Requires improvement

Coventry and Warwickshire Partnership NHS Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RYG58	Caludon Centre	Westwood, Spencer, Sherbourne, Swanswell, Hearsall	CV2 2TE
RYG79	St Michael's hospital	Rowans Ward, Larches, Willowvale	CV34 5QW

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership 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 Coventry and Warwickshire Partnership Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership 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?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
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 acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- The wards did not provide a safe environment. There were ligature risks in all wards. A ligature point is a fixed item to which a person could tie something for the purpose of self-strangulation. The trust had completed ligature risk assessments. However, there was no clear plan to help staff manage these risks. There had been a recent serious incident on one of the in-patient wards, which involved the use of a plastic bag, which was still under investigation. Wards had multiple blind spots where staff could not easily observe patients. In Larches, there was a plastic bag by the patient telephone, which was not in a part of the ward that staff can easily observe. This caused a risk to patient safety. Staff were unable to open the anti-barricade doors on one ward.
- The trust did not conform to standards for accommodating young people admitted to adult wards. Department of Health guidance says, 'A young person's sleeping area should be in a securely separated area of the ward away from the opposite sex. All young people should bathe and wash in privacy and in areas separate from the opposite sex.' The environment on Rowans ward did not meet this guidance for the young person on the ward. However, the inpatient wards only admit young people as an exception. The environment was based on commissioned services for adults.
- The trust was non-compliant with the Mental Health Act code of practice guidelines on single sex accommodation in their psychiatric intensive care units (PICU). Sherbourne ward had a mixed corridor. Rowans ward did not meet the mixed sex accommodation regulations. There were no separate bathrooms for women. There was no separate female lounge.
- There was one seclusion room available based on Sherbourne ward which required improvement.
- There were nurse call bells in the bedrooms and bathrooms on the wards. However, the bells were silenced. This meant that patients expecting a response from a call bell would not receive one. During the unannounced phase of the inspection, we returned to the wards. Call bells were activated. However, there remained confusion due to there being two systems. One had been deactivated. It was not clear which bell was working and which had been deactivated. However, the call bell in the bathroom in Larches was not working.
- Staff did not always print risk assessments, date them and place them in care records. Not all staff had access to the electronic risk assessment. Staff could not verify the risk assessments in the records were up to date.
- On Sherbourne and Westwood wards a second member of staff had not signed records for controlled drugs on five occasions. Controlled drugs are drugs that require additional controls because of their potential for abuse. The Standards for Medicines Management by the Nursing and Midwifery Council states 'It is recommended that for the administration of Controlled Drugs a secondary signatory is required within secondary care'.
- Some staff did not allow patients to access hot drinks on some wards after 9pm until the next morning. However, the trust advised there was a trolley with hot drinks available between 10pm and 11pm each night.
- Patients were unable to charge their mobile phones during the day on two wards.
- Patients on Larches and Willowvale wards were unable to access the garden freely at the time of inspection. Larches ward is upstairs. The trust advised the garden was closed for safety reasons due to its location. Informal patients also required a staff escort to the garden.

However:

- Staff were actively involved in clinical audit.
- Staff told us that the ward managers were known on the wards, approachable and supportive. Teams were cohesive and enthusiastic.

Summary of findings

- There were good systems for reporting, recording and reviewing complaints.
- Staff were passionate and enthusiastic about providing care to patients. We observed positive and meaningful interactions between staff and patients.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- Neither Rowans ward nor Sherbourne ward met the requirement to provide same-sex accommodation. There were no separate bathrooms for men and women on Rowans ward and there was no separate lounge. One bedroom corridor on Sherbourne ward was mixed sex. This meant that one gender had to walk passed bedrooms of the opposite gender to access their own space.
- Rowans ward was unable to provide a young person with a separate lounge due to the limited space on the ward. However, the inpatient wards will only admit young people as an exception. The environment was based on commissioned services for adults.
- There were ligature risks in all wards. A ligature point is a fixed item to which a person could tie something for the purpose of self-strangulation. The trust had completed ligature risk assessments. However, there was no clear plan to help staff to manage these risks. Wards had multiple blind spots from where staff could not easily observe patients. Staff were unable to open the anti-barricade doors on one ward.
- There were ten minutes allocated for handover between shifts. Staff reported there was insufficient time to handover up to 20 patients as well as carrying out an environmental check.
- Staff discarded medication waste into the sharps bins, which is not in line with guidance on the safe disposal of medication. Staff could not demonstrate they completed medicine reconciliation in a timely manner, as there were no indications on the charts for its completion.
- Patients were unable to access hot drinks after 9pm, until the following morning. On two wards, patients were unable to charge their mobile phones during the day. Staff displayed signs on the ward to this effect.
- Patients admitted to the first floor wards could not access outside garden space unless escorted by staff.

However:

- There were good processes for the storage, recording and administering of medicines. Clinic rooms were clean and tidy. Staff checked emergency equipment daily and it was in good working order. Staff had access to emergency medicine on all inpatient sites, supplied by the medicines management team.

Summary of findings

- Staff reported that ward managers were supportive when incidents occurred and held debriefs quickly for the benefit of staff and patients following incidents.
- Appropriate arrangements were in place for children visiting.
- Patients said they felt safe on the ward.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There were some discrepancies with Mental Health Act (MHA) paperwork, for example, staff did not offer a copy of section 17 leave forms to the patients.
- Staff did not fully complete patients' rights forms, under section 132 of the MHA. There was no evidence of staff reading detained patients their rights to have an Independent Mental Health Advocate (IMHA) upon admission to the ward.
- Medical staff had made errors on consent to treatment documents (T2 and T3 forms) on two wards, relating to three patients. Prescribing did not adhere to the agreed plan, which made the treatment invalid for the detained patients in question. We informed the doctor who corrected the form immediately.
- Staff completed care plans for patients. However, the quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs. There was evidence of care plans not being up to date on all acute wards. Staff did not always fully complete the physical health assessment on admission to the ward.

However:

- Mental Health Act paperwork was stored correctly and the trust had systems in place to ensure the detention paperwork was lawful.
- Patients had access to psychological therapies. The wards had a range of staff to deliver care and treatment to patients.
- Staff were actively involved in clinical audit.
- Sherbourne ward had a robust system to review physical healthcare needs weekly via implementation of a wellbeing clinic.

Are services caring?

Good

We rated caring as good because:

- Staff were passionate and enthusiastic about providing care to patients. We observed positive and meaningful interactions between staff and patients.

Summary of findings

- Patients called staff wonderful, respectful, warm and friendly.
- Patients said they had access to advocacy and we observed posters on the wall for advocacy services.
- Staff invited patients to the multi-disciplinary reviews, along with their family where appropriate.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Patients were actively involved in the running of the ward through a weekly community meeting.
- Sherbourne ward care plans demonstrated patient involvement in all records we reviewed.

However:

- Two patients on Willowvale said staff did not knock before opening the viewing panel to their room. This compromised their privacy and dignity.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Patients did not have keys to lock and unlock their bedroom doors.
- The bedrooms did not have secure space for patients to lock valuables. There was a cupboard where items could be handed to staff for safekeeping.
- One patient on Rowans had complained of a broken window latch in their bedroom, which meant they were very cold, particularly at night. Staff were unclear what action had been taken to resolve this. Inspectors reviewed this during the unannounced follow-up inspection. The window had not been repaired; however, staff were making every effort to resolve the issue.
- Staff left the viewing panels on bedroom doors open. Patients were unable to close the panels on several of the wards. This affected patient privacy and dignity.
- When patients returned from leave earlier than expected, the bed management team would transfer patients to other wards up to three miles away. This is disruptive to continuity of patient care.

However:

- Patient information leaflets were visible on all wards and covered a range of subjects including local services, advocacy and how to complain.

Summary of findings

- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs.
- Spiritual support was available to patients for a range of faiths. Information was visible on notice boards and patients used this service.
- There were good systems for reporting, recording and reviewing complaints.
- All wards had information on how to complain displayed and there were leaflets, which patients could access. Patients told us they knew how to complain. Staff confirmed they knew how to support patients to make a complaint.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address how to manage the risks. An unacceptable number of ligature risks remained on the acute wards.
- The trust used acuity tools to determine safe staffing levels. However, wards employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable to cover higher levels of patient need. Wards operated short of staff when bank or agency staff were not available.
- All staff expressed concern, particularly around changes to the roster system, planned new shifts and the ten-minute handover.
- At St Michael's hospital, staff said middle and senior management are rarely on site.
- Staff expressed concerned about the possible change of use of the site and what this would mean to them as there had not been any communication from senior management.

However:

- Ward managers confirmed they felt supported by their managers.
- Staff told us that ward managers were highly visible on the wards, approachable and supportive. Teams were cohesive and enthusiastic.
- Staff we spoke with was aware of their responsibilities to be open and honest with patients and families when things went wrong.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Coventry and Warwickshire Partnership Trust are part of the trust's acute division. The wards are situated on two sites, the Caludon Centre and St Michael's hospital.

The Caludon Centre is in Coventry and has four acute wards for adults of working age: Westwood, Swanswell, Spencer and Hearsall wards. These wards are single sex wards. They range from 14 beds to 20 beds.

The centre also has a psychiatric intensive care unit (PICU) on Sherbourne ward, which has 11 beds, and is a mixed sex ward.

St Michael's hospital in Warwickshire has two acute wards for adults of working age: Larches (male) and Willowvale, (female). It also has a PICU on Rowans ward with five beds and is a mixed sex ward.

Our inspection team

Our inspection team was led by:

Chair: Paul Jenkins, Chief Executive, Tavistock and Portman NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health, CQC

Inspection Manager: Margaret Henderson, Inspection Manager, mental health, CQC

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of 13 people: four inspectors, three specialist advisors (one consultant psychiatrist, and two nurses), two experts by experience and one Mental Health Act reviewer.

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

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 services, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- visited all wards at the two hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 37 patients who were using the service

Summary of findings

- interviewed eight ward managers
- spoke with 40 other staff members individually, including doctors, nurses, student nurses, activity co-ordinators, psychologists, pharmacists, administrators and support workers
- reviewed 42 care and treatment records of patients
- carried out a specific check of the medication management on all wards
- collected feedback from patients using comment cards and direct interview
- 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

All patients were positive about their care and treatment and felt that staff were compassionate and caring. Families and carers had the opportunity to be involved in care reviews. Patients told us they felt safe on the wards.

Six patients we spoke with told us there were not always enough staff on duty to allow them to engage in ward activities or access outside space.

Patients' views about the food were variable. Some patients we spoke with enjoyed the food, while others told us food was lukewarm and uninteresting. Patients felt safe, supported and said staff treated them with dignity and respect. Twenty-one of the 37 patients spoken with said there were enough activities on the ward.

Patients said staff did not always inform them of their rights on admission.

Thirty-three out of 37 patients we spoke with said they knew how to complain and felt able to raise concerns.

The latest patient led assessment of the care environment audit (PLACE) showed 99% for cleanliness at Coventry and Warwickshire. The trust scored higher than the England average for 2015, which was 98%.

The 2015 patient led assessment of the care environment audit (PLACE) showed 92% satisfaction for privacy, dignity and wellbeing for wards at Coventry and Warwickshire Partnership Trust. The trust scored higher than the England average for 2015, which was 86%.

Good practice

Sherbourne ward provided six hours protected time every six weeks to staff. The ward manager organised this time for local audit, specific training, peer supervision and psychology led patient discussions.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure adherence to the guidance on mixed sex accommodation.
- The trust must take action to remove identified ligature risks and ensure that ligature risk assessments contain plans for staff to manage risks.
- The trust must mitigate where there are poor lines of sight.
- The trust must provide young people with a separate room to sit in other than the bedroom area.

Action the provider SHOULD take to improve

- The trust should ensure that patients have been informed of their rights to access an Independent Mental Health Advocate (IMHA) under section 132 Mental Health Act (MHA) and that this is documented in accordance with the MHA code of practice.

Summary of findings

- The trust should ensure that consent to treatment documentation for patients detained under the Mental Health Act is completed correctly.
- The trust should ensure the safe disposal of waste medication.
- The trust should ensure blanket restrictions in relation to hot drinks and the charging of mobile phones are not in place, as per their own guidance. Restrictions should only be used when clinically justified.

Coventry and Warwickshire Partnership NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Westwood Ward Swanswell Ward Hearsall Ward Spencer Ward Sherbourne Ward	Caludon Centre
Rowans Ward Larches Ward Willowvale Ward	St Michael's hospital

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 did not record that they had informed patients of their rights to speak to an Independent Mental Health Advocate (IMHA) on the section 132 documentation. Posters and leaflets informing patients of their right to access the IMHA were visible on all wards and information was contained in the patients' admission packs. Staff were clear on how to access the service on behalf of patients.
- The trust delivered Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards training together. Figures provided by the trust showed 74% of staff were up to date with this training. The lowest ward was Swanswell ward with a 66% completion rate; the highest was Rowans ward with a 90% completion rate.

Detailed findings

- Medical staff had made errors on consent to treatment documents (T2 and T3 forms) on two wards, relating to three patients. Prescribing did not adhere to the agreed plan, which made the treatment invalid for the detained patients in question.We informed the doctor who corrected the error immediately.
- Staff did not record that they had offered a copy of Section 17 paperwork to patients or carers. Patients confirmed they were not asked to sign nor were they offered a copy.
- Staff completed Mental Health Act (MHA) initial detention paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with showed varying degrees of knowledge about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Between 1 July 2015 and 31 December 2015 53 applications for DoLS had been made on the acute wards.
- None of the patients receiving care and treatment during our inspection was subject to a (DoLS).
- There was some evidence in clinical notes that the multidisciplinary team had considered capacity during care reviews. The trust had procedures for assessing capacity for significant decisions for patients who may lack capacity.

Inadequate

Are services safe?

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

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

Our findings

Acute wards

Safe and clean environment

- Staff could not observe all parts of the ward on some wards. There were multiple blind spots. The trust had installed observation mirrors in some areas and not in others. Managers advised they managed risk by increased observations and individual risk assessment.
- There were multiple ligature risks in all wards. A ligature point is a fixed item to which a person could tie something for the purpose of self-strangulation. The trust had completed ligature risk assessments. Some risks identified included bedroom doors, bathroom handles, door handles, taps and sinks. However, there was no clear plan to help staff to manage these risks nor a record of any actions completed since the audit in June 2015.
- Staff could not find the key and were unable to open the anti-barricade doors on one ward. This was a risk to patient safety.
- The trust had robust processes for the storage, recording and administering of medication. Clinic rooms were clean and tidy. Staff recorded fridge temperatures daily but did not routinely monitor the temperature of the clinic room. The trust could not be sure that medicines were stored appropriately to ensure their quality and efficacy. Westwood Ward staff recorded the fridge temperature but it was out of range with no evidence of staff informing the pharmacist.
- Controlled drugs are drugs that require additional controls because of their potential for abuse. The Standards for Medicines Management by the nursing and Midwifery Council states It is recommended that for the administration of Controlled Drugs a secondary signatory is required within secondary care'. On Westwood ward, a second member of staff did not sign records for administration of controlled drugs on four occasions. Controlled drugs are medicines that require additional controls because of their potential for abuse. Staff disposed of waste medication into the sharps bin on all wards. Staff confirmed this was usual practise and inspectors witnessed this taking place. We also observed medication in the sharp bins. This was not in line with the Nursing and Midwifery Councils safe disposal of waste medication.
- There were no environmental action plans on any ward. Ward managers were unable to keep a track on any environmental issues and actions. This meant some works were slow to be resolved and the ward did not follow up in a timely manner.
- The latest patient led assessment of the care environment audit (PLACE) showed 99% for cleanliness at Coventry and Warwickshire. The trust scored higher than the England average for 2015, which was 98%.
- The inspection team noticed a broken boxing panel behind a toilet in Larches. Patients used the space behind the panel to dispose of cigarette ends and pushed paper down the gap creating a fire risk. We escalated the damage immediately to the ward manager. We returned the following week for an unannounced inspection and found that staff had arranged the repair of the boxing panel behind the toilet.
- Staff understood and followed the safeguarding systems across all the wards. All staff interviewed could identify what safeguarding was and what to do in the event of a concern. There was evidence of safe reporting and actions taken on all wards.
- At the Caludon Centre, nurse call systems had been turned to 'night mode' on two wards. This meant that no audible sound was made. Staff were unable to explain this. At the St Michael's hospital site, nurse call systems had been turned to 'disable' on Larches ward and were not working. This caused a risk to patients who may press the bell and reasonably expect a member of staff to respond. We returned the following week for an unannounced inspection at St Michael's hospital and found that the nurse call bell was working in all areas except the main bathroom on Larches ward. However, there remained confusion with the nurse call system as there were two systems in place. Staff told us one

Inadequate

Are services safe?

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

system had been de-activated but not removed or covered. This could be confusing for patients and staff and lead to unnecessary delays in patients receiving assistance from staff.

Safe staffing

- The trust told us recruitment to vacant positions was ongoing. The trust reported difficulties in recruiting into vacant positions for qualified nurses. The trust supplied data related to staff establishment and vacancies between 1 September 2015 and 30 November 2015. Spencer ward had the highest number of vacancies for qualified nurses with a vacancy of 4.6 qualified nursing posts.
- The trust used acuity tools to assess and monitor effective staffing levels. Ward managers stated that they were able to access extra staff when required. The staffing skill mix on Willowvale (a female acute ward) was lower than other wards. Willowvale had two qualified nurses for each shift during the day whereas other similar wards had three qualified staff. Staff were unable to explain why this was the case. Staff on the ward stated staffing was inadequate to safely support patients on the ward and support patients to use leave off the ward. There were up to four extra patients on the ward over the bed occupancy. These patients, if not on home leave, may sleep over on another ward and return to the ward during the day. This could mean up to 20 patients and 2 qualified staff. Willowvale also had the highest number of shifts unable to be filled by bank and agency between 1 September 2015 and 30 November 2015.
- Staff told us that Spencer ward was originally built as two separate wards, later combined into one. It was a large area and we were concerned that staffing levels might not allow staff to observe patients in all areas of the ward, or respond to patient needs in a timely manner.
- Staff on all wards told us they were not always able to facilitate leave off the ward with patients due to insufficient staff.
- There was significant use of bank and agency staff in all wards. The highest use of bank between 1 September 2015 and 30 November 2015 was on Hearsall ward with 300 shifts covered by bank or agency staff. The lowest figures are 135 bank and agency shifts used on Larches. The highest figures for shifts left uncovered were on Willowvale with 98 shifts worked below the required staffing. The lowest number of shifts left uncovered was on Hearsall with 22 shifts were the ward fell below required staffing. Not all wards had a clear system in place to ensure that the bank and agency staff had the appropriate handover to include use of alarms, risks and knowledge of their environment.
- Staff duty rotas allowed for a ten minute handover between shifts. There were up to 20 patients to safely handover in this time as well as carrying out an environmental check. All staff told this was insufficient. Staff often had to stay beyond the end of their shift to ensure information was shared correctly and safely.
- The trust required staff to complete mandatory training. The lowest completion of mandatory training was Swanswell ward with 75% up to the end of November 2015.

Assessing and managing risk to patients and staff

- The trust provided data for between 1 June 2015 and 30 November 2015, which confirmed there were three episodes of seclusion across the acute adult in patient wards. The trust reported no incidents of long-term segregation.
- There had been seven occasions when staff had used rapid tranquilisation across all six acute wards between 1 June 2015 and 30 November 2015.
- All staff understood to use least restrictive practice in any planned interventions. Care plan goals, however were not personalised. There were standardised care plans in place regarding using least restrictive means. In the care plans reviewed, they did not reflect the patient involvement or view.
- The trust supplied data which showed between June 2015 and December 2015 there were 99 incidents of restraint. Twelve resulted in the use of prone restraint. The highest use of restraint was recorded on Westwood ward with 27 incidents, six of which were in the prone (face down) position. The Department of Health guidelines, Positive and Proactive Care (2015) placed particular emphasis on the reduction of the use of prone restraint. The trust has implemented new training for staff in order to reduce the number of prone restraints used on the wards.

Inadequate

Are services safe?

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

- All ward staff interviewed stated that a debrief following an incident was carried out but not always by those involved. There was no documented evidence of this.
- Ward staff did not allow informal patients to leave the ward on request. An informal patient is someone who has not been detained and has the right to free access to and from the ward. Ward staff requested a review by a doctor and patients were unable to leave until that was undertaken. There was an informal leave form where informal patients have leave agreed in the same way as legally detained patients. The trust had an informal patient leave policy specifically for this patient group.
- Staff completed risk assessments for patients. However, staff had not updated the risk assessment for one patient following transfer from the psychiatric intensive care unit. Community staff completed another risk assessment two days prior to admission. Ward staff did not update this assessment on admission.
- Staff completed risk assessments on an electronic system. The current risk assessments were not always printed, dated and placed in the paper care records. Not all staff had access to the electronic risk assessment. Staff could not be sure, therefore, that the risk assessment in the paper records was the current one. This was a risk to patients and staff.
- On Larches, one patient's risk assessment stated there was no risk; however, the admission paperwork clearly stated risks. It is essential that risk assessments are accurate and current to reduce risk of harm to patients, staff and the public.
- The trust was a 'smoke free' site. Staff reported that incidents had increased directly as a result. Patients had hidden lighters and smoked indoors in bathrooms or bedrooms. There were incidents of increased anger and frustration directly because of the no smoking policy. The trust had provided alternatives such as smoking cessation plans and e-cigarettes.
- There were no seclusion facilities available on the acute wards. Seclusion is defined as "the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others". Staff referred patients who required seclusion to Sherbourne ward, the psychiatric intensive care unit (PICU).
- Staff did not allow hot drinks for patients after 9pm until the next morning on Larches and Willowvale. Patients were unable to charge their mobile phones during the day on two wards. Signs on the wall reminded patients of this. The trust was not aware of these practices.
- Patients on Larches were unable to access the garden at any time due to it being located downstairs. Informal patients required a staff escort to access the garden. Patients were able to use the garden unescorted once unlocked unless their individual risk assessment stated otherwise.
- There were safe procedures in place for children that visited the ward.

Track record on safety

- Trust information stated there were nine serious incidents reported from the acute and PICU wards.
- There had been a recent death in one of the in-patient wards, which involved the use of a plastic bag. The trust was conducting an investigation. In Larches, there was a plastic bag by the patient telephone, which was not in a high visibility area. This caused a risk to patient safety. Staff removed it when it pointed out to them.

Reporting incidents and learning from when things go wrong

- Staff described the electronic system used to report incidents and their role in the reporting process. Each ward had access to the online electronic system. All wards adhered to the system of reporting. Managers reviewed reports and conducted investigations at both local and senior management level.
- Clinical leads attended a monthly quality meeting where they discussed incidents and lessons learned. Ward managers took it in turns to attend. Some ward managers confirmed that they did not consistently receive information and were not able to share information with their teams. We saw outcomes of investigations were an agenda item for team meetings. Team meetings did not happen regularly due to the difficulties of shift patterns and handover times.
- Staff said their managers and senior managers were supportive when incidents occurred and debriefs were held quickly for the benefit of staff and patients

following incidents. Staff on Westwood ward told us that the senior management team offered support following a recent serious incident. Support included counselling, specific team meetings and individual staff support.

- Staff were able to give good account of the process for reporting drug errors, and shared learning from errors.

Psychiatric intensive care unit (PICU)

Safe and clean environment

- The layout of the psychiatric intensive care units (PICU) wards did not allow staff to observe all parts of the ward. On Sherbourne there were mirrors and an appropriate risk management plan.
- There were ligature points in both PICU wards. The ensuite bathrooms in Sherbourne bedrooms had doors which could be used for ligature purposes. Some staff were unaware of plans to change the doors. Following the inspection, the trust confirmed there was a rolling programme of installing anti-barricade doors, which the trust advised, would also address the anti-ligature issue. This was a risk to patient safety.
- The two PICU wards admitted both men and women. The trust was non-compliant with the Mental Health Act code of practice guidelines on eliminating mixed sex accommodation in their PICU. Both PICU, wards failed to meet the Mental Health Act code of practice paragraphs 8.25-6, which states that: "All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms." On Rowans ward there were no ensuite bedrooms. There was a bath and toilet, which both males and females used, and no separate lounge areas. All bedrooms were in the same corridor. The environment was very small with limited space. However, the trust managed risk with high staffing levels, which we observed during both the initial inspection and the follow up unannounced, which took place at night.
- The care environment on Sherbourne ward was more spacious, had separate lounge areas and bedrooms had ensuite facilities. During inspection, one corridor was mixed gender with individualised management plans in place. However, patients of one sex had to walk passed bedrooms of the opposite sex to reach their bedroom.
- On Rowans ward a young person under the age of 18 years did not have a separate lounge area away from other patients. This breached the Mental Health Act code of practice which states that a young person must have access to a separate lounge. However, the trust advised that inpatient wards only admit young people as an exception. The environment was based on commissioned services for adults. The patient had been on the ward for two months.
- The MHA code of practice states that seclusion should only take place in a designated seclusion facility that is not used for any other purpose. There was one seclusion room for the whole acute service based on Sherbourne ward (PICU). There was no two-way communication system and the patient had to shout through the door to communicate. There was a metal frame to the window in the toilet area, which had very sharp edges. The doorway into the seclusion room was very small and cramped which staff reported caused problems when trying to support patients into the room.
- There was no seclusion room on the St Michael's Hospital site, therefore patients requiring seclusion would be transferred to Sherbourne Ward in Caludon Centre.
- The PICU wards were generally clean, however we observed Rowans ward to have dirty bath.

Safe staffing

- Wards had good levels of staffing for safe care and treatment. Both teams reported feeling there were sufficient staff to meet patient need. We observed that there was also a significant use of agency, however there was a high number of patients on one to one observations requiring additional staff. This extra support was sourced using bank and agency staff.
- Wards used less bank and agency than the acute wards, unless patients were on level three observations (1 staff to 1 patient).
- Staff reported feeling safe and supported by the ward managers.

Inadequate

Are services safe?

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

Assessing and managing risk to patients and staff

- The trust provided data for between 1 June 2015 and 30 November 2015, which confirmed there had been 46 episodes of seclusion in Sherbourne Ward. Sherborne ward has the only dedicated seclusion room for the trust. The trust did not report any incidents of long-term segregation.
- Between 1 June 2015 and 30 November 2015 there were 159 incidents of restraint. 31 of those resulted in prone restraint. The highest use of restraint was on Sherbourne ward.
- Staff completed individual risk assessments for each patient. Medical staff considered leave as part of the patients' care plan. This helped in managing and reducing risk in preparation of return to the wards, or occasionally for discharge directly from the PICU.
- The wards had policies in place for children visiting and visits were risk assessed as appropriate.
- Staff completed a ligature risk assessments on both wards. Sherbourne ward plan was detailed and explained how staff managed risks. Rowans ward plan did not contain detail on how risks should be managed.
- Wards had an information folder for all staff with guidance on what to do if a patient was in seclusion.
- The trust provided data which showed between June 2015 and November 2015 the highest use of restraint occurred in Sherbourne ward (103) with 43 different patients followed by Rowans (56) with 16 different patients.
- Staff administered rapid tranquilisation on 18 occasions on Sherbourne ward and seven occasions on Rowans, for the same period. When staff administered rapid tranquilisation medication, all documentation was completed including physical health checks.

Track record on safety

- The trust provided data, which showed there were nine serious incidents reported from the acute and PICU wards.

Reporting incidents and learning from when things go wrong

- Sherbourne ward had a robust system in place to discuss lessons learned during staff protected time. There was evidence of lessons learned being a standard agenda item for staff team meetings.
- Wards had learning from incidents as a standard agenda item.
- There were no environmental action plans on any ward. On Rowans ward, one patient reported being cold as the bedroom window would not close properly. Staff had reported the problem to the estates department; however, the window latch had been broken for more than 10 days. Staff did not know when it would be repaired. The ward manager was not aware of the damage. Staff offered extra blankets at night to the patient, as there was no alternative room to offer. We escalated this to the ward manager.
- On Rowans ward, we observed a patient in the communal area sitting close to a portable radiator due to being cold. The radiator was too hot to touch but was two inches away from the patient. The patient was at risk of injury. We escalated this immediately to the ward manager.
- Staff did not check food temperature on Rowans ward. Staff checked it on the ward next door prior to arrival on the ward. Patients told us the food was not always warm.
- There were processes for the storage, recording and administering of medication. Clinic rooms were clean and tidy. Staff recorded fridge temperatures daily but did not routinely monitor the temperature of the clinic room. Staff could not be sure that medicines were stored appropriately to ensure their quality. Medicines, including controlled drugs, were stored securely.
- On Sherbourne ward a second member of staff did not sign records for controlled drugs on one occasion. Controlled drugs are drugs that require additional controls because of their potential for abuse.The Standards for Medicines Management by the Nursing and Midwifery Council states It is recommended that for the administration of Controlled Drugs a secondary signatory is required within secondary care'.

Inadequate

Are services safe?

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

- There was a practice across all the wards of disposing of waste medication into the sharps bin. Staff left discarded medication on work surfaces in the clinic room on Sherborne ward. For example, a blue capsule was in a medicine pot and a strip of paracetamol tablets was on the worktop.
- We found clinical pharmacists were involved in patients' individual medicine requirements, including involvement in multi-disciplinary meetings. Prescription charts were clear and well documented with pharmacist interventions documented on the chart.
- We saw effective arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them. If patients were allergic to any medicine, this was recorded on their prescription chart.

Are services effective?

Requires improvement

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

Our findings

Acute wards

Assessment of needs and planning of care

- Staff carried out comprehensive and timely assessments following admission to the ward.
- Staff completed and recorded physical health examinations and assessments on admission. However, assessments were incomplete.
- Staff monitored physical observations and physical health problems. Staff discussed physical health needs at weekly multi-disciplinary team meetings and physical health needs were considered in some care plans. Staff did not apply this consistently in all care records reviewed.
- The quality of care plans was variable. Many care plans were not holistic, for example, they did not include the full range of patients' problems and needs. There was evidence of care plans not being up to date on all acute wards. Care plans were generic and did not always consider patient views.
- Patients had signed a copy of the care plan; however, there was no evidence of staff offering a copy for them to keep. Patients told us that staff did not offer them a copy.
- Patient identifiable information was stored safely and securely.
- A 17 year old was on an acute ward and had been there for two months. The ward manager could not find any evidence in the notes of an initial assessment by the children and adolescents mental health services on admission, which is a requirement. There was input from a nurse by Children's and Adolescent services the following day. The trust notified the Care Quality Commission of the admission.

Best practice in treatment and care

- Staff made referrals for assessment and treatment for physical healthcare needs to the local acute hospital.
- We reviewed the medication administration records of all patients. Medical staff prescribed medicines in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Prescription charts were clear and well documented with pharmacist interventions documented on the chart.
- We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them. If patients were allergic to any medicine, staff recorded it on their prescription chart.
- Medicines were stored securely and within safe temperature ranges. Staff regularly carried out audits to ensure safe storage.
- Staff carried out regular checks on emergency equipment to ensure it was safe for use at any time.
- Access to medicines was good and medicines for discharge were available
- The trust monitored and audited Staff participated in clinical audit on either a weekly or a monthly basis. We saw examples of audits for infection control, medication, and physical health checks.
- Psychological therapy was available on all wards.
- Staff completed health of the nation outcome scales (HoNOS). Staff used HoNOS scores to allocate patients to pathways of care, known as 'clusters', based on groups of patients with similar diagnosis and individual needs.

Skilled staff to deliver care

- Ward staff consisted of nurses, psychiatrists, occupational therapists, health care support workers, activity co-ordinators, pharmacists and psychologists. This meant that patients had access to a variety of skills and experience for care and treatment.
- New staff underwent a formal induction period to teach them about the ward and trust policies.
- Ward staff participated in supervision. The ward manager and deputy ward managers supervised their junior colleagues. All wards reported difficulties in finding time to undertake this. Ward managers all kept

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.

local records that demonstrated staff received supervision but not as frequently as trust policy required. Staff told us that informal supervision took place. However, this was not documented.

- Appraisals a method by which the job performance of an employee is documented and evaluated. The trust provided data which showed completed appraisal figures for non-medical staff on the acute wards for the 12 month period from November 2014 to November 2015. The lowest figure of 80% completion was in Hearsall ward and the highest 100% in Willowvale ward.

Multi-disciplinary and inter-agency team work

- Staff held ward reviews, which included nurses, patients, psychiatrists and carers. Staff invited other members of the multi-disciplinary team to attend reviews, to include occupational therapists, psychologists, pharmacist and community teams. However, staff told us that these professionals did not regularly attend.
- Staff told us ward handovers were ten minutes in duration. Staff were concerned that it was not possible to handover up to 20 patients safely.
- Occupational therapists and psychologists worked across all wards. We saw that they worked effectively with patients and the multi-disciplinary team, community teams and crisis teams.

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

- The trust provided Mental Capacity Act (MCA) training combined with Mental Health Act (MHA) training and Deprivation of Liberty Safeguards (DoLS) training. The lowest completion of training was 66% on Swanswell, the highest on Willowvale, 89%. The figures demonstrated a wide variance in meeting this requirement. None of the wards met the trust target of 95%.
- We observed all MHA detention papers were completed correctly, up to date and stored appropriately.
- There was no evidence on the Section 17 forms that staff offered patients a copy of the paperwork. Section 17 paperwork describes leave arrangements for patients completed by the consultant psychiatrist in charge of the patient's care. Providers have a legal obligation to ensure patients know their rights. Staff must offer patients a copy of the form. Staff must tick the form and a patient must be given the opportunity to sign the form.
- Medical staff completed consent to treatment and capacity requirements. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA. However, on Westwood ward the legal documentation for one patient detained under the MHA had not been completed accurately on the T3 form. We informed the consultant on the day, who immediately amended the paperwork.
- Patients on Westwood, Larches, Swanswell, Spencer and Willowvale all said they did not receive information on their rights under the Mental Health Act (MHA) on admission. This had been identified during previous Mental Health Act review inspections. Patient feedback confirmed that not all staff informed them of their rights upon admission.
- There was information on the wards informing patients on how to access advocacy services. Care records showed patients were using the advocacy service.

Good practice in applying the Mental Capacity Act

- We saw capacity statements in the patients' contemporaneous notes, however they were hard to find and not consistently reviewed.
- There was a completed formal capacity assessment in one set of notes on Westwood ward. However, it had been completed on a PICU prior to transfer. On Westwood ward, staff completed a capacity assessment form incorrectly. The form did not specify the purpose of the assessment.
- Staff had varying degrees of knowledge about Deprivation of Liberty Safeguards (DoLS). Between 1 July 2015 and 31 December 2015, one application for DoLS had been made on the acute wards.

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.

Psychiatric intensive care unit (PICU)

Assessment of needs and planning of care

- Staff monitored physical observations and physical health problems. Staff discussed physical health needs at weekly multi-disciplinary team meetings and physical health was considered in some care plans. Staff did not apply this consistently in all care records reviewed.
- Staff on Sherbourne ward completed care plans which demonstrated collaborative, person centred care planning. Patients were actively involved in the development of their care plans.
- Patient identifiable information was stored safely and securely.
- A 17 year old was on Rowans ward and had been there for two weeks. There was evidence of the ward manager seeking a more appropriate bed, and there was involvement with the children and adolescence mental health services. The bed management team had been unable to secure a more appropriate placement and the young person remained on PICU.

Best practice in treatment and care

- Staff made referrals for assessment and treatment for physical healthcare needs to the local acute hospital.
- Three patients with a diagnosis of emotionally unstable personality disorder were being cared for on Rowans ward. There was a lack of evidence with regards to effective care planning with this disorder as per NICE guidance CG78. The guidance states specifically that "Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person)." There was no evidence of collaborative multidisciplinary care planning in the patients records.
- We reviewed the medication administration records of all patients. Medical staff should prescribe medicines in accordance with the NICE guidelines. On Rowans ward, prescribing for people with borderline personality disorder was not in line with NICE guidelines (CG78 Guidance 1.3.5).There was evidence of prescribing more than one anti-psychotic which has little evidence of increased efficacy over the use of one antipsychotic with 4 out of 5 patients.
- The consultant psychiatrist on Sherbourne ward delivered a weekly wellbeing clinic for patients.
- The trust monitored and audited other o Staff participated in clinical audit on either a weekly or a monthly basis. We saw examples of audits for infection control, medication, and physical health checks.
- Psychological therapy was available on both wards.
- Staff completed a health of the nation outcome scales (HoNOS). Staff used HoNOS scores to allocate patients to pathways of care, known as 'clusters', based on groups of patients with similar diagnosis and individual needs.

Skilled staff to deliver care

- Ward staff consisted of nurses, psychiatrists, occupational therapists, health care support workers, activity co-ordinators, pharmacists and psychologists. This meant that patients had access to a variety of skills and experience for care and treatment.
- New staff underwent a formal induction period to teach them about the ward and trust policies. A student nurse reported feeling well supported and enthusiastic about the placement.
- Ward staff participated in supervision. The ward manager and deputy ward managers supervised their junior colleagues. All wards reported difficulties in finding time to undertake this. Ward managers all kept local records, which demonstrated staff received supervision but not as frequently as trust policy required.
- On Sherbourne, the ward manager had implemented a system in which all staff received six hours protected time every six weeks. Staff used this time for group supervisions, ward audits, training and shared learning from incidents.
- Trust data showed completed appraisal figures for nursing staff on the acute wards for the 12 month period

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.

from November 2014 to November 2015. Rowans ward completed 100% of appraisals and Sherbourne 92%. Appraisal is a method by which the job performance of an employee is documented and evaluated.

- Wards had occupational therapy and psychology staff, able to offer two or three sessions per week for patients.
- Wards had an activity coordinator, offering two or three sessions per week for patients.

Multi-disciplinary and inter-agency team work

- Sherbourne ward evidenced strong multi-disciplinary work. Staff made referrals to other services to meet patient need and we saw evidence of this. On the day of inspection, a patient transferred to a specialist service best supported to meet their needs.
- Wards had doctors, nurses, occupational therapist, psychologists, community teams and carers all involved in patients' care.

Adherence to the MHA and the MHA Code of Practice

- The trust provided Mental Capacity Act (MCA) training which combined with Mental Health Act training.Ninety percent of staff on Rowans and 89% on Sherbourne completed this training.
- All wards stored mental health act paperwork in line with policy.
- Forms reviewed on Rowans did not evidence that staff advised patients of the Section132 right to an Independent Mental Health Advocate (IMHA). Paragraph 6.15 of the Code of Practice clearly states that hospital managers to inform qualifying patients of their right to an IMHA "as soon as practicable after they are detained". We also noted this was raised during previous Mental Health Act review visits.
- Medical staff completed consent to treatment and capacity requirements. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA. However, on Westwood ward the legal documentation for one patient detained under the MHA had not been completed accurately on the T3 form. We informed the consultant on the day, who immediately amended the paperwork.

Good practice in applying the MCA

- Staff completed capacity assessments and recorded outcomes in all care records reviewed.
- Staff demonstrated knowledge and understanding of the Mental Capacity Act.
- Staff supported patients to make decisions on a day-to-day basis.
- We observed staff offering choices and communicating at a level appropriate to the patients' level of understanding.

Good

Are services caring?

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

Our findings

Acute wards

Kindness, dignity, respect and support

- We spoke with 31 patients receiving care and treatment on the acute wards and observed how staff cared for patients. Many patients told us staff were kind and compassionate.
- We observed staff interactions with patients. Staff were responsive to patient needs, discreet and respectful. We observed good relationships between patients and staff on all wards.
- Staff were passionate and enthusiastic about providing care to patients. We observed positive and meaningful interactions between staff and patients.
- Patients called staff wonderful, respectful, warm and friendly in the majority of cases.
- All patients spoken with disliked the limited access to hot drinks and not being able to have a hot drink after 9pm on some wards.
- There was a sign on the wall advising patients on Larches that they could only charge their mobile phones at night.
- The 2015 patient led assessment of the care environment audit (PLACE) showed 92% satisfaction for privacy, dignity and wellbeing. The trust scored higher than the England average for 2015, which was 86%.

The involvement of people in the care that they receive

- Staff discussed patients' needs in their care planning meetings and records showed this. However, overall, care plans contained little evidence of patient involvement with the care planning process. For example, care plans did not contain patients' views.
- Patients signed their care plans in the majority of cases. However, patients and staff confirmed staff did not routinely offer a copy of their care plan.
- Patients said they had access to advocacy. Wards had posters on the wall to inform patients of advocacy services.
- Staff invited patients to the multi-disciplinary reviews, along with their family where appropriate.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Patients were actively involved in the running of the ward through a weekly community meeting. Staff recorded minutes of community meetings.

Psychiatric intensive care unit (PICU)

Kindness, dignity, respect and support

- We spoke with six patients receiving care and treatment on the psychiatric intensive care unit (PICU) and observed how staff cared for patients. All patients told us staff were kind and compassionate.
- We observed staff interactions with patients. Staff were responsive to patient needs, discreet and respectful. We observed good relationships between patients and staff.
- Patients said staff were visible, respectful and polite. One patient said staff were absolutely fantastic.
- One patient on Sherbourne ward felt unsafe on the ward and preferred to stay in their bedroom.
- Staff showed good knowledge of the care and treatment needs of patients on an individual basis, for example, re-directing patients towards meaningful activity during periods of agitation and distracting patients away from situations that were stressful to them. We observed kindness and understanding towards patients.
- The wards had a calm and relaxing atmosphere.
- Staff understood the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.
- The 2015 patient led assessment of the care environment audit (PLACE) showed 92% satisfaction for privacy, dignity and wellbeing for wards. The trust scored higher than the England average for 2015, which was 86%.

The involvement of people in the care they receive

- Staff discussed patients' needs in their care planning meetings and records showed this.

Good

Are services caring?

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

- We reviewed eight care and treatment records. Staff completed personalised care plans. Patient views on their care and treatment were recorded in their own words. This was particularly evident on Sherbourne ward.Patients signed their care plans. However, there was no evidence that a copy of the care plan had been given to the patients. Patients confirmed they did not get a copy offered routinely.
- Patients were aware of the advocacy services. Posters containing advocacy information and contact details were visible on wards.
- Staff invited patients to the multi-disciplinary reviews, along with their family where appropriate.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Patients were actively involved in the running of the ward through a weekly community meeting. Staff recorded minutes of community meetings for future reference.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Acute wards

Access and discharge

- The trust provided data which showed bed occupancy was high on all wards. There were no empty beds. Trust figures for 1 June 2015 to 20 November 2015 demonstrated that all acute wards were above 100%. Spencer ward had the highest occupancy of 121% and Larches and Willowvale were both 106%.
- There were 14 patients placed out of area between 1st April 2015 and 29 February 2016. At the time of the inspection April 2016, there was one patient placed outside of the Trust.
- Staff on Willowvale advised there were six patients awaiting admission.
- There were 20 patients admitted to Willowvale ward. The ward had 16 beds. This meant that patients were admitted into beds while patients were on planned leave. Staff told us when patients returned from leave earlier than expected, the bed management team would transfer patients to other wards up to three miles away. This is disruptive to continuity of patient care.
- The crisis team were able to support wards with early discharge arrangements to help with flow through and patient safety.
- The trust provided data which showed there were 81 delayed discharges in the eight-month period up to 30 November 2015 and 51 readmissions for the same period.

The facilities promote recovery, comfort, dignity and confidentiality

- All acute wards were single sex.
- There was no separate lounge allocated for a young person on one acute ward as recommended by the Mental Health Act code of conduct. However, the inpatient wards only admit young people as an exception. The environment was based on commissioned services for adults.
- On Larches ward we found one bathroom out of order. Staff had reported this in the maintenance log on 11 April 2016. During the unannounced follow up inspection, we observed the bathroom was still out of action. Staff could not be sure whether the bathroom had been repaired. The ward had three separate maintenance logs, all running contemporaneously. Staff told us this was confusing. Maintenance staff did not sign to indicate whether work had been completed. Staff were not, therefore, aware if the bathroom was now ready for patient use. Staff advised they could contact the maintenance team by telephone during the day, if needed.
- The patient led assessments of the care environment (PLACE) scored 92% for ward food at Caludon Centre and 87% at St Michaels Hospital. The England average for 2015 was 89%.
- Staff left the viewing panels on bedroom doors open. Patients were unable to close the panels on several of the wards. This affected patient privacy and dignity.
- Patients did not have keys to lock and unlock their bedroom doors.
- The bedrooms did not have secure space for patients to lock valuables. There was a cupboard where items can be handed to staff for safekeeping.
- Wards had a quiet area where patients could meet visitors.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and patients gave examples of actions taken to meet these needs.

Meeting the needs of all people who use the service

- Wards had facilities to meet the needs of patients with disabilities, for example, assisted bathrooms.
- Patient information leaflets were visible on all wards and covered a range of subjects including local services, advocacy and how to complain.
- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs.
- Spiritual support was available to patients for a range of faiths. Information was visible on notice boards and patients used this service.

Are services responsive to people's needs?

Requires improvement

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

Listening to and learning from concerns and complaints

- All wards had information on how to complain displayed and there were also leaflets which patients could access. Patients when asked during inspection said they knew how to complain.
- Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint. Staff confirmed they knew how to support patients to make a complaint.
- Ward managers told us they shared learning amongst their staff via staff meetings and communications. The number of complaints received for all eight wards was 12 in total in the 12 month period between 1 December 2014 and 30 November 2015.

Psychiatric intensive care unit (PICU)

Access and discharge

- The trust provided data which showed bed occupancy on Sherbourne ward was 90% and Rowans was 94%.
- The trust did not provide data individual to this ward regarding delayed discharges.
- Senior staff told us that, due to bed pressures, the trust had admitted patients to the PICU, who did not meet the admission criteria. The trust has a duty to consider the least restrictive environment when admitting patients to wards. It is not appropriate for patients to be admitted to a more secure environment if not clinically indicated. We observed a poster on the office wall advising staff on what to do in this event. Senior staff told us patients were moved to a more suitable environment at the earliest opportunity.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had easy access to outside space on both wards. Sherbourne ward had gym equipment in the garden.
- The patient led assessments of the care environment (PLACE) scored 92%for ward food at Caludon Centre and 87% at St Michaels Hospital. The England average for 2015 was 89%.
- The ward had locks on the main entrances with entry and exit controlled by staff. An air lock system operated, where staff closed one door before opening the other.
- Sherbourne ward had a range of rooms for care and treatment including quiet rooms, an activity room and a clinic room. The ward had rooms where patients could meet visitors in private.
- Both wards had phones for patients' use. Patients could make a phone call in private. Patients could also use mobile phones, following a risk assessment.
- One patient on Rowans had complained of a broken window latch in their bedroom which meant they were very cold, particularly at night. There was poor communication on action taken and eventually we confirmed that staff had reported the window to the maintenance team. However, the window was still broken. This had been ongoing for two weeks. We returned for an unannounced inspection one week later and found the window issue had not been resolved but staff and maintenance department were making every effort to resolve the problem.
- Patients had access to hot drinks and snacks at set times throughout the day. Staff responded to individual requests outside of these times.
- Patients had their own sleeping accommodation with ensuite facilities on Sherbourne ward. Patients' bedrooms were unlocked, meaning anyone could access patients' bedroom at any time. Patients could request that staff could lock their room. However, this would also restrict their own access, as the patient would then need staff to respond promptly to a request for the room to be unlocked.
- Patients could store their personal possessions in lockers provided outside of their bedrooms, however they did not have keys to this space.
- Patients told us the food was of good quality.
- We saw the ward had an activity programme. Patients on all wards said there were activities. However, they also said that activities may be cancelled due to staffing and that there were not enough.

Meeting the needs of all people who use the service

- We spoke with six patients receiving care and treatment on the PICU wards and observed how staff cared for patients. All patients told us staff were kind and compassionate.
- There was no separate room available for the young person on Rowans ward.
- Rowans ward did not accommodate separate areas for male and female patients.

Are services responsive to people's needs?

Requires improvement

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

- Patients were able to access their own mobile phones or access one provided by the ward.
- There was access to the garden. In Sherbourne there was gym equipment in the garden for patients to use.
- There was a room available for visitors.
- Patient information leaflets about local services, advocacy and how to complain were available.
- Spiritual support was available to patients for a range of faiths. Information was visible to staff in nurses' offices and some patients used this service.
- We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

Listening to and learning from concerns and complaints

- All wards had information on how to complain displayed and there were leaflets which patients could access. Patients we spoke with knew how to make a complaint. Staff confirmed they knew how to support patients to make a complaint.
- The trust provided data, which showed there were 12 complaints between 1 December 2014 and 30 November 2015 and March 2016.
- Ward managers told us they shared learning amongst their staff via staff meetings and communications.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Staff we spoke with were aware of the trust's vision and values. There were posters on wards and in corridors with the vision and values displayed.
- Staff were able to tell us who the most senior managers in the trust were, and said they had visited the wards.
- Two senior staff told us the chief executive had had a positive impact and they felt they were developing trust in him.

Good governance

- The trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and an unacceptable number of ligature risks remained on the acute wards. The risk assessment did notaddress how to manage the risks, many stating the word 'manage' next to the ligature point.
- The trust had procedures for raising safeguarding concerns for patients.
- The trust had procedures for implementing, recording, storing and auditing Mental Health Act paperwork.
- Staff received supervision, however this was not regular and consistent. All ward managers reported it was difficult to find time to support supervision.
- Staff received appraisals. The trust provided data which showed appraisal completion on Rowans ward for the 12 months to 30 November 2015 was 100%. On Sherbourne, it was 92%.
- The trust used acuity tools to determine safe staffing levels. However, wards employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable to cover higher levels of patient need. There was a high reliance on the use of bank and agency staff and, on occasion, wards operated short of staff when bank or agency staff were not available.
- Individual patient risk assessments were not always printed, dated and placed in care records. Not all staff had access to the electronic risk assessment. Staff could not verify the risk assessments in the records were up to date, as the date of completion did not show on the printed version.
- Staff participated in clinical audit and had access to clinical dashboards, which provided information about completion of clinical documentation such as care plans and risk assessments.
- The trust had developed reports to monitor performance. Five out of six ward managers were able to demonstrate knowledge and involvement in inputting and using the report.

Leadership, morale and staff engagement

- The ward managers confirmed they felt supported by their managers. Most staff felt supported by their ward manager. However, staff did not feel listened to by the senior trust managers.
- Staff told us that the ward managers were highly visible on the wards, approachable and supportive. Teams were cohesive and enthusiastic. Staff told us that they felt part of a team and received support from each other.
- Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.
- All staff expressed concern, particularly around changes to the roster system, planned new shifts and the ten minute shift handover.
- At St Michael's, staff told us middle and senior management were rarely on site. Staff expressed concern about the possible change of use of the site and what this would mean for them. There had not been any communication from senior management.

Psychiatric intensive care unit (PICU)

Vision and values

- Staff we spoke with knew of the trust's vision and values. There were posters on wards and in corridors with the vision and values displayed.
- Staff told inspectors who the most senior managers in the trust were, and said some had visited the wards.

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.

Good governance

- The trust had procedures for raising safeguarding concerns for patients.
- The trust had procedures for implementing, recording, storing and auditing Mental Health Act paperwork.
- The trust supports supervision for staff. Sherbourne had well considered arrangements in place to support and develop staff.
- The trust used acuity tools to determine safe staffing levels. However, wards employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable to cover higher levels of patient need. There was a high reliance on the use of bank and agency staff and, on occasion, wards operated short of staff when bank or agency staff were not available.
- Staff participated in clinical audit and had access to clinical dashboards, which provided information about completion of clinical documentation such as care plans and risk assessments.
- The trust had developed dashboards to monitor performance. Both ward managers were able to demonstrate knowledge and involvement in inputting and using the dashboard.

Leadership, morale and staff engagement

- The ward managers confirmed they felt supported by their managers. Staff felt supported by their ward manager and felt they valued their work. Staff told us that they felt part of a team and received support from each other.
- Staff told us that the ward managers were accessible on the wards, approachable and supportive. Teams were cohesive and enthusiastic.
- Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.
- All staff expressed concern regarding change to the roster system, planned new shifts and the ten-minute shift handover.
- Staff said they did not feel listened to by senior managers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Wards and courtyard areas had potential ligature points that had not been fully managed, mitigated, or addressed. • Some wards had poor lines of sight. Staff could not easily observe patients. **This was a breach of Regulation 12 (1)(2) (a)(b)(d)(e)**