inspection manager, two inspectors, two specialist advisors (one mental health nurse and one consultant psychiatrist), a mental health act reviewer and one expert by experience who had used acute services in the past

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all six of the wards at the three hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 34 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 39 other staff members including doctors, nurses, occupational therapists, support workers, psychologists and a clinical pharmacist
- interviewed the senior nursing staff with responsibility for these services
- attended one patient-led community meeting on Laurel ward
- attended and observed two handover meetings and six multidisciplinary rapid review meetings
- looked at 32 treatment records of patients
- carried out a specific check of the medication management on three wards
- spoke with service user and carer groups about the service
- 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

At all three hospitals, most of the patients we spoke with were positive about the care they received from staff. Patients said that staff were kind and caring and did their best to provide a good service.

Each ward displayed patient feedback, which staff updated weekly. For instance, on Chebsey ward; 100% of patients had said they had enough 1:1 time with staff, 63% of patients felt involved with care planning and 91% said that they would recommend the service

Good practice

The service had embraced new patient-focused models of care that had positive impacts on patient care and service delivery. The purposeful inpatient admission (PIPA) model encouraged short admissions with minimal restrictions. The occupational therapy team had introduced the model of creative ability (MoCA) to the wards. The MoCA enabled staff to assess the motivational levels of patients. This helped to define realistic goals for care plans that would progress recovery and give hope to the patient. The Safewards initiative, implemented by the service managers aimed to improve communication between staff and patients on the ward and avoid conflicts caused by misunderstandings.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that their policy on rapid tranquillisation is up-to-date and reflects current prescribing guidance from NICE. The trust must ensure that clinical staff have a consistent approach to the use of rapid tranquillisation, understand its risks and record its usage.

Summary of findings

- The trust must comply with the Mental Health Act Code of Practice requirements for documenting observations and decision making during any episodes of seclusion and long-term segregation.

Action the provider SHOULD take to improve

- The trust should take action to reduce the noise levels on the wards at St Georges' Hospital.
- The trust should review and ensure that comprehensive environmental risk assessments are carried out following any construction work on the wards.
- The trust should not place female patients in rooms on male corridors without offering support, risk assessments and seeking ongoing consent from the woman unless there is an urgent clinical need in line with national guidance.
- The trust should ensure that staff receive training in writing personalised care plans that reflect an individual patients' voice.
- The trust should ensure that staff receive regular supervision in line with local policy and professional guidelines.

South Staffordshire and Shropshire Healthcare 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
Laurel Ward	Redwoods Centre
Pine Ward	Redwoods Centre
Chebsey Ward	St George's Hospital
Brocton Ward	St George's Hospital
Norbury Ward PICU	St George's Hospital
West Wing	George Bryan Centre

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.

Staff had a good understanding of the Mental Health Act that was part of their mandatory training. All staff had completed this training when we inspected.

Prescription charts had the relevant T2 or T3 form attached to them when required which were fully completed and correct.

Patients told us they had been fully informed them of their rights. Care notes showed that patients received the reading of their section 132 rights on a weekly basis or until they understood them.

Detailed findings

An audit system was in place to make sure all paperwork was up-to-date and in place.

Patients had access to an independent mental health advocate (IMHA) and information was available on ward notice boards. We saw ward staff actively encouraging patients to make use of this service.

The trust had organised training on the latest edition of the Code of Practice issued in March 2015, made electronic copies available on all computer desktops, and produced information sheets on key changes for clinical staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated good knowledge of the Mental Capacity Act (MCA) and the principles of Deprivation of Liberties Safeguards (DOLS). Staff on some wards had experience of the use of a DoLS authorisation as a less restrictive option to the Mental Health Act.

Staff received MCA training as part of their mandatory training.

Care records indicated where staff had involved patients in making decisions about their treatment and care.

Medical staff regularly reviewed capacity and consent to treatment and discussed it in the multidisciplinary team meetings (MDT). Where a patient lacked mental capacity, the consultant psychiatrist recorded how they made in their best interests.

There was one DoLS authorisation in place at the time of our inspection.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- The two wards at the Redwoods Centre share a similar modern design with clear lines of sight. Brocton, Chebsey and Norbury wards at St George's Hospital are older wards that do share some problems of direct observation. Staff were able to limit these difficulties by their knowledge of potential risks and increased observations. At West Wing, we found that there were restricted lines of sight from the ward into the garden area. This meant that staff could not see patients in the garden without walking the full length of the garden. This would increase the time needed to find and attend to a patient in need.
- The trust had a policy to address the potential risk of ligature points on the ward through annual audits and action plans. A ligature point is any feature in the ward environment, which could support a noose or other strangulation device. Each ward had a ligature risk assessment completed in the last year. On Norbury ward the inspector found that in patient bathrooms, taps, grab rails and door hinges could be potential ligature points. These had been noted in the most recent ligature risk assessment in December 2015 and had been prioritised for action as a high risk. Staff supervision and awareness of the potential for harm was the mitigation in place whilst awaiting works to remove these fittings. On our inspection of West Wing at the George Bryan Centre, we identified a number of potential ligature risks. The most significant of which was new and was not covered in the ligature risk assessment for the ward. Contractors had fitted a new alarm system to the ward and the garden space outside. The work was still in progress but loops of wire had been fixed to the walls and the junction/sensor boxes provided fixed points for a these wires to be used as a ligature. When our inspector pointed this risk out there was immediate action from the ward manger to increase observations in that area and the estates visited to assess and contact the contractor to amend their work in line with the anti-ligature specification in the original job brief. Two potential ligature points we had identified in exposed wiring within the ward were addressed on the same day with Maintenance staff addressed on the same day two potential ligature points we had identified within the ward securing loose wiring in trunking affixed to the wall. Following two incidents where patients used a ligature in an accessible toilet on one ward at Redwoods, staff had locked the facilitated toilets across all wards. Patients were encouraged to use the toilet facilities in their own bedrooms as a result. Service leads were looking at how they would mitigate potential risk by refitting the accessible toilets with ligature free equipment that would also serve the needs of those patients and visitors with limited mobility and a need for aids.
- Both of the wards, Laurel and Pine, at Redwoods offered single bedroom accommodation with ensuite toilet facilities. We found that two female patients had bedrooms allocated on the male corridor because of an uneven demand for male and female beds. We interviewed one female patient who staff had given a room on the male corridor on her original admission to the unit. She described feeling frightened there, complaining of a male patient regularly looking in on her through the door window, when she made her fears known to staff she was moved to the female corridor. Staff told us that when women are placed in rooms on the male corridor it was always risk assessed and they would seek the patient's consent if possible. Brocton ward provided single bedroom accommodation, 18 of which had ensuite shower rooms. There were three bedroom corridors, one of which had been commissioned for the use of Ministry of Defence (MoD) personnel. Males and females were accommodated on separate corridors, although we were told this was sometimes not possible due to the patient mix, and at those times risk assessments would be undertaken and the risk managed. There was a small female only lounge. The MoD corridor also had a small sitting room. On Chebsey ward accommodation was provided in single bedrooms the majority of which had ensuite toilets and wash basins. During our visit, we found the ward had not been able to accommodate men and women in separate bedroom corridors. Staff had admitted a woman to a bedroom in the middle of the male corridor and then moved her to a bedroom off the

day room. As this bedroom did not provide an ensuite toilet, she had to cross the day room, used by both men and women, in order to access a toilet. This move had reduced one risk by moving her into a more central area of the ward but affected her privacy and dignity. There was a small female only sitting room. Men who wished to access male only space were permitted to use the small meeting room. On Norbury ward there was a plan for it to become an all-male ward and only three women remained there at the time of our inspection. Female rooms were separated from the male corridor and a female lounge was available. However, male patients would have to pass through this lounge to access the ward-based gym that managers had already moved in anticipation of the change to a single sex ward.

- Each ward had a very fully equipped clinic room including diagnostic equipment such as electro cardio grams that nursing staff were trained to use to support physical health assessments. Emergency equipment was available on all wards and under local policy; nursing staff completed weekly checks on its availability and readiness for use. We found that from January 2016 to the end of March 2016, evidence of weekly checks was missing for six occasions on Pine ward and once on Laurel ward. The other wards fully complied with the local policy within that period.

- West Wing had the only dedicated seclusion room in the service. Seclusion is the supervised confinement of a patient in a room, which staff may lock. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others. Best practice is that staff use a room designed to reduce the risk of a patient harming themselves or others. We inspected the seclusion room and found that it did not fully meet the recommendations set out in the Mental Health Act Code of Practice. The intercom, which would allow safe communication without opening the door, was broken, with one panel missing on the outside. There was no clock within the line of sight of a patient placed within the room. This is recommended to help the patient remain orientated to time. There was no access to the room apart from the main door. This meant that any food or drink required by a patient would require the door to be opened potentially putting the patient and staff at risk. The design of the room did include a robust, reinforced window that provided natural light. There was externally controlled lighting, including a main light and subdued lighting for nighttime. Staff could also control room temperature from outside. Toilet and washing facilities were provided in an adjacent room. A patient in seclusion had to ask permission of staff to leave the seclusion room to use the toilet. If it were not considered safe to do so, they would be offered a toilet aid to use in the room.

- In reaction to our comments, the ward manager reacted quickly to rectify some of these problems. On the same day as our inspection visit a clock had been fitted for within the view of any patient using the seclusion room. In a follow up visit a week later staff showed us that replacement parts had been ordered for the intercom and a new door, with a hatch to allow drink and food to be delivered, was being made.

- All three hospital sites take part in the patient led assessment of the care environment (PLACE) inspection programme. Teams made up of at least 50 per cent members of the public (known as patient assessors) carry out these self-assessment annually. The condition, appearance and maintenance of wards and their cleanliness are two aspects of the environment rated in this annual survey. In 2015, the scores awarded to the acute wards for cleanliness were; Redwoods 95.8%, St George's & the George Bryan centre 98.3%. The 2015 PLACE score for South Staffordshire & Shropshire NHS Foundation Trust as a whole for cleanliness was 97.0%; this figure is just 0.6% below the national average. The PLACE scores for condition, appearance and maintenance in 2015 for the three hospitals were Redwoods 96.8%, St George's 94.2% and the George Bryan Centre 94.85%; he national average score for condition, appearance and maintenance across all NHS sites is 90.1%

- All wards had prominent displays about hand washing and the use of alcohol gel to cleanse hands at their entrances and within the wards. Patient kitchen areas provided further hand washing facilities and we saw staff prompt visitors to use the alcohol hand gel on entry to the ward. Staff on all wards had received training in infection control. A dedicated infection control nurse delivered this training to all staff at induction and then again at annual updates. Nursing staff completed

Requires improvement

Are services safe?

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

regular audits around aspects of infection control including handwashing, the cleanliness and integrity of mattresses and the control of other potential sources of infection.

- Throughout the service, we found that clinical equipment was well maintained and kept clean as part of a weekly schedule. Clinical cleaning schedules were available on each ward and subject to monthly audit.
- Domestic staff at the Redwoods centre showed us their monthly cleaning log, which reflected a daily cleaning rota and also highlighted how any outstanding tasks where highlighted to the next shift for completion. Across all the wards, we found a good knowledge of and safe storage of cleaning materials and information folders detailing the hazards of each product. Equipment was colour coded in line with infection control policies and used only in specific areas of the ward to reduce any risk of cross contamination.
- All the ward managers maintained a log of environmental risk assessments for their clinical areas. Staff completed regular audits concerning infection control precautions (handwashing), security of sharps and cleanliness of equipment (including mattresses). They also maintained a log of work requests to the facilities department and risk assessments to manage short-term environmental problems.
- There was a variation in the level of nursing call and alarm systems available across the three sites. At the Redwoods Centre, the two wards had an emergency alarm system in place that linked into a general system that covered the whole hospital. This meant staff could call on a response team from other wards. Patients had access to a nurse call system to seek assistance when in need in their bedrooms and bathrooms. The nurse call was also available in public areas of the ward. At St George's there was nurse call system in bedrooms, bathrooms and public areas of the ward that nursing staff checked weekly. Staff on the ward and visitors also had portable alarms that when activated would identify where the incident was taking place and support would come from a response team from that and other wards. On West Wing at the George Bryan Centre, contractors were installing a new alarm system. There was a nurse call system in place and support in an emergency could be sought from staff in the East Wing of the hospital.

Safe staffing levels as of September 2015:
Establishment levels: qualified nurses (WTE).

Laurel ward 15.2, Pine ward 15.2, Brocton ward 13, Chebsey ward 22 Norbury PICU 22.9 and West Wing 14.5

Establishment levels: nursing assistants (WTE).

Laurel ward 10, Pine ward 10, Brocton ward 11, Chebsey ward 16 Norbury PICU 24.9 and West Wing 13.4

Number of vacancies at the time of inspection: qualified nurses (WTE).

Laurel ward 0.72, Pine ward 4.01 (includes staff being recruited to support 136 suite), Brocton ward 4, Chebsey ward 0.2, Norbury PICU 3.9 and West Wing 1 (appointing two)

Number of vacancies at the time of inspection: nursing assistants (WTE).

Laurel ward 0.45, Pine ward 0.5, Brocton ward 0.5, Chebsey ward 1.4, Norbury PICU 1.5 and West Wing 2

Number of shifts filled by bank or agency staff from August 2014 to August 2015

Laurel ward 83, Pine ward 39, Brocton ward 95, Chebsey ward 132 Norbury PICU 232 and West Wing 35

Number of shifts not filled by bank or agency staff from August 2015 to October 2015

Laurel ward 7, Pine ward 12, Brocton ward 5, Chebsey ward 7 Norbury PICU 1 and West Wing 6

Staff sickness at the end of February 2016

Laurel ward 11.97%, Pine ward 10.35%, Brocton ward 4.32%, Chebsey ward 5.49% Norbury PICU 5.91% and West Wing 5.19%

Staff turnover from march 2015 to February 2016

Laurel ward 13.4%, Pine ward 19.5%, Brocton ward 12.38%, Chebsey ward 17.91% Norbury PICU 6.74% and West Wing 11.9%

- Following the requirements of NHS England in implementing the recommendations of the Francis Report, the Trust managers had completed a review of staffing levels in June 2014. They had committed to ongoing reviews every six months, monthly discussions at board meetings and publication of safe staffing data

on the trust website. The National Quality Board requires NHS Trusts to use 'evidence based tools to inform staffing capacity and capability'.Health Education England supported a project across the West Midlands to develop tools to help mental health and services plan their staffing numbers. This included validating an updated version of a tool for inpatient services that was developed by Dr Keith Hurst. South Staffordshire and Shropshire Foundation Trust was a participant in this process and all the wards within the acute service were included.

- When agency and bank nurses are used, they have to complete an induction to orientate them to the ward and receive a specific handover on risk management from permanent staff members. Managers made block bookings for agency or bank staff to achieve consistency in care and familiarity with patients and ward systems.
- Ward managers or the nurse in charge of a shift had the ability to adjust staffing levels and request extra staff when required. At the two larger hospital sites; Redwoods and St George's, the site co-ordinator was responsible for reviewing the availability of staff on other wards to cover any short-term shortfall. For instance if staff had decided to raise the observation level of a patient to require the constant presence of a staff member help might be sought from another ward whilst bank or agency staff were contacted to cover the next shift.
- An additional demand for staff was supporting patients admitted to the 136 suites based in each of the three hospitals. These units are a place of safety for those felt to be at risk in the community and detained by the police under their powers within the Mental Health Act. It provides a safe place to which police can detain a person whilst a mental health act assessment is organised. At least two members of nursing staff attended to support this process. In the six months prior to our inspection (September 2015 to February 2016 inclusive), there had been 48 admissions to the 136 suite at Redwoods, 16 to St George's Hospital and three to the George Bryan Centre. At St George's hospital, this duty was managed on a monthly rotation between the wards with ward managers placing extra staff on duty for nights during that month. At the George Bryan Centre, the duties were shared between the two wards with West Wing providing a qualified nurse and East Wing a support worker from the basic ward numbers.
- Qualified nursing staff were not always available in communal areas of the wards as some tasks, such as dispensing medicines, required two nurses to be present. However all wards had at least two qualified nurses on duty, day and night, to support safe staffing recommendations.
- Basic staffing levels on all wards would allow staff to carry out physical interventions safely. At the two main hospitals, extra staff were available in an emergency from other wards.
- There is an on call medical rota to cover days and nights. In the case of a psychiatric emergency, a junior doctor was the first level of medical response and attended the wards. Senior medical staff were available for telephone consultation day and night.
- Across the service, the average mandatory training rate for staff was 83%. The lowest level of compliance was 75% on Laurel ward; Chebsey had the highest rate at 98%. The Trust target for mandatory training is 85%.

Assessing and managing risk to patients and staff

- There were 28 episodes of seclusion across the service in the six months between 1 April and 30 September 2015. These occurred on West Wing with 19 episodes, Norbury PICU 6 times and Pine ward on 3 occasions.
- There were 388 episodes of restraint in the same period. These were most prevalent on Norbury PICU. The PICU accounted for 196 (50% of the total for the service) episodes of restraint involving 31 individual patients.
- There were 31 episodes of prone restraints. Norbury PICU accounted for 13 (41%) of these incidents with eight resulting in rapid tranquillisation of the patient restrained.
- We examined 32 care records in total. Every patient had a risk assessment completed by the admitting team before arriving on the ward. Following the initial medical and nursing interviews and assessments of mental state, staff updated these assessments on the ward. The clinical staff reviewed the preliminary risk assessment at the first rapid review meeting after admission and daily

afterwards using a traffic light rating system (red, amber or green). Changes in risk assessment and management plans were updated daily on weekdays following these reviews and as required following any incidents. Staff used the Functional Analysis of Care Environments (FACE) risk assessment. This is a widely used tool recognised by the NHS in best practice advice. FACE was also the risk assessment used by community services and this supported continuity and assurance in measuring and planning risk reduction through the patient's journey between hospital and home.

- The acute wards had a policy of trying to maintain an open door when risk would allow. Informal patients were given information in their ward induction pack explaining their right to leave at any time. During our inspection at Redwoods, staff had locked the doors of Pine and Laurel wards and there was a very clear note explaining why and prompting patients to see staff to open the door if required.
- The trust had an observation policy in place, which was ratified by the board in September 2015. This notes that 'Observation should not be considered as a stand-alone or passive intervention; rather it must be part of an overall management plan addressing the identified clinical risks.' It also states that 'observation should be a supportive intervention that engages the service user. This positively reflects the commitment to person centred care. Recognising that enhanced observation and engagement is an intervention used for the highest risk and often acutely ill patients the policy states that they should not be carried out by unqualified staff. Ward managers increasing staffing levels in line with high-level observations requested support workers rather than qualified nursing staff.
- We saw on all the wards inspected that clinical observations were taking place and the level of observation and rationale discussed with the patient involved.
- We saw clear evidence in risk management plans across all areas that staff only considered restraint after they tried less restrictive options. Nursing staff had written these care plans to reflect their personal knowledge of the patients involved and they on occasion reflected the patient's wishes on how they would like to be manged if in a state of distress. Permanent staff on the wards received training in Promoting Safer and Therapeutic Services (PSTS) and De-escalation, Management Intervention (DMI). DMI training gives staff the skills to support patients when they present with behaviours that may challenge in the least restrictive way. As of October 2015, 94% of staff across the service had completed PSTS training and 83% were up to date with DMI practice.
- A rapid tranquillisation policy dated November 2013 was available on how to treat patients with sedative medicines in order to manage episodes of agitation when other calming or distraction techniques had failed to work. In November 2015, the pharmacy team identified that ward staff were not using rapid tranquillisation in accordance with the trust policy. We also found that the policy was not always followed or staff failed to report that they had undertaken rapid tranquillisation. The specialist pharmacy inspector identified that the trust had not updated the policy to include new NICE guidance. This meant that trust staff was following out of date guidance for rapid tranquillisation. The pharmacy team were aware of this and told our inspector that the Medicine Incident Review Group was reviewing the policy with a planned implementation date of May 2016. Staff administered rapid tranquillisation to one patient on Laurel ward during the inspection. We witnessed that the person was distressed, was not responding to staff and had refused oral medicines. Nursing staff then administered a single dose of intra-muscular (IM) haloperidol. When we asked staff if they were going to record this as a rapid tranquillisation incident they told us that as they had given the medicine to a patient who had capacity this was not considered to be rapid tranquillisation. We discussed the policy with staff and on this occasion, the nurses recorded the episode as rapid tranquillisation. On checking the patients' clinical notes, we found two further recorded incidents where staff had given the patient Intramuscular lorazepam for agitation. However, the nurses had not followed the rapid tranquillisation policy. Staff failed to record any of the physical observations required to maintain the safety and well-being of the patient. The nurses had not reported them as a rapid tranquillisation incident using a restrictive practice form. Our specialist adviser looked in detail at four more patient files. We cross-referenced clinical notes with prescription charts for dates when staff had administered rapidly tranquilising medicines. Out of the

twelve incidents of rapid tranquillisation, we noted only one record demonstrated that nurses had completed a restrictive practice form and physical observations taken. Seven out of the twelve records did not evidence nurses attempting or completing any physical observation after they administered the medicines. Of the five entries where we could identify that staff had taken physical observations, the detail or frequency fell short of the trust policy. We sampled two patient records from Pine ward and found six incidents of the use of rapid tranquillisation. Staff had not recorded any of these as a restrictive intervention and we could not find evidence of any physical observations in line with trust policy and best practice. We immediately discussed our concerns with the Modern Matron, ward managers and nurse consultant on the acute unit at Redwoods. They agreed that staff were not managing episodes of rapid tranquillisation appropriately and this implied that there had been a significant under reporting of these incidents. They agreed to review local processes immediately to ensure that the safeguards were in place to protect patients from potential harm. The nurse leaders identified a potential cultural problem in staff believing that administration of sedative medicines was considered as a 'normal' or routine practice in line with other as required medicines and was not a restrictive practice-requiring recording and further observations. At West Wing, we found further variations in relation to the rapid tranquillisation policy. All intra-muscular medication used for rapid tranquillisation had been identified on the prescription charts as 'RT' by the pharmacist. When medical staff had prescribed the same medicines by mouth, the pharmacist had not marked them as rapid tranquillisation. This was despite the use of medicines by mouth being the starting point of the rapid tranquillisation pathway. One patient record demonstrated that nurses had used oral medication for rapid tranquillisation as well as for general symptom management. On three occasions, the patient had been administered the medicines via intra-muscular injection. We could find no restrictive practice forms or physical observations recorded on the electronic care record. One use of a low stimulus environment was the only note of restrictive practice recorded against these episodes. At St George's Hospital on Norbury ward PICU, where the clinical team used rapid tranquillisation most frequently, we reviewed local processes. Staff we spoke with were able to describe the rapid tranquillisation policy and recognised it required updating to include current NICE guidance. We looked at the medicine records for one patient who nurses had given rapid tranquillisation. The nursing staff had followed the rapid tranquillisation policy with observations and clinical checks recorded to ensure the safety and well-being of the patient. The nurse involved had recorded the event as a rapid tranquillisation incident. We also found that good practice concerning rapid tranquillisation on Brocton and Chebsey wards at St George's Hospital. As a whole service, we found that the practice around rapid tranquillisation was not up to date with the latest national guidance published by NICE in May 2015. There was evidence of inconsistencies and omissions in following the existing policy on two out of the three hospital sites. That despite the local pharmacy team having identified this issue in November 2015 there had been no local action plans put in place to mitigate the potential risks to patients. Given the potential complications of administering sedating medication to patients in distress and possibly under restraint, the service had put patient safety at risk.

- The Trust had introduced a policy in January 2016 to clarify the use of seclusion outside of a dedicated seclusion room. The aim of this policy was to ensure that the same level of safeguards through assessments, reviews and observations to protect the patient were in place. We identified two recent examples of the use of seclusion outside of West Wing that had the only dedicated seclusion room. Both incidents, one on Pine ward and the other on Norbury PICU, had occurred since managers had introduced this new policy. Staff recording these incidents had not documented that they had completed all the required observations and assessments. We addressed these problems with senior ward staff and clinical leaders inside the trust who informed us that they were monitoring the introduction of this policy and they would fully implement it into practice. On West Wing, we examined records of four incidents of seclusion as recorded on RIO. None of this sample met the standards required by the Mental Health Act Code of Practice or local policy. Missing from all was any record of the required observations of the patient every 15 minutes during a period of seclusion. We also found delays in the required medical reviews and missing nursing reviews in these records.

Requires improvement

Are services safe?

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

- We found that staff had a good knowledge of safeguarding and could identify when they should raise a concern about any abuse. Safeguarding training includes Child Protection Levels 1 and 2 and Safeguarding Vulnerable Adults. Staff received this as part of their annual mandatory training. Staff logged all safeguarding concerns on the electronic patient record and this produced an alert for any staff reviewing that record in the future. Information was available on all the wards informing staff, patients and visitors how to directly report concerns about abuse to the relevant local authority.
- Pharmacists and pharmacist technicians visited wards to check patients' prescription charts and to ensure that medicines were available. They were involved in patients' medicine requirements from the point of admission through to discharge. This included undertaking a check of patients' medicines on admission. Pharmacy staff ensured that any known allergies or sensitivities to medicines were on patients' prescription charts. When staff discharged a patient, the pharmacy provided medicine information leaflets for patients to refer to at home. This information provided a summary of what each medicine was for, how to take it, side effects and any warnings or cautions. Medicines were stored securely and within safe temperature ranges. Staff performed daily checks to ensure medicines were stored safely. Two nurses checked the prescription charts at the end of each medication administration round. They performed this check to ensure that they had given all medicines or recorded the reasons for any omissions. By ensuring there were, no gaps in the records the nurses hoped to reduce medication errors and avoidable harm to patients.
- The trust has a protocol in place to support young people (under 18) admitted to the adult wards. The young person was placed on constant observation; received daily support from the CAMHS team and the use of some dedicated social space on the ward. The ward clinical team in liaison with CAMHS service specialists would daily review risk assessments and progress until they found a more suitable placement or the young person could be discharged. The admission of under 18s is always reported to the CQC as required and the young person offered age appropriate advocacy as required..
- Each hospital site had arrangements in place to allow the visit of children to the ward. Where possible parents would be encouraged to use areas off the ward where the patient could join them with an escort if required.

Track record on safety

- Across this service, there were 28 reported serious incidents in the 12-month period from 1 March 2015 to 29 February 2016. The most commonly reported type of incident was the admission of an under 18 year old to an adult mental health facility. These accounted for 12 out of these 28 records. Four related to staff injuries following assault by a patient or during physical intervention. There was one death of a patient on an acute ward in that period.

Reporting incidents and learning from when things go wrong

- All staff we spoke to were able to describe the incident reporting process using the trust online incident reporting form.
- The ward manager or charge nurse reviewed all incidents and 'lessons learnt' were fed back to staff in monthly team meetings and individual supervision.
- Staff told us they were aware of the duty of candour and were encouraged to be open and honest when things go wrong to patients' and carers. Incident forms included a link to a duty of candour action to complete following investigation and action. On Norbury ward, we saw two incidents, an incident of self-harm and an assault as examples of where duty of candour had been actioned. This also linked to clinical records and we saw a note of apology in the RIO notes.
- Staff received debrief sessions when things go wrong. Psychology staff took a lead in organising these sessions and offered individual support as required. On Brocton ward, the psychologist organised a patient event relevant learning (PERL) session every two weeks following rapid reviews. The most recent PERL was on paracetamol poisoning and information was available from the session for staff that were not on duty at the session.
- Staff discussed and shared across the service lessons learnt in one area through attendance at regular acute care forums.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We reviewed a total of 32 care records across the six wards.

- The trust managers had set a standard that each patient should have initial assessments and a formulation of need completed within 72 hours of admission. All the records we reviewed met this standard.
- All except one of the records we reviewed demonstrated that patients' had received a complete physical health examination on admission. In that one case, we saw nursing staff had completed physical observations of the patient but medical staff had not completed a physical examination. There was clear evidence of continued reviews of physical health with observations repeated, weight monitored and referrals made for specialist opinion when required.
- Overall, we found the care records to be in good order. Care plans were present in all but one case. For that patient only community care plans were evident. There was some evidence that staff had discussed general care goals with the patient in the collaborative plans section of the record. We found that care plans were personalised and included patients views and in all but three cases reflected the full range of patient's needs. One of these omissions was a cultural need raised by a patient who reported they were not receiving support requested for care of his skin and hair. This patient was from an Afro-Caribbean background and felt staff had not recognised the personal importance of this need. All care plans had clear goals and were recovery orientated reflecting the teams' commitment to the PIPA model and a short purposeful stay. In only two cases, we could not find evidence that staff had given copies of care plans to patients. Despite this, a common concern from inspectors on all sites was that the care plans, although reflecting some personalisation, relied heavily on wording found in the care plan library on RIO. This meant that some plans contained generic phrases and some clinical terms that did not reflect a patient's view of the world. At best, the care plans reflected a patient's opinion but interpreted into a clinical language. In one case where there was no patient involvement due to refusal, staff had not attempted to formulate care plans as if there were. Staff had written the care plan as a series of directives rather than in the first person, which would have suggested the plans were a collaborative effort between staff and patient.
- Advance decisions by patients about the care they wished to receive were evident in some care plans. However, it was not possible to determine whether staff routinely discussed these preferences with patients on admission or used notes from previous admissions and community teams.
- Throughout the service, RIO (an electronic clinical record system) is in use. This system was under ongoing development and was the system also used by the Trust's community service. Whilst this should have allowed timely access to information across services to aid admission and discharge planning some notes were not universally available to all clinical staff. At the time of our inspection, staff were moving care plans specific to the acute wards and PICU within RIO. They were moving the care plans from a restricted folder to one more generally accessible to other clinical staff. This was responsive to a request from community staff for access to promote continuity in care.

Best practice in treatment and care

- Across the service, we examined the medication records of 74 patients.
- With the exception of the guidance on rapid tranquillisation, trust policy and prescribing practice was in line with NICE guidance. Pharmacy staff conducted reviews and audits of medication use and highlighted any inconsistencies with NICE guidance as in the case of rapid tranquillisation discussed above. The trust had developed a 'High Dose Antipsychotic' monitoring form. Pharmacy staff used this to highlight to prescribers and nursing staff when patients were prescribed high doses of antipsychotics either alone or in combination. This was a useful tool, which helped prescribers in their clinical decisions for treating patients.
- In response to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) the trust had appointed a Medicine Safety Officer (MSO) who had the responsibility to oversee medication error incident reporting.

Are services effective?

Good

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.

- All of the wards had a psychologist as a member of their multidisciplinary team. They offered individual and group sessions for patients related to their needs and best practice guidance. Psychology staff also provided support for other team members and led on maintaining a formulation of a patient's needs that care plans from individual disciplines addressed.
- Where there was a need for specialist medical opinion and referral for physical healthcare, the ward staff would seek to prioritise appointments and provide transport and escorts as required to support patients.
- Clinical staff are able to monitor a patient's progress and the severity of their symptoms with recognised outcome scales that are stored in the electronic patient record. Beck's Depression Inventory (BDI) and the Brief Psychiatric Rating Scale (BPRS) were in regular use. Staff routinely measured the overall well-being of patients with the use of the Health of the Nation Outcome Scales (HoNOS). HoNOS also formed part of the Care Cluster Allocation Tool (CCAT) that staff completed to inform commissioners of the mix of clinical needs on the wards. Occupational therapy staff in the service had led on the introduction of the Model of Creative Ability (MoCA) first had St George's hospital and then across the service. The occupational therapy led introduction of the models of creative ability (MoCA) had equipped to staff to consider the levels of motivation and engagement with care plans and work with patients to identify personal strengths and hope for the future.
- The ward managers had introduced the Safewards model of care onto the wards. This model seeks to reduce incidents by reducing potential triggers through developing an understanding of another person's perspective. It focuses on improving communication between patients and staff and avoiding confrontations arising from misinterpretations. To develop the approach staff had organised a series of 'getting to know you sessions' with patients on the wards. Out of these workshops, staff had compiled a set of 'mutual expectations' that informed communication and behaviour on the ward. These included patience, mutual respect and taking time to listen as key to good relationships between staff and patients.
- Clinical staff from a range of professions (medical, nursing and therapists) had been involved in audits at the core service and local ward level.

Skilled staff to deliver care

- All the wards across the service were able to demonstrate input to patient care from the full range of mental health disciplines. Medical and nursing teams were present on all wards alongside occupational therapists and assistants, activity workers and psychologists.
- All new staff at the trust, permanent and bank, received a central trust induction upon appointment. Staff followed up on the general topics covered at the central induction with a ward specific local orientation and induction programmes.
- The trust has a policy that emphasises the importance of providing supervision to staff. It sets out that staff delivering clinical services, should attend a minimum of six managerial supervision sessions and twelve clinical supervision sessions annually that should last at least one hour on a monthly basis. Occupational therapy, occupational therapy assistants and activities organisers on the wards were involved in a supervision schedule that was up to date. Medical staff had individual and peer group supervision under the leadership of the medical director. The average (for Jan, Feb and March 2016) percentage of nursing staff having received monthly supervision on the wards (allowing for absences for sickness and leave) were; Laurel ward 53%, Pine ward 48%, Brocton ward 70%, Chebsey ward 68 % Norbury PICU 71% and West Wing 42%.
- The individual supervision records we reviewed on West Wing evidenced detailed discussions of personal issues and concerns, sharing of learning points and action planning for personal development. Ward managers and professional lead maintained supervision records and carried out audits at a local hospital level.
- The percentage of non-medical staff that had an appraisal in the 12 months to the end of February 2016 was 79%. The individual rates for the six wards were Laurel ward 81%, Pine ward 88%, Brocton ward 81%, Chebsey ward 81% Norbury PICU 67% and West Wing 80%.
- Appraisal rates across all professions were good and the trust had succeeded in embedding supervision as a routine part of reflective professional practice in all professions apart from nursing.

Are services effective?

Good

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.

- Each ward team had regular meetings to discuss developments across the service and issues on their individual wards.
- Across the service, there was additional specialist training available to clinical staff to meet the needs of their role. Clinical staff had identified some of these needs through reviews of past patient care. For instance, two episodes of caring for patients who had learning disabilities at Redwoods had highlighted a gap in skills around non-verbal communication. As a result, managers organised specialist staff training to improve staff communication skills with people whose verbal language skills might be limited.
- Ward managers, with the support of the Human Resources department, managed performance issues and sickness in a timely manner.

Multidisciplinary and inter-agency team work

- The acute inpatient service had adopted a common model of multidisciplinary team working that focused on providing shorter admissions that are more purposeful for patients. This model, purposeful inpatient admissions (PIPA), had the patient focused aim of getting you as well as possible, as quickly as possible with the least intervention.
- Each weekday, there was a meeting on each ward comprising of the multidisciplinary team to review the clinical state and risks of patients. After a brief discussion of each patient some the team highlight those in need of more in depth discussion. Each patient has traffic light rating (red, amber or green) assigned which relates to how ready they are to leave the hospital. Staff rated patients red they considered as still presenting a significant risk and need to remain on the ward, at amber patients are likely to be accessing community leave. If the team allocate a green rating that means there is active discharge planning in place to support the patient in returning home. Tasks were then allocated to team members in relation to each patient. This might be the need to see a doctor to review medication, or one to one time with their nurse or psychologist to discuss concerns. These tasks were tracked and outcomes reviewed at the next rapid review meeting. One consultant described the benefits of this model as decisions being more responsive to need and patient focused. Staff felt that having a dedicated consultant psychiatrist to lead each ward team had improved decision making on the wards. The previous system had relied on locality-based consultants, whose main role was in the community and were present to conduct in depth in patient reviews once a week at a ward round. This had meant that clinical decisions were delayed, as a patient's needs would change faster than the team could react with a new plan of care.
- Staff on Laurel and West Wing were generally positive about PIPA but had found that recent changes in consultant psychiatrist cover to the ward had undermined its effectiveness. Laurel ward was using a locum consultant for cover and a community psychiatrist was providing cover for West Wing at the time of our inspection. However, a Psychiatrist had been appointed in February and is due to commence work on West Wing at the end of June. The psychiatrist on Pine ward was due to leave his post the week following our inspection. This meant that only St George's Hospital had regular permanent psychiatrist in post although mangers told us they were actively recruiting to these three vacant posts.
- Clinical pharmacists were regularly involved in multidisciplinary team meetings to discuss patients' medicine requirements. The pharmacist answered concerns and gave advice about medicines, particularly any high dose antipsychotic prescribing. Nursing and medical staff told us that the pharmacist was a valued member of the multidisciplinary team.
- Crisis/home treatment teams were involved in or updated following the daily reviews.
- There was evidence of good working relationships with local acute hospitals and local authority safeguarding teams. There was also liaison with local police services whose officers regularly visited the hospital sites to discuss concerns with staff and patients.

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

- Across the service, 89% of staff had training in the Mental Health Act. West wing had the highest compliance with 100%, Brocton ward was 94% and the lowest was on Laurel & pine wards at 75%.
- When people were detained under the Mental Health Act (1983), we saw that the legal documentation for the treatment with medicines for mental disorder was

Are services effective?

Good

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.

completed accurately. We also found that checks were undertaken once a week by nurses to ensure that the treatment documentation was in date and completed accurately.

- .We saw that staff presented information on rights to patients detained under the Mental Health Act and informal patients at the point of admission. Staff continued to explain to patient's rights throughout an admission. On our last mental health act visit to Brocton ward in June 2015, we found that detained patients did not all understand their rights including their right to an independent mental health advocate (IMHA) and there was nothing in their notes to confirm they had been given information about this. On this inspection visit, we found that the information given to detained patients included information about the right to an IMHA. This updated information was available throughout the service.
- The trust has an administrative team dedicated to the maintenance of mental health act procedures and paperwork. Ward staff felt confident to seek their advice in regard to any queries about the MHA
- We found that staff filled in MHA paperwork correctly, stored it securely and regularly audited records for completeness. We were able to view copies of the paperwork on the electronic record system. The MHA administrators held the original documents and provided additional scrutiny of the paperwork. They prompted clinicians to make corrections and revisions as required.
- Each ward completed monthly returns on aspects of their compliance with the MHA. A trust wide Mental Health Act legislation committee reviewed the data the wards produced and set actions to improve areas highlighted as potential risks. For example, we saw in their minutes of the January meeting that work on recording consent to treatment had been prioritised following a rapid improvement workshop event in November 2015.
- The availability of the advocacy services who supported the different hospitals was well publicised and staff were clear about how to make a referral. Clinical staff on the wards felt the advocacy services were very responsive and offered valuable support to patients.

Good practice in applying the Mental Capacity Act

- We found that 84% of staff across the service were up to date with their mandatory training; this included the Mental Capacity Act.
- In interviews with clinical staff, we found that there was a good recognition of the five statutory principles of the MCA.
- Staff had made three DoLS application for patients in the past year. They all originated from Redwoods Centre and one was still in place during our inspection. We discussed one case with the ward manager of Pine ward. She explained how an application for DoLS had been chosen as representing the least restrictive option for holding a vulnerable young woman whose treatment was wholly psychological and so did not require the powers of the Mental Health Act to treat.
- There was a policy on MCA including DoLS, which staff were aware of on the trusts' intranet system.
- Doctors completed assessments of mental capacity regularly and recorded the results. We observed a good initial assessment of a patient that included capacity to consent. Capacity assessments had also been the focus of a Rapid Process Improvement Workshops (RPIW) led by staff on Brocton ward to improve the process that was being trialled across the service. We also saw assessments of informal patients' capacity to consent to admission. On Brocton ward there was a form in place for a young person (under 18) placed on the adult ward. Staff had offered them a referral to a specific children and young person's advocacy service but they had declined. We did not see evidence that Gillick competency was a routine consideration when staff admitted a young person under the age of 16 to the service.
- Advice regarding MCA, including DoLS, within the Trust was available from the mental health and mental capacity act specialists based on the two main hospital sites
- There were arrangements in place to monitor adherence to the MCA within the Trust through regular audit that had led to improvement plans.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff interacting with patients in a caring and compassionate way. Staff responded to people in distress in a calm and supportive manner.

When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.

- During our visits, we observed some positive interaction between patients and staff. We saw staff engaging with patients in a variety of ward-based activities. We heard staff talking with patients in a way that showed patient involvement.
- Some patients told us they did not feel staff considered their wishes and feelings, or listened to their concerns. However, most patients told us that staff did listen to them. One patient said staff were kind. Overall, patients were positive about staff and felt that they were caring.
- Three patients expressed concerns about the strong focus on planning discharge from clinical staff. They felt they were not being allowed enough time to heal before being moved out of the service.
- In 2015, the Patient Led Assessment of the Care Environment (PLACE) awarded scores to the three acute hospitals for privacy, dignity and wellbeing; Redwoods scored 95.8%, St George's hospital and the George Bryan Centre each scored 98.3%. All these were above the average result for all NHS trusts of 86%.

The involvement of people in the care they receive

- All the wards offered an introduction pack to newly admitted patients. This detailed the routines of the ward, meal times and a guide to staff. It included a leaflet about the ward, individualised for each patient, giving details of their care team. There were also rights information leaflets for both detained and informal patients.
- At the Redwoods Centre, information included expectations of behaviour on the ward and details of activities available on the hospital site. The sharing of expectations about behaviours was part of the ongoing Safewards initiative.
- Although we observed that patient involvement informed discussions, and most patients told us they believed staff listened to them, this was not always reflected in all care plans or progress notes.
- There was clear information about advocacy services on all the wards and advocacy workers regularly visited the wards.
- Carers received a welcome pack after their relatives had been admitted to the hospital. This included detailed information about the ward, support for carers and the complaints procedures. From the focus groups we held, we heard mixed reports from carers about their level of involvement in care on the wards. Some carers thought that staff did not always take seriously their specialist knowledge of their relatives and concerns about their wellbeing. Carers said staff sometimes cited confidentiality as the reason for not giving out information about their relatives even where patients had given permission.
- We found records of good discussions with carers, and invitations to care reviews. We also found notes indicating that staff shared care plans with carers.
- We reviewed minutes of the last three patients' meetings for adult acute wards and PICU. These showed that staff noted patients' concerns and ideas and responded by making changes or explaining why they could not take action.
- At Redwoods, a service user representative led weekly community meetings. This gave continuity to meetings. She followed up any concerns if the patients raising them were discharged before they were dealt with.
- Managers involved patients and former patients in decision making about service developments. Patients also took part in recruitment panels for staff up to the executive level of the trust.
- In reviews of case notes, we saw that advance decisions were in place for a minority of patients. On Brocton ward, we saw an initiative to improve this situation. Staff had introduced a patient journal that included a prompt to patients to discuss the option of making advance statements by talking to staff. It explained that advance statements would help a patient inform clinical teams about their wishes if they became unwell again.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Average bed occupancy over the six months between April and September 2015 was 92%; Brocton ward had the lowest occupancy; averaging 80%. Laurel ward at Redwoods had the highest average occupancy at 100% during that time.
- It was apparent that on some occasions there was a difficulty getting a bed at the Redwoods centre. As an alternative to moving patients out of area, the Crisis team admitted patients to beds at St George's hospital. Carers at one of our pre inspection focus groups reported that the staff at St George's were always very mindful of difficulties in travelling to Stafford and positively worked to support access and communication. One initiative to overcome difficulties in visitors accessing Redwoods from rural areas with poor transport links was using SKYPE on the wards.
- Using their rapid review process the wards were able to manage patient flow such that we were told that it was very rare that a patient would return from leave without a bed. When this had happened ward staff negotiated an extended leave if they assessed the patient as low risk. If they needed to return to the ward because things were not going well, spare capacity elsewhere in the service would be used to accommodate their immediate need to be back in hospital.
- There was a commitment from the hospital managers that a patients admission should be uninterrupted by moving ward or hospital. Continuity of care was prioritised within the PIPA model the trust had adopted. However, moves would be made to bring patients closer to home or if justified by particular risk or clinical considerations. Staff told us they always tried to involve patients in the decision making.
- Norbury ward at St George's Hospital at Stafford operated as the local Psychiatric Intensive Care Unit for the acute service. It received referrals from all five of the acute wards we inspected. In the six month period between September 2015 and the end of February 2016 17 transfers had been made to Norbury from the acute wards. One from both Pine and Laurel wards at redwoods, four from West Wing, five from Brocton and six from Chebsey.
- In the six months between April 2015 and September 2015, there were six delayed discharges from inpatient facilities. The ward with the highest number of delayed discharges was Chebsey ward with three declared delayed transfers of care.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a complaint common across the wards at St George's Hospital of a high level of noise on the wards. This was felt to be very intrusive and distracting by patients we spoke with on the ward. One patient wore ear defenders whilst on the ward as he found the levels of sound so distressing. On Norbury ward, three patients complained to us about the ward being too noisy. We spoke to a visiting carer with hearing difficulties who reported finding the ward environment stressful. Staff members also commented that the noise levels were not conducive to a relaxing environment. The trust was consulting on the future refurbishment of the wards at St George's hospital but there were no short term plans to address this problem.
- Each ward offered a range of rooms and equipment to support treatment and care. All wards offered a general lounge and also a female only lounge to sit in, socialise and watch television
- The service as a whole allowed access to mobile telephones so patients could keep in touch with carers, relatives and friends in the community. Public telephones were also provided and since our last visit, a privacy hood around a telephone for patient use had been installed in the day room on Brocton ward. On the occasions when the patient phone was broken, staff had facilitated patients using the office phone.
- All wards had access to outside space.
- In 2015, the Patient Led Assessment of the Care environment (PLACE) awarded scores out of a maximum 100% to the acute wards for quality of the food. The wards at Redwoods scored 99.6%, St George's 95.29% and the George Bryan Centre 100%. The national average score for the Ward-based food assessment across all sites was 89.3%
- All the acute wards had kitchens available to patients to make drinks and simple snacks (toast and cereal)

Are services responsive to people's needs?

Good

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

twenty-four hours a day. We were told that access was only ever limited if any individual patients were felt to be at risk of harm through unaccompanied access to boiling water.

- Patients are able to personalise their bedrooms with personal items and temporary decoration during their admission to hospital. Each bedroom provided a small key coded safe for storing valuable items. There was also a common policy in place across both hospitals about the management of personal items that could present a risk. For instance, staff kept mobile phone chargers in a separate locked cupboard with staff only access as the electrical lead could be a potential ligature. Patients would have to request staff support to charge their phones when required and staff used plugs in the ward office to do this.
- All patients on all wards had access to either small safes for valuables and lockers or other secure storage for personal items that were not routinely allowed on the ward. For instance, staff would lock away chargers for mobile phones whose leads could be used as a ligature and allow patients to recharge their phones from power points in the staff office.
- We saw activity plans for all the wards. There was a wide range of activities on offer, individual and group sessions, some with a therapeutic purpose and others to encourage social activity. Groups were concentrated on weekdays but there were also options available on evenings and weekends. On Norbury ward, we found that a multi gym had been provided for the use of patients. However, only 30 % of staff were trained at that time of inspection to supervise this activity. This limited its usefulness, as on some days it was wholly inaccessible to patients.

Meeting the needs of all people who use the service

- All of the wards across the service had ground level access that would allow patients with limited mobility or using a wheelchair to use the services without additional adaptations. Staff would allocate a wheelchair user one of the larger individual bedrooms available on each ward where toilet and bathing facilities can be readily adapted for their use.
- The trust had provided core information around services and MHA rights in languages other than English. Versions of information in additional languages were accessible for individual patients as required.
- Each ward inspected had plentiful information on local support services, advocacy and rights under the mental health act. In addition, there was information on how to complain or make a compliment. There was also information feeding back how the ward staff had responded to the concerns of patients and details of the improvements it had made as a result.
- Staff could access interpreters and/or signers to enable communication to meet a patient's clinical and social needs.
- Each site was able to offer patients access to menu plans designed to meet specific needs of the religious and ethnic groups likely to be admitted. Catering staff told us that further options could be made available for any individual needs that were not routinely covered.
- A chaplaincy service was available across all sites and rooms available for private worship.

Listening to and learning from concerns and complaints

- The total number of complaints received across the five acute wards in the 12 months prior to November 2015 was 25. This represented 21% of the total number of complaints received by the Trust in that time.
- One complaint had been fully upheld and nine complaints had been partially upheld. There had been no complaints either referred to or upheld by the parliamentary health service ombudsman (PHSO) during the above period.
- Patients told us they knew how to complain formally and said they were happy to raise issues at community meetings or directly with individual staff.
- There were leaflets and other information available on how to make a compliment, complaint, and advocacy details. There was a leaflet signposting patients and carers to the Patient Advice and Liaison Service, which was the trust's central point for dealing with concerns,

Are services responsive to people's needs?

Good

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

complaints and compliments. Managers had made this leaflet available on the ward and in the introductory packs given to patients and carers on admission to the wards.

- Staff know how to handle complaints appropriately and support patients in forwarding their concerns.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings.

Are services well-led?

Good

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

Our findings

Vision and values

- Across the service, we found that staff of all professions and grades knew the trust's visions and values. We also saw in the ward philosophy on Pine ward that the three core values were reflected in the team's objectives.
- Staff universally knew the trust's chief executive across all three hospitals. A majority of staff, across different professions and grades, could report some personal dealing with him.

Good governance

- We found that 84.1% of staff across the service were up to date with their mandatory training; that included updates on the Mental Capacity Act.
- There was evidence of local and clinical audits taking place and this was related to the relevant national institute for health and care excellence (NICE) guidance.
- The ward managers used key performance indicators, such as the number of discharges, to monitor the safety and success of their wards.
- We reviewed minutes from the last three patient meetings for each of the adult acute wards and PICU. Ward staff were able to raise concerns and we could see were they had been discussed by managers and changes made in response. Staff from the wards had also been involved in rapid improvement workshops and listening into action events, which had led directly to change.
- Staff reported that they felt involved and listened to by senior managers. Those who had attended a listening event felt that the discussions had been honest and open,

Leadership, morale and staff engagement

- General staff morale was positive with staff expressing confidence in local and trust wide leadership.
- There were no cases of bullying or harassment reported from this service.
- Staff knew how to use the whistle-blowing process but felt confident in being able to raise concerns without fear of victimisation.
- The trust was committed to an approach to service development and improvement based on the LEAN model and cited evidence from the UK and USA to support this. A key element of this approach was that managers should listen to staff and acknowledging their knowledge and expertise. The trust had run a number of rapid improvement workshops that staff of all grades attended and produced action plans to develop services. There was also regular listening into action events for staff to offer immediate feedback into service development plans. Staff felt empowered by this approach and morale was high on the wards visited.
- Each hospital had a modern matron in place as well senior clinical nurses as consultants and nurse prescribers. They mentored junior nursing staff and supported the nurse development programme for developing leaders at Band 6. Nurses on this development programme attended a leadership course run at Aston University to develop their skills and knowledge.
- Service managers had recognised the future recruitment of staff nurses to the wards as a significant organisational risk. Their nursing plan identified having a clear pathway for professional development as a priority for attracting and retaining nurses. The successes of this programme and the high profile of senior nurse practitioners was being used as part of their ongoing recruitment campaign to attract new nurses to the service.
- The daily rapid review meetings had brought together the different disciplines into strong teams committed to working for their patients. We heard positive comments from staff about the teams providing mutual support across professional boundaries. We also heard staff report nothing but respect for the work of other professions.
- Team members understood their responsibility to be open and candid about mistakes with patients and carers. Each ward could provide examples of how they had met their duty of candour and apologised for errors.

Commitment to quality improvement and innovation

- Norbury ward was in the process of undertaking the self- and peer-review stages of its first accreditation cycle for AIMS PICU.
- Occupational therapy staff had presented on the implementation of the model of creative ability across

Are services well-led?

Good

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.

adult acute mental health wards in Stafford to the College of Occupational Therapy in 2015. The allied health professional team were continuing to assess the implementation of this model onto the acute wards. Occupational therapists had introduced this model service wide after an initial trial at St George's Hospital.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust policy on rapid tranquillisation was out of date and did not reflect current prescribing guidance from NICE. Clinical staff have an inconsistent approach to the use of rapid tranquillisation, failing to understand its risks and record its use. This was a breach of Regulation 12 (2) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance Staff did not consistently record all the observations and reviews required to safeguard a patient when they were in seclusion. This was a breach of Regulation 17(2)(c)