

Good 

Avon and Wiltshire Mental Health Partnership NHS  
Trust

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

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RVN2A	Hillview Lodge	Sycamore Ward	BA1 3NG.
RVN6A	Green Lane Hospital	Imber Ward	SN10 5DS
RVN4B	Longfox Unit	Juniper Ward	BS23 4TQ
RVN8A	Sandalwood Court	Applewood	SN3 6BW
RVNEQ	Callington Road Hospital	Silver Birch Ward	BS4 5BJ
RVNEQ	Callington Road Hospital	Lime Ward	BS4 5BJ

# Summary of findings

RVN9A	Fountain Way	Beechlydene	SP2 7FD
RVN3N	Southmead AWP	Oakwood Ward	BS10 5NB
RVNEQ	Callington Road Hospital	Elizabeth Casson	BS4 5BJ
RVNEQ	Callington Road Hospital	Hazel Unit	BS4 5BJ
RVN9A	Fountain Way	Ashdown Ward	SP2 7FD
RVNEQ	Callington Road Hospital	ECT	BS4 5BJ
RVN6A	Green Lane Hospital	ECT	SN10 5DS

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.

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

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

### **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

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# Summary of findings

## Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units good overall because:

- Statutory and mandatory training was good. Staff were receiving regular supervision and appraisal rates were good. Staff morale and team spirit was high on most wards and staff meetings were occurring regularly.
- Medication management was good. The storage and disposal of medicines was well managed and recording errors were addressed.
- Overall, safeguarding procedures were being adhered to and incidents that should be reported were reported and there were lessons learnt from incidents.
- Overall care plans were good, up to date and recovery orientated. Risk assessments were completed and aligned with plans of care. We found that physical health care monitoring was good and occurred routinely and regularly.
- Handovers were structured, comprehensive and informative. Information that was shared amongst staff was risk based and comprehensive.
- Overall, adherence to the Mental Health Act and Mental Capacity Act was good.
- Patients were treated with kindness and respect with regular community meetings held on wards. In addition, wards held drop in sessions for family members. Patients told us that they felt safe and patient complaints were investigated. Patients had access to advocacy services who visited the wards regularly. There was a range of psychological, educational and recreational activities to meet patient's needs.
- Two electroconvulsive therapy (ECT) suites within the trust were well managed and organised with good governance arrangements in place

# Summary of findings

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

### Are services safe?

We rated acute wards for adults of working age and psychiatric intensive care units requires improvement for safe because:

- Not all ligature risk areas and items had been identified. Some wards had failed to audit whole areas that were patient accessible.
- Seclusion practices at Callington Road Hospital were not safe. Silver Birch did not have adequate resources or facilities to care for patients requiring seclusion.
- Seclusion rooms on four wards did not have easy access to toileting facilities. This compromised the privacy and dignity of patients who were in seclusion.
- Staff were not adhering to local and national guidance around rapid tranquilisation (RT). All wards did not recognise oral rapid tranquilisation medication as a RT event and therefore did not monitor patients' physical health post administration.

However:

- Staffing vacancies remained high in some areas. However, the trust was being proactive with regards to recruitment, retention and career progression.
- Statutory and mandatory training was good. Staff were skilled and experienced.
- Medication management was good. The storage and disposal of medicines was well managed and recording errors were addressed.
- Risk assessments were completed and aligned with plans of care.
- Overall, safeguarding procedures were adhered to all incidents that should be reported were reported. We saw that there were lessons learnt from incidents.
- Mixed sex accommodation was being managed well on all wards. Most wards were providing en-suite facilities and separate areas for females were provided on all wards.

Requires improvement



### Are services effective?

We rated acute wards for adults of working age and psychiatric intensive care units good for effective because:

Good



# Summary of findings

- Staff were receiving supervision regularly. Annual appraisal rates were good.
- Physical health care monitoring was good. Patients physical health was routinely and regularly monitored.
- Overall care plans were good, up to date and recovery orientated. Care plans were reviewed regularly and we saw evidence of patient participation.
- Handovers were structured, comprehensive and informative. Information that was shared amongst staff was risk based and comprehensive.
- Overall, adherence to the MHA and MCA was good.

## Are services caring?

We rated acute wards for adults of working age and psychiatric intensive care units good for caring because:

- Patients were treated with kindness and respect. Patients told us that they had good relationships with staff and patients told us that they felt safe.
- Wards held drop in sessions for family members. These sessions were used to support relatives and provide information around mental health disorders, symptoms and associated behaviours.
- Community meetings were held regularly. Patients had an opportunity to share their thoughts about the ward environment, activities and the care that they received.

Good



## Are services responsive to people's needs?

We rated acute wards for adults of working age and psychiatric intensive care units good for responsive because:

- There was a range of psychological, educational and recreational activities to meet patient's needs.
- Patients had access to advocacy services who visited the wards regularly. Advocate staff worked closely with staff to ensure that patients received a positive experience during their inpatient stay.
- Patient complaints were investigated. Patients told us that they were confident that making a complaint would lead to action.
- There were disabled facilities for those patients that required it.
- There was a range of information available on all the wards relating to care and treatment, complaints and advocacy.

Good



# Summary of findings

However:

- Some patients were being cared for by other health providers, sometimes far from home. This made visiting difficult for family members.
- When on extended leave, the same beds were not always available for patients returning to hospital.

## Are services well-led?

We rated acute wards for adults of working age and psychiatric intensive care units good for well led because:

- Staff morale and team spirit were high on most wards. Staff told us that they felt supported and empowered to do their job. Staff were proud of the work that they did and were proud to work for the organisation.
- Staff meetings were occurring regularly. Minutes were shared amongst staff and action followed up.
- Staff were receiving regular supervision and had completed annual appraisals.
- Ward managers were able to access an electronic system to monitor the services key performance indicators which drove service improvement.

Good



# Summary of findings

## Information about the service

The acute admission wards are based in seven hospital sites across Bristol, Weston Super Mare, Bath, Swindon, Devizes and Salisbury. The psychiatric intensive care units (PICU) were across two hospital sites, which were situated in Bristol and Salisbury. All provide inpatient mental health services for adults.

Sycamore ward was a 15-bedded acute admissions ward for both men and women. There were no en-suite facilities here. The ward was light and airy

Juniper ward was an 18-bedded acute admissions ward for both men and women. There were no en-suites.

Lime ward was a 23-bedded acute admissions ward for both men and women with en-suite facilities.

Imber ward was a 20-bedded acute admissions ward for both men and women. There were no en-suite facilities here. At the time of the inspection, the ward was only admitting 16 patients as four beds were closed.

Silver Birch was 19-bedded acute admissions ward for both men and women. All bedrooms had en-suite facilities. There were two separate gender corridors. There were seven male and 12 female beds on the ward. Each corridor contained a bedroom that was equipped to accommodate a patient with physical health needs.

Oakwood ward was a 23-bedded acute admissions ward for male and female patients. All bedrooms had en-suite facilities. There were two separate corridors for male and

female patients and three single rooms available for either men or women. Each corridor contained a bedroom that was equipped to accommodate a patient with physical health needs.

Applewood was an 18-bedded acute admissions ward for male and female patients. There were separate male and female corridors. Each corridor had seven bedrooms and a further two bedrooms which could be used for any gender dependent on need. All bedrooms had en-suite facilities. At the time of our visit two beds were closed to admissions.

Elizabeth Casson was an eight bedded psychiatric intensive ward for women in the acute stages of psychosis. There were en-suite facilities available.

Hazel Unit was a 12-bedded psychiatric intensive care ward for men in the acute stage of psychosis. There were en-suite facilities here.

Ashdown was a nine-bedded psychiatric intensive care unit for men in the acute stages of psychosis. Ashdown ward had en-suite facilities.

Beechlydene was a 22 bedded unit for both men and women all rooms had en-suite facilities and there were clear male and female parts of the ward.

Electroconvulsive Therapy was provided at both Callington Road and Green Lane Hospital.

## Our inspection team

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

Head of Hospital inspection: Karen Bennet-Wilson

The team that inspected acute wards and Psychiatric Intensive Care Units consisted of three CQC Inspectors: three Mental Health Act reviewers: four specialist advisors.

## Why we carried out this inspection

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

The trust had previously been inspected in June 2014. At the time we issued a number of compliance actions. We reviewed these. The compliance actions, and outcome of the most recent inspection, were:

# Summary of findings

- On some units, there were not clear arrangements for ensuring that there was single sex accommodation. This had been met.
- Individual patient risk assessments had not always been reviewed and updated following incidents of potential or actual harm. This had been met.
- Observation practice did not meet the guidance set out by the National Institute for Health and Care Excellence. This had been met.
- There was inadequate provision of appropriate activities on Sycamore Ward and Juniper Ward. This had been met.
- There was inadequate provision of structured activities on some units. This had been met.
- At Hillview Lodge, emergency life support equipment was not properly maintained and suitable for its purpose. This had been met.
- A number of units were experiencing significant staff shortages, which may have impacted on patient care and safety. Although the trust continued to experience staff shortages, every effort was being made to ensure shifts were fully staffed. In addition, the trust was being proactive with regards to ongoing recruitment. Therefore, we consider this requirement to have been met.
- Arrangements for medical cover were not always sufficient. This had been met.
- On a number of units, we found that there was not appropriate procedures in place for the administration, management and audit of medications. This had been met.
- On additional units, we found that temperature checks necessary for ensuring the integrity of medications had not been undertaken. This had been met.
- We found occasions where the trust had not taken prompt and appropriate action to manage risks identified by serious incidents and concerns. This had been met.
- The trust has failed to have regard to reports prepared by CQC relating to their compliance following a CQC visit to Hillview Lodge in November 2013. This had been met.
- Staff at Hillview Lodge had not received training in the application of the observation policy and observation practice. This had been met.
- Not all staff at Hillview Lodge had received training in advanced life support. This had been met.
- Staff told us that they do get access to mandatory training but there was a lack of developmental training. This had been met.
- At Hillview Lodge, the ward did not meet the required level of cleanliness and the design and decoration of the ward did not support a therapeutic environment. The garden was not well maintained and contained overgrown trees and shrubs that may have posed a ligature risk or a means of escape. Shower and bathroom facilities were in a poor state of repair. Areas of the ward and grounds were staff could not easily observe patients. The design of the unit did not promote privacy or dignity. This had been met.
- Staff told us that they do not always have access to effective supervision. This had been met.
- Not all staff at Fountain Way had received life support. This had been met.
- We found occasions where the trust had not taken prompt and appropriate action to manage risks identified by serious incidents and concerns. This had been met.
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- Not all patients were involved in the planning of their care and treatment. This had been met.
- Elizabeth Casson House and Ashdown ward were experiencing significant staff shortages, which may have impacted on patient care and safety. This had been met.
- Arrangements for medical cover were not always sufficient at Callington Road. This had been met.
- At Fountain Way, emergency life support equipment was missing, not properly maintained and suitable for its purpose. This had been met.
- We found delays in transferring patients where an alternative service was required. We found occasions when a patient may have been transferred earlier than their presentation had indicated. This had been met.

# Summary of findings

- Individual patient risk assessments had not always been reviewed and updated following incidents of potential or actual harm. This had been met.
- We found that seclusion was not always recognised and managed within the safeguards set out in the MHA Code of Practice This had been met.
- We found that physical health observations were not always carried out when people were secluded. This had been met.
- There was inadequate provision of structured activities on some units as required by the MHA Code of Practice meaning some patients complained of boredom. This had been met.
- In Hazel PICU, we found potential ligature risks that had not been effectively mitigated or managed. This had been partially met.

## 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 three focus groups.

During the inspection visit, the inspection team:

- visited all eleven wards at seven hospital sites, looked at the quality of the ward environment, and observed how staff were caring for patients.
- visited the two electroconvulsive therapy suites (ECT) at two hospital sites

- spoke with 22 patients who were using the service
- spoke with the managers or acting managers for each of the wards and ECT suites.
- spoke with 37 other staff members; including doctors, nurses, physiotherapists, pharmacists, administration staff, occupational therapists and other workers including advocacy staff.
- Attended and observed two hand-over meetings and one multi-disciplinary meetings.
- Held focus groups for staff prior to the inspection weeks.
- Collected feedback from six patients using comment cards.
- Looked at 60 treatment records of patients and carried out a specific check of the medication management on all wards.
- 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

- Most patients we spoke with told us that they were happy with the care that they received on the acute and PICU wards.
- Patients we spoke with told us that they felt safe on the wards.
- Patients told us that they felt included in the care and treatment they receive and that they have good relationships with the staff.
- Patients we spoke with told us that they knew how to make complaints and that they were confident complaints would be dealt with appropriately.

# Summary of findings

## Good practice

Green Lane Hospital ECT provided treatment at local general hospital sites for patients who required ECT treatment but had underlying physical health problems.

## Areas for improvement

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

- The provider must ensure that rapid tranquilisation practices are in line with NICE and DOH guidelines and local policy.
- The provider must ensure that all ligature risks are identified through audits and continue with their ligature reduction programme.
- The provider must ensure that Silver Birch provides adequate resources and facilities for the management of patients requiring de-escalation and seclusion.

- The provider must ensure that they review the seclusion facilities on Elizabeth Casson, Oakwood, Lime and Hazel unit and patients have access to toileting facilities whilst secluded.

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

- The provider should consider alternative child visiting arrangements on Imber ward to avoid children having to enter the ward area to access the visiting room.

## Avon and Wiltshire Mental Health Partnership NHS Trust

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

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Sycamore Ward	Hillview Lodge
Imber Ward	Green Lane Hospital
Juniper Ward	Longfox Unit
Applewood Ward	Sandalwood Court
Silver Birch Ward	Callington Road Hospital
Lime Ward	Callington Road Hospital
Beechlydene	Fountain Way
Oakwood Ward	Southmead AWP
Elizabeth Casson Ward	Callington Road Hospital Callington Road Hospital
Hazel Unit	Callington Road Hospital
Ashdown Ward	Fountain Way
ECT	Callington Road
ECT	Green Lane Hospital

# Detailed findings

Mental Health Act responsibilities

Mental Capacity Act and Deprivation of Liberty Safeguards

# 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

- All wards had some areas that were not in clear sight of staff. All wards used patient observation to check on the whereabouts and wellbeing of patients. However, we did find on Ashdown and Hazel unit gaps in the observation records indicating that patients had not been checked on within specific time frames. All wards had used wall and ceiling mounted mirrors to aid observation. However these were not always sited in the best place. For example, on Hazel Unit, there was a blind spot within the extra care area that had no additional aids to help observation. Juniper and Sycamore Unit had addressed lines of sight by removing recesses into bathroom and bedroom areas. Additional mirrors had been mounted on ceilings and walls to aid observation.
- All of the wards had ligature points, but staff had taken action to mitigate the associated risks. All wards had completed an annual ligature assessment that was up to date. However, Juniper ward had not included any of the areas within the therapies corridor, which had several rooms located off the ward that were accessed by patients under supervision. We brought this to the attention of the ward manager and the matron, who completed a ligature audit and submitted to the CQC post the on-site inspection. Lime ward had not included the de-escalation and seclusion area on their annual audit. We brought this to the attention of the ward manager and an assessment of the area was undertaken and added to the ligature assessment. In addition, we did find ligature points on Ashdown, Beechlydene, Sycamore, Imber Elizabeth Casson and Hazel Unit that had not been added to the ligature assessment. We brought this to the attention of all ward managers at all locations who acted immediately. On Ashdown ward we found the ligature risk assessment to be generic throughout. For example, all ligatures identified simply related to 'doors to room'. We spoke with staff who were unable to identify what the ligature risk was with the doors. Existing control measures were the same throughout and all actions and target dates for work to be completed were the same. Staff that had completed the risk assessment had not received any training in identifying risk. Not all ligature risks in the garden or on the ward had been identified. For example, wall lights in the corridors and metal support beam pole in the male lounge. Staff used observations as a form of mitigation. We reviewed the live records on all wards. We found on Hazel, Sycamore and Ashdown wards gaps in these records, indicating that patients had not been seen as safe and well by the staff within specific time frames. All wards required that all patients on a minimum basis should be observed by staff hourly. The trust had a ligature risk reduction programme in place. We saw a ligature assessment action to remove fire key box from the lounge on Beechlydene, which should have been completed by 1 April 2016 but was still in place at the time of our visit. New beds had been ordered for all acute and PICU wards where required and were due to be replaced in June 2016. Hazel ward had addressed some of the ligature risks identified in the previous inspection and had new anti-ligature bathroom items on order. All staff we spoke to on every ward knew where the ligature cutters were kept and knew how to access them and how to use them.
- Imber, Juniper, Lime, Silver Birch, Beechlydene, Sycamore, Oakwood and Applewood wards were mixed gender ward. Staff were managing the mixed sex environment well. There was a female only lounge on all wards that were mixed sex. Beechlydene bedrooms were arranged around a central ward area. All other ward bedrooms were split into two corridors, male and female. One female patient on Imber ward told us that staff were able to isolate the female bedroom corridor if there were any problems. Juniper ward were also able to isolate both male and female corridors. Sycamore ward did not have en-suite bedrooms but did have separate bathroom facilities for men and women which were clearly labelled.
- All wards had clinic rooms and emergency medical equipment. Emergency equipment was checked on a weekly basis and we saw records to show this was the case. However, on Beechlydene we did find airway equipment that was out of date. We brought this to the attention of the ward staff and this was replaced immediately.

# Are services safe?

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

- Elizabeth Casson, Oakwood, Lime and Hazel Unit all had seclusion rooms that did not allow free access to toilet facilities. If it was considered too high risk to end seclusion to allow patients to use the toilet facilities safely, patients would be provided with disposable bowls to use. Not all seclusion rooms had two-way communication systems. The seclusion room on Lime had an unpleasant odour. We brought this to the attention of the ward manager who advised a new mattress had been purchased. Silver Birch ward did not have a seclusion room. When seclusion was required, patients were escorted under restraint out of the ward and across the grounds of the hospital to an available seclusion room. Female patients would go to Elizabeth Casson. Male patients would go to Hazel ward. If neither seclusion room was available, patients would be taken to Lime ward. This was dangerous practice and was not private or dignified for the patient involved. As a result, restraint was often prolonged and staff were sometimes restraining patients across the hospital grounds at night with poor lighting. Concerns had been escalated by the ward and matron. The trust had advised that Silver Birch use secure transport to transfer patients. However, we were told by ward management that secure transport often took in excess of five hours to respond causing further delays in ensuring that patients who were highly aroused were cared for in an appropriate area.
- All wards were clean, well-furnished and well maintained. Some wards had displayed artwork and other creative items that had been made by patients.
- All of the wards across the service scored 96% and above with regards to their condition, appearance and maintenance. This score was awarded during the last patient led assessments of the care environment (PLACE) visit in 2015.
- All staff on all wards adhered to infection control principles. Staff we spoke with were able to verbalise how they would respond to an infection control concern. All hand washing areas had signage instructing all ward members and visitors how to wash hands effectively. However, on Oakwood we found ongoing issues with legionella bacteria in the water system. Although staff had, applied infection control principles and had a reduced admission criteria for patients at risk of contracting legionella, staff had failed to display appropriate signage advising visitors of the risks.
- Where applicable, electrical equipment was subject to safety testing on all wards.
- Cleaning schedules were displayed on all the wards, describing when areas and rooms would be cleaned and how often. All wards were clean and tidy and we saw teams of domestic staff on every ward we visited. One patient on Imber complained about the cleanliness of their room. However, on inspection this appeared to be general wear and tear for example, marks on the wall rather than a cleaning issue.
- Environmental risk assessments were undertaken monthly by all wards. Each month required a different subject including health and safety, fire, work place equipment assessments and control of substances hazardous to health (COSHH).
- All wards had access to personal alarms. However, the alarm system on Ashdown was not effective. Ashdown staff carried a bleep, which sounded in the event of an incident, directing staff to the right area. However, during our visit, this malfunctioned throughout the day and staff were unclear as to where the alarm was instructing them to go. This meant delays may occur with regards to staff responding to incidents.

## Safe staffing

- The trust had recently undertaken a staffing review. As a result, wards had their staffing resources increased. However, this had created vacancies. In addition, Imber ward had recently had their staffing levels increased due to their taking responsibility for staffing the 136 suite at Green Lane Hospital. The trust was proactive in recruiting additional nursing staff of all grades. However, not all the posts could be filled. This was a particular issue with qualified nursing staff. Sycamore ward had taken the decision to fill qualified nursing posts with qualified occupational therapy staff. Once in post, Sycamore ward management told us that the shifts would continue to work with one registered mental nurse (RMN) at all times, alongside the occupational therapist. As part of the staffing review, additional Band 2 health care assistant (HCA) posts had been created. These posts would have a career progression pathway, with Band 2 developing over time into Band 3 health care assistant posts.

# Are services safe?

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

- Following the staffing review the following wards had the following vacancies (all of which are whole time equivalent):
- Four health care assistant (HCA) vacancies and three registered nurse vacancies at Sycamore ward.
- Three HCA vacancies on Lime ward.
- Oakwood had no vacancies.
- There were two registered nurse vacancies on Silver Birch.
- There were four HCA vacancies and four registered nurse vacancies on Elizabeth Casson ward.
- There were three HCA and three registered nurse vacancies on Hazel unit. There were five registered nurse vacancies on Juniper ward.
- There were nine HCA vacancies and four registered nurse vacancies on Applewood ward.
- There were 12 HCA vacancies and two registered nurse vacancies on Beechyldene ward.
- There were 11 HCA vacancies and four registered nurse vacancies on Imber ward.
- There were two HCA vacancies and five registered nurse vacancies on Ashdown ward.
- The acute and PICU service ran a three shift system consisting of early shifts (7am until 3pm), late shifts (1.30pm until 9.30pm) and night shifts (9pm until 7.30am). Ashdown ward also allowed for long day working which were from 7am until 9.30pm. All acute wards, with the exception of Imber ward had five staff on both the morning and afternoon and four staff on the night shift. All shifts required a minimum of two registered nurses to be on duty. We saw staff rosters to show that on the majority of cases this had happened. Where this was not possible, the ward would employ registered bank and agency nurses. Imber ward required eight staff on each shift, including one registered mental nurse during the week working 9am until 5pm. Imber ward held responsibility for staffing the new 136 health based place of safety that had recently opened on the hospital site. The PICU wards all ran on five staff for each shift.
- All wards were using bank and agency staff and where possible used the same staff consistently. All wards provided local orientation to the wards and we saw records on all wards to show that this was the case.
- All ward managers were able to adjust staffing levels when bank staff were required. If bank staff were not available, ward managers had to seek authority for agency from service managers.
- All wards told us that ward activities can be cancelled at short notice. However, this was usually due to unexpected clinical demand and subject to postponement as opposed to cancellation. Patients we spoke to on all wards confirmed that this was the case. Patients on all wards told us that they had access to activities that were varied and interesting. For example, Juniper ward had birds of prey and Shetland ponies bought to the ward.
- With the exception of Beechyldene, which reported that 64% of staff were trained in the prevention and management of violence and aggression (PMVA), most staff on all other wards were trained in PMVA. Training figures for the remaining wards ranged between 76% and 100%. However, we were concerned to learn that student nurses on placement in PICU wards were not trained in breakaway techniques.
- All wards accessed the out of hours on call rota when requiring medical staff out of hours.
- All staff on all wards had access to statutory and mandatory training, including safeguarding, medicine management and physical restraint. The total number of staff who had completed statutory and mandatory training across the service was 87%. During our previous inspection in 2014, we found issues with regards to advanced life support training at Sycamore ward. As a result, Sycamore ward was issued with a compliance notice. We found during our visit that compliance to advanced life support training had improved with 94% of staff having completed basic life support training and 77% having completed physical emergency response training (PERT).

# Are services safe?

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

## Assessing and managing risk to patients and staff

- Between the 1 October 2015 and the 31 March 2016, the trust reported 71 seclusion episodes across the acute and PICU service. The highest use was on Sycamore ward with 12 seclusion episodes.
- In the same time period the trust reported 374 episodes of restraint across the acute

And PICU service, of which 294 were in the prone position. The highest use was on

Ashdown ward, which reported 73 incidents involving the use of restraint.

Of these 73 incidents, 35 were reported as a rapid tranquilisation event.

- We reviewed 33 care records across the acute and PICU service and found that staff completed a risk assessment of patients on admission, which was reviewed regularly. Where risks had been identified these had been aligned with plans of care.
- There were no blanket restrictions in place. The trust had introduced a service-wide garden protocol following a serious incident on Juniper ward. This was then subject to review and alteration to suit each individual ward environment. These local protocols outlined what access restrictions were in place and what level of observation is required whilst the garden is occupied.
- All informal patients we spoke with on all wards told us that they were able to leave the ward. All patients we spoke with told us that they understood that they still may be subject to a pre leave risk assessment and understood the reasons why.
- Elizabeth Casson house practiced good privacy and dignity when searching patients on their return from leave. Clothes were removed from patients however; they were provided new clothes that had been checked by staff previously in order to maintain their dignity. It was necessary to conduct searches of this degree due to the high level of patients secreting instruments to use for self-harm purposes. All other acute and PICU wards adhered to a search policy that was based on individual risk of patients.

- All staff on all wards were able to verbalise their understanding of least restrictive practices. We found evidence in care records and on incident report records to show that staff always attempted to de-escalate situations and only used restraint as a last resort.
- Not all wards we visited were adhering to trust policy or best practice guidelines in line with the national institute for health and care excellence when using rapid tranquilisation. Staff recognised intramuscular use of rapid tranquilisation medication as a rapid tranquilisation event, but not for oral administrations of the same medication. Furthermore, staff across all wards were not monitoring or recording physical health observations before and after a rapid tranquilisation event. Failure to do this leaves the patient at risk of developing serious health complications. Flumazenil, which is a medicine that reverses the potential effects of respiratory distress, (which can be a symptom of taking lorazepam medication), was kept on all wards. All staff we spoke to knew where flumazenil was stored. However, not all staff knew what it was used for. During our visit, Hazel ward began adhering to policy following a rapid tranquilisation event and we saw records to show that this was the case.
- With the exception of Silverbirch ward, which had access to seclusion off the ward, we found no evidence on any ward to show that seclusion was used inappropriately. We found examples across all wards to show that seclusion exit plans had been put in place and that reviews of patients in seclusion in the majority of cases, had taken place as and when they should have. We found one care record on Ashdown ward which did not demonstrate that all necessary discussions with medical staff during one episode of seclusion had occurred. Records for seclusion were kept in both a paper and electronic format and were found to be in order.
- Most staff on all wards were trained in safeguarding and all staff we spoke to were able to verbalise their understanding of the trust safeguarding procedure. However, we did ask that an historic allegation against one staff member by a patient on Imber ward be escalated to safeguarding, as this had not been done at the time. On Sycamore ward, we found one incident where a patient who was vulnerable to sexual

# Are services safe?

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

exploitation by a male patient had not been escalated to the safeguarding department. However all PICU wards considered and reported all patient on patient assaults as a safeguarding event.

- All wards had good medication management practices in place. Storage and transport arrangements of medicines were good. Disposal of sharps in appropriate containers was taking place. Omissions of medicines, which were few across the service, were recorded as an incident.
- All wards provided facilities for children to visit the ward. There was a baby changing facility and a separate area away from the inpatient environment on both Elizabeth Casson and Sycamore ward. Imber ward provided a child visiting space which could be accessed through the 136 suite (health based place of safety), adjacent to the ward. However if the 136 suite was occupied, children had to enter the main inpatient area of Imber ward to access the child visiting facilities. Applewood and Oakwood ward had double access doors to the visiting rooms. This meant that they could be accessed directly from the ward or from the garden and so children and visitors did not need to come into the ward environment.

## Track record on safety

- There had been serious incidents on most wards over the past 12 to 24 months. Juniper, Sycamore, Imber, Applewood and Lime ward had all experienced incidents resulting in loss of life and serious injury, mostly due to acts of self-harm by patients. All were able to demonstrate learning because of these incidents. Learning included training and improved practices for staff around patient observations, the searching of patients returning from leave and structural changes to the environment. All staff on all wards we spoke with told us that they had felt supported following incidents. Staff told us that they were able to access one to one support and group debrief following incidents.
- Garden protocols and staff adherence to the observation and engagement policy had been implemented. Structural work and changes had occurred to minimise future events where incidents had involved ligatures and height to cause self-harm. Imber ward had introduced a search and remove policy to manage the use of sharp implements. However, this has

since been reviewed and risk is now considered on an individual basis. One of the gardens on Applewood ward remained closed at the time of the inspection due to ongoing building works to safeguard patients from a low-lying roof.

## Reporting incidents and learning from when things go wrong

- All wards used an electronic incident report system called safeguard. All staff had access to this. All staff we spoke with knew what type of incidents needed to be reported and how to do this. Ward managers reviewed incident forms once submitted.
- We saw examples across all wards to show that all incidents were reported appropriately. For example, patient on patient assaults, medication errors, self-harm and illicit substance use. However, we did find on Applewood one patient on one staff assault that had not been recorded as an incident.
- Not all staff were familiar with the term 'duty of candour'. However, once explained, all were able to provide examples of when they have been open and honest with patients and their families when things have gone wrong.
- Where incidents had occurred, staff told us that they received information and feedback following the events. Other information was cascaded through the Trust newsletters, through emails and shared during staff meetings; We saw records across the service to show that this was the case.
- Staff we spoke with told us that they received support and opportunity for debrief following serious incidents. Staff were able to access one to one support and attend group debriefs sessions when necessary.

## Electroconvulsive Therapy Services at Callington Road and Green Lane Hospital

- Both ECT suites were fully staffed. There were registered mental health nurses and registered general nurses, medical staff including consultant psychiatrists and anaesthetists.
- Both ECT suites had ligature points, which were mitigated through audit and staff presence. Ligature audits were completed annually and updated regularly and patients were always observed by and in the

# Are services safe?

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

company of staff. At Callington Road the toilet had many ligature risks, including sink taps and assistance rails. The manager was concerned due to patients not always being observed in this area. The manager told us that they have raised this with the trust but have not been scheduled for any works to take place.

- Medication management was good. Controlled drugs were stored in locked cupboards and were checked on a daily basis. All fridge and room temperatures were checked on a daily basis and we saw records to show that this was the case. Medicines were disposed of properly.
- Statutory and mandatory training levels were good with all areas of fundamental training in excess of 75%.
- All patients were given a full and comprehensive information pack upon arrival to both ECT suites.
- All patients underwent a full medical check prior to treatment commencing and we saw records to show that this was the case.
- On our previous visit, we found occasions when incidents relating to procedures were not being reported. For example, damage to dental work or a bruised or split lip during anaesthesia. The previous inspection stated, “these incidents were not routinely reported as they are regarded as well-known possible outcomes in anaesthesia nevertheless we encourage the reporting of all incidents however minor so that for example mouth care might be improved”. We found during this visit that this had been addressed and all incidents that should have been reported had been.
- Both ECT suites were clean and comfortable. There were waiting rooms for patients and their families. The treatment room and the recovery room on both ECT suites were private.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

- All care records we looked at on all wards showed that patients were receiving physical health checks on admission and routinely thereafter.
- Care records we reviewed were generally good. They were up to date, need specific and recovery orientated. However, with the exception of Imber ward, we found evidence across all wards to show that on occasion care plans were not personalised and had used a standardised format. Beechlydene and Hazel Unit had not always provided copies of care plans to patients.
- All information needed to deliver care was stored securely on an electronic system that was password protected, called RIO.

### Best practice in treatment and care

- All wards were following NICE guidance when prescribing medication. We found one record on Silver Birch that was not in line with T3 prescribing conditions. The combination of medicines allowed had exceeded the combined British national formulary (BNF) percentages by 25%. Exceeding recommended doses could lead to ill health.
- All wards were offering access to psychological services and therapies tailored to the patients' needs. For example, there was access to drama and art therapists and speech and language therapists (SALT).
- Staff resourced dental care locally when required. On all wards, the ward medical staff provided general health care. All wards were monitoring patient's vital signs on a minimum weekly basis. Lime ward was monitoring patient's vital signs on a daily basis. We saw records on all wards to show that this was the case. Dietetic care was by referral. However, we were told by Juniper that dietetic advice was sourced locally as no dieticians had been employed for that locality. Physiotherapists worked on a part time basis on all wards. Juniper ward had exclusive access to a fully equipped gymnasium which was used daily.
- Clinical staff were involved in clinical audit across all the wards. For example, infection control monitoring and medications management.

### Skilled staff to deliver care

- All wards had access to a range of professionals including medical staff, nurses, psychologists (Sycamore ward by referral) occupational therapists and pharmacists. In addition, each ward had their own physiotherapist and access to dieticians was by referral.
- The trust provided an induction for all new starters. New Health Care Assistants were expected to complete the care certificate. New staff received a local induction to the ward when starting and we saw records on all wards to show that this was the case.
- All staff on all wards were receiving supervision on a regular basis. As of April 2016, records showed that supervision ranged between 70% and 97% across the service. Where figures were lower this was due to staff absences such as sickness and annual leave.
- As of 31 March 2016, records showed that staff who had had an appraisal ranged between 84% and 100% across the service.
- Ward managers and deputy ward managers were accessing leadership and management training. Some staff had received solution focused management training.
- Imber ward had been identified as an area of risk by the executive team, with regards to quality and conduct issues surrounding staff performance. We were shown evidence as to how this was being managed. We saw evidence to show what actions had been taken to address poor conduct and performance, including supervised practice and termination of contracts. All ward managers were able to verbalise their understanding of the staff performance policy. Most wards had experience of addressing staff performance issues and all were able to share with us how they would manage these issues effectively.

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

- All wards held ward rounds which varied between once weekly and several times a week. Patients we spoke with across all wards told us that they were able to attend.
- Handovers occurred three times a day at each change of shift. We observed handovers on Sycamore ward and Hazel unit. These were well informed. Patient's risk, legal

# Are services effective?

Good 

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

status, current and historic issues and presentation were all discussed at length. Staff used a structured patient agenda to follow. This format was used through the acute and PICU service.

- Most wards told us that there was good interface with other trust services including community and crisis teams. However, some staff did say that they found care coordinators did not attend the ward and were not engaged in patients' inpatient care once admitted to wards. Some wards told us that they felt under pressure by community and crisis teams to discharge patients, due to patients waiting to be admitted from community settings.
- None of the wards we visited were registered with local general practitioners as all patients' physical health needs were met on the wards by medical staff.
- All wards who had had contact with local authority agencies with regards to social care and safeguarding said that this had been a positive experience.

## Adherence to the MHA and the MHA Code of Practice

- Mental Health Act training ranged between 78% and 100% across the service.
- All staff we spoke with on all wards had a good understanding of the mental health act (MHA), the code of practice and its guiding principles.
- Where applicable records we looked at showed that consent to treatment and capacity requirements were being adhered to. Consent to treatment forms where applicable were attached to medication cards.
- Where applicable records we looked at showed that patients were having their rights under the MHA explained to them.
- Staff could seek legal advice surrounding the MHA from a local MHA office. The trust also had a central MHA office which had oversight of all MHA practices within the trust.
- Where applicable records we looked at showed that detention paperwork was filled in correctly, up to date and stored appropriately.

- There were regular audits to ensure that the MHA is being applied correctly. These were completed monthly on all wards.
- Independent mental health advocate (IMHA) information was displayed around the wards and across the service. Patients were able to contact IMHA services directly or seek assistance doing this from staff. We saw examples in care records of where IMHA staff had attended the ward on request.

## Good practice in applying the MCA

- Mental Capacity Act training ranged between 80% and 100% across the service.
- All staff we spoke with on all wards had a good understanding of the mental capacity act (MCA) and its five statutory principles.
- There was a policy on MCA including deprivation of liberty safeguards (DoLS) which staff are aware of and can refer to.
- Where applicable, records we looked at showed overall that where patients' capacity was impaired, assessments of capacity had taken place. These were decision specific and made in the best interests of patients, recognising the patients' wishes, feelings, culture and history. However, on Hazel unit, there was no evidence of a mental capacity assessment surrounding medication issues in two care records having been made. On Elizabeth Casson ward, although there was evidence of mental capacity assessments for specific issues, there were no details provided of how conclusions were reached. On Ashdown, ward one patient had not received a capacity assessment with regards to future placements once discharged from hospital.
- All staff we spoke to understood the MCA definition of restraint. Staff were able to describe their understanding of least restrictive practices and were able to provide examples of how this would be achieved.
- Staff could seek guidance and advice on matters surrounding the MCA from a locally based MHA and MCA office. There was also a central MHA and MCA department who had oversight of all legal practices within the trust.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- We observed care on all wards that was supportive, respectful, good humoured, patient and kind. We observed difficult moments between staff and patients due to the level of acuity on some wards. Despite some patients being confrontational (due to the nature and severity of their mental illness) staff remained calm, respectful and solution focused.
- All patients we spoke with told us that they were treated well by the staff on the wards. Where patients were unhappy with their care, this was more centred around their detention in hospital as opposed to staff attitudes.
- Staff we spoke with on all wards had a good understanding of the needs of all patients. We observed handovers on Hazel Unit and Sycamore ward where staff were able to demonstrate their knowledge of individual needs.
- Patient led assessments of the care environment (PLACE) scores for privacy and dignity ranged between 84% and 99% across the acute and PICU service.

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

- All patients we spoke with told us that they received appropriate information about their inpatient stay and treatment plans when first admitted to the ward.
- Active involvement and participation in care planning was variable. However, most patients we spoke with told us that they felt involved when planning their own care pathway. Most patients told us that they had received copies of their care plans, and were happy that they could raise any concerns about the details in their care plans with staff.

- Advocacy staff visited all the wards on a minimum weekly basis. We saw information displayed on all wards about the advocacy services available. We spoke with one advocate on Sycamore ward who talked positively of their involvement working with patients and ward staff.
- We saw evidence to show that families and carers were involved, with the patients' consent in their care. All the wards across the service held drop in sessions for families and carers on either a weekly or a monthly basis. These sessions were used to support and provide information to families' and carers about their relatives' hospital stay and mental health condition. The trust also hosted monthly area wide family support meetings in the local communities.
- All wards were holding community meetings for patients on a weekly basis. We saw minutes to show that these meetings were happening. We saw patient requests and complaints were being addressed. For example, one patient had asked for daily newspapers and the ward manager had arranged this.

### Electroconvulsive Therapy Services at Callington Road and Green Lane Hospital

- There was no one receiving treatment on the day of our visit to either ECT suite. However, we were able to view testimonials made by patients who were receiving care. All spoke about the professional and caring attitude of the staff.
- We were able to speak with the two managers for both ECT suites and the consultant psychiatrist at Callington Road Hospital. All were knowledgeable about ECT, the care required and the treatment. All spoke positively and passionately about the service they provided.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

- In the six months prior to the inspection, bed occupancy levels ranged between 83% and 99%, with Silver Birch ward being the highest and Juniper ward being the lowest.
- Beds across all wards were not always available to patients living nearby. Some patients were occupying beds in other parts of the Trust. Given the geographic spread and rural areas of the trust, this made it difficult at times for some families to visit regularly. There were seven patients across the service that were placed in other NHS and private providers around the country. Distances from home ranged between 93 and 225 miles. This would make visiting for families difficult.
- All wards tried to reserve beds for patients to return to when they went on leave. However, due to bed pressures and availability this was not always possible. Ward managers told us that overnight leave beds were retained for patients on their return. However, any leave beyond one night could potentially be used for new admissions.
- All wards tried to avoid moving patients between wards unless there was a clinical need to do so. However, bed pressure and availability sometimes required staff to move patients to other wards when there was no clinical reason to do so. All ward staff on all wards described being subject to discussions about premature discharge to allow for patient admissions. However, all said that they were able to assert themselves if they did not agree. We found only one occurrence, involving Elizabeth Casson House of when more senior trust staff had made the decision to use beds that had been decommissioned 18 months previously. However, the ward was provided with additional resources to manage the two extra patients over one weekend period.
- The Trust had closed 16 beds recently which was having an impact on bed availability within the Trust. However, the four bed closures on Imber ward were temporary, allowing building work to happen. The four beds between Juniper and Applewood (two on each) had been closed. The closures on Juniper ward were to help with providing a more manageable patient caseload and were permanent closures. The closures on Applewood were temporary and were to help with privacy and dignity issues whilst work to reduce ligatures was being carried out. The eight beds that had been closed on Sycamore ward were a series of measures to improve patient safety, privacy and dignity. The Trust planned to reopen these beds when Sycamore was relocated to a new build in the next 12 to 24 months.
- The trust had purchased beds from two private health providers to help with bed availability and bed pressure. Since July 2015 to May 2016, the amount of patients accessing these beds ranged between 10 and 17 patients.
- Movement between wards and discharge happened at an appropriate time of day. This was usually only deviated from when a PICU bed was required for an acutely unwell patient.
- All acute wards described having difficulty in accessing PICU beds when they were needed. This was because all three PICU facilities ran at 100% bed occupancy most of the time. Acute wards that were on the same site as the PICU wards (Callington Road and Fountain Way) described better and quicker access due to direct interface and close proximity.
- There were delayed transfers of care for reasons other than clinical need. This was mainly due to delays in finding appropriate placements for patients prior to discharge.
- The trust reported 33 delayed discharge patients across the service in the six months prior to our visit. In the majority of cases, this was due to the need to find appropriate placements for patients prior to them being discharged.

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

- All wards had areas that were used to provide group and one to one activities. Sycamore had access to a large gymnasium. All wards provided access to multi faith areas.
- Beechlydene had a large concierge desk that was difficult for some patients to see over. Patients we spoke with told us they found this obstructive.

# Are services responsive to people's needs?

Good 

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

- Ashdown ward had a 'safe box' and Beechlydene had a calm box, which contained items that were useful in engaging agitated or distressed patients. For example, there was access to a foot soak and a soft blanket.
- All wards provided quiet areas on the wards for patients. All wards provided areas for visitors to meet with patients.
- Subject to risk assessment, all wards allowed patients to use mobile phones and all wards provided access to a public phone.
- All the wards provided access to outside space. Wards had direct access to gardens and patients who were able to leave the wards, where able to use hospital grounds.
- Most patients that we spoke with on all wards told us that the food was of good quality. There was a range of choice and dietary requirements were catered for. The last PLACE survey in 2015 between 86% and 97% of patients said that they were satisfied with the food on the wards. All the wards provided access to drinks and snacks 24 hours a day, seven days a week. All wards were able to isolate access to boiling water in an emergency.
- All wards encouraged patients to personalise their bedroom spaces. However, this would be subject to risk assessment.
- All wards provided a secure place for patients to store their belongings. This was either a safe within their bedrooms or locked storage space on the ward that patients could have access to.
- All wards provided activities throughout the week and at weekends. For example, there were cooking classes, arts and crafts, music groups, current affair discussions and movie evenings. Occupational staff led on this and were supported by nursing staff.
- All wards displayed information regarding advocacy services, available treatments, ward activities and how to complain.
- All wards told us that they were able to access interpreting services when required. All wards used an external provider for this service.
- All wards provided food that met specific dietary requirement including religious and ethnic needs. We saw menus and records to show that this was the case.
- All wards had access to spiritual support and multi faith room. Representatives from different religious groups would attend the ward when requested to do so.

## Listening to and learning from concerns and complaints

- Between the 1 February 2015 and the 31 January 2016, the trust reported a total of 63 complaints across the acute and PICU service. Of these, ten were fully upheld and 24 partially upheld. Three were referred to the ombudsman. Examples of these complaints were short notice transfers between wards, lack of communication with relatives, excessive force during restraint and medication issues. In addition, for the same time period the trust reports having received 219 compliments across the service. We were able to see during our visit examples of these including, friendly and helpful staff and good food.
- All patients we spoke with across all wards knew how to make a complaint. Two patients told us that staff had helped them to make their complaints.
- Staff we spoke with were able to verbalise how they would manage a complaint when brought to their attention. All staff said they would seek to resolve the issue at the point of contact. All staff said if they were unable to they would engage the support of their line manager and the patient advocacy liaison service (PALs).

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

- All wards provided facilities for disabled visitors and patients. Wards were accessible and disabled bedrooms and assisted bathrooms were present on all wards.
- Information leaflets in other languages were available to all staff across the service to give to patients.

## Electroconvulsive Therapy Services at Callington Road and Green Lane Hospital

- Both ECT suites had a range of professionals who specialised in ECT and anaesthetic care. There was medical staff, registered mental health nurses and registered general nurses and anaesthetists.

# Are services responsive to people's needs?

Good 

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

- There was a range of information leaflets available for patient's about their care and treatment.
- Both ECT suites provide care and treatment twice weekly. Waiting lists were well managed and flexible to meet urgent cases.
- Green Lane Hospital did not treat people with underlying physical health conditions on site. The Green lane Hospital ECT service held clinics in the local general hospital when providing ECT to patients with physical

health problems. This was to ensure optimum safety and ensure that in the event of a physical health emergency, they were able to access assistance immediately. The Callington Road ECT suite did provide treatment to patients with underlying physical health conditions but did consult with the local general hospital which was nearby if they had concerns. If they had any concerns about a patient physical health treatment, they would discuss this with the local hospital as a matter of precaution.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- All staff we spoke with on all wards were generally aware of the organisations visions and values. All staff we spoke with felt that this reflected their own ward philosophies and attitudes to care which were positive and enthusiastic.
- All staff on all wards were aware of who their immediate managers were including who the matron was as they were visible and approachable. However, most staff we spoke with did not know who the executive team were and told us that they had not visited the wards. Some staff did say that they had met the Deputy and the Director of Nursing and that they had visited the wards.
- Oakwood and Applewood ward had a mutual expectations board. This set out agreed values and expectations between patients and staff. The ward manager told us that they reviewed this approximately every 12 months due to the turnaround of patients on the wards.

### Good governance

- Governance arrangements within the service were good. Staff were receiving statutory and mandatory training. Staff were receiving supervision regularly and had completed an annual appraisal. Staffing remained a challenge for the trust however; they were taking measures to fill vacancies. Staff reported all incidents. All incidents were monitored through local clinical governance meetings, the outcomes of which were cascaded through staff meetings.
- The Trust used an electronic system called information quality (IQ) which contained information on key performance indicators (KPI's). All ward managers had access to this and all were able to see how their individual wards performed against indicators, such as seven day follow up and delayed transfers of care.
- All ward managers across all wards said that they felt they had sufficient authority with regards to the management of their individual wards. All wards had administration support.
- All wards were able to contribute to a local risk register that was held centrally in each locality area.

### Leadership, morale and staff engagement

- Sickness and absence rates for March 2016 ranged between 5% and 14% across the service. Sickness and absence issue were being managed locally in line with trust policy.
- We were told of bullying and harassment cases on Imber ward only. These issues had been identified previously by the executive board and were under continuous review.
- All staff we spoke with across all wards knew how to access the whistleblowing procedure, and told us that they felt confident to use the procedure.
- All staff we spoke with on all wards said that they were proud of the work that they did for patients and were proud to work for the trust. All said that there was a good sense of team spirit. However, Silver Birch ward staff told us that morale was low due to high levels of acuity and a lack of appropriate resources to manage disturbed patients. Silver Birch did not have its own seclusion room or a de-escalation area. Imber ward had also been through a period of staff performance issues which had had an impact on staff morale. However, staff we spoke with told us that as a result of staff conduct and performance issues being addressed, morale was improving. Juniper ward had introduced a staff wellbeing project, which focused on a different theme each day, for example, exercise and healthy eating.
- Staff across the service were acting into positions of ward management. Ward managers were able to access management training with the institute of leadership and management (ILM) and solution focused ward management training.

### Commitment to quality improvement and innovation

- All the acute wards were involved in AIMS accreditation and had achieved excellence status. All of the PICU wards were members of the national association of psychiatric intensive care unit (NAPICU).

### Electroconvulsive Therapy Services at Callington Road and Green Lane Hospital

- Both ECT suites were delivering care and treatment in line with the National Institution for Health and Clinical

# Are services well-led?

Good 

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

Excellence (NICE) guidelines for ECT. Both ECT suites had been accredited with the Royal College of Psychiatrists' ECT Accreditation Service (ECTAS) certificate of excellence.

- The manager at Green Lane ECT suite was a member of the Royal College of Psychiatrists, representing the national association of lead nurses for ECT.

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

**To ensure that patients using the service are treated with respect and dignity at all times while they are receiving care and treatment.**

Elizabeth Casson, Oakwood, Lime and Hazel Unit all had seclusion rooms that did not allow free access to toilet facilities. This was a breach of Regulation 10: 1 and 2 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### 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

**To prevent patients from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.**

Silver Birch ward had to access seclusion facilities off the ward. Patients would be taken under restraint into the hospital grounds and to another ward to access seclusion facilities. This was a breach of Regulation 12: 1 and 2 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12.

#### 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

**To prevent patients from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.**

This section is primarily information for the provider

## Requirement notices

All wards were not adhering to best practice in line with national and local guidance with regards to a rapid tranquilisation event. This was a breach of Regulation 12: 1 and 2 (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12.

### 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

**The trust must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of patients using services.**

All wards had had not adequately identified areas or items or mitigated the risks surrounding the potential use of ligatures. This was a breach of Regulation 12 1 and 2 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12.