

Requires improvement South West Yorkshire Partnership NHS Foundation  
Trust

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

## Quality Report

Fieldhead  
Ouchthorpe Lane  
Wakefield  
WF1 3SP  
Tel: 01924 327000  
Website: [www.southwestyorkshire.nhs.uk](http://www.southwestyorkshire.nhs.uk)

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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)
RXGCC	The Dales	Ashdale	HX3 0PW
RXGCC	The Dales	Elmdale	HX3 0PW
RGDD	Priestley Unit	Ward 18	WF13 4HS
RXG10	Fieldhead Hospital	Trinity 1 PICU	WF1 3SP
RXG10	Fieldhead Hospital	Trinity 2	WF1 3SP
RXG10	Fieldhead Hospital	Priory 2	WF1 3SP
RXG82	Kendray Hospital	Beamshaw Suite	S70 3RD

# Summary of findings

RXG82	Kendray Hospital	Clarke Suite	S70 3RD
RXG82	Kendray Hospital	Melton Suite PICU	S70 3RD

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

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

Where applicable, we have reported on each core service provided by South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

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:**

- Some wards had poor lines of sight, which put patients at risk where the trust had not mitigated ligature risks or in some cases identified them.
- Bathroom facilities were not adequate on Beamshaw and Clarke wards.
- Patients on Beamshaw and Clarke wards could not take a bath without staff present. This was a blanket restriction.
- Staff did not routinely carry out monitoring of high doses of medication.
- Managers did not ensure staffing levels were always sufficient to keep patients safe. Escorted section 17 leave was either cancelled or cut short due to staffing levels.
- Staff on ward 18 had either not completed patients' risk assessment or had not completed them on time.
- Line managers did not provide regular supervision to staff on all of the wards.
- It was not always clear in records whether people had capacity and therefore whether there was any requirement for capacity assessments to be undertaken where necessary. Staff did not always follow the best interest process.

- There was not always a bed available on patients' return from leave and in some cases beds were put in communal rooms.
- Access to activities was limited at weekends.
- Information on how to complain was not displayed on Trinity 1.
- We observed one example of a patient's privacy and dignity being compromised.

However:

- We observed staff interacting with patients in a respectful manner and in ways that were appropriate to the needs of the person.
- The provider had introduced a co-production care plan. However, this had not been adopted in all areas.
- Ward rounds involved the patient and patients were very positive about the care they received.
- Patients had good access to advocacy services.
- Patients were given a pack of information on admission to the wards.
- Staff reported good support within the teams and there was a good team spirit on most wards.
- Staff followed duty of candour by being open and transparent and verbally apologising when something went wrong.
- My physical health and my mental health documents had been introduced on some wards.

# 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:

- Lines of sight on Ashdale and Elmdale ward at The Dales were poor. This was also the case at Trinity 2 at Fieldhead Hospital.
- Not all ligature risks had been mitigated where these were identified. Some ligature risks had not been identified on Beamshaw and Clark ward, for example, patients on these two wards were not able to use the bathroom without a member of staff present due to ligature risks within the bathroom.
- Staffing levels were not always sufficient to keep people safe. Section 17 leave was often cancelled or cut short.
- Risks assessments were not completed when an incident occurred or in a timely manner on ward18, The Priestley Unit.
- We saw no evidence that high dose monitoring was routinely carried out.

However:

- Wards carried out Infection control audits and where necessary, acted upon any issues found.
- Clinic rooms were clean and well ordered. Staff carried out daily checks of emergency equipment including defibrillators.

**Requires improvement**



### Are services effective?

We rated effective as requires improvement because:

- Staff across all wards did not receive regular clinical and managerial supervision.
- Healthcare assistants did not receive Mental Capacity Act training.
- It was not always clear in records whether people had capacity and therefore whether there was any requirement for capacity assessments to be undertaken where necessary. Staff did not always follow the best interest process.

However:

- Staff carried out comprehensive assessment of patients' needs on admission and their needs were reviewed regularly.
- Staff carried out physical health assessments on admission to wards and care records showed that staff monitored patient's healthcare needs.

**Requires improvement**



### Are services caring?

We rated caring as good because:

**Good**



# Summary of findings

- Staff interaction with patients was respectful and appropriate to the needs of the patient.
- The trust had introduced co-production care plans; however these had not been adopted in all areas.
- Ward rounds involved the patient and patients were very positive about the care they received.
- Patients had good access to advocacy services.
- Staff gave patients a pack of information on admission to the wards.

However:

- We observed one example of a patient's privacy and dignity being compromised.

## Are services responsive to people's needs?

We rated responsive as requires improvement because:

- There was not always a bed available on patients' return from leave and in some cases beds were put in communal rooms to accommodate patients.
- Access to activities for patients was limited at weekends.
- Information on how to complain was not displayed on all wards.
- On Beamish and Clarke ward, the shower facilities were not appropriate.

However:

- My physical health and my mental health documents had been introduced on some wards as good practice documents.
- A carer's assessment was offered to a patient's relative during a multi-disciplinary team meeting.

**Requires improvement**



## Are services well-led?

We rated well led as requires improvement because:

- There was some low staff morale and periods of stress related sickness on some wards. Reasons given for this were the introduction of 12 hour shifts, the smoking ban and in some cases gender specific wards.
- There was not an effective system in place to ensure safe staffing numbers.
- Managers did not ensure rotas allowed time for staff supervision and appraisals.

However:

**Requires improvement**



# Summary of findings

- Staff reported good support within the teams and there was a good team spirit.
- Staff followed duty of candour by being open and transparent and verbally apologising when something went wrong.



# Summary of findings

## Information about the service

South West Yorkshire NHS Partnership Foundation Trust has nine acute wards for adults of working age, spread across three hospital sites. These wards provide care for patients aged 18-65 who require hospital admission for their mental health problems.

Ashdale and Elmdale wards are two mixed sex 24 bedded wards based at The Dales, Calderdale Royal Hospital site in Halifax.

Priestley unit is a mixed sex 23 bed ward based at ward 18, Dewsbury District Hospital, Dewsbury.

Trinity 2 is a male unit and Priory 2 a female unit both with 22 beds and Trinity 1 is a mixed sex psychiatric intensive care unit with 14 beds based at Fieldhead Hospital, Wakefield.

Beamshaw is a male unit and Clarke a female unit both with 14 beds and the Melton Suite, a mixed sex psychiatric intensive care unit with six beds at Kendray Hospital, Barnsley.

During a routine inspection of Trinity 2 ward at Fieldhead Hospital in 2013, we found there was a breach of Regulation 15 - Safety and suitability of premises. During this inspection, we found Trinity 2 were no longer in breach of this regulation.

## Our inspection team

The team was led by:

**Chair:** Peter Jarrett, Retired Medical Director

**Head of Hospital Inspection:** Jenny Wilkes, CQC

**Team Leaders:** Chris Watson, Inspection Manager, mental health services, CQC

Berry Rose, Inspection Manager, community health services, CQC

The team that inspected this core service comprised: two CQC inspectors, a Mental Health Act reviewer, an expert by experience and three specialist advisors. The latter were a consultant psychiatrist, a registered mental health nurse, and an allied health professional. An expert by experience is someone who has developed expertise in relation to health services by using them, or through contact with those using them – for example, as a carer.

## Why we carried out this inspection

We inspected this core service as part of our on going 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 at two focus groups.

During the inspection visit, the inspection team:

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

# Summary of findings

- Spoke with 27 patients who were using the service.
- Spoke with the managers or acting managers for each of the wards.
- Spoke with 50 other staff members; including doctors, nurses, occupational therapists and health care assistants.
- Attended and observed two ward rounds, four multi-disciplinary meetings and attended four staff focus groups.
- Looked at 19 care records of patients.
- Carried out a specific check of the medication management on all wards.

## What people who use the provider's services say

We spoke with 27 patients who had some very positive comments about the service they received and staff delivering their care. Patients said staff were very polite, nice, respectful and helpful.

Most patients said they felt safe although there were occasions where they felt threatened by other patients.

Patients told us that staff sometimes cancelled leave and activities due to either a lack of staff or the use of agency staff.

Patients on most wards said there were not enough activities especially on a weekend.

## Good practice

A member of staff from Trinity 1 PICU had introduced 'my mental health' and 'my physical health' booklets. Patients

were able to go through these booklets with staff and give their views in relation to what support they needed with their physical and mental health. These booklets had then been shared with the other acute and PICU wards.

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must ensure that staff are able to observe all areas of the ward on Trinity 2, Ashdale, Elmdale and Priory 2.
- The trust must ensure that staffing levels, skill mix and how staff are deployed is appropriate on all wards.
- The trust must ensure that staff receive appropriate supervision on all wards.
- The trust must ensure that consent to treatment and where appropriate, capacity assessments are completed and recorded appropriately.
- The trust must ensure high doses of medication are monitored.

### Action the provider **SHOULD** take to improve

- The provider should ensure that ligature risks are mitigated on all wards where possible.

- The provider must ensure that shower facilities are appropriate on Melton suite, Clarke and Beamish ward.
- The provider should ensure patients are able, with appropriate risk assessments, to have a bath without supervision on Beamshaw and Clarke ward.
- The provider should ensure the complaints policy is on display on all wards.
- The provider should ensure where possible that a bed is available for patients when they return from leave.
- The provider should ensure that activities are available seven days a week and on Beamish and Clarke ward patients should be able to use the gym at weekends.
- The provider should have systems in place to ensure staff, where necessary, are aware of and working in accordance with current guidance in relation to the Mental Health Act and the Mental Capacity Act.

## South West Yorkshire Partnership NHS Foundation Trust

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

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ashdale	The Dales
Elmdale	The Dales
Ward 18	Priestley Unit
Trinity 1 PICU	Fieldhead Hospital
Trinity 2	Fieldhead Hospital
Priory 2	Fieldhead Hospital
Beamshaw Suite	Kendray Hospital
Clark Suite	Kendray Hospital
Melton Suite PICU	Kendray 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.

We looked at the rights of patients detained under the Mental Health Act (MHA) 1983. The MHA was being complied with, patients were aware of what section they

# Detailed findings

were detained under and were regularly reminded of their rights. Patients understood their rights and had good access to independent health advocates. MHA leaflets were available in various languages and easy read format.

Patients detained under the Act understood their leave entitlement and confirmed this was agreed with their responsible clinician.

The trust told us that Mental Health Act training was not a mandatory subject. However, with the exception of health care assistants staff we spoke with told us they had completed Mental Health Act training and had a good understanding of their duties under the Act.

Staff sometimes cancelled section 17 leave. The trust did not routinely monitor when staff cancelled section 17 leave on each ward on a consistent and frequent basis. This meant we were unable to evidence what staff and patients were telling us.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff had a good understanding of the mental capacity act. Managers told us that most qualified staff had received Mental Capacity Act training; however, this was not always available to other members of staff.

Staff did not always carry out mental capacity assessments when patients consented to treatment.

The trust told us that Mental Capacity Act training was not mandatory.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

The ward manager had carried out environmental risk assessments on each ward. There was a plan in place to manage each risk, which included adhering to trust policies and procedures, individual risk assessments, engagement/ observation levels and risk management plans.

All the wards had ligature risk assessments. The trust had installed mirrors on some wards where observation was restricted. However, we saw on Ashdale, Elmdale, Priory 2 and Trinity 2 wards there were several blind spots without mirrors or any other way of ensuring staff would have a clear view of patients at all times. The ward manager on Priory 2 told us a ligature risk assessment was completed annually and an action plan produced. Since January 2016, a monthly environmental audit was undertaken, which assessed the environment against the annual ligature audit. Staff had identified door handles as a risk and said the trust would address this in their plans to build a new unit. The ward was having fire door hinges replaced to ligature light ones.

On Beamshaw ward, in the patient lounge there was a television on a bracket and electrical cables were present. The bracket and cables had been identified as potential ligature risks. On the ward ligature risk assessment tool it stated that “risk migrated by external wall therefore viewable by staff at all times.” However, throughout the course of our inspection, we saw patients watching television in the lounge and there were long periods where no staff were situated in an area where they would have been able to observe the lounge.

Patients told us there was a problem with the en suite showers on Beamshaw, Clarke and Melton suite wards. We checked the showers and found that to turn them on a button needed to be pressed. The shower then stayed on in some cases for less than 10 seconds. Ward staff told us they had been reported this to the hospitals maintenance team. However, the maintenance team had said the work to resolve the problem was significant as the shower system was in a sealed unit. Patients said that where

showers stayed on longer this would cause flooding in their bedrooms. We saw this minuted in the community meetings where patients had said they needed to put their towels on the floor to stop water escaping out of the door.

All the wards we visited complied with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation. Some wards operated on a single sex basis and those that did not had en suite bedrooms with areas designated either male or female. Melton Suite PICU was a mixed sex ward for up to six patients. There were several rooms available for patients to spend time besides a general communal area including separate male and female lounges.

All the wards we visited appeared clean. However, we found on ward 18 the male corridor toilet had a small area of graffiti scratched into the wall and wood coming away from the door in another area. Staff told us these areas were on the redecoration schedule. A fire door had the bottom panel boarded up, which compromised the safety of the door. Staff said a replacement had been ordered around a month previously. The premises were not owned by the trust and they were therefore reliant on the company who acted as the landlord.

Wards carried out Infection control audits and where necessary, acted upon any issues found. The provider had effective cleaning schedules in place which showed wards were cleaned on a daily basis, either by housekeeping staff or by ward staff.

Clinic rooms were clean and well ordered. Emergency equipment including defibrillators were checked daily. Clinics had blood pressure monitors, examination couches and scales. Staff carried out and recorded daily medicine fridge temperatures. Medical devices and emergency medication were checked weekly.

There was a shared seclusion room on Elmdale and Ashdale wards, a seclusion room was also shared between Beamshaw and Clarke ward. All seclusion rooms we saw were appropriate and met seclusion guidance. There were two way communication systems, individual temperature control, mirrors enabled full observations and patients were able to see a clock.

# Are services safe?

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

Beamshaw and Clarke ward shared a 'swinging-wall' arrangement, which allowed up to four bedrooms to form part of either ward, which maintained single-sex environments whilst accommodating fluctuations in the demand for male and female beds.

## Safe staffing

Ward managers told us there was access to medical cover at all times. All of the wards had medics which they could access at core daytime hours, the majority of whom were based on the ward or on site. At times when medics were not on site, there were on call arrangements in place which managers and staff told us worked well. There were no identified concerns with lack of medic availability following physical interventions and episodes of seclusion.

All of the ward managers we spoke with told us that staffing, and the level of nursing vacancies in particular, had been identified as an issue of concern at trust level and that there were measures in place to try to improve this across the wards. They said they had scope and flexibility within the management of their own wards to adjust their staffing levels to meet the need of the patients and would try to fill absences and vacancies when these occurred. However, they said there were times where this had not been possible. Primarily, bank and agency staff were used across the wards in order to fill gaps in staffing. Therefore shifts were being undertaken by staff who may not be familiar with the ward routines and the patients. This meant there was a risk that patients may not receive a consistent level of care by staff aware of their needs.

At the time of our inspection there were four and a half WTE vacancies for qualified staff and four WTE vacancies for unqualified staff. There were 8,510 shifts filled by bank and agency to cover sickness, absence or vacancies in the three months leading up to our inspection and 597 shifts that were not filled. The staff sickness rate in the three months leading up to our inspection was 5% and the turnover was 7.5%.

The majority of ward managers, nursing and support staff we spoke with told us that they had concerns about the staffing levels in place as they felt these were unsafe at times. Staff at Melton Suite, Beamshaw and Clarke wards told us they were often moved at short notice onto other wards during their shifts. One member of staff on the Melton Suite PICU told us about an incident which they felt

had occurred due to a member of staff being moved to assist on another ward. They felt staff could have averted an incident of violence between two patients if there had been an adequate number of staff on the ward.

Community meeting minutes from the three months prior to our inspection showed that some patients had expressed concerns with the staffing levels in place. Patients on Ward 18 had unease about the current acuity of the ward and the apparent poor staffing levels in place to manage this. One patient had commented that they felt the ward was unsafe and others felt the reliance upon agency staff was a problem as agency staff were not familiar with the patients and their needs. An advocate who attended the joint community meetings for Beamshaw, Clarke and Melton suite wards stated that patients had told them they were not able to access section 17 leave due to a lack of staff. The minutes reflected that lack of staff was an issue which was said to be raised on a weekly basis with little resolution.

Elmdale, Ashdale, Priory 2, Trinity 1, were shown to have not always met the Trust's monthly targets for safer staffing for the period November 2015 until February 2016. On these wards, the target for qualified staff at night was missed the most during the period. Elmdale and Trinity 1 had not been able to meet their full requirement for nurses at night, for three of the months during this period. Ashdale did not meet their overall target of both qualified and non-qualified staff for two of the months.

We looked at the rotas for all wards for a period of up to eight weeks prior to our inspection. We saw that on all wards, staffing levels were not always consistent. For example, the rotas showed that all of the wards had occasions where there were fewer qualified nurses than planned working alongside support staff. On several occasions, out of the staff rostered on shift, only one was qualified nursing staff. These occasions, when they occurred, were more frequent at night when there would also be no ward manager working. All wards except the Melton suite could accommodate between 14 and 24 patients. This meant that should several patients need clinical assistance or nursing input, there was a risk this may not be available in a timely manner due to a lack of suitably skilled and qualified staff available to provide this.

# Are services safe?

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

It was also not clear how, during these occasions, staff would have been able to safely cope with any emergencies, incidents, or instances of restraint and seclusion that may occur.

Several ward managers and staff told us about the introduction of a twilight shift which was where an additional staff member worked at busy hours during the day time. This was in addition to the staff members who were scheduled to work the standard 12 hour shifts. Rotas showed that this twilight shift was not in place on weekends and was not in effect for each weekday. The frequency of this shift and how often it occurred differed between each ward. On wards where this tended to be used more, such as Elmdale and Ashdale, staff told us that they found this extra shift was useful as it meant that there was more availability for them to focus on core tasks and patient care.

The trust monitored mandatory training. We found sickness levels and new staff had affected the compliance rates with mandatory training. When staff returned from long term sick leave, mandatory training dates were sought to ensure training was brought up to date as soon as possible. The average mandatory training rate for acute and PICU services was 84%, this was within trust guidelines of 80%.

## Assessing and managing risk to patients and staff

There was a comprehensive range of risk assessments used across all acute and PICU wards. On most wards, we found staff had completed risk assessments within trust guidelines and policies and procedures. Staff on ward 18 had not followed trust policies and procedures. We reviewed the care records of six patients and found staff had not fully completed five risk assessments within trust guidelines. One patient had made several attempts, both historically and more recently, to take their own life or self-harm. There had been an incident of this nature in February 2016. We could not find a risk assessment relating to this incident and staff confirmed the first 'Sainsbury's Level 1' risk assessment had not been completed until 10 March 2016. Another patient had been identified as being at high risk of arson; again, we were unable to find a 'Sainsbury's Level 1' risk assessment relating to this risk. There was no plan in place as to how this risk was to be managed by staff. Without clear guidance in place for staff on how these risks should be managed, they may be unaware of what actions to take to maintain safety in the most effective way.

Another patient had been identified as a medium risk under the nutritional risk assessment, which meant their risk assessment should be, updated every '1-2 weeks'. We found this had been completed on 12 November 2015 and 17 December 2015 and had not been completed since then. A member of staff said they thought the person had been referred to a dietician, another member of staff confirmed this, but it had not been recorded on the person's care file. Therefore, we were unable to see what actions had been agreed in relation to the person's nutritional risk and whether these were being followed.

Staff had up to date training in both adult and children safeguarding. Staff understood their responsibilities with regard to safeguarding. Staff were able to describe safeguarding policies and what they would do should they suspect any kind of abuse was occurring. Staff said they thought their managers would take any allegations seriously and they would use procedures in place to report any incidents.

There were seven safeguarding concerns raised with the CQC about acute and PICU services between 1 January 2015 and 31 December 2015, and two safeguarding alerts raised.

Appropriate arrangements were in place for the management of medicines on all of the acute and PICU wards. We reviewed the medicine administration records for 111 patients across the wards we visited. Pharmacy staff carried out clinical checks of prescription and administration records.

We saw no evidence that high dose monitoring was routinely carried out. Pharmacists had noted on charts that it should be done; however, we could not find evidence of the monitoring taking place. There were no completed monitoring forms and no information in patient records.

Pharmacy staff were available for advice and involved in discussions at admission and ward round.

Blanket restrictions were minimised in most areas of the acute and PICU wards. However, all the patients on Beamshaw and Clarke ward were unable to take a bath without a member of staff present behind a shower curtain. This meant patient's individual risks had not been taken into account. However, other wards were managing the risk through individual risk assessment.



# Are services safe?

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

## Track record on safety

On one ward, we were told about three fires which had been started by patients, one in the roof void, one in an activity room which had destroyed the room and one in a patients waste paper bin. Because of this the fire service had been involved in assessing the safety of the ward. The trust had installed an improved fire detection system which would ensure fires in the ceiling void would be detected sooner.

## Reporting incidents and learning from when things go wrong

Staff were very clear about what would require an entry onto the trust's electronic incident recording system, Datix.

Ward managers told us they reviewed every incident recorded on Datix. Consultants said they were copied in when incidents occurred to enable them to review the incident and make changes to patients care where necessary. We were shown the trust's dashboard which gave a breakdown of the type of incidents occurring. For example, since the introduction of a smoking ban trust wide a new category had been added to review the number of 'breaches of the smoking ban'.

Ward managers said they would ensure that after any serious incident there would be a team debrief. Where appropriate, patients would also be involved in a debrief exercise.



# Are services effective?

Requires improvement 

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

## Our findings

### Assessment of needs and planning of care

Patients had a comprehensive assessment of their needs on admission, along with a review of their medication. We reviewed 19 care records and found they included the patients full mental and physical health history. Patients views, details of their families and carers and if they had carers responsibilities were also recorded.

Most records we saw had been regularly reviewed and information of the review was recorded in the patient's progress notes.

Patients had a full physical health assessment on admission to the ward and care records showed that staff monitored people's healthcare needs. One person's physical health assessment identified that they were in constant pain due to osteoarthritis. The patient had been prescribed medication including pain patches to alleviate the pain and information in the patients progress notes showed that this was monitored.

### Best practice in treatment and care

Wards made referrals for psychology input although patients on some wards were often unable to see a psychologist until after they were discharged from hospital. On Beamshaw and Clarke wards, patients could usually see a psychologist within five days. On Trinity 1 a psychologist visited the ward every Monday.

Clinical staff participated actively in documentation audits. Ward managers said they used the behaviour flexibility rating scale (BFRS), BARS for the monitoring of drug induced akathisia and LUNSERS for the monitoring of anti-psychotic medication.

Acute and PICU services carried out several local and clinical audits detailed below:

- Medicine reconciliation audit – Psych report.
- Clozapine Monitoring in the Community (presentation).
- Annual Health and Safety monitoring Audit report – 2014/15 (trust wide results)
- MHA Section 132 Audits – July 2015.
- Trust mental health services clinical record keeping audit – summary report – May 2015.
- Hand hygiene audit report (Kendray Hospital) – April 2015.

- Audit of Assessment and Recording of Capacity to consent to treatment by service users within the Wakefield, Working Age Adult Inpatient Units as highlighted by the CQC report Jan-Mar 2015.
- SWYPFT – Bed Management Report – March 2015.
- SWYPFT – Leadership Development Report – July 2015.
- SWYPFT – Performance Indicators Report – September 2015 (Draft)
- SWYPFT – Transformation Report – September 2015.

### Skilled staff to deliver care

The percentage of non-medical staff that have had an appraisal in the 12 months to 17 February 2016 was 89%.

Staff across all the wards told us they had not received either clinical or managerial supervision for some considerable time, in some cases this was over 12 months. This was confirmed by ward managers and our review of staff files. Staff told us this was due to the introduction of 12 hour shifts. The 12 hour shifts meant handover between shifts was restricted to 15 minutes. Some wards had recently introduced a twilight shift to allow time for supervision. Other wards had instigated group supervisions.

As at 17 February 2016, there had been five (83.3%) doctors revalidated during the last 12 months for acute and PICU services.

### Multi-disciplinary and inter-agency team work

We observed four multi-disciplinary team (MDT) meetings. We found they were effective in sharing information about patients and reviewing their progress. Each meeting involved the patient and in some cases either family members of the patient or their advocate. There were various professionals involved, including the patients named nurse or keyworker, doctors, occupational therapists, social workers and in some cases a physiotherapist. However, staff told us that members of the community healthcare teams struggled to get to meetings at The Dales due to the distance they had to travel to attend and problems with parking on site. Staff at The Dales said they had raised this as a concern as they thought community teams were key in patients discharge process.

Professionals involved in the MDT had detailed knowledge of the patient. The patient was fully engaged in the process and discussions involved the patient. During a MDT we observed, there was a discussion about the patient's medication and we noted the patients views were taken

# 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.

into account. In another MDT, it was clear a patient's relative needed assistance and the clinician suggested and agreed to refer the relative for a carers assessment. MDT meetings were comprehensive; however, not all care records showed that decisions made during MDT's had informed the patients care planning.

Staff told us the pharmacist visited wards every day during the week.

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

Prior to our inspection, we spoke with all the independent mental health advocates (IMHA) who were involved with acute and PICU services across the trust. The IMHAs told us they had a good relationship with the wards and visited most wards every day Monday to Friday. This was as a result of referrals made by ward staff and direct requests from patients.

South West Yorkshire Partnership do not routinely capture compliance information around MHA training, as this had not been identified as mandatory training. Some staff told us they had received training on the revised code of practice, others said they had taken part in some training which covered, MHA, the mental capacity act and safeguarding. Staff told us it was only qualified staff who attended training for the MHA, MCA and Deprivation of Liberty Safeguards and not all qualified staff had undertaken this training. This meant we could not be assured that all staff were fully aware of the changes to the MHA to ensure they worked in accordance with current guidance to protect people's rights. All the qualified staff we spoke with told us they had recently had receipt and scrutiny training.

Care records we reviewed detailed patient's detention under the MHA. Patients told us staff had informed them of their legal status and their rights under the MHA at the time of detention, and staff had regularly reminded them of their rights during their period of detention. Staff receipted and scrutinised MHA documentation in accordance with the MHA code of practice. Detention papers were held centrally and copies were kept in the patient's file. Patients told us they were aware of their rights.

Not all care records showed that mental capacity assessments had taken place to ensure that where patients were consenting to treatment they had the capacity to do so. In one patient's care records there was no information of a T2 being completed, although the care plan information described medication being given for in excess of three months. The intervention statement did not reflect the fact that the patient could consent to continuing treatment under the T2. The care plan stated that after three months, a second opinion must be sought, but it did not state that this was required only if the person refused treatment or lacked capacity.

## **Good practice in applying the Mental Capacity Act**

Some staff were able to confidently talk about the application of the mental capacity act, others were less well informed. One member of care staff told us the mental capacity act did not apply to their work. It was not always clear in records whether people had capacity and therefore whether there was any requirement for capacity assessments to be undertaken where necessary. South West Yorkshire Partnership did not routinely capture compliance information around MCA training, as this was not identified as mandatory training. Staff on some wards said training on the mental capacity act was due to start in April 2016.

We found on Elmdale ward a member of staff had been nominated as the mental capacity act lead, and they said they made sure all staff were up to date with their training and understood the act.

Staff had recorded detailed information on a patient's care record with regards to them being subject to financial abuse. We saw the care coordinator had carried out a decision specific mental capacity assessment and had found the patient to lack capacity to manage their finances. An application to the court had been made for appointeeship, however, there was no evidence the best interest decision process had been followed. A best interest decision meeting should have been conducted with all appropriate parties involved to identify and agree on what the best course of action was for the patient. We could not evidence this had taken place.

# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

During our inspection, we observed staff treating patients with kindness and respect. There was an appropriate conversation with patients and patients responded well to staff. Our observations were that staff knew patients very well.

On one ward, a patient liked to spend time with the ward manager, the ward manager was happy to spend time with the patient. The manager had allocated the patient a bedroom opposite their office, which the patient said was great. The manager told us this was not unusual and they always ensured that patients who required more assistance would be allocated a bedroom close to their office.

### The involvement of people in the care that they receive

Staff gave patients a 'welcome pack' when they were first admitted to the ward, this included leaflets about the ward and their medication.

Staff in some cases had co-produced care plans with patients; we saw evidence of this in some care records. Some staff told us they wrote the care plans and then shared it with patients and then altered it until the patient

was happy with it. Some patients said they had seen their care plans and had a copy, others said they did not want to see it and others said they had never seen one. My physical health' and 'my mental health' booklets were implemented to encourage patients to discuss and for staff to capture the information. A staff member on Trinity 1 had introduced the booklet with input from pharmacist. The trust had rolled the booklets out to other wards.

Community meetings were held on each of the wards weekly. In some cases these were chaired by an occupational therapist. Minutes of the meetings varied across wards. Minutes for Beamshaw and Clarke ward were comprehensive and patients clearly had opportunity to bring up any issues or concerns they had. The format of meetings followed a standard agenda with detailed information recorded. We saw patients were updated with the answers to questions raised at the following meeting. Minutes for wards at Fieldhead hospital were very basic and followed a standard agenda with very little information documented. Some agenda items just had either the answer yes or no with no further explanation or context. In these examples, patient's views were not clear and it was not evident whether any further actions were required in response to patient's comments and queries.

# 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

There had been 37 out of area placements in the last six months. Nine of the 37 placements were where patients needed a gender specific PICU bed. These beds were not commissioned from the trust but they did class these as out of area for financial purposes. Staff told us there were often problems in accessing a bed in PICU locally. During our inspection there was a possibility that one patient would need to go to London to access a bed on PICU.

Staff told us there was often a problem when patients leave broke down and they needed to return to the ward earlier than planned. This on occasions meant patients could not return to the ward and needed to go to a hospital out of their area. Ward managers told us of times where patients would return to the ward and have to sleep in rooms other than bedrooms, for example, visitor rooms or interview rooms where beds had been provided. Ward managers told us this was in line with the trust's policy to keep patients safe. We saw the policy which reflected what the managers told us and stipulated that this should be in an emergency only and recorded as an incident on the Trust's Datix system. The policy stated that ward managers would have to implement contingency plans to accommodate this when such an instance happened. Managers we spoke with told us they could increase staffing levels to reflect this and would work to ensure that the patient was moved to suitable accommodation as soon as possible.

Average bed occupancy over the last 6 months was 97.6% including leave and 89.3% excluding leave. However, on some wards the occupancy including leave was over 100%.

In the last 6 months, there had been 190 readmissions within 90 days. The ward with the highest number of readmissions within 90 days was Ashdale.

In the last 6 months, there had been 16 delayed discharges for acute and PICU services. The highest numbers of delayed discharges were from Ward 18 (Priestly Unit) ward.

The wards at Fieldhead Hospital had implemented patient flow process monitoring, involving social care and community teams. Any patients in hospital for more than 40 days were automatically added to this. The trust had instigated this to manage the pathway of the individual patient rather than managing the 'bed'.

Average length of stay for patients discharged in the last 6 months was 36 days. The average length of stay for current inpatients (as at 30 September 2015) was 53 days excluding leave and 55 days including leave.

### The facilities promote recovery, comfort, dignity and confidentiality

All the wards had various communal rooms, which patients and staff could use for private interviews and meetings. Each ward had quiet rooms, lounges, beverage kitchens, and rooms where patients were able to meet with their families and visitors. Some wards had rooms to enable children to visit wards safely. The trust had a 'safeguarding and promoting the welfare of children policy' in place which contained the procedures to be followed by staff for children visiting inpatients. Managers and staff told us that when children did visit, then this would be risk assessed on an individual basis to ensure the visit could be undertaken safely.

Most wards had activity rooms; some wards had a pool table, relaxation rooms with beanbags and special lighting. All wards had access to a gym for informal patients and those with section 17 leave. Managers of Beamshaw and Clarke wards told us patients were unable to access the gym at weekends due to previous issues of the gym being damaged when staff trained to use the gym were not present.

The provision of activities was variable; there were activities advertised for Monday to Friday but not all wards had planned activities over the weekend. The majority of the community meeting minutes we viewed showed that patients said they would like more activities available to them. We looked at the activities schedules available for each ward where these were available. Only Ward 18 and Trinity 2 had pre planned activities advertised at the weekend. Some posters we saw on display in the wards stated that activities at the weekend were dependent upon staffing levels. This meant that there was a lack of activities and therapy available for people, which were, in part, contributed to by a lack of staff to facilitate these. NICE guidance for 'service user experience in adult mental health services' states that service providers should ensure systems are in place for patients in hospital to access meaningful and culturally appropriate activities seven days a week.

Activity facilitators carried out activities on some wards along with, occupational therapists (OT) and ward staff. The

# Are services responsive to people's needs?

Requires improvement 

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

occupational therapists told us they used evidence based occupational therapy assessments and interventions. These included the model of human occupation screening tool (MOHOST), occupational self-assessment (OSA) and therapy outcome measures (TOMs). Staff said there was an effective occupational therapy pathway supporting recovery. We saw evidence of OT interventions in people's care records. Staff said there were various groups patients could attend, including baking, breakfast, art therapy and relaxation groups.

Patients were able to attend 'recovery college'. This is a partnership with volunteers and other supporting organisations to run a range of workshops and courses, which promote well-being and good mental health. The trust, had implemented Creative Minds, which is about the use of creative approaches and activities in healthcare; increasing self-esteem, providing a sense of purpose, developing social skills, helping community integration and improving quality of life. The therapy assistant on Elmdale ward had put in a recent bid to get art therapy on the ward, which had been successful.

All wards had access to outside space; however, in some cases patients would have to leave the ward to access it. This meant those without section 17 leave were unable to access this space.

Patients commented positively about the food provision. Some said they would like more choice. There was good access to drinks throughout the day; patients were able to make their own hot drinks and we observed them doing so.

## Meeting the needs of all people who use the service

All wards had good access for people with physical disabilities. There were bathroom facilities for people with limited mobility and those who used a wheelchair. Staff told us they could accommodate different cultural, spiritual and religious needs. Staff could access interpreters and the trust could provide written information in other languages. The trust was able to provide a choice of food in order to meet the dietary requirements of different religious and health needs. Staff said there was a diversity team at the trust from whom they could seek advice.

Staff provided contact details for representatives from different faiths and local faith representatives visited

patients on the wards. There were multi-faith facilities either on the ward or on hospital sites. Informal patients or those with section 17 leave were able to visit their chosen place of faith.

Each ward had leaflets available about a range of physical and mental health conditions and patient rights. There was information about advocacy services, which included, independent mental health advocates and independent mental capacity advocates.

Patients had access to their mobile phones where individual risk assessment allowed. On some wards, chargers were not allowed in rooms due to ligature risks. Staff charged patients phones on the units at certain points in the day. The ward manager on Clarke ward recognised that mobile phones needed charging more often due to patients using them for music and the internet so had put in a bid in to ask for wireless charging devices to allow safe charging and eliminate the ligature risk. There was a payphone located on all wards. However, we found that on some wards the location of the payphone did not enable private conversation. For example on Melton Suite, Beamshaw and Clarke wards, the phone was in the main communal area of the ward.

Patients could access their bedrooms dependent on individual risk assessment with their own key fobs on most wards.

## Listening to and learning from concerns and complaints

Thirty-four compliments were received in the 12 months 1 February 2015 – 31 January 2016; with Priory 2 receiving the most with 12.

Staff we spoke with were very clear about the trust's complaint policy. They said should a patient complain directly to them they would in the first instance try to resolve the patient's concern and if the complaint were more serious, they would ensure it was directed to the ward manager. Patients said they would speak with staff if they had concerns and others said they would have no problem speaking with the ward manager. On Trinity 1 PICU, information about how to complain was not displayed on the ward which meant patients may not be fully aware of how to make complaints.



# Are services responsive to people's needs?

Requires improvement 

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

There were 40 complaints received from patients of acute and PICU services and of these, 40 were upheld. Four complaints were referred to the ombudsmen and of these, none were upheld, although one was under review

Ward managers told us they had received duty of candour training. They were able to confidently talk about the duty of candour and gave examples of when they had responded to a complaint or incident under duty of candour. They said in the first instance they responded to the complainant verbally and apologised in advance of an

investigation. On one ward, the manager told us about two recent separate incidents where patients had come to harm from their own actions. The ward manager had recorded, reviewed and investigated the incidents. The ward manager had a one to one conversation with each patient and apologised for allowing this to happen. The manager had followed this up by apologising in writing. The trust had delivered duty of candour training to staff at all acute and PICU services.

# 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 trust values are :

- Honest, open and transparent
- Respectful
- Person first and in the centre
- Improve and be outstanding
- Relevant today, ready for tomorrow
- Families and carers matter

The trust vision and values were displayed around the wards at each hospital and also as a screen saver on each ward computer. Staff told us they thought the care offered was the best care; some said their ethos was putting the patient at the centre.

Staff said they knew their senior managers and that some had visited acute and PICU wards.

### Good governance

Staff carried out audits at ward level, these included, infection control, hand hygiene, medication audits, care records audits, consent to treatment, escorted leave and mental health act audits. However, when trying to ascertain if there were adequate staffing levels in place, we found that due to ward managers moving staff between wards it was difficult to ascertain from rotas if staffing levels were sufficient to keep people safe. Planned and actual staffing levels were displayed on the wards we visited, as required by the department of health guidance. Staff told us they were often short staffed and section 17 leave was sometimes cancelled, however, the trust did not routinely monitor when section 17 leave was cancelled on each ward on a consistent and frequent basis. This meant we were unable to evidence what staff and patients were telling us.

Ward managers told us they felt they had sufficient authority to make decisions affecting their wards.

### Leadership, morale and staff engagement

Morale was varied across acute and PICU wards. Some staff and managers told us they were a lot happier than they had been and that they were embracing the changes the trust had made. Others said the challenges of lots of

changes at once were causing stress amongst the teams which included the instigation of 12 hour shifts and some units had recently changed to gender specific. The trust had been introduced a smoking ban across in December 2015. Staff felt the impact of these changes could be seen in the number of incidents relating to the introduction of the smoking ban. The Trust had changed the Datix system to monitor all breaches of the smoking ban where service users had smoked on site, but not the incidents which staff felt had arisen as a result of the smoking ban.

Ward managers and staff across each of the units told us they felt there was a strong team spirit. Staff said they supported each other during stressful situations. Ward managers told us they were proud of their teams and said they could not expect more from them. Managers said the staffing situation had been very difficult and felt that existing staff members had pulled together to ensure patients were safe. In some locations, staff were unhappy that they were unable to fill vacant shifts on overtime, whereas overtime on other wards had been approved.

The introduction of a 'trio' for each location was seen to be positive. The trust formed the trio to provide strengthened leadership and management arrangements, stronger business collaborating between support and operational services, health intelligence and innovation, and business planning processes at service line level.

### Commitment to quality improvement and innovation

Creative Minds, which was an initiative that used creative approaches and activities in healthcare, had won the Health Service Journal Award for Compassionate Patient Care. The Melton suite, Beamshaw and Clarke wards at Kendray Hospital were applying for accreditation by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation scheme called AIMS. The CCQI aims to raise the standard of care that people with mental health needs receive by helping providers, users and commissioners of services assess and increase the quality of care they provide. This is done by collecting information from patients, carers and staff about standards of care using national clinical audits, surveys and peer review visits.

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

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

Treatment of disease, disorder or injury

#### Regulation

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

**How the regulation was not being met:**

Patients on ward 18, Priestley Unit, Dewsbury did not have risk assessments that had been fully completed or completed within trust policies and procedures.

Staff did not have clear lines of sight on Trinity 2, Fieldhead Hospital and Ashdale and Elmdale wards at The Dales.

Not all ligature risks had been identified on Beamshaw and Clarke ward at Kendray Hospital.

12 (2)(a)(b)

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

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

**How the regulation was not being met:**

High dose medication was not routinely monitored across all wards. There were no completed monitoring forms and no information in patient records.

12 (2)(g)

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**How the regulation was not being met:**

Staff supervisions had not been completed across all wards for in some cases over 12 months.



This section is primarily information for the provider

## Requirement notices

Staffing levels and staff skill mix did not meet the trust's minimum staffing levels at times on Ashdale and Elmdale wards at The Dales Hospital and Trinity 1 and Priory 2 at Fieldhead Hospital.

18 (1)(2)(a)