

Requires improvement

Avon and Wiltshire Mental Health Partnership NHS
Trust

Wards for older people with mental health problems

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)
RVNEQ	Callington Road Hospital	Aspen and Laurel Wards	BS4 5BJ
RVN9A	Fountain Way	Amblescroft North and Amblescroft South Wards	SP2 7FD
RVN4B	Longfox Unit	Cove and Dune Wards	BS23 4TQ
RVN2B	St Martins Hospital	Ward 4	BA2 5RP
RVNCE	Victoria Centre	Hodson and Liddington Wards	SN3 6BW

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS 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.

Summary of findings

Where applicable, we have reported on each core service provided by Avon and Wiltshire Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health Partnership NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

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 Wards for older people with mental health problems as requires improvement because:

- There were not sufficient staff numbers to meet the needs of people using the services. There was a high level of qualified nurse vacancies on some wards with no psychology input.
- Levels of emergency response training and practical patient handling training were low.
- Staff did not consistently adhere to Mental Health Act legislation and standards described in the Mental Health Act (MHA) 1983 code of practice.
- Staff completed mental capacity assessments but did not document decision specific assessments.
- Staff were inconsistent when reporting of incidents.
- Staff did not always follow agreed actions or involve patients in care plans.
- Staff did not all use the health of the nation outcome scales for over 65s. They were not consistently monitoring patient's outcomes.
- Multidisciplinary team meetings did not all have a full range of professions.

- The standard of the environments was variable. They were not all “dementia friendly”. Safety alarms were of variable quality or were not available. Some bedroom windows did not protect patient’s privacy and some patients slept in dormitories.

However:

- There was a recruitment plan in place to address shortages of qualified nurse vacancies.
- Staff met the mandatory training targets set by the trust in most subjects.
- Medicines management was effective throughout the services. Where medicines were kept on site, they were stored, monitored and audited safely.
- All patient files contained holistic, patient centred care plans.
- All wards had access to physical health care for patients. Staff assessed physical health on admission and monitored it frequently.
- Staff were very caring and demonstrated a high level of positive regard and respect to people accessing the services.
- Staff confirmed that they felt comfortable raising concerns with managers and were able to use the trusts whistle blowing process.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- The ligature risks to patients had been mitigated on the majority of wards, but a risk assessment for ligatures had not been completed in a timely manner on Cove and Dune ward. Management of ligature risks at Amblescroft North was not consistently maintained.
- The alarms on some wards were either of variable quality or were not available.
- There was a blanket restriction in Amblescroft South regarding patient access to their wardrobes where they kept clothes and personal items.
- A number of wards had vacancies for qualified nursing staff. Liddington Ward had the highest number at 11.8 whole time equivalent (WTE) nursing vacancies. This had the potential to affect patient safety.
- Staff had access to training to manage patient's aggression, but completion rates on all wards apart from Ward 4, Liddington and Amblescroft North were below the trust's compliance rate of 85%.
- There was inconsistent reporting of incidents.
- There was a high use of prone restraints in a six month period. There was not a review of the use of prone restraint and action taken to reduce its level of use.
- The managers had ensured that staff met the mandatory training targets set by the trust. However, further improvements need to be made in relation to physical emergency response training and practical patient handling because the completion rate was below 85%. Managers conducting root cause analysis to investigate serious incidents had not received training to do so. Therefore, the service had partially met the requirement of the September 2014 report.
- Patient's records did not always give clear information as to when a patient's seclusion commenced and who authorised it. Paperwork also did not indicate who had made the decision to end the seclusion.

However:

Requires improvement



Summary of findings

- The trust had a recruitment plan in place to address shortages of qualified nurse vacancies.
- The managers had ensured that staff met the mandatory training targets set by the trust.
- On all wards there were clear arrangements for single sex accommodation, therefore the trust had met the compliance action from the previous inspection.
- All wards had fire extinguishers available and signage that indicated the actions in the event of a fire; therefore the trust had met the compliance action from the previous inspection.
- Eight of the nine wards completed regular documented checks of emergency equipment. In Cove ward there was one period of two weeks in the last year where checks were not made. The trust had met the compliance action from the previous inspection.
- All wards had lifting and safety equipment that was serviced and maintained; the trust had met the compliance action from the previous inspection.
- All wards had medication management processes in place, including the checking of fridge temperatures; therefore the trust had met the compliance action from the last inspection.
- There was clear evidence of learning from incidents and actions taken to reduce the risk of a repeat event; therefore the trust had met the compliance action from the previous inspection.
- All wards had medication management processes in place, therefore the trust had met the compliance action from the last inspection.
- Staff received training in restraint, therefore the trust had met the compliance action from the previous inspection.

Are services effective?

we rated effective as requires improvement because:

- Staff had formulated care plans for patients but we saw staff not always following these plans.
- There was no psychology input in Swindon. This meant staff members were not able discuss strategies to manage patients with difficult behaviours with a psychologist.

Requires improvement



Summary of findings

- Staff had not completed health of the nation outcome scales for over 65s; completion of this would enable staff to measure a patient's improvement or decline in mental health.
- Staff received training to manage patients' aggression but did not have access to additional training to manage increased levels of aggression effectively.
- The records we saw indicated de facto detention of informal patients in Cove ward.
- Two patients on Cove ward did not have capacity to consent to treatment from a second opinion approved doctor attached to their prescription chart; there was also a patient that received covert medicines without a rationale documented in their notes. There was no formal process that ensured staff sent Mental Health Act Paperwork to the local administrator in Cove ward.
- Staff completed mental capacity assessments. However, only Ward 4 staff completed and documented decision specific assessments.
- Multidisciplinary team meetings in Cove ward did not have a full range of professions. They were not held in an appropriate safe room.

However:

- All patient files contained holistic, patient centred care plans; this meant that the trust had met the compliance action from the previous inspection.
- All wards had access to physical health care for patients. Aspen and Laurel wards had funding to employ two registered general nurses full time.
- Staff assessed physical health on admission and monitored it weekly using a variety of assessment tools.
- Staff received regular monthly supervision and annual appraisals.
- Staff had read patients their rights under the Mental Health Act (MHA) 1983 and contacted an independent mental health advocate if required.

Are services caring?

We rated caring as good because:

Good



Summary of findings

- We observed kind, discreet, compassionate and respectful interactions by staff towards patients.
- Staff used patient directed techniques to reduce the distress that patients displayed.
- Feedback from patients and carers regarding the staff was uniformly positive across all wards.
- We saw evidence of staff engagement with families.
- All wards provided an information pack for carers and patients at admission.
- All wards displayed posters for advocacy services to protect their patients' rights.

However:

- Only one ward had documented advance decisions within the patients' care records.
- Two wards did not have records of patient involvement in the care plans.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- The bedrooms at Amblescroft north, Amblescroft south, Liddington and Hodson wards did not have privacy film on their windows to protect patients' privacy and dignity.
- Staff were inconsistent about the storage of patients' personal possessions.
- In Ward 4 patients slept in dormitories with only curtains dividing the bed spaces; staff confirmed that they would give patients a commode to use in these areas if required.
- Wards for patients experiencing dementia in Salisbury, Bristol and Weston-Super-Mare had few adjustments made to make them "dementia friendly".
- There was a lack of structured activity at the weekend on all wards apart from Ward 4.

However:

- All wards had access to garden space for fresh air. However, these were of variable quality.
- Staff spoke positively about closer working links with discharge teams in the community.

Requires improvement



Summary of findings

- Staff provided a good range of activities on each ward in the week.
- There was a good process established to manage complaints made by patients and carers.
- All wards had access to the moving and lifting equipment they required to help their patients.

Are services well-led?

We rated well-led as requires improvement because:

- Patients who were detained under the Mental Health Act (MHA) 1983 rights were not protected, as there was no effective governance arrangements to monitor and review the way the functions of the Act were exercised on Cove ward.
- Reporting of potential safeguarding incidents was inconsistent across the wards.
- The trust did not sufficient governance systems in place to ensure patients were safe in all wards. For example, in Cove and Dune ward had not completed a ligature risk assessment for two years prior to the inspection.
- The structures in place to monitor training were inconsistent.
- Staff confirmed that they felt comfortable raising concerns with managers and able to use the trusts whistle blowing process.
- Staff confirmed that morale was generally good on most wards and that managers were supportive and a visible presence on the wards.
- All staff we spoke with described being part of a mutually supportive team that worked hard to provide care for their patients.

Requires improvement



Summary of findings

Information about the service

Avon and Wiltshire Mental Health Partnership NHS Trust provides wards for older people with mental health problems at five sites within the trust.

In Bath and North East Somerset, there is Ward 4 at St Martin's Hospital. A 12-bedded mixed gender ward for people experiencing dementia.

In Bristol, there are two wards at Callington Road Hospital. Laurel ward is an 18-bedded mixed gender ward for people experiencing dementia and Aspen Ward. Aspen is a 24-bedded mixed gender ward for people with functional illnesses such as schizophrenia, bipolar disorder or depression.

In Salisbury, there are two wards. Amblescroft South is a 20-bedded mixed gender ward for people experiencing dementia. Amblescroft North is a 20-bedded mixed gender ward for people with functional illnesses such as schizophrenia or depression.

In Swindon there are two wards. Liddington Ward is a 12-bedded mixed gender ward for people experiencing dementia. Hodson Ward is a 14-bedded mixed gender ward for people with functional illnesses

In Weston-Super-Mare, there are two wards. Dune Ward is a 10-bedded mixed gender ward for people experiencing dementia. Cove Ward is a 15-bedded mixed gender ward for people with functional illnesses.

We completed a comprehensive inspection of the trust in June 2014. We issued compliance actions about records, the assessing and monitoring of the service, safeguarding arrangements, medicines management, safety and suitability of premises, safety, availability and suitability of equipment, respecting and involving service users, staffing and supporting workers. The requirements made at the last report were not just for the inpatient wards listed above, they also included the covered the community teams across the area like the Bath and North East Somerset CIT (OPMH), Swindon CIT (OPMH), Bristol CIT (OPMH).

At this inspection we found that the service had met or partially met all the requirements from the 2014 inspection above which related directly to their service. Three requirements were partially met because further improvements were still required to the wards environments, potential ligature risks and training in emergency response and physical interventions.

Our inspection team

Our inspection team was led by:

Chair: Maria Kane, Chief Executive, Barnet, Enfield and Haringey Mental Health NHS Trust

Team leader: Karen Wilson, Head of Hospital Inspection

The team in week one of the inspection comprised: Three CQC inspectors, an assistant inspector, and two specialist advisors with experience of working with older adults.

The team in week two of the inspection comprised: two CQC inspectors and four specialist advisors with experience of working with older adults.

Why we carried out this inspection

We inspected this core service as part of our on-going 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 staff at a number of focus groups.

During the inspection visit, the inspection team:

- visited all nine of the wards at the five hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 19 patients who were using the service and collected feedback from 19 patients using comment cards
- spoke with 10 carers of patients using the service
- spoke with the managers or acting managers for each of the wards and a selection of senior managers including service managers and modern matrons.
- spoke with 79 other staff members; including doctors, nurses, occupational therapists, a pharmacist, psychologists, physiotherapists, art psychotherapist, a pharmacy technician, support workers and activity coordinators.
- attended and observed seven hand-over meetings and four multi-disciplinary meetings.
- looked at 58 treatment records of patients
- looked at 79 medication charts for patients.
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Patients who used the service and their carers were extremely positive about the care that they received. Carers and patients described staff as being kind,

respectful and prepared to do what they can to help their patients. Families described being involved in the care process by the nursing staff which they felt was very important.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure it takes all actions required to protect patients from the risk of ligatures in a timely fashion.
- The trust must ensure that appropriate and effective alarm systems are in place for the use of patients and staff in all wards.
- The trust must ensure that ward environments are dementia friendly and fit for the purpose of managing patients with these conditions.
- The trust must ensure changes to ward environments to protect patients' dignity and privacy.
- The trust must ensure that all staff members complete the physical emergency response training or practical patient handling training. Managers must receive training in root cause analysis to ensure that they can complete their role effectively when investigating incidents.
- The trust must ensure that there is psychologist cover for Hodson and Liddington Wards in Swindon.
- The trust must ensure that staff follow risk assessment and care plans completed to ensure both their own and patient's safety.
- The trust must identify a safe and dignified method of transferring patients in need of seclusion between wards.

Summary of findings

- The trust must ensure that staff adhere to Mental Health Act legislation and standards described in the Mental Health Act (MHA) 1983 code of practice.

Action the provider SHOULD take to improve

- The trust should ensure that patients on Ward 4 have access to a telephone to make private calls if they do not have access to their own.
- The trust should ensure that the multidisciplinary team meetings in Weston-Super-Mare have a full range of professions and are held in an appropriate room.
- The trust should ensure that they have the patients' or their representative's consent before locking a patient's private property in cabinets in their rooms.
- The trust should ensure that there are effective governance arrangements, to monitor and review the criteria for reporting both safeguarding and incidents across the service, to ensure consistency and patient's safety.
- The trust should ensure that patient's records always give clear information as to when a patient's seclusion commenced, who authorised it and who had made the decision to end the seclusion.
- The trust should ensure that the recruitment programme to recruit qualified nurses continues.
- The trust should ensure that staff member's complete health of the nation outcome scales (HONOS) for over 65s; completion of this would enable staff to measure patients' improvement or decline in mental health.
- The trust should ensure that all patients have the opportunity to make advance decisions which are then recorded in their case records.
- The trust should ensure that staff members ensure that there are records of patient involvement in the care plans.
- The trust should ensure that there is a review of the use of prone restraint and action taken to reduce its level of use.

Avon and Wiltshire Mental Health Partnership NHS Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Aspen and Laurel Wards	Callington Road Hospital, Bristol
Amblescroft North and South Wards	Fountain Way, Salisbury
Cove and Dune Wards	Longfox Unit, Weston-super-Mare
Ward 4	St Martin's Hospital, Bath
Hodson and Liddington Wards	Victoria Centre, Swindon

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.

Patients received their rights (under section 132 of the Mental Health Act). If they lacked capacity to understand, staff repeated them at regular intervals or requested an independent mental health advocate (IMHA).

Mental Health Act documentation had been stored correctly in all but one case.

We had concerns about de facto detention (where the threat of detention is used to induce a patient to consent to admission or treatment) on Cove ward that we raised at the time of inspection.

Wards displayed posters informing patients of how to contact the independent mental health advocate (IMHA).

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust offered mandatory training in the Mental Capacity Act (MCA) to all qualified staff. Staff had a working knowledge about the MCA and Deprivation of Liberty Safeguards (DoLS).

In most of the records we reviewed, staff had assessed patients' capacity on a generic basis and not on a decision specific basis.

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

- Five wards had blind spots where staff could not observe patients. However, the staff teams managed these to ensure patient safety. For example, Amblescroft North and Amblescroft South had curved corridors with lounges attached that reduced the level of visibility. Laurel and Aspen wards were large, so it was difficult to have unimpeded sight lines from all parts of the ward. Ward 4 had good visibility up to the end of the main corridor. At that point, a corner impeded sight of the bedrooms at the end of the ward. To mitigate the risk the nurse in charge of each ward allocated staff to undertake observations of patients at a minimum frequency of hourly. If the staff team assessed patients' risks as having increased staff checked them every ten minutes or nursed patients on one to one observations. Ward 4 had a map that showed optimum positions for staffing at night to help support patients and maintain the integrity of single sex accommodation. The sight lines on Cove, Dune, Hodson and Liddington wards ensured the staff team had good visibility of patients to ensure their safe care and treatment.
- All nine wards had completed a ligature point (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) audit. Managers used a recognised assessment tool to do this. Seven ward managers had completed the audit for their respective ward in the previous 12 months. However, the managers for Cove and Dune had completed theirs in June 2014. Guidance indicates completion of ligature audits every 12 months to ensure patient safety.
- To reduce the risks posed by the ligature points the trust had taken a number of actions. For example, on seven wards (not Laurel and Dune) they had "lower ligature risk" rooms for patients staff had assessed as being at risk of self-harm. The trust published standards for lower ligature risk rooms. These included the removal of en-suite doors, fitting shower curtains to maintain privacy, removal of grab rails. In Liddington and Hodson wards, managers were unhappy with the removal of en-suite doors so fitted anti ligature hinges instead which met the criteria of the lower ligature risk guidance. Managers also felt that the client group using the wards were more at risk of falls than self-harm by ligature, so they insisted that the grab rails remained in the bathroom. Laurel and Dune did not have designated lower ligature risk rooms. Trust managers deemed they were low risk services as they worked with people with organic diseases such as Alzheimer's. The modern matron of Laurel ward was reviewing whether this position should change as other organic wards had lower risk rooms. In the garden on Amblescroft North, a fenced off area was open and contained an air conditioning unit. Staff advised us that patients could be in the garden unsupervised for up to ten minutes at a time. We highlighted the potential risks from the air conditioning unit, ligature points and possibility of patients going absent without leave to the modern matron. There was a movable bench, a relatively low wall and blind spots in the garden. The modern matron stated that staff should escort patients in the garden at all times. Before we left, the modern matron had arranged for the lock to be fixed on the fencing, the bench to be condemned and had advised ward staff that patients had to be supervised in the garden. They told us that they had also started rewriting the policy for patients having time in the garden.
- All nine wards were compliant with guidance on single sex accommodation. In Amblescroft South there was a bathroom for men in the women's designated corridor. In Amblescroft North, there was a women's bathroom in the men's designated corridor. In North, the patients passed through a locked dividing door and walked five feet to reach the bathroom. However, patients did not pass a bedroom used by the opposite sex to do this. Staff reduced any risk by ensuring that the patients going to the bathroom were fully clothed and staff remained with them at all times. Signage to indicate which corridors contained female rooms and which contained male rooms were present on Hodson, Liddington, Dune and Cove. Staff had reported at least one incident due to patients not being aware that they were in the wrong corridor. Wards had specified female lounges to provide them with a safe space. Managers

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confirmed that they had a policy to allow wards to admit patients to beds allocated to the opposite gender in an emergency. The protocol specified what actions managers had to take to ensure that the trust had not breached single sex accommodation guidelines. The trust had written to CQC for clarification regarding this.

- The wards all had emergency equipment including external defibrillators and oxygen. Staff had checked these regularly to ensure that they were working. Staff also checked that the physical emergency response team bag was complete and contained all the required equipment. We found a two-week gap where staff had not checked the crash trolley on Cove ward. This had the potential to put patients at risk.
- The managers on each of the nine wards ensured cleaning staff maintained cleaning records. They were up-to-date and demonstrated the environment was cleaned daily. The trust completed environmental risk assessments on a regular basis. These covered issues such as slips and trips, fire and control of substances harmful to health. Ward 4 had dolls and toys they used for attachment theory work. There was no cleaning rota or method of checking staff had cleaned the toys. However, staff implemented a new checking process during the inspection.
- All wards had fire extinguishers in place with clear signage and instructions in the event of a fire.
- Patients on three of the nine wards could not be assured they could alert staff if they required assistance. The alarms on the wards were either of variable quality or were not available. In Amblescroft North and South, the alarms were louder than those on other wards. They were very intrusive for patients. An inspector accidentally pulled the trigger cord on his alarm and it did not sound at all. A member of staff removed the battery from theirs during an interview with an inspector, as the noise was invasive. In Ward 4, nurse call buttons were not present in communal areas and patient bathrooms and bedrooms so patients could not alert them if they required assistance. The alarms on Laurel and Aspen worked but on two occasions, staff was unable to find where they had triggered. The personal staff alarms at Liddington, Hodson, Cove and Dunewode worked effectively. In Liddington and Hodson wards, there were sensors in patient rooms, which staff activated for patients at risk of falls or self-harm.

Safe staffing

- Figures quoted by the trust from November 2015 until February 2016 confirmed that all wards had vacancies for qualified nurses. However, there was a recruitment plan in place to address these concerns. The trust had calculated the number of staff required on each shift using the safer staffing tool and process. The vacancy levels varied from 2.6 whole time equivalent (WTE) on Ward 4 up to 11.8 WTE on Liddington Ward. Overall, the trust had 38 vacancies for qualified nurses in the wards for older people. During this period, the trust used temporary staff to fill 1425 shifts. During the 12 months from February 2015 and January 2016, 30 staff left the service, leading to a turnover rate of 16.7%. The overall percentage of staff sickness for the older people's wards was 5.1%. The lowest was 2.6% on Liddington ward and the highest was 8.5% on Aspen ward. This compares to a national average sickness level of 4.2%. Staff shift fill rates for qualified staff did not breach the trust's target.
- The trust used bank and agency staff across all wards to fill shifts that were vacant. Staff we spoke with told us that they tried to use regular bank staff as a preference to ensure continuity of care.
- Ward managers told us that they increased staffing numbers if staff placed patients on 1-1 observations. The first member of staff required to manage this came out of the ward numbers. If they required more than one member of staff to manage 1-1 observations, staff were able to book additional workers. However, managers in Swindon confirmed that they booked all the additional staff they required rather than take one out of the existing ward establishment.
- A qualified nurse was always available on the wards as part of the shift numbers.
- Staff members and patients across all wards confirmed that senior nurses allocated patients to named staff. The expectation was that staff would then engage with their patients. Staff confirmed that this happened on most occasions but when it was busy this became more difficult.
- Staff we spoke with confirmed that staff rarely cancelled activities due to low staffing numbers. However, they stated they made decisions about activities dependent

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on the acuity of the patient group on the ward. The trust confirmed that incident forms received to report short staffing did not indicate that staff had cancelled activities.

- On the majority of wards, there were sufficient numbers on each shift to complete physical interventions.
- All wards had access to medical staff during office hours. During evenings and weekends, staff contacted an on-call duty doctor for support.
- The managers ensured mandatory training completion rates were above the trust target of 85% with average completion rate of 86%. Three courses did not meet this target. These were physical emergency response training with completion rates between 67% to 80%. Practical patient handling had a completion rate between 41% and 63%. Restraint training had an average completion of 76%. This varied between 57% on Amblescroft north and 93% on Ward 4.

Assessing and managing risk to patients and staff

- Staff members in all nine wards undertook a risk assessment of patients on admission. In the 58 treatment records reviewed, staff completed the risk assessment tool on RiO (the IT system). Staff updated risk assessments following incidents or changes in care required. They used identified risks to create patient centred care plans. Staff implemented methods of reducing and managing risk using the care plans. For example, patients at risk of self-harm had observation levels reviewed and increased. Patients at risk of falls had a care plan highlighting that risk and staff referred them to the appropriate professionals for a falls assessment. However, staff did not consistently follow risk assessments related to care plans which placed patients and staff members at risk of harm. For example in Swindon ward there was a detailed plan about managing one patient's challenging behaviour but a staff member was seen not following this plan. They put themselves in danger of being struck as they were physically too close to the patient.
- All wards had implemented the "safe wards" initiative to reduce the level of risk and produce a calm ward environment. They used different tools and methods of engagement to reduce the amount of conflict on the wards. For example, positive words, where staff give positive feedback on each patient during

handover; discharge messages, where patients and their carers leave messages of hope for others to read when they are discharged. Carers spoken with said they found this useful.

- There was a blanket restriction on all nine wards about the removal of all plastic bags from patients' bedrooms. This was a response to a serious incident in the trust and came into effect from May 2015. Its aim was to reduce the risk of self-harm. Staff were mixed about this restriction with some staff stating that it compromised infection control when they provided personal care and affected the privacy and dignity of the patients they cared for. In Amblescroft south there was also a restriction about patient access to their wardrobes where they kept clothes and personal items. Staff locked patients' wardrobes and retained the key. They advised us this prevented patients taking items that did not belong to them. However, there was not consistent evidence in patients care files that staff had explained fully to them and had their or their representative's consent. There was no sign on the wardrobe to advise patients that staff could unlock the furniture.
- Staff ensured that signs on all ward doors stated that informal patients had the right to leave. In eight of the nine wards informal patients told us they understood their rights. However, in Cove ward one informal patient had not understood they could leave the ward and had jumped over the garden wall. The inspection team raised this with the manager and they agreed to ensure the staff team made patients fully aware of their rights.
- Staff in all wards followed the policies and procedures around the observation of patients to ensure their safety. Staff stated they searched patients' property at admission. After this staff searched patients' property if they had a suspicion that patients had purchased inappropriate items.
- We saw evidence in patient records that staff created individualised care plans for patients who displayed challenging behaviours. This encouraged staff to use different methods to reduce distress that were patient centred and used their likes and dislikes. Examples seen were to give a patient a cup of tea, talk about their dog or give them a doll for them to hold. Staff told us they used restraint once they had considered all

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other options including unmet needs or use of de-escalation techniques. Staff received training in understanding, preventing and managing aggression. This meant they used passive holds to restrain patients.

- Doctors prescribed medication for rapid tranquilisation in line with guidelines from the National Institute for Health and Care Excellence when patients required it. In Liddington ward, doctors prescribed twice the recommended dose for older adults. However, the doctor had recorded the rationale in the patient notes. If necessary, a second opinion authorised doctor had completed an authorisation on a T3 form (confirmation from second opinion doctor that treatment is appropriate). Pharmacists advised us that there had been a new prescribing guideline introduced for prescribing rapid tranquilisation for frail older adults which was followed by the staff team.
- Staff we spoke with told us that they do occasionally seclude patients due to increased risks. The wards for older adults do not have purpose built seclusion rooms. We saw three incident forms that referred to seclusion incidents between 1 October 2015 and 31 March 2016. These forms indicated that two patients had been secluded in their bedrooms for periods of no more than 15 minutes. Daily entries did not give clear information as to when seclusion commenced and who authorised it. Paperwork also did not indicate who had made the decision to end the seclusion.
- Trust staff received training in safeguarding. The trust provided three levels of training, adult and child safeguarding level one, child safeguarding level 2 and child safeguarding level 3. The number of staff who completed this training on each ward varied between 72% on Hodson ward and 100% on Ward 4. However, staff we spoke with had a good working knowledge of safeguarding and were clear about how they escalated concerns. Each ward had a point of contact for safeguarding. Whilst there was clear evidence that all managers reported and acted upon safeguarding incident there was some level of inconsistency about criteria if the issue was a safeguarding issue or an incident. For example in the Swindon wards and Dune ward managers stated they did always report safeguarding issues like patient to patient violence to the local authority if they felt they had managed it appropriately by updating care plans and risk assessments. There were only two examples of this seen, so it was not endemic, but managers stated they would discuss and agree consistent criteria.
- Managers of each ward ensured that good medicine management practices were in place across all wards. Pharmacists and medicine management technicians visited the wards. They monitored stock levels and completed reconciliation of medicine for new admissions. Pharmacists checked that Mental Health Act consent paperwork covered medicine doctors had prescribed if applicable. They also checked if doctors had prescribed medicine within National Institute for Health and Clinical Excellence guidelines. Staff completed weekly audits of patient medicine administration records.
- Staff ensured completed risk assessments that included details of falls or pressure ulcer concerns. We saw care plans that staff had completed to manage these issues. Staff referred patients to appropriate professionals for further assessments of falls risks or pressure ulcers. District nursing staff or tissue viability nurses managed pressure areas and ulcers. Laurel and Aspen had general nurses employed on the wards and they had managed and reduced pressure area patients had suffered from on admission.
- The trust published a policy regarding the visiting of children on the wards. Staff we spoke with told us that all visits involving children were risk assessed. Some wards allowed children to visit on the ward dependant on how settle the wards was and the level of risk. Other wards stated that visits involving children did not occur on the ward.

Track record on safety

- There had been 26 serious incidents between 27 April 2015 and 16 May 2016 on wards for older people with mental health problems.
- The trust had two teams who completed root cause analysis of serious incidents. One team was based in Bristol and exclusively dealt with the information and completed the investigation. In Wiltshire, the trust allocated managers on a rota basis to complete the investigations. Managers in Wiltshire told us that they had not received root cause analysis training.

Are services safe?

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

- There had been 143 incidents of restraint on the wards for older people with mental health problems. Twenty-three of the restraints were in the prone position (held face down on the floor) over a six-month period. Restraints were well documented to ensure patients' safety. However, the trust should ensure there is a review of the use of prone restraint and action taken to reduce its level of use.

Reporting incidents and learning from when things go wrong

- All staff we spoke with understood the process of reporting incidents. They demonstrated an awareness of the incidents that they needed to report. Staff confirmed that the staff member who witnessed the incident completed the form.
- We had concerns that staff did not report all incidents that occurred due to the high level of acuity staff reported and low number of incidents being reported. For example, a patient with a long history of aggression needed three staff members to provide him with personal care. There were a small number of incidents involving this patient during a six-month period. When asked about this, staff confirmed that there was a culture that this kind of thing was expected which could result in under reporting of incidents.
- Staff demonstrated knowledge of the principles of the duty of candour. They recognised the need to be open and honest with people who used the service and their carers (where appropriate) when things went wrong.
- Staff received feedback after incidents. Staff that completed incident forms received feedback as part of the process of review by the ward manager. Managers ensured that staff received feedback from incidents at handovers and ward team meetings. Staff also received feedback emailed to their email accounts. Staff we spoke with told us that they received debriefs and support after serious incidents. On wards with psychology support, psychologists provided this in addition to senior nurses.

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

Safe and clean environment

- Five wards had blind spots where staff could not observe patients. However, the staff teams managed these to ensure patient safety. For example, Amblescroft North and Amblescroft South had curved corridors with lounges attached that reduced the level of visibility. Laurel and Aspen wards were large, so it was difficult to have unimpeded sight lines from all parts of the ward. Ward 4 had good visibility up to the end of the main corridor. At that point, a corner impeded sight of the bedrooms at the end of the ward. To mitigate the risk the nurse in charge of each ward allocated staff to undertake observations of patients at a minimum frequency of hourly. If the staff team assessed patients' risks as having increased staff checked them every ten minutes or nursed patients on one to one observations. Ward 4 had a map that showed optimum positions for staffing at night to help support patients and maintain the integrity of single sex accommodation. The sight lines on Cove, Dune, Hodson and Liddington wards ensured the staff team had good visibility of patients to ensure their safe care and treatment.
- All nine wards had completed a ligature point (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) audit. Managers used a recognised assessment tool to do this. Seven ward managers had completed the audit for their respective ward in the previous 12 months. However, the managers for Cove and Dune had completed theirs in June 2014. Guidance indicates completion of ligature audits every 12 months to ensure patient safety.
- To reduce the risks posed by the ligature points the trust had taken a number of actions. For example, on seven wards (not Laurel and Dune) they had "lower ligature risk" rooms for patients staff had assessed as being at risk of self-harm. The trust published standards for lower ligature risk rooms. These included the removal of en-suite doors, fitting shower curtains to maintain privacy, removal of grab rails. In Liddington and Hodson wards, managers were unhappy with the removal of en-suite doors so fitted anti ligature hinges instead which met the criteria of the lower ligature risk guidance. Managers also felt that the client group using the wards were more at risk of falls than self-harm by ligature, so they insisted that the grab rails remained in the bathroom. Laurel and Dune did not have designated lower ligature risk rooms. Trust managers deemed they were low risk services as they worked with people with organic diseases such as Alzheimer's. The modern matron of Laurel ward was reviewing whether this position should change as other organic wards had lower risk rooms. In the garden on Amblescroft North, a fenced off area was open and contained an air conditioning unit. Staff advised us that patients could be in the garden unsupervised for up to ten minutes at a time. We highlighted the potential risks from the air conditioning unit, ligature points and possibility of patients going absent without leave to the modern matron. There was a movable bench, a relatively low wall and blind spots in the garden. The modern matron stated that staff should escort patients in the garden at all times. Before we left, the modern matron had arranged for the lock to be fixed on the fencing, the bench to be condemned and had advised ward staff that patients had to be supervised in the garden. They told us that they had also started rewriting the policy for patients having time in the garden.
- All nine wards were compliant with guidance on single sex accommodation. In Amblescroft South there was a bathroom for men in the women's designated corridor. In Amblescroft North, there was a women's bathroom in the men's designated corridor. In North, the patients passed through a locked dividing door and walked five feet to reach the bathroom. However, patients did not pass a bedroom used by the opposite sex to do this. Staff reduced any risk by ensuring that the patients going to the bathroom were fully clothed and staff remained with them at all times. Signage to indicate which corridors contained female rooms and which contained male rooms were present on Hodson, Liddington, Dune and Cove. Staff had reported at least one incident due to patients not being aware that they were in the wrong corridor. Wards had specified female lounges to provide them with a safe space. Managers confirmed that they had a policy to allow wards to admit patients to beds allocated to the opposite gender in an emergency. The protocol specified what actions managers had to take to ensure that the trust had not breached single sex accommodation guidelines. The trust had written to CQC for clarification regarding this.

Are services effective?

Requires improvement 

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- The wards all had emergency equipment including external defibrillators and oxygen. Staff had checked these regularly to ensure that they were working. Staff also checked that the physical emergency response team bag was complete and contained all the required equipment. We found a two-week gap where staff had not checked the crash trolley on Cove ward. This had the potential to put patients at risk.
- The managers on each of the nine wards ensured cleaning staff maintained cleaning records. They were up-to-date and demonstrated the environment was cleaned daily. The trust completed environmental risk assessments on a regular basis. These covered issues such as slips and trips, fire and control of substances harmful to health. Ward 4 had dolls and toys they used for attachment theory work. There was no cleaning rota or method of checking staff had cleaned the toys. However, staff implemented a new checking process during the inspection.
- All wards had fire extinguishers in place with clear signage and instructions in the event of a fire.
- Patients on three of the nine wards could not be assured they could alert staff if they required assistance. The alarms on the wards were either of variable quality or were not available. In Amblescroft North and South, the alarms were louder than those on other wards. They were very intrusive for patients. An inspector accidentally pulled the trigger cord on his alarm and it did not sound at all. A member of staff removed the battery from theirs during an interview with an inspector, as the noise was invasive. In Ward 4, nurse call buttons were not present in communal areas and patient bathrooms and bedrooms so patients could not alert them if they required assistance. The alarms on Laurel and Aspen worked but on two occasions, staff was unable to find where they had triggered. The personal staff alarms at Liddington, Hodson, Cove and Duneworth worked effectively. In Liddington and Hodson wards, there were sensors in patient rooms, which staff activated for patients at risk of falls or self-harm.
- calculated the number of staff required on each shift using the safer staffing tool and process. The vacancy levels varied from 2.6 whole time equivalent (WTE) on Ward 4 up to 11.8 WTE on Liddington Ward. Overall, the trust had 38 vacancies for qualified nurses in the wards for older people. During this period, the trust used temporary staff to fill 1425 shifts. During the 12 months from February 2015 and January 2016, 30 staff left the service, leading to a turnover rate of 16.7%. The overall percentage of staff sickness for the older people's wards was 5.1%. The lowest was 2.6% on Liddington ward and the highest was 8.5% on Aspen ward. This compares to a national average sickness level of 4.2%. Staff shift fill rates for qualified staff did not breach the trust's target.
- The trust used bank and agency staff across all wards to fill shifts that were vacant. Staff we spoke with told us that they tried to use regular bank staff as a preference to ensure continuity of care.
- Ward managers told us that they increased staffing numbers if staff placed patients on 1-1 observations. The first member of staff required to manage this came out of the ward numbers. If they required more than one member of staff to manage 1-1 observations, staff were able to book additional workers. However, managers in Swindon confirmed that they booked all the additional staff they required rather than take one out of the existing ward establishment.
- A qualified nurse was always available on the wards as part of the shift numbers.
- Staff members and patients across all wards confirmed that senior nurses allocated patients to named staff. The expectation was that staff would then engage with their patients. Staff confirmed that this happened on most occasions but when it was busy this became more difficult.
- Staff we spoke with confirmed that staff rarely cancelled activities due to low staffing numbers. However, they stated they made decisions about activities dependent on the acuity of the patient group on the ward. The trust confirmed that incident forms received to report short staffing did not indicate that staff had cancelled activities.
- On the majority of wards, there were sufficient numbers on each shift to complete physical interventions.

Safe staffing

- Figures quoted by the trust from November 2015 until February 2016 confirmed that all wards had vacancies for qualified nurses. However, there was a recruitment plan in place to address these concerns. The trust had

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- All wards had access to medical staff during office hours. During evenings and weekends, staff contacted an on-call duty doctor for support.
- The managers ensured mandatory training completion rates were above the trust target of 85% with average completion rate of 86%. Three courses did not meet this target. These were physical emergency response training with completion rates between 67% to 80%. Practical patient handling had a completion rate between 41% and 63%. Restraint training had an average completion of 76%. This varied between 57% on Amblescroft north and 93% on Ward 4.

Assessing and managing risk to patients and staff

- Staff members in all nine wards undertook a risk assessment of patients on admission. In the 58 treatment records reviewed, staff completed the risk assessment tool on RiO (the IT system). Staff updated risk assessments following incidents or changes in care required. They used identified risks to create patient centred care plans. Staff implemented methods of reducing and managing risk using the care plans. For example, patients at risk of self-harm had observation levels reviewed and increased. Patients at risk of falls had a care plan highlighting that risk and staff referred them to the appropriate professionals for a falls assessment. However, staff did not consistently follow risk assessments related to care plans which placed patients and staff members at risk of harm. For example in Swindon ward there was a detailed plan about managing one patient's challenging behaviour but a staff member was seen not following this plan. They put themselves in danger of being struck as they were physically too close to the patient.
- All wards had implemented the "safe wards" initiative to reduce the level of risk and produce a calm ward environment. They used different tools and methods of engagement to reduce the amount of conflict on the wards. For example, positive words, where staff give positive feedback on each patient during handover; discharge messages, where patients and their carers leave messages of hope for others to read when they are discharged. Carers spoken with said they found this useful.
- There was a blanket restriction on all nine wards about the removal of all plastic bags from patients' bedrooms. This was a response to a serious incident in the trust and came into effect from May 2015. Its aim was to reduce the risk of self-harm. Staff were mixed about this restriction with some staff stating that it compromised infection control when they provided personal care and affected the privacy and dignity of the patients they cared for. In Amblescroft south there was also a restriction about patient access to their wardrobes where they kept clothes and personal items. Staff locked patients' wardrobes and retained the key. They advised us this prevented patients taking items that did not belong to them. However, there was not consistent evidence in patients care files that staff had explained fully to them and had their or their representative's consent. There was no sign on the wardrobe to advise patients that staff could unlock the furniture.
- Staff ensured that signs on all ward doors stated that informal patients had the right to leave. In eight of the nine wards informal patients told us they understood their rights. However, in Cove ward one informal patient had not understood they could leave the ward and had jumped over the garden wall. The inspection team raised this with the manager and they agreed to ensure the staff team made patients fully aware of their rights.
- Staff in all wards followed the policies and procedures around the observation of patients to ensure their safety. Staff stated they searched patients' property at admission. After this staff searched patients' property if they had a suspicion that patients had purchased inappropriate items.
- We saw evidence in patient records that staff created individualised care plans for patients who displayed challenging behaviours. This encouraged staff to use different methods to reduce distress that were patient centred and used their likes and dislikes. Examples seen were to give a patient a cup of tea, talk about their dog or give them a doll for them to hold. Staff told us they used restraint once they had considered all other options including unmet needs or use of de-escalation techniques. Staff received training in understanding, preventing and managing aggression. This meant they used passive holds to restrain patients.
- Doctors prescribed medication for rapid tranquilisation in line with guidelines from the National Institute for Health and Care Excellence when patients required

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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

- During the inspection, we observed staff interactions with patients that were kind, discreet, compassionate and respectful. We observed staff giving appropriate emotional support to patients who were distressed. For example, in the Swindon wards they used de-escalation techniques like hand massage. On another occasion, they used dolls to give comfort to a patient who was crying. Staff helped patients eat as appropriate, and they were patient and kind in their approach. However, we witnessed occasional moments of care that was less satisfactory. For example, in Bristol wards, an inspector observed a member of staff asking a patient to stop acting in a childlike manner whilst eating.
- Feedback from patients was positive. They reported that the care provided by staff was good. They were positive about the respect they were shown and how staff protected their privacy and dignity.
- Staff demonstrated a high level of knowledge about the needs of their individual patients. In feedback sent to us, carers stated that the staff went the “extra mile” to try to make their relative’s stay more comfortable and less distressing. We saw clear evidence in care plans that staff engaged with patients to establish their likes and dislikes to help plan the care they provided.

The involvement of people in the care they receive

- All wards provided information packs for patients and carers. These contained information about items patients may require during their stay, how to complain and visiting hours.

- We found evidence of patient involvement in care planning and risk assessment on Hodson, Liddington, Aspen, Laurel and Ward 4. Staff on Amblescroft North and South advised us that they obtained patient views, but they had not consistently documented them. In 12 of 16 patient notes we reviewed there was no record of patient involvement.
- On all wards, we saw posters for advocacy services. These also provided independent mental health advocate (IMHA) and independent mental capacity advocate (IMCA) services. This helped protect the rights of the patients admitted to the wards. Patients confirmed they had access to advocacy if needed.
- Hodson, Liddington, Aspen, Laurel and Ward 4 clearly evidenced family and carer involvement within the patient records we reviewed. We saw evidence of family involvement in best interest meetings, care planning and risk assessments. The wards working with patients experiencing dementia produced “this is me” documents. Relatives contribute information so staff are able to develop an understanding of the patients in their care.
- Patients in all wards could access community meetings to influence care provision. For example in ward four patients made decisions about the garden. In other wards, decisions were made about the food.
- Patient’s advanced decisions were documented in patient notes on Ward 4 for all patients. In other wards, advanced decisions were inconsistent.

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

Access and discharge

- The average length of stay on the functional wards was 90 days during the previous 12 months. The shortest length of stay was 77 days on Aspen ward. The average length of stay on the organic wards was 91 days. However, two wards, Ward 4 and Dune, had short stays of 49 and 64 days respectively. The average bed occupancy for the wards for older adults was 91% over the previous six months. The bed occupancy on Ward 4 was lower than average at 72%. However, this was because of an assessed need for a patient to have single occupancy of a shared room.
- Bed managers attempted to find beds for patients within their local catchment area. However, this was not always possible as it was dependant on local availability. Managers offered patients a bed elsewhere within the trust if they required admission. For example, staff had admitted patients from Bristol to Salisbury and Swindon. All ward managers confirmed that they liaised with bed management teams to return patients to their local area as soon as possible.
- Managers on all wards said patients always had access to a bed on return from leave. Patients transferred to general hospital due to physical needs taking priority over their mental health needs had a bed available on their return. Patients mostly had overnight stays at home to assist them in the build up to their discharge.
- Managers confirmed that patients rarely moved between wards during admission unless there was a clinical need for a move to an acute ward.
- The managers on all wards confirmed that they discussed with patients and carers discharge or transfer plans. Staff discussed with patients and carers the times for transfer or discharge. Patients and carers decided the times when discharges or transfers occurred. Staff tried to discharge patients during working hours on Monday to Thursday. Staff attempted to avoid discharge on Fridays in case patients needed to access services that would be less available at weekends.
- Managers said that patients were rarely admitted to a PICU. They often sought their advice to manage the behaviour of residents within their wards. However, we read in one patient's file on Laurel Ward who was very agitated and aggressive on admission was transferred to a PICU. Staff transferred the patient back to Laurel ward when settled. Staff recorded mediations administered appropriately and recorded the decision making process with in the care notes.
- The number of delayed discharges varied between wards but was not raised as a concern by managers. Cove ward had no delayed discharges during the previous six months. Three more wards had low numbers of delayed discharges (under 10). Amblescroft South had the highest with 26 patients experiencing delayed discharge. The organic wards experienced a higher number of delayed discharges because of a lack of specialist provision for patients with behaviour that challenged. Functional wards had less delayed discharges as staff discharged patients home on most occasions.
- Staff spoke positively about the impact of a recent review of the discharge arrangements by an independent company. This had made the discharge process more streamlined. In Salisbury, matrons from the inpatient units and wards for older adults, the ward managers and social work lead met to discuss discharge. The multi-disciplinary team questioned the estimated date of discharge at every ward round. Patient passports now contained detailed information about discharge planning. Cove and Dune wards had a daily bed management call with a modern matron and access service manager to discuss bed management. The ward manager of Cove and Dune talked positively about the dementia enhancement support team in North Somerset. The team worked with care homes to avoid admissions and to assist patients move into community beds. In addition, a new care home liaison team worked with staff in the community to avoid admission. In Swindon at Hodson and Liddington wards, the manager told us it had been so successful they had not had an admission from a care home in the last three months. At Hodson and Liddington wards, there was close working with teams in the community to help with discharge. A care home liaison team worked to manage patients within their placements and prevent hospital admissions. The managers had good access to community mental health teams, as they were located in the same building.

Are services responsive to people's needs?

Requires improvement 

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

The facilities promote recovery, comfort, dignity and confidentiality

- During the inspection, we noted that windows in the bedrooms at Liddington and Hodson wards did not have film to maintain patients' privacy. This compromised patient dignity and privacy as the bedrooms looked out onto gardens that other patients used to exercise and a public car park. Therefore, members of the public could see into the bedrooms. When asked about the fitting of privacy film, senior staff advised inspectors that patients could close their curtains to protect their privacy. There was no perception that this may not be acceptable when patients may not have capacity to protect their own dignity. Staff advised us later that a contractor had arrived to fit privacy film but it was opaque not one-way glass film. They asked them to return with a product that was more appropriate. We had also noted this issue at Amblescroft North and South. The team confirmed they had also had a contractor who arrived with inappropriate film for the ward windows. In Amblescroft North we noted that patients in the female wing had a clear view into the bedroom of a male patient when looking through a locked dividing door. All wards had en-suite bedrooms apart from Ward 4. There were two single rooms without en-suites and then dormitories sleeping either two or three patients. Curtains divided the bed spaces in these dormitories, which reduced the level of privacy patients had. Staff confirmed that if patients needed to use a commode they would provide one. However, they encouraged patients to use the nearby toilets. The use of commodes in shared spaces compromised patient's dignity. One patient had objected to sharing so staff had decided not to admit a second patient into his dormitory at the time of inspection. Staff reviewed the patients on the ward regularly to ensure they matched suitable patients to share these spaces. Staff told us that they spoke to families before admission to confirm that relatives would be sharing a bedroom.
- All the wards had designated clinic rooms. All the clinic rooms were clean and tidy apart from Amblescroft north and south. They had small, cluttered clinic rooms that could not contain an examination bench. Ward 4 also had a small clinic room without an examination bench.
- Laurel, Amblescroft North and Dune were all wards that cared for people experiencing dementia. However, they had minimal adjustments to make the wards dementia friendly. Laurel and Amblescroft were bleak and sparse with little in the way of decoration and no dementia friendly signage. Staff had made changes on Dune, with some tactile artwork, appropriate signage and brightly coloured furniture. Ward 4 in Bath and North East Somerset had a number of features to make the ward more comfortable for people experiencing dementia. They had orientation boards for patients, themed picture displays and dolls for attachment theory work. They also had artwork completed by patients, dementia appropriate signage and red toilet seats that assisted in allowing patients to self-care.
- All wards apart from ward 4 had access to occupational therapy (OT) kitchens and other therapy rooms. These were either on the wards or within the building that contained the ward, apart from for Laurel and Aspen. These wards used rooms within another building. This meant that patients under a section of the Mental Health Act (MHA) needed leave agreed by their consultant before accessing the facilities. Staff escorted patients when they used these facilities. Ward 4 was based in a general hospital ward provided by an organisation outside of the trust. There was an OT kitchen on Amblescroft north but staff reported difficulties with access to it.
- Wards had lounges for patients to use. Staff on Amblescroft north confirmed that they had recently lost the use of some lounge space due to the creation of a male dining room and a ward round room. Some lounges contained televisions. Others had no television and quiet time was encouraged. The furnishings in these rooms varied. Some appeared unwelcoming, with hard chairs and no comfortable sofas.
- Wards had different methods of accommodating visitors to the ward. Some allowed patients to have visitors in their rooms. This was risk assessed first. Some used quiet lounges on the wards for visitors to use. Others had access to rooms off the ward to use. This was particularly relevant when young children visited the wards.
- On the functional wards, patients used their own mobiles to contact friends or family once risk assessed. They also had access to a portable phone from the staff

Are services responsive to people's needs?

Requires improvement 

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office. However, in the organic wards patients relied more on staff taking the phone from the office to their bedrooms. In ward four, they did not have a portable phone so relatives could not speak to patients in private. Aspen ward had no phone signal and laurel had a poor signal.

- All wards had access to outside space. The gardens varied in size and quality. Some were very large with poor sight lines and contained ligature risks. The garden at Laurel ward had a steep slope from the back door of the ward to the garden space. Unless patients had been risk assessed as not needing an escort, staff escorted patients when they used the gardens. Patients smoked in the gardens if they wished to. A local charity had identified Ward 4 as a "good cause" and volunteers had worked to improve the garden space. The OT on Ward 4 made regular use of the garden for groups. We witnessed patients gardening during our inspection. The manager at Cove ward advised us that the trust had reviewed the garden at his ward and had decided to reduce the size. This was to aid the ward to maintain the safety of their patients.
- Food was prepared and cooked off site and reheated. Patients had mixed views about the food. Some patients spoken with said they enjoyed the food others were less complimentary. Food choices changed on a three-week or monthly rota. Patients have the options of jacket potatoes on occasion. Managers at Swindon ensured the patients had a weekly cooked breakfast. Staff at Ward 4 baked patient's homemade cakes.
- On the functional wards, patients had access to hot and cold drinks at all times. Staff obtained them snacks on request. On the organic wards, staff obtained patients hot drinks when they requested them. Snacks were available on request. There were also regular drinks rounds.
- Patients personalised their rooms if they wished. In Swindon and Bath, patients made their rooms homely with pictures and photographs. In wards in Salisbury and Bristol there was some personalisation but it was limited.
- Patients had access to lockable storage for their possessions. Patients in Amblescroft south had wardrobes with three lockable compartments. We

viewed ten rooms; staff had locked the wardrobe in all but one. The patients did not have the keys. Staff stated that this was to stop patients removing each other's property as this caused distress. No signs were present to advise that staff would open the cupboards on request. On Ward 4 staff locked patient wardrobes but signs were present to advise staff would unlock storage on request. On other wards, patients had access to their possessions and valuable items were stored in the office.

- Weekly activity programmes were available on all wards. On some wards, programmes were fixed; others used a "menu" approach where patients chose what they wished to do. There were exercise groups and gardening groups available in Salisbury. Art and crafts groups were available. Wards in Swindon used the my dementia console to provide patients with one to one time. Each patient had the opportunity to take part in activities using the technology. Staff said patients had enjoyed national papers although the budget to purchase newspapers had reduced. We saw activities including musical bingo and ball games in Swindon. In Bristol, we observed a music session with patients and staff. In Bath, volunteers facilitated a singing group for patients. Staff rarely cancelled activities due to lack of staff. Ward 4 had an allocated activity worker who worked weekends. They did art, gardening, memory work and life story work. Other wards relied on nursing staff to run activities at the weekend. Staff had access to activity boxes in some wards. In Bath, a local art project had worked closely with patients to produce artwork for the ward. The project had exhibited the art at a local gallery. When the exhibition had closed, the art project was to donate all art from the exhibition to the ward. Eight patients across eight wards told us there were limited activities at weekends and six reported being bored. Only ward four had activities led by an activity coordinator at the weekends. On other wards they relied on staff members to initiate activities.

Meeting the needs of all people who use the service

- All wards were on ground floors and accessible to patients with limited mobility or in a wheelchair. In Amblescroft, the OT completed a mobility assessment on admission. Other wards had access to physiotherapists or OT's to assess mobility needs. There

Are services responsive to people's needs?

Requires improvement 

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

was flat paving around buildings, grab rails, walk in showers and adjustable beds. All wards had assisted baths for patients' use. A range of hoists and moving aids were available on each ward. Maintenance staff had checked these in the previous six months.

- Staff ensured they met patients' individual needs. These included their cultural, language and religious needs. Patients requested a visit from representatives from different faiths. A chaplain visited wards weekly or fortnightly and assisted patient's access information about other faiths. In Swindon, the chaplain actively contributed to patient's care plans where appropriate.
- The managers in all wards could access interpreters to help assess patient's needs and explain their rights, as well as their care and treatment. Leaflets explaining patients' rights under the Mental Health Act (MHA) 1983 were available in all wards. Staff obtained these in alternative languages if patients required. In Swindon, information boards were outside the ward. These included information about local groups, how to make a complaint, friends and family charter.
- A choice of meals was available if patients did not want the meal provided. The menu included patient's choices and ensured patients with particular individual assessed needs or preferences ate appropriate meals. Patients were involved in some decisions about the food. There were discussions at patient meetings. They could add choices like fish and chips.

Listening to and learning from concerns and complaints

- There were 13 formal complaints made between February 2015 and January 2016 across the service. Managers had fully upheld four complaints, two had been partially upheld and one investigation was on going. One complaint record had not recorded the outcome. Themes from the complaints included

concerns about patients' treatment, patients' physical health concerns and the loss of a patient's property. Patients from all wards stated they were confident staff would resolve complaints promptly.

- Patients could make complaints via patient feedback forms and community meetings. Managers monitored these sources of complaint. Senior staff members from the trust conducted quality assurance visits. Staff made patients, relatives and others involved in supporting patients aware of how to make a complaint at admission and at reviews. All wards displayed information on how to make a complaint on notice boards. Information was included in the welcome packs for patients and their representatives.
- The modern matron for Laurel ward had a weekly surgery for families. They had an open door policy where relatives were encouraged to talk about any concerns about their relatives. A patients advice and liaison service (PALS) representative came onto the ward. There was a weekly advocacy meeting with Bristol mind and South Gloucestershire advocacy service. We saw evidence on all wards of robust complaints investigation and resolution.
- Staff addressed patients concerns informally as they arose. There was a complaints policy and procedure. Managers reviewed staffs' understanding through training, supervision and appraisals. All staff were aware of what to do if patients made a complaint and how to support them.
- Ward managers ensured staff discussed learning from complaints at team meetings and changes had taken place. For example in Swindon, they had employed a housekeeper in response to patient complaints about missing clothes. Patients and carers spoke positively about this.

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

- The majority of staff spoken with understood the trust's visions and values. Staff upheld these values within the practice they demonstrated and we observed on the ward.
- Staff told us that senior managers from the trust visited the wards.

Good governance

- Staff reported incidents using the trust's incident reporting system. Records indicated that managers reviewed incident forms and provided feedback to staff. Managers' implemented lessons learnt and changed practice to reduce the likelihood of incidents occurring again. A dedicated team in the Bristol area provided root cause analysis (RCA). In the Wiltshire area managers across all services on a rota basis provided this. For example, a manager with no experience of providing care and treatment for adults with dementia could investigate an incident involving patient falls on a ward for patients with dementia. Managers who investigated incidents were concerned that there was no specific training for the investigations.
- Ward managers across the locality did not have a consistent approach to safeguarding or incidents. Whilst there was clear evidence that all managers reported and acted upon safeguarding incident there was some level of inconsistency about criteria if the issue was a safeguarding issue or an incident.
- The governance of the application of the Mental Health Act (1983) was not effective, as managers in Cove and Dune wards had not ensured the protection of patient's rights under the Mental Health Act. Following the admission of a detained patient to the ward, the section paperwork remained in the ward safe for 6 days. There was no process in place to ensure ward staff contacted the mental health administration team to confirm they had admitted a patient out of hours. The management team could not assure us that the paperwork would not have remained in the ward safe if we had not inspected the ward.

- Not all staff members had completed the physical emergency response training or practical patient handling training that would assist them in the safe care of patients.
- The trust did not sufficient governance systems in place to ensure patients were safe in all wards. For example Cove and Dune wards had not completed a ligature risk assessment for two years prior to the inspection.
- Ward managers stated that they had sufficient authority to enable them to complete their tasks and manage their wards.
- All wards had clear systems to ensure staff received support and supervision to assist them with patient care and treatment. The completion rates for appraisal and supervision were above the trust's target for most wards. The wards with lowest completion rates for appraisals were only slightly below trust targets.
- Managers and staff members could place items on the trust risk register.

Leadership, morale and staff engagement

- Staff we spoke with told us that the ward managers were approachable and supportive. They described them as having a visible presence on the wards. Morale was generally good although described by staff as fluctuating dependent on the ward and the acuity of the patients.
- The trust's average sickness and absence rate was above the national average. However, there were wide fluctuations in these figures. The highest rate was 8.5 % and the lowest was 2.6%. The trust average was 5.1 % compared to a national average of 4.2%.
- All staff we spoke with told us that they had a strong sense of teamwork. All teams described themselves as hardworking and mutually supportive of each other. All staff felt able to raise any concerns with their local manager and believed that the manager would be supportive.
- All staff we spoke knew about and demonstrated that they understood the whistleblowing policy. Staff stated they would be comfortable with whistle blowing if they observed inappropriate care. Records indicated that on one occasion of whistle blowing in Bristol that managers supported staff investigated the incident appropriately.

Are services well-led?

Requires improvement 

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

- Staff had the opportunity to feedback on the service they provide during ward team meetings. Feedback from staff had influenced the activities and development of the environment in wards. For example, following discussion in staff meetings staff in ward four staff had redesigned the garden to make it more accessible to patients
- Managers described opportunities to access leadership development classes to assist them in being able to develop within their role. For example in Swindon, there were opportunities' for temporary roles into senior positions.

Commitment to quality improvement and innovation

- At the Victoria Centre in Swindon, the consultant described how they had published a paper on the management of aggression in patients experiencing dementia. The consultant confirmed that they liked to try to ensure that staff from the centre published two to four papers every year.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>Patients could not be assured that when they raised an alarm staff members would respond promptly.</p> <p>In Amblescroft south there were had ineffective and intrusive alarms for nursing staff.</p> <p>In Ward 4 there were no nurse call bells in any of the communal areas, patient bedrooms or bathrooms.</p> <p>Cove and Dune ward had not completed a ligature risk assessment since June 2014.</p> <p>In some wards the design and decoration of the ward did not support a therapeutic environment.</p> <p>This is a breach of regulation 15 1 (c)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Patient's privacy and dignity was not protected in all wards. In Amblescroft north and south and in Liddington and Hodson wards patients' bedroom windows did not have privacy film fitted. This enabled other patients and visitors to see into these rooms from car park and garden areas.</p> <p>Patients on Ward 4 slept in single sex dormitories with only a curtain to provide privacy.</p>

This section is primarily information for the provider

Requirement notices

Female patients on Amblescroft north could see into the bedroom of a male patient through locked dividing doors between corridors.

This is a breach of regulation 10 (2)(a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
The staff teams did not contain sufficient numbers of qualified, competent, skilled and experienced staff to meet the patients' care and treatment needs.

In Hodson and Liddington wards there was no psychology support for the ward.

Staff members did not receive sufficient training to enable them to carry out their duties.

All staff members had not completed the physical emergency response training or practical patient handling training that would assist them in the safe care of patients. Managers completed incident investigations without training in root cause analysis.

All staff members working with patients with dementia had not completed specialist training

This is a breach of regulation 18 (1) (2) (a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Staff were not doing all that is reasonably practicable to mitigate risks to both themselves and patients. They did not follow risk assessments related to care plans this placed patients and staff members at risk of harm.

The service transferred patients to other wards when patients required seclusion facilities. This compromised patients' safety.

Patients were not protected, as records on wards did not always give clear information as to when a patient's seclusion commenced and who authorised it. Paperwork also did not indicate who had made the decision to end the seclusion.

This is a breach of regulation 12 (2) (b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Patients detained under the Mental Health Act were not protected, as there was no effective governance arrangements to monitor and review the way the functions of the Act were exercised.

In Cove ward a staff member documented in handover notes that a patient should be detained under Section 5 (4) of the Mental Health Act if they tried to abscond. An informal patient tried to abscond over the wall of the ward garden, as they were not clear about their right to leave the ward.

Two patients that required Section 58 documentation did not have documentation completed by a Second Opinion Approved Doctor.

This section is primarily information for the provider

Requirement notices

The paperwork for a patient detained under the Mental Health Act 1983 had not been sent to the local administrator for 6 days, as staff understood the patient to be informal.

This is a breach of regulation 17 (1) (2) (a)(b)