Good

Central and North West London NHS Foundation 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)
RV3Y1	Campbell Centre	Hazel Willow	MK6 5NG
RV312	Park Royal Mental Health Centre	Caspian Pine Pond Shore	NW10 7NS
RV320	St Charles Mental Health Centre	Amazon Danube Ganges	W10 6DZ

Summary of findings

		Nile Shannon Thames	
RV346	The Gordon Hospital	Ebury Gerrard Vincent	SW1V 2RH
RV383	Northwick Park Mental Health Centre	Eastlake Ferneley	HA1 3UJ
RV3AN	Hillingdon Hospital Mental Health Site	Colne Crane Frays	UB8 3NN

This report describes our judgement of the quality of care provided within this core service by Central and North West London 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 Central and North West London NHS Foundation Trust and these are brought together to inform our overall judgement of Central and North West London NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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Summary of findings

Overall summary

Following this inspection, we rated acute wards for working age adults and the psychiatric intensive care unit (PICU) as **good** because:

- In February 2015, staff on the wards were not properly managing ligature risks that they had identified. When we visited in October 2016, staff were taking appropriate steps to manage ligatures.
- In February 2015, staff were not effectively managing blind spots on the wards and observing patients safely was difficult. When we re-visited in October 2016, staff were managing blind spots appropriately.
- In February 2015 staff were not putting appropriate measures in place to help reduce the numbers of patients absconding from the wards. During this inspection we saw that measures had been put in place to reduce the numbers of patients absconding.
- In February 2015, not all staff were trained in how to undertake the safe physical restraint of patients. During this inspection we found that staff had completed necessary restraint training.
- In February 2015 the records completed by staff relating to the seclusion of inpatients did not provide clear evidence that staff had undertaken seclusion in accordance with the Mental Health Act Code of Practice. During this inspection we found that records overall showed that staff had secluded patients appropriately and monitored them when this had taken place.
- In February 2015, staffing levels were not sufficient to guarantee the safety of patients and staff and that the lack of staff had a significant impact on the quality of life of patients. During this inspection the wards had sufficient staff on duty to meet patients' needs.
- In February 2015 the wards were over-occupied and there were no plans to managed needs which impacted upon the experience of patients using the services. During this inspection we found that plans were in place to manage these issues more effectively.
- Bed management across the inpatient sites had improved considerably since the last inspection and was closely monitored by the trust.
- In February 2015, we saw that information had not been available to inform patients how to make a complaint on the PICUs. At this inspection, we saw that information about complaints was visible on all the wards we visited.
- In February 2015 we found that patients were not always able to make phone calls in private. At this inspection we found that all patients were able to make private calls.
- Patients told us that they felt safe on the wards. Wards across all sites were clean and well maintained.
- Multidisciplinary teams were consistently and pro-actively involved in patient care, support and treatment.

However:

- In February 2015 we found staff were not always attending adequately to patients' physical health needs and monitoring of physical observations following administration of rapid tranquilisation RT tranquilisation (RT). At this inspection we found that some improvements had been made but there were still gaps in the recording of physical observations.
- Staff did not always keep good records when physical restraint was used.
- Further work was required to monitor and reduce the use of restraint and prone restraint across the service in line with national best practice guidance.
- Systems to monitor patients physical health and to ensure that where the patient was deteriorating, appropriate help was made available were not being used consistently.

Summary of findings

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

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- In February 2015 we found that monitoring of physical signs was not always maintained until the patient was alert following the use of rapid tranquilisation (RT). At this inspection we found that some improvements had been made but there were still gaps and inconsistencies in the recording of post RT physical observations. This meant that we could not be provided with assurance that the correct observations had taken place when RT had been used.
- There were variations between different trust locations on the use of restraint. The trust had a target of reducing restraints by 50% across wards; however the number of incidents of restraint had continued to rise. Specific work on the use of restrictive practices was being carried out in Brent where the number of restraint incidents were significantly different from those in the other trust locations.
- Physical restraint records were not always completed fully. This included information on the numbers and identity of staff involved. This was contrary to the policy of the trust and meant that the records did not evidence that the restraint was done safely.
- Some risks to patients were not identified and risk management plans did not record enough details about risks to patients. Risk management plans did not contain sufficient information on the risk and how this was to be managed. Some risk management plans were hard to locate in the patients record.
- Staff on the PICU wards did not have a clear understanding or knowledge of incidents which had taken place particularly when incidents had happened on different hospital sites within the trust.
- Not all staff had completed mandatory training in immediate life support and fire training,

However:

- In February 2015 we found that staff on the wards were not properly managing ligature risks that they had identified. During this inspection we found that staff were taking appropriate steps to manage ligatures.

Summary of findings

- In February 2015 we found that staff were not effectively managing blind spots on the wards, which meant that they could not always see into all areas of the ward. This made the wards unsafe. During this inspection we found that blind spots were appropriately managed.

- In February 2015 we found that staff were not putting appropriate measures in place to help reduce the numbers of patients absconding from the wards. During this inspection we saw that measures had been put in place to reduce the numbers of patients absconding.

- In February 2015 we found that not all staff were trained in how to undertake the safe physical restraint of patients. During this inspection we found that overall necessary restraint training had been completed.

- In February 2015 we found that the records completed by staff relating to the seclusion of inpatients did not provide clear evidence that staff had undertaken seclusion in accordance with the codes of practice of the Mental Health Act 1983. During this inspection we found that records overall showed that staff had secluded patients appropriately.

- In February 2015, we found that staffing levels were not sufficient to guarantee the safety of patients and staff and that the lack of staff had a significant impact on the quality of life of patients. During this inspection we found that the wards had sufficient staff on duty to meet patient's needs.

- Patients received care in a clean and hygienic environment.

- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. There was an active recruitment and retention programme.

- Staff were aware of incident reporting procedures. Staff confirmed they had received feedback from incidents.

- Staff were knowledgeable about how to recognise signs of potential abuse and aware of the reporting procedures.

Summary of findings

- There were safe and effective arrangements in place for medicine management.

Are services effective?

Good

We rated effective as **good** because:

- Patients were assessed in a timely manner on admission and most care plans were comprehensive and holistic.
- Staff assessed patients' physical healthcare needs on admission.
- Staff used a number of different outcome measures to gauge the progress of patients during their admission and to ensure that input was effective.
- There were multi-disciplinary teams on all the wards with input from different professional groups. Teams worked well together. In February 2015, we had identified concerns that full multi-disciplinary teams were not directly inputting information on patients' records. At this inspection we saw that this was no longer the case and had been an improvement.
- Patients were cared for safely by a staff team who received appropriate training and supervision to meet their needs.
- Staff had a good understanding of the Mental Health Act and were able to give examples across the service of their use of the Mental Capacity Act in practice.
- Staff on the wards worked well with external agencies including benefits advice services and housing services as well as social care and primary healthcare in order to ensure patients' needs were met.

However:

- There were inconsistencies in the way that modified early warning system (MEWS) records were monitored and escalated between wards across the service which meant that key information and changes in patterns regarding patients' physical health may not be picked up in a timely manner.

Summary of findings

- Some care plans were not in a format that was accessible for patients and where they could include their views.
- Staff supporting patients with a learning disability or autism had not received training on this.

Are services caring?

Good

We rated caring as **good** because:

- Most patients spoke positively about the care, support and treatment they received.
- We observed positive interactions on wards between staff and patients.
- Patients had access to an independent advocate.
- Staff displayed a good understanding of patient's individual needs.
- Information on the service was provided to patients on admission.
- Regular community meetings took place on the wards, patients were able to give their views and on most wards staff provided feedback in a 'you said we did' format.

However:

- Patients' needs were discussed in ward rounds, patients were encouraged to express their views and wishes. However, care plans contained little evidence of patient involvement with the care planning process.
- Staff did not always respect patients' privacy and dignity. For example, on Pond ward, three patients told us that staff entered their rooms without knocking. At Northwick Park MHC, patients described the staff at night as having a poor attitude, intimidating, abrupt and dismissive.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

Summary of findings

- In February 2015 we found evidence that the wards were over-occupied. This meant that patients sometimes slept on a different ward to the one where they were admitted and their bed was not always available when they returned from leave. The lack of bed capacity also meant that staff sometimes moved patients for non-clinical reasons in order to make a bed free. However, during this inspection we found that plans were in place to manage these problems more effectively. This meant that it was rare for patients not to have a bed when they returned from leave, staff rarely moved patients for non-clinical reasons and patients did not sleep on different wards to the one they were treated on.

- Bed management across the inpatient sites had improved considerably since the last inspection and was closely monitored by the trust. Further work was needed to improve the timelines of discharges and to reduce the number of patients waiting more than four hours once they had been clinically assessed as needing an inpatient bed, especially at weekends. The trust was aware of both these areas for improvement and there was on-going work in place to address this.

- In February 2015 we found that patients at the Campbell Centre were not able to make telephone calls in private and that shared rooms did not provide an adequate level of privacy and dignity. During this inspection we found that improvements had been made. Patients could make a telephone call in private and doors had been fitted to the en-suite bathrooms.

- There was a good range of facilities including quiet rooms, therapy rooms and outdoor space to meet the needs of patients. However, the patients on Caspian ward had not been able to access the gym on the ward for several months due to technical reasons. The lounge areas at St Charles MHC were sparse, minimally decorated and furnished. They did not create an atmosphere of recovery and comfort.

- There was a programme of activities for patient throughout the week. However, patients on all the wards said that there were too few activities for patients at weekends. This risked impacting the care and recovery of patients on the wards.

Summary of findings

- Patient feedback on the quality of food was mainly positive and met their individual dietary and cultural needs. Northwick Park MHC was an exception. Here, some patients told us that the service did not cater for food that met their religious and cultural needs.

- Patients were supported to meet their religious and cultural needs. such as religious or spiritual texts to support patients' spiritual needs.

- In February 2015, we saw that information had not been available to inform patients how to make a complaint on the PICUs. At this inspection, we saw that information about complaints was visible on all the wards we visited.

However:

- In February 2015, we identified that the trust did not have systems in place to ensure that verbal complaints were addressed. At this inspection, we found that while staff told us verbal complaints were addressed, we did not see that there were systems in place to document how this happened.

Are services well-led?

Good

We rated well-led as **good** because:

- In February 2015, we found that the acute wards for working age adults were not well managed overall because contingency plans were not in place to meet the increases in the demand for acute inpatient beds. During this inspection we found that significant improvements had been made in this area. Bed management was robustly managed and monitored.

- Staff enjoyed working at the service and were committed to providing good quality care and support to people. They had a good understanding of the values of the organisation and knew who the senior managers were.

- Staff were provided with opportunities to develop their management skills.

- There was a commitment to quality improvement and innovation across the service, for example the Shine project to improve physical healthcare for patients.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Central and North West London NHS Foundation Trust are part of the trust's acute service line. There are six hospital sites, which have the following acute wards and PICU wards:

The Campbell Centre in Milton Keynes:

Willow ward – 19 beds, for both men and women

Hazel ward – 19 beds, for both men and women

Park Royal Mental Health Centre (MHC) in Brent:

Pine ward – 24 beds, for men.

Pond ward – 24 beds, for women.

Shore ward – 18 beds, for both men and women

Caspian ward – 13 beds, a PICU for men

St Charles Mental Health Centre (MHC) in Kensington:

Amazon ward – 17 beds, for both men and women

Danube ward - 16 beds, for both men and women

Thames ward – 17 beds, for both men and women

Ganges ward – 17 beds, for both men and women

Shannon ward – 12 beds, a PICU for women

Nile ward – 14 beds, a PICU for men

The Gordon Hospital in Westminster:

Vincent ward – 20 beds, for both men and women

Ebury ward, 19 beds, for both men and women

Gerrard ward – 18 beds, for both men and women

Northwick Park Mental Health Centre (MHC) in Harrow:

Eastlake ward - 23 beds, for both men and women

Ferneley ward – 22 beds, for both men and women

Riverside Mental Health Centre (MHC) in Hillingdon:

Crane ward – 18 beds, for women

Frays ward – 23 beds, for men

Cole ward – 8 beds, a PICU for men

This service was last inspected in February 2015 where it was part of the comprehensive inspection of acute wards for adults of working age and the psychiatric intensive care unit (PICU).

Since this inspection there have been eight visits to these services by the Mental Health Act reviewers.

This inspection was a short-notice, announced inspection. We also carried out an unannounced evening visit to Shannon and Danube wards at St Charles Mental Health Centre as a part of this inspection.

Our inspection team

The team which inspected this service included nine CQC inspectors, two CQC inspection managers, one head of hospital inspection, two assistant inspectors, two pharmacy inspectors, three Mental Health Act reviewers, seven specialist advisors who had experience of working in acute and psychiatric intensive care units and three experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether Central and North West London NHS Foundation Trust had made improvements to the acute wards for adults of working age and the psychiatric intensive care units since our last comprehensive inspection of the trust on 23-27 February 2015.

Summary of findings

When we last inspected the trust in February 2015, we rated the acute wards for adults of working age and the psychiatric intensive care units as inadequate overall. We rated the core service as inadequate for safe, good for effective, good for caring, inadequate for responsive and requires improvement for well-led.

Following that inspection, we told the trust it must make the following improvements to the acute wards for adults of working age and the psychiatric intensive care units:

- The trust must address the blind spots in the ward environment of St Charles MHC, Park Royal MHC and the Gordon Hospital to enable clearer lines of sight and reduced risks to patients and staff.
- Staff working on the wards must be able to articulate how they are assessing and managing the potential risks from ligature points for the patients using this service. The use of blanket restrictions must be reviewed and risks from ligatures managed to reflect the needs of the patients on the ward.
- The provider must ensure that staffing levels are adjusted to reflect the actual numbers of patients on the wards. This number must include those patients spending the day on the ward even if they are sleeping on another ward or at another hospital overnight
- The trust must implement the training of all staff in new restraint techniques to ensure that staff working together on wards are all trained in the same techniques and in line with current best practice on the use of prone restraint, to prevent injury to staff and patients.
- Staff working on the wards must be able to articulate how they are assessing and managing the potential risks from ligature points for the patients using this service. The use of blanket restrictions must be reviewed and risks from ligatures managed to reflect the needs of the patients on the ward.
- The trust must take further steps at the Gordon Hospital and other sites where acute inpatient services are provided to ensure that risks to detained patients from being absent without authorised leave are minimised
- The trust must ensure that records relating to the seclusion of patients provide a clear record of medical and nursing reviews, to ensure that these are carried out in accordance with the code of practice.
- The trust must take further steps at the Gordon Hospital and other sites where acute inpatient services are provided to ensure that risks to detained patients from being absent without authorised leave are minimised.
- The trust must ensure that, on admission to a ward, patients have a designated bed that is within the ward occupancy levels.
- Staff must always monitor and record physical vital signs in the event of the use of rapid tranquilisation until the patient is alert. They must improve medical reviews of patients receiving rapid tranquilisation to ensure patients are not at risk.
- The trust must promote the privacy and dignity of patients. Patients must be able to make calls in private. At the Campbell Centre patients in shared rooms must be able to attend to their personal care needs with an adequate level of privacy and dignity
- The trust must ensure that, on admission to a ward, patients have a designated bed that is within the ward occupancy levels.
- Patients returning from leave must have a bed available on their return to the ward. The trust must take steps to reduce the number of times that patients are moved to other wards to sleep for non-clinical reasons. Where it is unavoidable, staff must ensure that a thorough handover takes place to promote continuity of care. Patients must only be moved at reasonable times so that they are not adversely affected.
- The trust must ensure information is available to inform patients how to make a complaint. They must ensure verbal complaints are addressed and, if needed, patients and carers have access to the formal complaints process
- The trust must ensure the acute wards for adults of working age are well led by having contingency plans in place for when the numbers of patients needing a bed increases above the beds available.

Summary of findings

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation - 9 Person-centred care

Regulation - 10 Dignity and respect

Regulation -12 Safe care and treatment

Regulation -13 Safeguarding service users from abuse and improper treatment

Regulation -16 Receiving and acting on complaints

Regulation -17 Good governance

Regulation -18 Staffing

We also told the trust that it should take the following actions to improve the acute wards for adults of working age and the psychiatric intensive care units:

- The trust should provide individual lockable space for patients to keep their possessions safe.
- The trust should ensure that maintenance issues at Park Royal MHC are resolved in a timely manner.
- The trust should ensure that patients are not confined to bedrooms and that seclusion is implemented in accordance with the code of practice: Mental Health Act 1983.
- Staff at the Gordon Hospital should ensure copies of consent to treatment forms are attached to medication charts.
- The trust should address the sound of the alarms at St Charles MHC so that they are as least disruptive to patients as possible, and do not affect their well-being.
- The trust should improve the new multi-disciplinary care planning system to ensure that all disciplines record directly onto this. Nurses informed us that they make entries for other professionals following reviews of care. The expectation for nurses to do this is not in the spirit of the system and could lead to inaccurate professional judgements being recorded.
- Male staff were reluctant to interact with female patients on Pond ward following a safeguarding investigation. Further support should be provided to staff to enable patients to approach any member of staff for support.
- Staff should encourage all patients to get involved in planning their care and treatment. This involvement should be clearly recorded.
- Discharge planning should be incorporated into the care planning for patients so that care and treatment is recovery focussed.
- The trust should monitor the impact of bed management pressures and the ability of staff to facilitate patients' entitlement to take Section 17 leave off the ward.
- The trust should promote any staff and patient feedback processes so that all people have an opportunity to be involved in the trust.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all twenty of the wards at the six hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 89 patients who were using the service
- spoke with the managers or acting managers for each of the wards

Summary of findings

- spoke with 123 other staff members; including doctors, nurses and social workers
- interviewed the borough director, deputy borough director and clinical director for Brent
- interviewed the bed manager, service manager for Kensington and Chelsea and the team manager of the Kensington and Chelsea community recovery team
- attended and observed three hand-over meetings and eight multi-disciplinary meetings
- attended and observed one London wide bed management meeting, one bed management meeting at St Charles MHC, one at Riverside MHC, one at the Campbell Centre and one at Park Royal MHC
- attended and observed two community meetings
- attended one staff safety meeting on Shore ward
- spoke with 5 advocates
- spoke with 1 carer
- looked at 90 treatment records of patients
- looked at 130 prescription charts
- carried out a specific check of the medication management on four 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

We spoke with 89 patients during the course of the inspection. Many spoke positively saying that staff were kind, patient and caring. However, some patients at Northwick Park MHC and St Charles MHC spoke about poor staff attitude. Most patients also said that they felt safe on the wards and there were enough staff to look after them. Patients also said that staff explained their rights to them and that they knew how to make a complaint.

Patients told us they were involved in their care and treatment. However, we received mixed feedback about people's involvement in their care planning. Many patients also said that they did not feel involved in the planning of their care. Patients said that nursing staff wrote the care plan and then presented the care plan to them for agreement. The majority of patients told us that there were very few activities at the weekend.

Patients told us there was good advocacy support.

Good practice

- On Danube ward at St Charles MHC, staff had put in place a quality improvement project (The Shine Project) to improve patients' physical health assessments. A patient held record and single physical and mental health assessment form were to be rolled out across the trust as part of the physical health implementation strategy.
- Staff held safety huddles on Shore ward. These enabled staff to reflect upon practice, improve safety on the ward and reduce the number of incidents.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that physical observations following rapid tranquilisation are consistently carried out and recorded.

Summary of findings

- The trust must take further action to reduce the number of incidents of prone restraint and the use of restraint across the service and also reduce the variations in the use of restraint between different trust locations.
- The trust must ensure that risks to patients are identified and the risk management plans must contain sufficient information on the risk and how the risks are managed. These risk management plans must be easily accessible for staff.
- The trust must ensure that all records of physical restraint of patients comply with the policies and procedures of the provider.

Action the provider SHOULD take to improve

- The trust should ensure that 'blanket' restrictions are reviewed regularly on the acute wards to ensure where possible that patients had access to quiet rooms, outside spaces, snacks and hot drinks.
- The trust should collate information on the numbers of patients on the acute and PICU wards where planned escorted leave is postponed.
- The trust should ensure that information on incidents and learning from incidents across the PICU wards is shared with all the hospital sites, so that this information can be used to improve all the wards. The trust should ensure that the records of team meeting minutes on the PICU wards reflect the discussions regarding incidents.
- The trust should ensure that staff complete the planned mandatory training on fire safety and intermediate life support.
- The trust should ensure that patients are fully involved in the planning of their care and that care plans are recovery focused.
- The trust should ensure that where wards support patients who have a learning disability or autism that staff have received training on how to meet their needs.
- The trust should ensure that MEWS records are monitored and appropriate action taken in response to changes in patient's physical health.
- The trust should ensure that staff treat patients with appropriate levels of dignity and respect, including when staff wish to enter patients' rooms.
- The trust should ensure that ward information leaflets on Caspian ward provide accurate information about any restrictions that are in place.
- The trust should continue to monitor and reduce the number of patients waiting more than four hours for an inpatient bed especially out of hours.
- The trust should continue to monitor and ensure that discharges from acute and PICU services are planned and the length of time for any delays for discharge is reduced.
- The trust should ensure that feedback provided by patients is responded to in a timely manner.
- The trust should ensure that food provision meets patients' individual cultural, religious and dietary needs.
- The trust should ensure that all facilities meet the needs of patients, including the provision of faith rooms and appropriately furnished and decorated lounge areas.
- The trust should ensure that there are sufficient activities available for patients to participate in at weekends to appropriately support their recovery.
- The trust should ensure that systems to records verbal complaints and any responses are implemented.

Central and North West London 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
Willow ward Hazel ward	Campbell Centre
Pine ward Pond ward Shore ward Caspian ward	Park Royal Mental Health Centre
Amazon ward Danube ward Thames ward Ganges ward Nile Ward Shannon Ward	St Charles Mental Health Centre
Vincent ward Ebury ward Gerrard ward	The Gordon Hospital
Eastlake ward Ferneley ward	Northwick Park Mental Health Centre
Crane ward Frays ward Colne Ward	Hillingdon Hospital Mental Health Site

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

- Staff received training in the MHA and codes of practice, although this was not mandatory. The majority of staff demonstrated a good understanding of the Mental Health Act 1983 (MHA), code of practice and guiding principles.
- We carried out a Mental Health Act review visits on Thames ward, Pine ward, Ebury ward and Caspian ward as part of our inspection to the acute wards for adults of working age. We also looked at detention records on the other wards that we visited.
- We found evidence overall of discussions of rights being completed with patients following their detention under the MHA in a timely manner. Staff had easy access to interpreters when required. Rights information could be provided in different languages if needed.
- There were Mental Health Act administrators on each site who were able to provide advice and support.
- Regular audits took place to ensure that the MHA was being applied correctly.
- Patients had access to an independent mental health advocate (IMHA) to support them whilst they were detained. An Patients were given information about the Independent Mental Health Advocacy (IMHA) Service. This information was displayed on a notice board.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff understood the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had undertaken training which was not mandatory.
- Between 1 April 2016 and 30 September 2016, four DoLS applications were made and all were authorised. The most applications were made at Hazel Ward at the Campbell Centre.
- Staff gave examples of when they assessed patients' mental capacity and supported them to make decisions in their best interest. For example, on Pond ward we saw that a decision specific assessment had been carried out and that staff had supported the patient as far as possible to make the decision for themselves, as required by the Act.
- Advice and guidance on the MCA was available from the MHA office. Flow charts showing how to apply the act were displayed for staff to use when needed.
- On the assessment lounge at Riverside MHC, staff used cue cards to aid them in assessing capacity which was positive as it assisted with communication. Training specifically around knowledge of the Mental Health Act and Mental Capacity Act was not mandatory and knowledge varied among the staff team. However, staff knew how to access support.

Requires improvement

Are services safe?

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

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

Our findings

Acute wards for adults of working age

Safe and clean environment

- In February 2015, we identified that there were a number of blind spots in the wards at St Charles MHC, Park Royal Mental Health Centre and the Gordon Hospital that did not have a clear line of sight. Measures were not always in place to reduce risks to patients and staff. At this inspection we found that improvements had been made in this area. Risks to patients and staff had been mitigated by the use of mirrors, staff observations and individual risk management of high risk patients. Some wards also had CCTV installed in communal areas. This was an improvement since the last inspection.
- In February 2015, we found that although numerous ligature risks had been identified on the acute wards staff were not able to articulate the measures being taken to manage these risks for the patients using the service. At this inspection, we found that improvements had been made. The trust had carried out extensive work to reduce the number of ligature points on the wards. Staff we spoke with were aware of the current risks that had been identified on the ligature audit for their ward. They were able to articulate clearly the measures in place to manage these though patient and environment observations. Ligature cutters were located in each ward office. On Pond and Shore wards maps indicating the position of possible risks were placed in the staff office to remind staff of their location, including temporary staff, who were less familiar with the environment.
- Since the last inspection the trust had implemented a ligature risk competency assessment that all staff were required to undertake to support their understanding of the risks posed by ligatures and how to manage those risks. For bank and agency staff ligature risk management was incorporated in the staff induction. Completion rates of the ligature competency assessment was reviewed annually as part of ward based audits.
- Staff had introduced some 'blanket restrictions'; such as locking laundry, therapy and quiet rooms where there were known ligature points. These areas could be accessed under staff supervision. At St Charles Hospital, all balcony areas were locked and could only be accessed with staff supervision. The reason for the wards locking the balcony areas was that the areas were in locations on the ward where there was limited visibility and safe observation from staff could not always be ensured. The impact of this was that patients were not able to use this area of the ward to have access to fresh air and space which was available. patients were unable to access the kitchen between midnight and 6.00am. Therefore, they were unable to make hot drinks. Some patients said they were unhappy about this and that they had not received any explanation of why this was the case.
- Some of the wards across the acute services were single sex wards. On the other acute wards there were separate male and female sleeping areas. These wards had 'flexible' or 'swing' rooms which could accommodate males or females. At St Charles MHC, these bedrooms could be sectioned off to accommodate male and female patients.

  However, at the Gordon Hospital all three wards were mixed and admitted both men and women. During our visit to Ebury and Vincent wards we found that female patients who were using the 'swing' beds on the male side of the ward had their privacy and dignity compromised when they wanted to use the female bathroom. This was because these patients needed to cross a communal day area and dining room used by both male and female patients. We raised this with the trust, who addressed this situation by the end of the inspection period and designated all swing beds to be occupied by one gender, ensuring that same sex accommodation guidelines were being maintained.
- There was a fully equipped clinic room on each ward. Clinic rooms were well organised, equipment was clean and well maintained. Emergency medicines and equipment were available and checked regularly to ensure they were within date and fit to use.

Requires improvement

Are services safe?

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

Safe staffing

- In February 2015, we identified that staffing levels needed to be adjusted to reflect the actual numbers of patients on the wards including patients spending the day on the ward even if they were sleeping elsewhere overnight. At this inspection we found that improvements had been made.
- Ward managers we spoke with felt they could adjust staffing levels when needed. When wards needed extra staff, for example, due to increased observation levels for patients, ward managers did not need to contact senior managers. Nurses also had the option to increase staffing levels out of hours.
- Staff spoke positively about the improvements and staffing challenges since the last inspection. For example, staff on Frays ward confirmed that the staff team was more effective and had a good skill mix. At Northwick Park MHC staff told us that the staffing was a challenge, when there was high acuity on the wards. This was mainly due to a high number of staff vacancies.
- Each ward displayed a safe staffing notice which detailed the number of qualified and unqualified staff for each shift. Safer staffing information was completed so that senior management could monitor and have an overview of the daily staffing requirements on each ward.
- The staffing establishment for the twenty acute wards was 366 whole time equivalent (WTE) qualified staff and 243 WTE unqualified staff. As at 31 August 2016, 31% of posts were vacant across the whole core service. The highest number of qualified staff vacancies were on Vincent ward with 47% vacant posts.
- The average total turnover rate for the 12 months leading up to our inspection across the service was 16%.
- The staff sickness varied across the different wards. This was the highest on Crane ward at 18.2%, Vincent ward at 10.8% and Ganges ward at 7.8%. This was mainly due to long term sickness.
- Wards operated morning, afternoon and night shift patterns with the ability to be flexible with staff cover where needed. On Frays and Crane ward staff were trialling long day shift patterns for staff who were able to do so. Managers indicated that this had resulted in staff being free to do more overtime and therefore less agency use.
- Managers had flexibility to adjust staffing levels to meet changes in clinical need such as levels of observation and escort duties. Any staff shortages were responded to appropriately. All the wards used bank and agency staff. The wards covered vacancies and staff absence through bank and less regularly, agency staff. To ensure continuity of care, staff that were familiar with the ward were booked to work. The total number of shifts covered by bank and agency staff across the service during the three months prior to the inspection was 6,026 shifts.
- The wards were not always able to find bank or agency staff to fill provide cover for vacant staffing positions or for the absence of staff. During the three months prior to inspection the number of unfilled shifts was 1,751. The highest number of unfilled shifts were on Fernely ward (166) and Eastlake ward (122). This was mainly due to the high number of staff vacancies.
- We observed that both unqualified and qualified staff were available in the communal areas.
- Staff acknowledged that during busy periods, patients had to wait for supervised leave. Staff said that patients' leave was rarely affected, as leave was a priority for them. Where leave had to be cancelled staff reported this as an incident, which was then assessed by senior managers to identify the reasons for staff shortage and any necessary remedies for this situation. The trust did not provide any data regarding how frequently patients' leave was cancelled, but both patients and staff said that this was rare.
- At this inspection, patients and staff said that activities were rarely cancelled because of a lack of staff.
- The staff and patients that we spoke to on the wards said that there were enough staff present at all times to keep the wards safe. This included sufficient numbers of staff to conduct physical interventions.
- There was sufficient medical cover provided over a 24 hour period and in an emergency. Regular ward rounds took place and the frequency varied on each ward.

Requires improvement

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- Staff completed mandatory training and managers kept an up to date record for each staff member showing what courses staff had done and when training was due for renewal. The average completion rate for training was 85%. However, training for intermediate life support (2 year training) was below 40% and inpatient fire safety training was below 65%. These areas had been identified and were being monitored by the trust. Where staff had not attended mandatory training they had been booked for the next available course. All training was electronically tracked and flagged as an issue if not completed and addressed individually through supervision.

Assessing and managing risk to patients and staff

- Between 27 March 2016 to 27 September 2016, there were 174 incidents of the use of seclusion across the acute wards. These were the highest in Pond, Pine and Shore wards at Park Royal MHC.

  Segregation was used for one patient. This was between the 3rd August and 17th October 2016. This was on Pond ward.

- Between 27 March 2016 and 27 September 2016 there were 410 incidents that required the use of restraint involving 282 different patients. Out of these, 203 were incidents of restraint in the prone position. Incidents of restraint were highest in Fernely ward at Northwick Park MHC and Pine, Pond and Shore wards at Park Royal MHC.

- The trust had set a target of reducing restraint by 50% across all the wards. However, the use of restraint had not reduced to this figure in the last 6 months and this was being monitored closely by the restrictive interventions group. Action plans and monitoring which had been put in place since the previous inspections have achieved a reduction in 225 incidents of restraint across the service from January 2015 to July 2016. During March 2016 – Sept 2016 the highest number of restraints took place at the acute wards at Park Royal MHC with a total of 151 occasions of restraint being used within this period.Within this figure, 77 occasions of restraint were in the prone position and 58 occasions involved administration of rapid tranquilisation. Staff attributed this to a high level of acuity in the months of April, June and July as well as patients who required the use of restraint on multiple occasions. Audits on the number of restraints were carried out regularly to review the number of restraints and this was being closely monitored by the trust. The trust had developed a quality improvement action plan following a review of restrictive practices in Brent which included intervention and training to manage agitation and challenging behaviour.

- In February 2015, we identified that all staff required training in new restraint techniques to ensure that staff working together on wards were all trained in the same techniques and in line with current best practice on the use of prone restraint, to prevent injury to staff and patients. At this inspection we found that improvements had been made. The majority of staff on the wards had undertaken training in supine restraint and de-escalation techniques with new staff booked to undertake this. Staff we spoke with had a good understanding of the use of preventative strategies and that physical intervention was a last resort. Staff understood that prone restraint was used only where necessary. We observed staff implementing good use of de-escalation with a patient at the Gordon Hospital.

- We looked at 23 records across all wards and reviewed the recording of physical restraint, to check that staff had carried out these procedures safely and according to the policy of the trust and best practice. The majority of these showed that staff had appropriately recorded all the relevant details, including that they had attempted to resolve the situation by seeking to verbally calm the patient. However, five records of patients on Pond ward did not contain any information regarding the number or identity of staff involved in restraining the patient. This was contrary to the policy of the trust and meant that the records did not evidence that the restraint was done safely.

- In February 2015 we found that monitoring of physical signs was not always maintained until the patient was alert following the use of rapid tranquilisation (RT). At this inspection we found that some improvements had been made but there were still gaps in the recording of post RT physical observations.

- During this current inspection we reviewed a sample of 35 records where patients had received RT. Overall staff had completed detailed records of the procedure, including the reasons for the administering of RT and attempts to monitor physical health. However, on Pond

ward we found that in one record of a patient there was no statement of why staff assessed that RT was required, or any record of either physical observations taking place, or why staff were unable to do them. There was also no record relating to the staff restraining the patient. There was therefore insufficient evidence to show that staff had either restrained the patient or administered RT in a way that was safe and in accordance with the policy of the trust. At St Charles MHC we found that physical observations had not been carried out for a patient on Amazon ward who had been administered oral rapid tranquilisation and for a patient on Danube ward who had been administered intramuscular RT. This remained a concern at this inspection and the monitoring of physical health observations was still not consistent with the trust policy.

- The trust carried out rapid tranquilisation physical health care monitoring audits. We viewed the most recent spot check audit reports which identified that there were gaps in the recording of physical observations. Following the inspection the trust informed us that audit methodology used across the London wards had been changed to ensure that all incidents of RT would be audited and not just a sample. The trust had implemented this as a measure to ensure that closer monitoring of physical health observations were being undertaken.
- At the previous inspection in February 2015 inspectors found that the seclusion records kept by staff did not always demonstrate that they had monitored and reviewed the care of secluded patients in accordance with the Mental Health Act code of practice. At this inspection we reviewed seclusion records and found that overall staff had appropriately monitored and reviewed the care of secluded patients. Staff kept seclusion records in a secure and appropriate way. However, we found that on one occasion a patient from Thames ward did not have their medical reviews carried out within the recommended timeframe due to the lack of staff being available to facilitate this.
- Risk management arrangements were in place. Staff discussed risk in daily handovers and multi-disciplinary team meetings. The majority of patients had a risk assessment carried out when they were admitted to the service. In most cases these were regularly reviewed and updated following an incident.
- The quality of the information in the risk assessments was variable. Many of the assessments were detailed and staff updated all of them where appropriate. Staff recorded in both patients' risk assessments and care plans how they planned to address and manage the risks they identified. However, several patients' records lacked information about how staff planned to manage risk, either in the risk assessment itself or in both the assessment and the patients' care plan. For example, on Pond ward the risk assessment of four patients contained no information about how staff intended to address identified risks, although their care plans did have this information. This meant that staff might find it hard to locate the plans explaining the action staff must take to minimize risks for individual patients.
- In the records of a further two patients on Pond ward there was neither a plan in the patients' risk assessment nor care plan to address identified risks. Risk management plans were also sometimes vague and lacked specific detail. For example, on Shore ward a plan to manage the risks to a patient's health simply said that staff would check the patient every 10 minutes. On Pond ward staff identified several separate risks relating to one patient, but the plan to address those risks simply stated that the patient should continue to take their medication and engage with staff. Specific risks to patients sharing rooms on Pond ward had not been assessed. On Ganges ward the risk assessment for a patient had not been completed until two weeks after admission. Risk assessments had not been updated for a patient that had been absent without leave on Ganges ward and at the Campbell Centre.
- Staff told us that the electronic risk assessment tool was soon to be replaced with a system that prompted staff to record more detail about risks, planning and patients' needs.
- In February 2015, we identified that the privacy and dignity of patients was not always promoted for patients in a shared room at the Campbell Centre due to

measures to manage ligature risks. At this inspection we found that improvements had been made. Curtains to the bathroom area had been replaced with bathroom doors.

- Staff provided appropriate information to patients who were not detained under the Mental Health Act concerning their legal rights on the wards, but who attended voluntarily. Such patients are known as 'informal' patients. This information included details about informal patients' rights to freely leave the wards at any time.
- Staff undertook close observations according to the policies and procedures of the trust.
- Safeguarding procedures were in place and staff knew how to identify a safeguarding issue and alert this as needed. Each site had a safeguarding lead and there was information available on all the wards we visited with contact details for the local authority safeguarding team and the safeguarding lead in the trust both locally and centrally.
- There were safe and effective arrangements in place for medicines in all of the areas we inspected. Arrangements were in place to order and supply medicines, so people did not experience delays in starting treatment, however did we see some discharge medicines in the medicines cupboards for patients that were already discharged and had left the ward. Staff said that this occasionally occurred when there had been a delay in the medicines arriving on the ward. In most cases these were collected by the home treatment team and delivered to the patient's own home. Medicines were stored securely in the relevant clinic rooms. Staff had daily access to trust pharmacists who also attended the white board and MDT meetings.
- There was good clinical input by the pharmacy team in optimising patients' medicines and providing support to both medical and nursing staff, as well as advising patients, and making clinical interventions with medicines to improve safety. When people were detained under the Mental Health Act, the appropriate legal authorities were in place for medicines to be administered. Medicines reconciliation was routinely carried out as per NICE recommendation for patients whose records we checked on the trust clinical system. Pharmacy staff had access to summary care records so were able to engage better with people about their medicines.

Track record on safety

- There were 19 serious incidents reported in the last 12 months across the acute wards.
- In February 2015 we found that a high number of detained patients were absconding from acute wards. However, during this inspection we found that staff were taking steps to reduce this. For example, wards had signs reminding all people leaving the wards to look behind them before opening the door to the ward and, having passed through it to wait for it to sound closed properly before moving away. At St Charles MHC, the trust had implemented a lock down mechanism that that could be activated by ward staff. This enabled the main entrance doors to the unit to be locked. Further work had been identified at the Riverside MHC as there had been an increase in the number of patients leaving the wards without leave prior to this inspection. Staff had identified a fault in the ward doors with a delay in locking after people entered or left. Plans were in place to replace the ward doors and appropriate action had been taken in the interim for all non-ward staff to access the unit.
- At Park Royal new entry doors to the wards were also fitted to help reduce absconding. At the Gordon Hospital improvements had been made by increasing staff vigilance in respect of 'tailgating' (patients following others out of a door when unlocked) and introducing double doors in the reception area of building, which stopped people leaving without a check from reception staff. Staff gave patients who had been granted leave a yellow card to show to reception staff to confirm their leave status. These measures had helped reduced incidents of patients absconding. In July 2016 there were five incidents of a detained patient going absent without leave (AWOL) from the acute wards. On the admission ward (Danube) between October 2015 – August 2016 the number of patients who attempted to leave the ward was 13 and the number of patients who went missing from the ward during the period was four. The number of patients absconding from the service had reduced.

Requires improvement

Are services safe?

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Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the trust's electronic recording system. Incidents were reviewed by the ward managers and the matron for each site. However, on Pond ward staff had not completed an incident report for a patient that required seclusion Therefore, there was no evidence that staff were able to review the causes of the incident that led to the seclusion of the patient, or learn the lessons from it.
- Staff were aware of the importance of reporting incidents and how it fed into the improvement of the service.
- Staff told us they received appropriate support following an incident, which included a de-brief session, staff support from the staff team and senior managers Staff on Shore ward participated in weekly safety meetings about incidents on the ward to discuss a range of issues, including patient safeguarding and physical restraints. The purpose of the meeting was to identify key learning from incidents and to collectively agree on how safety could be improved
- Staff shared examples of learning from when things go wrong. For example, following a serious assault of a staff member changes had been made to the response team at St Charles MHC. Following a self-harm incident involving discharge medicines on Eastlake ward, staff told us that learning from the incident had On Shore ward incidents had occurred where male patients had gained access to the female-only area of the ward at night. As a response to this staff had installed CCTV cameras in that area that alerted staff to any movement by people after 10pm at night so that staff could immediately check whether male patients had gained access. This had significantly reduced incidents of males entering this area.
- Patients told us about feedback they received following incidents. For example, two patients on Pond ward told us about how staff had discussed why they had restrained them and what had caused the patients to become agitated in the first place. Both patients said that this feedback helped them to realise the benefit of discussing their concerns with staff to reduce the possibility of them becoming angry in future.
- The lead consultants on Danube ward were aware of recommendations which had been put in place following a review of a serious incident earlier in the year.

Psychiatric intensive care units (PICU)

Safe and clean environment

- Wards we visited were clean and patients and staff told us that the environment was clean. Staff undertook regular infection control and environmental audits to ensure that a good level of cleanliness was maintained on the wards. For example, on Caspian ward staff undertook weekly infection control audits.
- All wards had ligature risk assessments which were available for staff to read. Staff had to undertake a competency test which managers or senior nurses signed off which ensured that all nursing staff working on the wards had an understanding of the risks related to the environment. At our inspection in February 2015, we found that some staff working on the wards we visited were not aware of the ligature risks on the ward. On this inspection, we found that this was not the case and that staff in the wards we visited were aware where the risk areas were on the wards. This was an improvement.
- We checked the seclusion rooms on Caspian ward and the seclusion room in St Charles Hospital which was used by patients in Shannon and Nile wards. There was no seclusion room on Colne ward. The seclusion rooms were equipped in accordance with the Mental Health Act Code of Practice recommendations. There were working intercom systems and the room temperature was controllable externally. There was a visible clock for patients who were accessing seclusion and the seclusion rooms had toilet and washing facilities which staff had access to observe while preserving patient dignity as far as possible.
- Staff on all the wards we visited had access to alarms which they carried with them. We saw that when alarms were activated, a member of staff on the ward was nominated on the shift to respond throughout the hospital site to assist on other wards when necessary.

Requires improvement

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- Medicines were stored in locked cupboards within a locked clinical treatment room on the wards. Some medicines were also stored in a locked medicines drug trolley. Staff secured the trolley to the wall of the clinic room when it was not in use.
- Clinical treatment rooms were clean and spacious with hand washing facilities available. Emergency equipment was available on the ward and checked daily by staff. The oxygen cylinder was full and in date. Staff had access to a defibrillator and an electrocardiogram.
- An emergency drug bag was available on the wards, and had a tamper proof seal. It included adrenaline and flumazenil. There was also naloxone available on the wards.
- Staff had appropriate facilities to dispose of medicines safely, including a sharps bin.
- The ambient room temperatures where medicines were stored were taken and found to be below 25°c. Staff took the medicines fridge temperatures daily (minimum, maximum and current temperatures). When the temperature reading was out of the recommended range of 2 - 8°c, staff sought advice from the ward pharmacist to ensure that the cold chain was maintained.

Safe staffing

- The nursing establishment numbers varied between the wards we visited. Staffing numbers were set locally by each borough. There had been a review of nursing establishments on Nile and Shannon wards and the staffing establishment was that six members of staff were on duty during day shifts with four staff at night. This varied from Caspian ward which had five members of staff during the staff with three staff at night.
- Some staff told us that they perceived that where there had been difficulties with staffing, they had noticed an improvement in the staffing levels. Staff across the service told us that they felt safe on the wards.
- Across the four wards visited, the average vacancy level for all staff was 36%. The highest level was on Shannon ward with 43% vacancy rate and the lowest was on Nile ward with 30% vacancy rate. Ward managers told us that they mitigated the impact of this by using regular bank and agency staff wherever possible. However, there were some shifts in three months prior to the inspection (June 2016 – August 2016) where there had been unfilled shifts on the wards. For example, on Nile ward 394 shifts (am, pm and night shifts each counted separately) had not been filled by bank or agency staff. In the same time period, there had been 12 unfilled bank or agency shifts which had not been filled on Caspian ward.
- Some staff and patients told us that planned escorted leave could be postponed when there were not enough staff on the ward. This information was not collated at a ward level.
- Medical cover on Caspian ward consisted of one consultant who covered three days a week and one staff grade doctor. This was lower than the provision at St Charles' for Nile ward which was a similar size and had a full time consultant as well as a specialist doctor and access to a junior doctor. The management team at Park Royal told us that this was being addressed and additional medical cover was being provided at Park Royal in the New Year.
- Most staff told us that they had completed their mandatory training. We checked on some of the wards we visited. We saw that on Caspian ward, some staff had not completed their emergency life support training. We discussed this with the manager who told us that staff who were not up to date with this training were booked onto the next available course. However, this meant that there was a risk that some staff who were on the ward may not have skills which were updated if there were an emergency on the ward.

Assessing and managing risk to patients and staff

- Between 27 March 2016 and 27 September 2016, there were 80 incidents of restraint on Caspian ward of which 34 were restraints which were in the prone position, however briefly and 23 of these resulted in the administration of rapid tranquillisation. On Nile ward, there were 25 incidents of restraint of which 16 were in the prone position and 14 resulted in the administration of rapid tranquillisation. On Shannon ward there were 76 incidents of restraint of which 42 where in the prone position and 40 resulted in the administration of rapid tranquillisation. On Colne ward there were 19 incidents of restraint of which ten were in the prone position and

Requires improvement

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8 had resulted in the administration of rapid tranquillisation. The significant number of incidents of restraint and prone restraint at Park Royal MHC had been identified as an area of improvement by the trust.

- Staff on the wards we visited had undertaken training specifically around the use of restraint and de-escalation techniques. Staff we spoke with had a good understanding of the use of preventative strategies and that physical intervention was a last resort. Staff understood that prone restraint was used only where necessary. We checked records of restraint and found that most records we checked were comprehensive. Two records of restraint we checked on Nile ward did not indicate clearly how long restraint had taken place and which members of staff had been involved in the restraint.
- Between 27 March 2016 and 27 September 2016, there had been 84 incidents of seclusion on Caspian ward, 14 on Nile ward, 7 on Shannon ward and none on Colne ward where there was no seclusion room. We spoke with managers at Park Royal about the differences between the use of restraint and seclusion on Caspian ward compared to other wards in the trust, particularly Nile ward which is of a similar nature and size. They told us that the trust had an oversight of this and was carrying out work specifically around the use of restrictive practices in Brent. This was on-going. We saw that some good practice had developed to audit restrictive interventions on Park Royal and ensure that documentation was up to date. The ward manager and matron checked the audits to ensure that this was completed.
- We checked seclusion records on Caspian ward, Nile ward and Shannon ward. We found that they were comprehensively completed with relevant checks including physical health checks having been carried out to ensure that safety and well-being of those who were subject to seclusion. On Caspian ward we saw that seclusion records were audited weekly.
- We checked risk assessments on the trust electronic database on the wards we visited. We found that risk assessments were up to date and that risk management plans were indicated. However, on Nile ward we checked three care records. One of the risk assessments we checked did not reflect risk information related to physical health which was identified on the patient's care plan. We also saw that on Nile ward, some of the risks which were identified in the risk assessment did not incorporate ways they would be managed in the care plan documentation.
- There were controlled drugs (CD) cabinet available on the wards we visited, there were no CDs stored on Caspian at the time of this inspection. Shannon ward had CD medicines which were appropriated stored and documented in the CD register and checked daily. If a service user brought illicit substances onto the ward, they were locked in the CD cabinet and logged in the CD register.
- However on Shannon ward, we found a locked CD cabinet which we were told was redundant and out of use. Staff were unable to locate the keys to open the cupboard. The ward manager contacted the Trust's Estates Department and had the cupboard removed immediately.
- We checked all prescription charts on Shannon ward and Caspian ward. They all had the patients' name, date of birth, allergy statuses, and whether the service user was under a section of the Mental Health Act. The pharmacist had conducted medicines reconciliation for the five service users whose records we checked on the trust clinical system. (Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP).
- The ward pharmacist visited the wards daily and we saw evidence that the prescription charts had been screened and appropriate clinical interventions had been made.
- We saw evidence that service users were offered oral rapid tranquilisation (RT) before intramuscular RT.
- We checked records of rapid tranquillisation on all the wards we visited. We found that most of these records included records of physical health monitoring after the administration of rapid tranquillisation. However, we checked the clinical notes for one patient on Caspian ward who had been given RT on four separate occasions. Whilst there were post dose observations for the 1st dose, we did not see evidence of this for the other three doses.

Requires improvement

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- Each site had a safeguarding lead and there was information available on all the wards we visited with contact details for the local authority safeguarding team and the safeguarding lead in the trust both locally and centrally. Most staff we spoke with had a good understanding of safeguarding on the ward and we saw some good examples of safeguarding issues being raised and addressed on the wards.

Track record on safety

- Three serious incidents had been reported for the PICU wards between October 2015 and September 2016.
- Staff on the wards were aware of incidents which had taken place on their wards. However, speaking to staff across the wards we visited, staff did not have a clear understanding or knowledge of incidents which had taken place across the core service, particularly when incidents had happened on different hospital sites within the same trust.

Reporting incidents and learning from when things go wrong

- We spoke with staff and managers on the wards we visited. We found that there was a good reporting culture across the service and that staff understood how to report incidents and were able to give us examples of how they reported incidents.
- Staff across all the wards we visited told us that after incidents occurred they had the opportunity to debrief.
- We were given examples across the service of changes which were made following serious incidents. For example, on Caspian ward there had been an incident which had reflected learning regarding consistency of physical health checks. We saw that the ward had ensured that patients had physical health checks twice a day following this incident and these checks were recorded. However, we did not see clear evidence of staff having an understanding or being able to reflect learning which had taken place from incidents on other wards in the core service. For example, following the incident on Caspian ward, there had not been an increase in the physical health checks on Nile, Shannon or Colne wards. Another example of a change made after an incident was when physical security was changed in the garden on Caspian ward following an incident where a patient managed to go absent without leave. This had not happened in the same way since the changes had been made.
- Staff on Nile ward told us that information and feedback from incidents was fed back through management round meetings. This meant that there was a risk that all staff were not involved if they were not present at the meetings. Staff across the service also told us that incidents were discussed at handovers and during reflective practice sessions. However, there was no clear documented channel through which staff were given information in a consistent way about incidents across the service on the wards especially if they were not present at the handover or meeting when the incident was discussed. We saw staff team meeting minutes on each ward and saw that discussion of incidents across the trust was not clearly discussed and minuted. This meant that there was a risk that incidents where there had been learning, not only on the ward and within the location where the ward was situated, might not lead to learning across the whole core service and trust.

Are services effective?

Good

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Our findings

Acute wards for adults of working age

Assessment of needs and planning of care

- We reviewed care and treatment records across all wards. Patients received a prompt assessment of their needs upon admission.
- Patients had a physical health check upon admission to the service and staff regularly reviewed their physical health using the modified early warning system (MEWS). This system monitors patients' health by staff regularly assessing a range of physical health indicators. Patients receive a score according to the results, with certain scores triggering clinical intervention by staff. The majority of records we looked at showed that staff appropriately responded to the physical health needs of patients using this system. At the Gordon Hospital, we checked MEWS charts on all the wards we visited. We found that there were inconsistencies around the recording, calculation and escalation of MEWS scores where concerns had been identified. For example, between Vincent ward and Ebury ward we checked eight MEWS charts. These charts did not have scores calculated to determine whether they needed to be escalated. On Gerrard ward we found that one MEWS chart where the score had been calculated to reflect a need to be escalated but there was no evidence that this had been done. At St Charles MHC we found that MEWS charts had not been completed for four patients on Danube ward. The inconsistency in the use and recording of MEWS meant that the system was not effective as an early warning system regarding physical healthcare needs and potential deterioration. On Ebury ward, we found that a patient had been prescribed medicine that required a health observation to be completed prior to the medication being given. We found that the records showed this had not occurred on three occasions. We raised this concern with the ward manager who said they would address the matter with staff.
- Staff completed care plans for patients on admission. Overall the care plans addressed a range of patients' needs. Staff updated these records, including when incidents had taken place. Care records indicated that patients had received a copy of their care plans and several patients confirmed this. Other patients we spoke with told us that they had not received a copy of their care plan. However, at St Charles MHC we found that the quality of the care plans to be variable. Some included the views of patients and evidence of discharge planning. Others used psychiatric diagnosis of the patient to explain what the needs of the patient were.
- The needs of patients on each ward were discussed at daily white-board meetings during which their legal status, specific risk areas, and leave status were also made clear to the staff team. The acute wards at St Charles hospital has completed a review of key planning priorities within the acute service pathway including, explanation of rights, physical health monitoring, leave status, and care plan completion dates. This information was stored and presented on large whiteboard for all staff to see and access.
- All information about patient assessment, progress and care delivery was stored on an electronic patient record. All staff were able to access these records using their personal password. Paperwork, such as statutory documents relating to the Mental Health Act, were scanned and uploaded to the electronic record.

Best practice in treatment and care

- Staff had a good knowledge of NICE guidance when prescribing medicine. This included making sure patients understood side effects of medicine and maximum doses of medication. Records showed that patients receiving anti-psychotic medication received comprehensive physical health checks covering weight, pulse, blood pressure, blood tests, electro-cardiograms and assessments of general health.
- Psychological therapies were available to patients across the service. Psychologists conducted assessments of patients, met with patients for one-to-one sessions and facilitated groups about hearing voices, mood management, emotional coping skills, recovery, mindfulness, anxiety sessions and self-esteem. At Park Royal, psychologists attended both wards twice a week and the Riverside MHC psychology input was available for three days a week. At the Riverside centre the psychology department had undertaken research into the use of a weekly 'dealing with your emotions' group on a female acute ward. The group included

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cognitive behavioural therapy, dialectic behavioural therapy and mindfulness skills. Some staff members told us that they thought patients would benefit from additional psychology input on the wards.

- Staff worked collaboratively with other professionals in the trust, as well as external professionals to ensure best outcomes for patients. Across the service staff made referrals to the relevant healthcare professionals, such as the diabetes nurse specialist, dentist, podiatry and pre-natal care. They worked with them to make sure any changes in people's care and health needs were addressed in a timely manner.
- The service used rating scales to assess and record the progress of patients. Different rating scales were used according to the needs of the patient. For example, the Core Outcome in Routine Evaluation and the Beck Depression Inventory were used for patients with depression. The Positive and Negative Syndrome Scale was used to measure symptom severity of patients with psychotic spectrum disorders. The psychology team used evaluation measures for specific groups, the generalised anxiety disorder, and the patient health questionnaire to measure outcomes for patients.
- Clinical staff regularly completed a range of audits to monitor the delivery of care and treatment. These included the auditing of staff recording patients' care notes and risk assessments, infection control procedures, environmental assessments and health and safety procedures.
- Staff had received training in smoking cessation in advance of the trust introducing smoke free environments in its locations. Nicotine replacement therapies were available to patients. The trust went smoke free on 3 October 2016.

Skilled staff to deliver care

- Care and treatment was delivered by a team of multi-disciplinary professionals. The teams on each ward consisted of medical and nursing staff as well as having access to pharmacists, gym instructors, occupational therapists, social workers, peer support workers, clinical psychologists and activities coordinators. However, on Willow Ward, the permanent consultant psychiatrist had left in September 2016.A locum psychiatrist was providing two sessions on the ward each week, equivalent to one day. As result, patients were unable to see their psychiatrist except in ward rounds. Other consultant tasks such as writing reports for managers' hearings and providing assessments and supervision of junior doctors were either delegated to less senior staff or not taking place. The service director informed us that a review of the consultant hours required was being carried out and would conclude at the end of November 2016. Domestic and administrative staff supported the wards.
- Staff on Shore ward had developed a new system of delivering patient care to help ensure that care met the patients' needs, including physical health monitoring, discharge planning, explaining of medical rights and one to one care and support. This system involved each patient being allocated a team of three staff members on the ward, comprising a team leader, nurse and healthcare assistant. There was no data to indicate whether this system had led to any measurable improvement in patient care, but several staff members spoke positively of the system, saying the mini patient teams encouraged collaborative working and ensured staff did not miss anything.
- Staff were suitably experienced and qualified to support the care and treatment of patients. This included all bank and agency staff that covered vacant positions or staff who were absent.
- The trust had a comprehensive induction programme for new staff. Newly qualified nurses confirmed they could access a preceptorship programme to support their development. Most wards had a specific induction programme for bank and agency staff.
- Staff received appropriate training, supervision, appraisal and professional development including bank and agency staff. Supervision and appraisal records were maintained on each ward. However, at the Riverside MHC
- At the Gordon Hospital we saw evidence of staff being given training on specific risks for specific patients, such as training on the risks of unmanaged diabetes, how to spot dangerously elevated blood sugar levels and the escalation procedure for vulnerable patients with unmanaged diabetes.
- Regular team meetings took place and enabled staff to discuss key issues with their workload and areas of improvement and development.

Are services effective?

Good

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- Managers addressed any poor staff performance through supervision and, where necessary performance management. Managers also received support from human resource colleagues in the trust when addressing any issues relating to sickness or conduct.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary meetings (MDT) occurred on a regular basis on every ward, where patient's progress and care was reviewed. All members of the MDT and staff worked together to understand and meet the range and complexity of people's needs. At Park Royal and at St Charles MHC we saw that the ward staff held daily clinical reviews to assess the needs of each patient and to determine which patients required to see a doctor that day. This had enabled patients to receive more frequent reviews of their care.
- In February 2015, we identified that the trust should improve the new multi-disciplinary care planning system to ensure that all disciplines record directly onto this, and nurses do not make entries for other professionals following reviews of care.
- Staff told us that this was now happening, and records we observed had separate entries from staff of different disciplines as appropriate.
- Each ward worked closely with external agencies to support patients' needs, including home treatment and community mental health teams, social workers, independent advocates, homeless persons unit and housing and welfare advice services. At Northwick Park MHC and at St Charles MHC wards had access to the hospital police liaison officer and felt this had improved the relationship with the local police and their response to patient assaults and drugs which had been confiscated on the wards.
- Staff worked closely with and liaised with external services to support patients, especially when planning discharge. For example, staff informed the GPs of patients about to be discharged of their medicine and worked with local authorities regarding safeguarding concerns.

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

- Staff received training in the MHA and codes of practice, although this was not mandatory. The majority of staff demonstrated a good understanding of the Mental Health Act 1983 (MHA), code of practice and guiding principles.
- We carried out a Mental Health Act Review visits on Thames ward, Pine ward and Ebury ward as part of our inspection to the acute wards for adults of working age. We also looked at detention records on the other wards that we visited.
- We found evidence overall of discussions of rights being completed with patients following their detention under the MHA in a timely manner. We found one exception on Ebury ward where there had been a delay of two days.
- Regular audits took place to ensure that the MHA was being applied correctly.
- Patients had access to an independent mental health advocate (IMHA) to support them whilst they were detained. An Patients were given information about the Independent Mental Health Advocacy (IMHA) Service. This information was displayed on a notice board.

Good practice in applying the Mental Capacity Act

- Most staff understood the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had undertaken training which was not mandatory. Health care assistants showed less understanding of the MCA.
- Between 1 April 2016 and 30 September 2016 four DoLS applications were made and all were authorised. The most applications were made at Hazel Ward at the Campbell Centre.
- Staff gave examples of when they assessed patients' mental capacity and supported them to make decisions in their best interest. For example, on Pond ward we saw that a decision specific assessment had been carried out and that staff had supported the patient as far as possible to make the decision for themselves, as required by the Act.
- Advice and guidance on the MCA was available from the MHA office. Flow charts showing how to apply the act were displayed for staff to use when needed.

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- On the assessment lounge at Riverside MHC, staff used cue cards to aid them in assessing capacity which was positive as it assisted with communication.

Psychiatric intensive care unit (PICU)

Assessment of needs and planning of care

- We checked patient records including care plans and progress notes on all the wards we visited. We found that most of the care plans we checked were comprehensive and reflected multi-faceted needs of patients including physical health care needs, mental health care needs and social care needs. We saw that assessments were updated when patients were admitted to the wards in a timely manner and that relevant information was added.
- Physical health checks were undertaken by staff regularly for all patients on the wards. We checked these were completed. The service used modified early warning scores (MEWS) to identify any underlying physical health concerns and we saw that this was undertaken. Staff on the wards had a good understanding of the physical health care needs of patients on the ward.
- We saw that some care plans reflected patient views. However, we saw that some care plans on Shannon and Nile wards did not reflect the views of patients. For example, on Shannon ward, we checked three care plans which reflected some preferences and interests had been discussed with patients but some of the language in the care plans was directed for staff where a patient had been "advised to comply with medication". It was sometimes unclear if the care plan documentation used was for the patient to keep and refer to or for staff to use to record clinical decisions and treatment plans. This meant that the document which was given to patients may refer to language which may not be easy to understand or relate to. We also saw that some care plans on Shannon ward referred to patient preferences, such as one patient where there was an indication to encourage areas of the patients' interest. However, there was little evidence in the progress notes that the preferred activities had been encouraged and supported so while there had been an indication to encourage participation in activities on the ward, only six activities were documented in the progress notes for September where two of those activities were "plan the day" sessions. This meant that it was not consistently clear that where preferences were identified, particularly regarding ward activities that these were offered to patients.

Best practice in treatment and care

- Patients on the wards we visited had good access to physical healthcare. As well as regular physical health checks on the wards, patients had access to medical staff who were able to provide support as necessary and liaise with secondary health care services.
- Staff on the wards used health of the nation outcome scales to record the acuity of patient need when they were admitted and through their admission to that outcomes could be measured.
- Occupational therapists on the wards used additional specific outcome measures such as the model of human occupation screening tool. However, at the time of our inspection, Shannon ward did not have specific occupational therapy input. This post was being recruited into.
- Psychology input varied between the wards. On Nile and Shannon wards, patients could access individual support from a psychologist based at St Charles' Hospital if required. However, there was no psychology input on Caspian ward as the position was vacant. However, the post had been recruited into. Patients who were allocated within community mental health teams that had access to a psychologist in the community, had access to the same psychologist as an inpatient. However, there were few psychology based or led groups on the wards.
- There were broad clinical audit programmes based on the wards and medical staff participated in the prescribing observatory for mental health audits relating to the use of anti-psychotic medications. On Caspian ward, staff told us that there was a regular audit programme for nurses at higher grades where there were audits of restrictive interventions. Wards had local programmes to audit care planning and risk assessment documentation to ensure it was up to date. The Mental Health Act office in relevant sites monitored and audited mental health act documentation.

Skilled staff to deliver care

Are services effective?

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- All the wards we visited had multi-disciplinary teams which included medical and nursing staff as well as activity coordinators. Occupational therapists were attached to the wards and members of the ward teams. However, there were vacancies for occupational therapists on Shannon ward and Colne wards and the occupational therapy time on Caspian ward was three days a week, whereas this post was full time on Nile ward. The occupational therapist vacancy on Shannon ward was being recruited into. Pharmacists were based at each of the hospital sites and visited the wards daily including attending ward rounds and being able to provide advice and support to staff and patients on the ward. We saw that this was valued by staff and patients on the wards we visited.
- Each site had access to social work input and advice. Patients who were not allocated to social workers or care coordinators when they were admitted were referred for allocation on admission. Psychology input was mixed between the wards. There was a vacant psychology post on Caspian ward which meant at the time of the inspection, there was not specific input onto the ward from a psychologist.
- Staff we spoke with told us that they had access to specialist training which updated their skills beyond mandatory training offered by the trust. We spoke with staff who had started in their roles since our last inspection in February 2015 and they told us that they had undertaken corporation and ward level inductions when they had started. We saw that when bank or agency staff worked on the wards, there were specific inductions which they had to complete.
- Staff across the wards we visited had access to reflective practice sessions which were run fortnightly. Some staff told us that this was primarily where incidents were discussed.
- Different wards had different practices and formats regarding team meetings and how they were documented as well as what was discussed during these meetings, who attended and how frequently they took place. For example, the ward manager on Nile ward told us that business meetings took place on the ward on a weekly basis, however, between 28 June 2016 and 4 October 2016, there were ten meetings which meant that there had been five weeks where no meetings had taken place. On Shannon ward between 15 April 2016 and 29 September 2016, we were provided with minutes from six staff meetings. However, the ward manager told us that this was due to an administration difficulty with accessing all the minutes which had been taken.
- At Brent, there was a regular practice development forum which took place weekly based to specific themes which all staff could access. Some recent topics had included rapid tranquillisation and the Mental Health Act Code of Practice.
- Staff we spoke with told us that they had regular supervision. However, the information regarding supervision and the regularity of it was not always available at the ward level on each of the wards we visited. For example, some managers were not able to tell us how often specific staff members had supervision in the previous year without looking at each record of supervision.

Multi-disciplinary and inter-agency team work

- Each ward had regular multi-disciplinary meetings, including ward rounds and management rounds where professionals from different professional backgrounds discussed patient care. These meetings included external agencies where necessary, for example, care coordinators in the community. Pharmacists were regularly a part of these meetings and were able to provide specific input.
- While clinical psychologists were able to provide input into the care of patients at St Charles' they were not routinely involved in multi-disciplinary meetings due to the availability.
- We observed three handover meetings including one handover on Shannon ward between the afternoon shift and the night shift staff. We saw that each patient was discussed with risk information being shared and key tasks which needed to be undertaken assigned. Handovers were recorded on paper and each shift had a shift lead who assigned specific tasks to members of staff working.
- The ward teams worked effectively with internal and external partners, including inviting them to relevant meetings such as care programme approach meetings and liaising with commissioners. Some of the beds,

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particularly on Shannon ward, were used by patients from other trusts and the service liaised with organisations who used the beds for their patients, providing updates and information as necessary.

Adherence to the MHA and the MHA Code of Practice

- During our inspection of this service, we carried out one Mental Health Act review visit on Caspian ward, which is a specific visit which looks at the use of the Mental Health Act on a ward. The Mental Health Act reviewer identified that documentation required was available. For example, documentation was attached to medical records which determined whether patients had consented to the medication which had been prescribed and if they did not consent or lacked capacity to consent that additional safeguards had been taken.
- Staff had a good understanding of their responsibilities regarding the Mental Health Act. Training related to the Mental Health Act was a part of the staff induction to the service so all staff had undertaken this training when they started work on the wards. Information was updated as necessary. For example, there had been a study day at Park Royal where staff had accessed updated information about the Mental Health Act Code of Practice.
- Each site had a Mental Health Act office and Mental Health Act administrators were based at the hospitals. This meant that staff had access to specific information and advice if necessary.
- Advocates visited the wards regularly and there was information available on the wards we visited which indicated when and how to contact advocates.

Good practice in applying the MCA

- Most staff we spoke with had a good understanding of the Mental Capacity Act and were aware of how it was used on the wards on which they worked. Some staff were able to give us examples of how it was used.
- Training around the Mental Capacity Act was undertaken when members of staff started on work for the trust as a part of their induction. This meant that there was a risk that understanding of the Mental Capacity Act was not updated on a regular basis for all staff and not only new starters. There had been a study session at Park Royal related to the Mental Capacity Act but the ward manager had not recorded attendance and this training was not indicated as a part of the mandatory training records. This meant that while we observed that most staff had a good understanding of their responsibilities related to the Mental Capacity Act, we could not be assured that all staff were receiving regular training and updates

Good

Are services caring?

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

Our findings

Acute wards for adults of working age

Kindness, dignity, respect and support

- We observed many interactions between staff and patients on the wards. These were mostly caring and supportive, with staff demonstrating patience and compassion when responding to patients' concerns and requests. Where patients became anxious or agitated we observed
- We received mixed feedback from the patients on the wards. Most patients spoke positively about the care and support that they received from staff. For example, at the Riverside MHC patients told us they felt listened to, they felt safe and that the increase in staffing had improved the support provided. On Danube ward patients reported that there had been a marked improvement in staff attitude, saying that they felt safe and secure because staff had taken the time to listen to them and speak to them regularly. Two patients on Shore ward praised all the staff highly, saying that the care they had received had changed significantly changed their lives.
- However, at Northwick Park MHC There was a contrast in the message we received from patients in regards to day staff and night staff. Patients were generally complimentary about the support they received during the day and felt staff were polite, treated them well and were pleasant. However, patients were negative about the staff at night and described them as intimidating, dismissive and treating them like children. Patients gave examples of staff telling them when to go to bed and locking the lounge so they could not access it at night. Staff attitude was generally seen as abrupt. Three patients on Pond ward said that staff did show them a lack of respect by not knocking on their doors before entering their rooms.
- We observed staff working positively with patients and displaying care and attention to ensure that they responded with kindness and respect. At the Gordon Hospital staff took a person-centred approach to caring for patients. Some patients were using their own bedding because they preferred it.
- Staff on all the wards we visited demonstrated a good understanding of the individual needs of patients on the ward. We observed staff discussing patients in handovers and multi-disciplinary meetings. This was done in a respectful manner and recognised people's individual needs.
- Staff described how they supported the dignity and privacy of patients. For example staff routinely kept observation panels in patients' bedroom doors closed except when they wished to observe a patient without disturbing them or when a patient requested that they were left open. On Pond ward we observed that staff took care to close the curtains around patients' beds in the shared rooms to help maintain their privacy.

The involvement of people in the care that they receive

- Patients received a welcome pack upon admission. This included basic information on care and treatment, meal times, visiting hours and ward rounds. They also contained information about people's rights whether detained or informally admitted, advocacy and how to make complaints.
- Patients were involved in the planning of their care, through ward rounds, care planning meetings and one to one meetings with their primary nurse. At the Gordon Hospital most patients told us they had been involved in developing their care plan. At the Riverside MHC we saw that care plans reflected the patient voice and where appropriate family or carer involvement. Most patients at Park Royal we spoke with confirmed that staff planned their care with them. For example, on Pond ward, in response to a proposed change to a patient's medication it was agreed by the staff present that this could only happen once the pharmacist discussed this with the patient.
- However, at St Charles MHC, we found that whilst patients were involved in their care and treatment, the care plans did not always reflect people's individual wishes. Three patients on Ganges ward and most patients at the Campbell Centre patients had been given a copy of their care plans and reviewed this with a daily tracker. Care planning was being monitored at St Charles Hospital using quality audit report which was reviewed during a monthly care quality meeting.

Are services caring?

Good

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- Information about how patients could access independent advocacy was clearly displayed and available on all the wards
- Staff worked with families and carers as agreed with individual patients. Staff encouraged families to attend the ward for visits as well as ward rounds. At Northwick Park MHC the occupational therapist ran carers sessions regularly and a trainee psychologist piloted a carers group for families and friends of patients.
- Patients were able to give their feedback to staff about the service they received through a variety of options. Patients could speak to their named nurse, or raise issues during their meetings with clinical staff, possibly with support from the independent advocate. In addition patients attended weekly community meetings to discuss issues on the ward, such as changes to food and requests for activities. Some wards had a daily planning meeting where staff and patients discussed plans and activities which were taking place on that specific day. 'You said, we did' boards were displayed on the wards for staff to inform patients how they had responded to the issues they had raised. However, some patients at Riverside MHC told us that feedback was not always responded to. For example at Riverside MHC, bath plugs and a remote control for the television being requested at three consecutive community meetings, and not addressed until we raised this at the inspection.

Psychiatric intensive care unit (PICU)

Kindness, dignity, respect and support

- During the inspection, we spoke with fourteen patients across the four wards we visited individually. We received mixed feedback. Some patients reported that staff were helpful, respectful and understanding, but some patients told us that they did not feel listened to by all staff. All patients told us that most staff responded positively to them but some patients identified some members of staff who were less empathetic.
- We observed staff interactions with patients. Most of our observations evidenced that staff were patient, understanding and helpful when approached by patients. However, on some wards, such as Shannon ward, where we saw staff carrying out close observations without much interaction with patients, particularly where patients had more than one member of staff observing them.
- Patients were very positive about the ward managers on all of the wards we visited.
- Staff had a good understanding of the individual needs of patients who were on the ward at the time of our visit.

The involvement of people in the care they receive

- Each ward had a welcome booklet or pack given to patients when they arrived. The information we were given on Nile ward was a leaflet co-produced with patients which gave information for visitors to the ward. On Caspian ward, the leaflet which was produced gave information which was not accurate in relation to some of the restrictions on the ward. For example, it stated that patients were able to keep mobile phones and laptops with them when they came to the ward when these items are not allowed to be used by patients bringing them into the wards. This meant that there was a risk that patients would have misleading information about restrictions in place on the ward when they first arrived.
- Most care plans we saw had examples of patient involvement and input. Patients we spoke with told us that they were aware of their care plans. Some patients told us that they had not received copies but some said that they had.
- On Caspian ward, the service had instituted a period of time every Friday where families and carers could come into the ward to speak with the ward manager and ward consultant. This was positive because it allowed additional time for carers to be involved in their family or friends' admission to hospital.
- At Park Royal, patients were involved in interviewed senior staff and patient representatives from a local user group joined some borough level clinical governance and quality meetings to ensure that the user view was represented.
- Leaflets and surveys, particularly the local family and friends test was evident on wards we visited. However, there was no evidence that feedback from these surveys was discussed at staff or community meetings and how the results of these surveys led to service level change and improvement. We asked some staff if they were aware of recent survey results and what happened as a

Good

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result of patients completing information on the wards and some members of staff told us that this information was collected centrally by the trust but they were not aware of the local data.

- Community meetings took place on all the wards we visited and we observed one community meeting on Shannon ward. We checked minutes from community meetings on all the wards we visited. While the meetings took place regularly, it was not clear from the format of the minutes or from the meeting we observed how these meetings led to change and what happened as a result of them. For example, on Caspian ward, we checked minutes from community meetings which had taken place in the three months prior to our inspection visit. We saw that some issues were raised by patients, for example, one patient had raised that they wanted more video games on 2 September. We did not see a clear response evidenced as to the action which had been taken as a result of this feedback. In the community meeting we observed, we saw that while it gave patients a voice and they were able to feedback concerns, minutes of the previous meeting was not discussed and patients did not have an agenda. This meant that patients, who are not directly involved, may not be aware of changes which take place as a result of their feedback.

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

Acute wards for adults of working age

Access and discharge

- In February 2015, the area that gave great concern was the access to acute beds for patients who were in need of inpatient care and the overall bed management for acute beds across the London services.
- At the previous inspection, the bed occupancy was over 100% at all the London acute inpatient centres. At this inspection we found again that all the London centres had high levels of bed occupancy. In September 2016 the average bed occupancy each week across the London centres was between 111% - 116% including patients who were on leave. If the patients on leave were excluded the bed occupancy was still 100%.
- At the previous inspection in February 2015, there were significant concerns about the impact on patients of these high levels of bed occupancy. These included patients sleeping on couches or temporary beds, patients transferring between wards for non-clinical reasons and patients sleeping on different wards to where they were receiving care. At this inspection all these areas had improved. No patients were sleeping on couches or temporary beds. No patients were sleeping on different wards to where they were receiving care. There were very few patients moving between wards for non-clinical reasons. In September 2016 only six patients had experienced multiple moves between wards.
- Our inspection in October 2016, found that the trust had significantly improved the processes in place for bed management. At each inpatient centre there were two bed management meetings each day. There was a London wide bed management meeting once a week looking at admissions and discharges for all the inpatient beds. The weekly meeting identified themes and areas for improvement in terms of bed management. There was a full time bed manager (weekdays 9-5) on each site and also a designated person out of hours on each site with responsibility for bed management. The out of hours bed management was often led by more junior staff. The trust had recognised that this could impact on the decision making associated with bed management and had recently introduced a more senior trust wide bed manager 7 days a week.
- The weekly bed management meeting which we observed at St Charles Hospital involved ward mangers, the bed management team, social work leads and external social agencies who were linked into discharge. The progress and recovery of each patient was discussed at these meetings to help prioritise and manage beds and admissions within the hospital.
- The trust was also working to improve the discharge of patients. Each inpatient centre had a discharge co-ordinator although how they performed this role varied between geographical areas. Throughout the inspection there were many examples of ward staff working closely with other trust teams and external organisations to facilitate the discharge of patients. For example, at the Riverside MHC had a dedicated staff member within the housing department to expedite patient referrals from the wards
- The trust was focusing on patients who had longer lengths of stay of over 60 and 100 days and were making progress with some individual patients. This was monitored at the bed management meeting and there was still more work to do.
- There were a total of 145 delayed discharges between 1 March 2016 and 30 August 2016 from the acute service. The ward with the highest number of delayed discharges was Vincent Ward, with 30, followed by Campbell Centre with 24. This is high number of delayed discharges.
- The trust had improved the quality of data available to support the bed management process. This included bed occupancy, patients clinically assessed as needing an inpatient bed waiting over 4 hours, patients moving between wards for non-clinical reasons and lengths of stays over 60 and 100 days. Trends in bed management were reported to the board.
- At this inspection, the trust had made arrangements to access beds external to the trust where needed. They had a block booking with two other London trusts for nine beds and purchased beds in the independent sector where needed. In September 2016, 28 patients were placed in beds outside the trust. In July and

Are services responsive to people's needs?

Good

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August 2016, 15 patients each month had been placed in beds outside the trust. The trust had also opened three temporary beds at St Charles on three wards. These were in rooms which were located in harder to observe areas of the ward. There was a protocol in place to say how these beds could be used safely. However, prior to the inspection the trust had decided to close these beds as the protocol was not being followed.

- At this inspection the trust was reviewing each incident where a patient waited more than four hours from the point at which they were clinically assessed as needing an inpatient bed. There were 22 breaches in July, 14 breaches in August and 35 breaches in September 2016 all for adult patients. Just under half of these breaches were at the weekend. Where the breach was over 12 hours there was a common theme about the time taken to place the patient in the independent sector. The trust reviewed the learning from each case but recognised there was still more work to do.
- At this inspection, staff working at St Chares Hospital told us that there were occasions where patients were held in the ground floor area of the hospital whilst a bed was being sourced. Staff felt that this was sometimes unsafe. Between May 2016 and Sept 2016 there were 18 incidents where a patient had been held in the ground floor area of St Charles hospital whilst waiting for a bed. The feedback from staff involved in bed was that these incidents involved occasion where the patient had been assessed by the home treatment team for admission, and was waiting for a bed.
- An assessment lounge was available at the Riverside MHC and at Northwick Park MHC. This was an area that where patients could stay voluntarily whilst waiting for a bed or waiting for a Mental Health Act assessment once they had been seen in the local accident and emergency department by the psychiatric liaison service. The assessment lounges were successful in reducing breaches of A&E waiting times and preventing unnecessary admissions. It was linked effectively to the home treatment team who were involved in assessment and provision of care to avoid an inpatient admission, ensuring good follow up of patients who did not require admission.

The facilities promote recovery, comfort, dignity and confidentiality

- Each ward had a range of rooms and equipment to support treatment and care. There were clinic rooms to examine patients and activity and therapy rooms. There were quiet areas on the wards. Facilities were available at each for patients to meet their visitors.
- At the previous inspection in February 2015, we found that many patients on the acute wards were not able to make a telephone call in private. At this inspection we found that improvements had been made and that patients were able to make private calls, either by using their own mobile phones, the telephone in the telephone booth or by using a cordless ward phone. This was located in the nursing station and patients were able to take this to their rooms or the quiet room.
- In February 2015 we found that patient's privacy and dignity was compromised at the Campbell Centre for those patients who shared a bedroom because the bathroom doors had been removed and only a curtain was in place. At this inspection we found that improvements had been made. Following a review of the shared bedrooms by the risk control team the doors to the bathroom areas were reinstated.
- The lounge areas on Amazon Ward, Danube Ward and Thames Ward at St Charles hospital were large and spacious areas. However the lounge areas were not fitted with comfortable furniture and there was only minimal seating space. The patient lounge rooms were very sparse and minimally decorated. The lounge areas were not comfortable or relaxing and did not create an atmosphere of recovery and comfort.
- Patients had access to outside space. At St Charles Hospital, due to ligature risks and limited visibility patients could only access the balcony areas with staff supervision and the balcony areas were locked.
- Patient feedback on the quality of food was mixed. Patients had access to a variety of menu options including halal food and culturally appropriate food. However, some patients at Northwick Park MHC that the food provided did not meet their cultural and religious needs and at St Charles MHC some patients commented that the quality of the food was poor.
- Drinks and snacks were available at all times. However, patients at the Campbell Centre were not permitted to make hot drinks between midnight and 6.00am. It was unclear why this blanket rule had been imposed.

Are services responsive to people's needs?

Good

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

- Each patient was provided with a personal safe in which they were able to store personal items securely.
- There was a programme of activities for patients throughout the week. These were facilitated by ward occupational therapists and activity co-ordinators. Most patients told us that there were very few or no activities that took place at the weekend. Some action had been taken to address this. For example, on Shore ward a healthcare assistant had been trained to be able to supervise patients to use a gym on another ward that was accessible at weekends. Patients spoke positively about the activities they participated in. However, this remained a concern.

Meeting the needs of all people who use the service

- Accessible rooms were available across the service for patients with mobility issues. Lift facilities were available. Willow ward frequently admitted women who were pregnant. The service had a specific policy on caring for pregnant patients, ensuring that they had access to one-to-one support at all times to ensure their safety.
- A variety of information leaflets was available for patients on the wards, including those related to medicines and their side effects, independent advocacy, activities on the wards, welfare and housing support services and physical health care services. These leaflets were in English only, although staff said that they could access information in other languages for patients who could not read English when required.
- The peer support worker at the Campbell Centre facilitated a patient resource room where patients could access information about treatment, local services, patients' rights and information on how to complain. At the resource room, patients could also use the computers and telephones.
- Staff had access to interpreting services to help support patients to ask questions about their rights and to meet with staff to discuss their care and treatment. Some staff at Northwick Park MHC
- Patients had access to meals which met different cultural, religious and dietary needs. However, at Northwick Park MHC patients told us that there was a lack of kosher and vegetarian options at meal times.
- Patients religious and spiritual needs were supported. Some local faith representatives visited the service such as religious or spiritual texts to support patients' spiritual needs.

Listening to and learning from concerns and complaints

- Patients we spoke with knew how to make a complaint. Complaints information was clearly displayed on each ward.
- There were 92 complaints received by the trust for the acute service in the previous 12 month period. The main themes were individual concerns about care and treatment, staff attitude and discharge planning.
- One complaint was referred to the parliamentary ombudsman. This was not upheld.
- The ward with the most complaints over the period was Gerrard Ward with 12.
- Complaints were discussed at team meetings and in supervision to ensure that learning was embedded in the service.
- The trust board had oversight of the all individual patient and carer feedback received in the form of compliments, enquiries, comments, concerns and complaints. This included themes that were emerging and reviewing any key areas of learning.

Psychiatric intensive care unit (PICU)

Access and discharge

- Between 1 March 2016 and 30 August 2016, there were six patients identified on Nile ward as being ready to be discharged but without provisions having been made for this discharge to take place in a timely manner. There were no delayed discharges indicated from Colne ward, Shannon ward or Caspian ward.
- While there were few identified delayed discharges in care, speaking to staff on the wards and observing handovers indicated that some patients were waiting to be allocated to care coordinators or for referrals to be determined from forensic wards.

Are services responsive to people's needs?

Good

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

- The occupancy levels on the wards between 1 March 2016 and 30 August 2016 was below 90% with the exception of Colne ward where it was 92%. This meant that beds were available on intensive care wards where necessary.
- Patients were admitted from other inpatient wards but the services also accepted referrals from prisons and court diversion services and community teams. Most discharges were to other open wards. However, some patients were discharged directly back to the community and some patients needed additional support in forensic services.
- Beds were allocated on the wards, apart from Shannon ward, according to catchment areas. For example, Caspian ward took patients from Brent and Harrow and had two beds for patients from Milton Keynes. Nile ward took patients from Westminster and Kensington and Chelsea. Two beds on Colne ward were allocated to patients who came from the Heathrow immigration and removal centres.
- Each site had regular meetings to discuss bed management and availability. Ward managers from the PICU wards were involved in these and they also involved ward managers from other acute wards, the home treatment teams, community teams and borough management.
- Each ward had a specific operational policy which establish admission criteria and exclusions. The clinical team would assess patients after referrals were received and even if it was not necessary or appropriate for a patient to receive care on a PICU ward, the ward team could offer advice to a referring ward.
- Wards reported that their average lengths of stay were between six and eight weeks. We checked the average lengths of stay between October 2015 and September 2016 and this ranges between 35 days on Shannon ward to 61 days on Nile ward. However, this includes patients who had been on the ward for over three months.

The facilities promote recovery, comfort, dignity and confidentiality

- All the wards had access to meeting rooms including facilities for visitors and outdoor space as well as areas for activities and groups to take place.
- Patients on all the wards we visited told us that leave was sometimes delayed or cancelled when staffing was an issue. We were unable to determine how frequently this happened because this information was not collated at a ward level or centrally which meant it was not clear how often patients were affected in terms of their leave arrangements when staffing levels were low.
- On Caspian ward and Nile ward the computers which were used to access the internet were not working on the day of our visit. On Caspian ward, there had been repeated difficulties both with the computer and with an internet connection to the ward which patients could use. This had not been operational for a number of months. However, the trust had made several attempts to resolve this with the telecommunication provider. During our inspection visit, the computer and internet access to Caspian ward was fixed. On Shannon ward there was a computer with internet access in the games room. Staff told us that this was popular with patients.
- There was a gym on Nile ward and patients on Shannon ward had access to a gym. However, while there was a gym on Caspian ward, patients on the ward had not accessed it for a number of months for a technical reason. This meant that patients who were admitted to Caspian did not have access either to a computer or to a gym, at the time of our inspection and both these facilities had not been available to them for a few months.
- Activities varied between the wards. For example, on Nile ward there were groups which included Tai Chi, Health Eating and Film nights. The ranges of groups were not as extensive on Shannon ward where there was no occupational therapy input or on Caspian ward where the occupational therapy input was lower. The occupational therapist vacancy on Shannon ward was being recruited into and sessional input was being provided by occupational therapists from other wards.
- Patients all had access to passcode encrypted safes in their rooms. Two patients on Shannon ward told us that they were not aware how to use the safes.
- On Shannon ward, we saw one care plan for a patient which stated that the patients' leave was dependent on staffing levels on the ward. This meant that consideration had not been given solely to the patients' needs when planning her care.

Are services responsive to people's needs?

Good

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

- We reviewed access to activities when looking at care plans on Shannon ward. We saw that one patient whose care plan specifically indicated that they engage with a therapy timetable had been facilitated to access five sessions between 31 August and 30 September. Two of these sessions were 'plan the day' sessions and one of the sessions the patient had chosen not to engage with. However, this did not reflect a care plan which encouraged and promoted therapeutic engagement. This meant that without access to a cohesive therapeutic timetable, some patient's needs were at risk of not being met.

Meeting the needs of all people who use the service

- Staff on the ward had a good understanding of the diverse needs of patients in different local community groups and displayed sensitivity to their specific needs. Information was available in different community languages if necessary.
- Staff told us that they had good access to interpreting services and that interpreters were booked as necessary. Staff on Colne ward told us that they book interpreters in advance when they are needed.
- Staff on Colne ward told us that there is a trust lead who can provide advice and support regarding patients' needs related specifically to their sexuality or to their transgender status.
- There were disabled accessible bedrooms on Nile ward and Shannon ward which could be adapted for patients who had mobility difficulties.
- The service provided a range of culturally and religiously appropriate food including halal options as well as kosher options.
- There was a chaplain available at all sites and different religions were catered for so support could be provided on the ward for patients with spiritual needs. While there were multi-faith rooms in the hospital sites, where patients had restricted leave, chaplains and religious representatives could access the ward.

Listening to and learning from concerns and complaints

- Between October 2015 and September 2016 there were 15 complaints across the PICU wards.
- In February 2015, we saw that information had not been available to inform patients how to make a complaint and asked the trust to ensure that patients and carers had access to the formal complaints process. In this inspection, we saw that this was not the case. Information about complaints was visible on all the wards we visited. We saw that patients had been facilitated to make formal complaints and had access to advocacy services. Patients we spoke with across the wards we visited told us that they were aware how to make a complaint. This meant that there had been an improvement since the last inspection in this area.
- In February 2015, we identified also identified that the trust did not have systems in place to ensure that verbal complaints were addressed. At this inspection, we found that while staff told us verbal complaints were addressed, we did not see that there were systems in place to document how this happened. For example, when issues were raised informally at patient community meetings and then we were told they were resolved, this was not documented consistently in minutes or action plans following community meetings. Managers at Brent told us that staff were asked to log informal complaints through the incident reporting process but staff on the ward were not aware this was a requirement. This meant that while we were assured that action was taken to respond to concerns raised by patients, there was little evidence that action was taken and that informal complaints were followed up.
- Staff were able to give us examples of learning from complaints and concerns. For example, the carers and family time on Friday afternoon where carers and family members could book time to talk with the ward manager and consultant followed concerns raised from family members regarding involvement and communication about a patient's care on the ward. This evidenced a willingness to lead and develop from feedback.

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

Acute wards for adults of working age

Vision and values

- Staff showed that they understood, agreed with and put into practice the vision and values of the trust. For example, their support for the trust value of respect for patients was demonstrated by staff ensuring they kept closed the screens on patients' doors and around their beds, unless safety required them to be open.
- Staff said that they knew the identity of senior managers in the trust and that they visited the wards to better understand the needs of patients and staff.

Good governance

- The trust had governance processes in place to manage quality and safety within the service. Ward managers had access to electronic dashboards that gave an overview of how their service was performing. Key performance indicators were monitored and wards received weekly individual performance reports.
- Staff received appropriate support to help them do their jobs. Mandatory training was mostly high and staff received regular managerial and clinical supervision, as well as yearly appraisals.
- There were sufficient numbers of staff to ensure that staff delivered patient care in a way that was safe and effective. There was an ongoing recruitment process to fill staff vacancies across the service. Staff were overwhelmingly positive about the improvements in this area.
- Staff participated in regular clinical audits to identify areas of improvement and monitor standards on the wards.
- Learning from incidents and complaint took place to improve safety on the wards and the effectiveness of patient care and treatment. However, we found that there was a lack of frameworks to learn across the trust between the different divisions.
- Ward managers were able to manage their wards autonomously and received support from their managers.
- Staff added risks to trust and local risk registers through the matrons. Managers discussed work place risk assessments and received visits from the trusts safety team who identified risks on the wards.

Leadership, morale and staff engagement

- In February 2015 we found that the acute wards for working age adults were not well managed overall because contingency plans were not in place to meet the increases in the demand for acute inpatient beds. During this inspection we found that significant improvements had been made in this area. Bed management was robustly managed and monitored. Staff spoke confidently of the escalation procedures they followed when a bed was required.
- The ward managers were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and were proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improving care. Staff said that they would feel comfortable to raise concerns without fear or victimisation.
- Staff were aware of the whistleblowing process if they needed to use it.
- Staff we spoke with said morale was good and they worked well as a team. Staff were positive about their jobs, colleagues and managers. They felt supported and fedback there were good professional development opportunities available.
- There were several opportunities for staff to give feedback regarding their work, including handovers, staff meetings and supervision. Nurses and staff from across all professional disciplines, including peer support workers and people with lived experience of in-patient mental health services also attended a monthly clinical network across the trust in order to share learning and best practice.

Commitment to quality improvement and innovation

- Staff on Shore ward took part in weekly safety meetings to discuss incidents and to collectively devise how to improve safety on the wards, including reducing incidents of physical restraint and patients absconding from the wards. This system had produced plans to

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reduce absconding, which were effective and staff said they felt empowered to develop new safety plans, rather than waiting for them to be introduced by senior trust managers.

- The provider demonstrated a commitment to quality improvement and innovation. The Campbell Centre had submitted evidence to the Accreditation for Inpatient Mental Health Services (AIMS) scheme and was waiting for a response. Following the inspection the trust informed us that the service had successfully received their AIMS accreditation. Ten other wards across the acute service were preparing to apply from 1 April 2017.
- At the Campbell Centre staff used the Mental Health Safety Thermometer to improve patient safety. This included the service reviewing all incidents of missed medicine, incidents of self-harm within the first 72 hours of admission and reviewed patients' psychological well-being.
- The Campbell Centre was one of six sites testing new approaches to delivering mental health care as part of NHS England's plans for 'Implementing the Five Years Forward View for Mental Health.' As part of this initiative, the service was looking at how incidents of patients being absent without leave could be reduced.
- At the Riverside MHC the occupational therapy team was involved in research with Brunel University with patients assisting as researchers on how OT could best support patients on the wards.
- At St Charles MHC, on Danube ward a quality improvement project (The Shine Project) was in place to improve patients' physical health assessment. A patient held record and single physical and mental health assessment form were to be rolled out across the trust as part of the physical health implementation strategy. The Shine project has been used as a case study of national best practice.

Psychiatric intensive care unit (PICU)

Vision and values

- The trust values are compassion, respect, empowerment and partnership. We saw that information about the trust values and vision were visible in the wards and on the hospitals. We saw that most of the staff reflected the values which were presented by the trust in the way that they worked with patients.
- Staff were very committed to the wards and we received positive feedback on the wards regarding the ward managers and matrons at a local level.
- Most staff we spoke to told us that they were proud of working for Central and North West London NHS Foundation Trust.
- Staff had a good understanding of their local management teams and recognised the trust chief executive but there was more distance noted from other senior management staff within the trust. Although one member of staff told us that they had contacted a board member directly to raise a concern regarding patient care on a ward.

Good governance

- The psychiatric intensive care units were based on three different hospital sites which were in different divisions of the trust so no one division had oversight of all the psychiatric intensive care units. This meant that the governance arrangements and oversight varied between the sites.
- At St Charles Hospital, where Shannon ward and Nile ward were located, there had been an review of staffing levels and the nursing levels had been increased with a higher establishment number in post on each of the shifts. At Park Royal, where Caspian ward was located, there was further work being undertaken regarding the staffing levels on the ward.
- Staff across the wards told us that they had regular supervision. We saw that some staff team meetings took place, but there was a gap in information about the regularity of supervision and the frequency and format in staff team meetings. This meant that some information might not be held at a local level which could evidence that staff received sufficient support locally and that where there was an incident on a ward, the learning had been shared across the whole staff team and not only nursing staff.
- While some staff were able to explain to us about incidents which had taken place on the ward on which they worked, they were less confident explaining

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incidents which had taken place on other wards in the service or on other wards across the trust. This meant that there was a risk that learning from incidents trust wide was not yet embedded and that the processes were not robust enough to evidence that this took place consistently. Staff were sent information, for example, there was an alert system in place when major incidents occurred but we did not see evidence that these were discussed in team meetings. However, the trust had instigated a PICU forum which ran quarterly to ensure that information was shared across the four wards within the trust.

- Services in Brent had developed a weekly meeting for staff on the ward which they referred to as a 'huddle' where incidents on the ward were discussed with staff. Information from the incident reporting system was displayed in the ward so that patients had this information as well.
- Each manager had access to a dashboard on which key performance indicators were collated and shared from the local governance teams. This meant that ward managers had oversight of the performance of the ward.
- Each ward had a specific action plan and risk register. This reflected information which was gathered through auditing on the wards, data collection such as monitoring the electronic database and feedback collected centrally such as patient feedback forms. This ensured that each ward had clear information about how it was going to improve.
- There was no administrative support on Shannon ward when we visited because the member of staff who had that role had left and had not been replaced. This placed additional work on staff on the ward to ensure that information was updated as necessary and may have may had an impact on patient facing time although no staff or patients raised this as a concern to us during our visit

Leadership, morale and staff engagement

- Staff told us that they felt confident raising concerns to their managers. Some staff on Shannon ward told us that this had improved since the last inspection in February 2015. Shannon ward had not had a permanent manager for two years. However, a new ward manager had been appointed earlier in the year and staff were positive about the impact that this had had.
- Staff on all the wards we visited told us that they felt supported locally and talked about improvements in the service since the last inspection in February 2015.
- We saw on Shannon ward where an incident had occurred regarding a patient where a member of temporary staff had been at fault, this had been acknowledged to the patient and the ward manager had apologised to the patient which reflected an understanding of the duty of candour.

Commitment to quality improvement and innovation

- All the wards were members of the National Association of Psychiatric Intensive Care Units and some members of staff spoke about conferences which they had attended as a means to share information nationally.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured that patients were appropriately assessed and that the welfare and safety of patients was maintained. The reasons for the administration of rapid tranquilisation, and the reviews of patients' physical health, including vital signs, following rapid tranquilisation were not always demonstrated to ensure patients were not at risk. Whilst improvements had been made in this area, we found gaps in the monitoring and recording of patients physical health following RT. This requirement was stated in the last inspection in February 2015 and is a continuing breach. Risk assessments did not include details about risk and there was no information in care records on how the risks were to be managed. This was a breach of Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust was not providing care or treatment in a way that minimised acts which involved the use of control or restraint. The number of incidents of prone restraint and the use of restraint across the service were significant. Further work was needed to reduce variations in the use of restraint between different trust inpatient services.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation13(4)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust was not ensuring that accurate, clear contemporaneous records of service users care and treatment were being maintained. Records of physical restraint of patients were not always complete and accurate. This was a breach of Regulation 17(2)(c)