Requires improvement

Oxford Health NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Date of inspection visit: 29 September and 1 October 2015
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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)
RNU09	Buckingham Health and Wellbeing Campus	Opal Ward	HP20 1EG

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated long stay/rehabilitation mental health wards for working age adults as **requires improvement** because:

- Two rooms were not fit to be occupied by the patients staying in them and we found lack of maintenance was an issue.
- Handover of important information between staff was poor and could have placed patients and staff at risk.
- The hospital had a policy in place of moving patients back and forth between the acute wards and Opal ward in order to create bed vacancies on the acute wards. This was disruptive to the patients.
- The hospital did not take into account the impact on patients when planning their policy.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Two rooms were not fit to be occupied by the patients staying in them and we found lack of maintenance was an issue.
- Handover of important information between staff was poor and may have placed patients and staff at risk.
- Risk assessments were not consistently completed and reviewed.
- The ward did not have enough staff to meet the requirements of the patients.
- Patients were sometimes restricted from making simple choices such as having a snack in their bedrooms or using the dining room apart from at mealtimes.

However :

- The ward was designed to minimise ligature risks.
- Patients told us they felt safe on the ward.

Requires improvement

Are services effective?

We rated effective as requires improvement because:

- We found that recording on the new electronic recording system was poor as it was hard to find information that had been recorded.
- Patients reported that they had little one to one time to discuss their care with their named nurse. Consequently their care plans did not reflect care that was holistic, person centred and recovery focussed.
- Patients detained under the Mental Health Act did not always have their rights properly explained to them.

However

- Older paper based care plans had a wide range of assessments relating to patients' needs and sufficient detail for staff to meet the patients' needs.
- Prescribing of medicines and monitoring of physical health for adverse effects was of a high standard.
- The team had a wide range of professionals to address the rehabilitation needs of the patients and a good program of activities. Patients valued the activities they attended as part of their recovery program.

Requires improvement

Summary of findings

Are services caring?

Good

We rated caring as good because:

- We observed many interactions between staff and patients throughout our two visits to the ward. Most of these were positive and caring.
- Patients reported good experiences of care and said when they had complained about negative experiences, that things had improved.
- Patients told us that staff supported them to keep in contact with their families.
- Patients were able to speak to advocates who would be able to help them make their voice heard in discussions about their care or detention.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- The hospital had a policy in place of moving patients back and forth between the acute wards and Opal ward in order to create bed vacancies on the acute wards. This was disruptive to the patients.
- One patient was upset that people were admitted to her room whenever they were on leave for a weekend.
- The hospital did not take into account the impact on patients when planning their policy.

However:

- We found that discharge planning with teams in the community was good, there were no delayed discharges and readmission following discharge was rare.
- The ward was designed to be accessible for people with physical disabilities and generally to promote privacy and recovery.
- A good range of rooms were available for quiet times or for activities.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was no plan in place to monitor and assess the impact of moving patients between wards and to plan how to reduce such moves.
- Maintenance and environmental risk audits took place but these failed to address the ongoing maintenance issues with regard to the drains and leaking roof

Summary of findings

- The ethos of care on the ward did not promote rehabilitation.

However:

- Staff were positive about the leadership on the ward. They told us that staffing levels had made the ward more stressful but they felt positive about the future.
- Staff of all grades felt they had opportunities for personal and professional development.
- This service achieved Accreditation for Inpatient Mental Health Services (AIMS) from the Royal College of Psychiatrists in March 2015. The ward achieved an 'Excellent' rating.

Summary of findings

Information about the service

Opal ward is the rehabilitation ward for adults of working age with mental ill health. It is a mixed gender ward for up to 20 people. Rooms are arranged on two corridors so that male and female patients' bedrooms are in separate parts of the ward.

The ward is part of Oxford Health NHS Foundation Trust and serves the counties of Oxfordshire and Buckingham. It provides a service intended to prepare patients for a return to the community.

In April 2014 Opal ward moved within the hospital site where it is based to newly built premises in the Whiteleaf Centre, Buckingham Health and Well Being Campus.

This is the first inspection of Opal ward since registering at its current location.

Our inspection team

The inspection team was led by:

Chair: Professor Jonathan Warren, Director of Nursing, East London Foundation Trust

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission

Team Leader: Serena Allen, Inspection Manager, Care Quality Commission

The inspection team for this core service comprised of four people: a CQC Inspector, a Mental Health Act Reviewer, a Consultant Psychiatrist and a Registered Mental Health Nurse.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information about the service

During the inspection visit, the inspection team:

- visited the ward on 29 September and 1 October to look at the quality of the ward environment and observed how staff were caring for patients.
- spoke with nine patients who were using the service.
- spoke with the acting manager for the ward.
- spoke with 14 other staff members including doctors, nurses, support workers, occupational therapists and the pharmacist.
- attended and observed a hand-over meeting, a multi-disciplinary meeting and two meetings for patients using the service.
- looked at eight care records of patients.
- looked at 20 prescription and medicine administration charts for patients.

Summary of findings

- carried out a specific check of the management of medicines on the ward.
- 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

- People told us that there were not enough staff on the ward. They told us that they felt safe. They also told us that when they had problems and discussed it with nurses that the problems were dealt with.
- Some patients told us they did not get much one to one time with their nurses and were not involved in writing their care plan. Half of the patients we spoke to said they were offered a copy of their care plan by nursing staff.
- Patients felt there were too many restrictions on the ward. They said they would like more access to their rooms and to be able to make and eat snacks at times they chose.

Areas for improvement

Action the provider MUST take to improve

- Managers must be able to assess the impact on patients moving between acute wards and Opal ward.
- Ward staff must ensure that they are aware of the risks and needs of any patient admitted to the ward, even if this is for a short period and that handovers are timely.
- When patients are able to express their views on their care and treatment then care plans must reflect the patients' views.
- Maintenance records held the by ward and Estates and Facilities must be accurate. Records should reflect work done and any work that remains outstanding.
- Rooms that are unfit to be occupied should not be occupied.
- Blanket restrictions should not be in place unless justified on care grounds. When in place they should be reviewed and reflect the changing population of the ward.

Action the provider SHOULD take to improve

- Ward staff should monitor the use of the female lounge as we observed that only male patients used this lounge during both our visits to the ward.

Oxford Health NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Opal Ward	Buckingham Health and Wellbeing Campus

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.

- The Mental Health Act (MHA) administration team were effective at supporting the ward staff to manage the legal aspects of the MHA.
- All permanent ward staff had or were due to have recent training on the new MHA Code of Practice. Staff we spoke with had good knowledge of the principles of the Code of Practice. We were not able to review training records for agency staff.
- Detention papers were available for scrutiny and they were all found to be in order. In the documents of some patients, we were unable to find evidence that staff had explained their rights on an on-going basis. In the documents of two patients, we found no record of a discussion of rights following the renewal of detention.
- There was input from independent mental health advocacy (IMHA) services. The IMHA attended the ward on a regular basis. Information about the IMHA service was available on the ward.
- Section 17 leave was authorised through a standardised system and included specified conditions. Used leave forms had been removed or crossed through. Patients informed us that escorted section 17 leave had been cancelled from time to time due to staff shortage.
- Informal patients were aware of their right to leave the hospital. Signs on the ward informed patients of this right.
- Consent to treatment provision on the ward was found to be reasonably good. All patients were assessed as to their ability to consent to treatment at the first administration of a medicine.

Detailed findings

- All the prescribed medicines were covered by consent form T2 or form T3 where patients refused consent or were unable to give consent.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were offered online training on the Mental Capacity Act (MCA). We were not able to access up to date records of the uptake of training specific to this ward.
- Staff we spoke with had poor knowledge of the MCA. The principles of the MCA were on display around the ward and staff could quote these. However, we found that staff were not able to describe examples of how they would use the MCA in practice, for example in creating a discharge plan with a patient.
- The ward has not made any applications under the Deprivation of Liberty Safeguards. However, none of the patients we met and whose notes we reviewed would have required such an application.

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

Safe and clean environment

- One bedroom we looked at smelt strongly of sewage. The patient told us that this was particularly a problem at night and was worse when the bedroom window was closed. Staff told us that this was due to a problem with the drains that had been recurring since the building opened in April 2014. They told us that the issue also affected the adjacent bedroom. We asked to look at maintenance reports and actions. Records staff showed us stated when issues were reported to the Estates department and when the Estates team had visited the ward. However there were no records of what actions were taken by the Estates department. This meant that the ward staff could not be sure if the ward, including patients' bedrooms, had been made safe.
- We asked the Trust to address the issue of a patient's bedroom smelling of sewage. This was addressed during the inspection by the affected patients being moved to other rooms while the drains were cleared. The patient later told the inspection team that they were pleased with the work the Trust had carried out to address the problem.
- Requests to repair a leaking roof and a broken water heater were also not carried out over eight weeks since first reported. The broken water heater had been made safe, but was unusable, and replaced by a kettle.
- We found one item of medical equipment that was overdue for an annual electrical check, but all other equipment was checked and maintained according to manufactures guidelines.
- The bedrooms all had ensuite shower rooms designed to be free of ligature points, apart from the shower room door. However the door could be locked in an open position if the patient was assessed to be at high risk of suicide or self-harm. The shower room could still be used in privacy if the door was open, so long as the observations took place from outside the bedroom door. This meant that a safe environment was maintained with little impact on the patient's right to privacy.
- Ligature points were minimised throughout the ward as part of the original design. While lines of sight around the ward were poor, the presence of staff in all areas where patients were present mitigated against the risk of harm to patients.

Safe staffing

- The regular staff cover for the ward was early and late day shifts consisting of two nurses and three healthcare assistants per shift, and a night shift consisting of two nurses and two healthcare assistants. Other healthcare assistants would be placed on the rota to allow for enhanced observations of patients when required.
- Information provided by the trust before the inspection showed that the ward had low staffing levels compared to the rest of the trust. This meant it could only cover less than 50% of the required shifts from its staff team and in one month only 33% of shifts. The ward relied on agency workers and staff from other wards to provide a full service. At the time of the inspection we were told that staffing levels had improved.
- We reviewed the rota for the week one month before the inspection took place. The available ward staff were unable to cover 37 out of 98 shifts on the rota. 14 shifts were covered by agency staff and 23 shifts were covered by Trust staff working extra hours.
- In the week when the inspection was taking place 16 out of 98 shifts required extra cover. Eight were covered by agency staff and eight by Trust staff working extra hours. The increase in cover was due to four new nurses and one new healthcare assistant starting work on the ward. One more appointed healthcare assistant was awaiting references and checks in order to start work. However this would still mean the ward was unable to cover the full rota from its substantive staff team.
- The ward used only one employment agency and several agency staff worked regularly on the ward, reducing the negative impact that frequent use of many different agency staff can create. We also saw evidence that agency staff had received a short induction before starting work on the ward.
- In addition to core staffing, there was also an occupational therapy team assigned to the ward that provided activities on the ward seven days per week. This also mitigated pressures on the healthcare staff.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

- There was a seclusion suite on the ward. In the six months prior to the inspection this had been used twice. One episode was for a patient who had been on the ward for a short time and was subsequently assessed as requiring a higher level of care than the ward provided. This patient was moved from seclusion to an acute ward within the hospital.
- The second episode was for a patient from an acute ward, where that ward's seclusion suite was already in use. The patient was accompanied and cared for by staff from the acute ward and the episode lasted only a few hours.
- In the six months before our inspection, there were no episodes of restraint on the ward.
- Previous reports from the trust about this service showed seclusion had been used five times in the past year and that restraint had been used seven times in the past year. This information referred to a period when staffing levels were very low and this may be the reason for higher incidents of seclusion and restraint.
- During our inspection two patients from acute wards were staying on the rehabilitation ward for several days. This was because they had returned from leave and were unable to access the acute wards for health and safety reasons. During the nurses handover the needs and risks of these patients were not discussed with the staff coming on shift. As these patients had higher levels of needs and risks this created a risk to all patients and staff on the ward.
- Patients from acute wards were accommodated on the rehabilitation ward for periods of up to four nights. In the 26 weeks up to and including our visit there was only one week where acute patients were not temporarily accommodated on this ward. Given the poor handover we observed this created an on-going risk to patients and staff on the rehabilitation ward.
- We found that blanket restrictions were placed on patients' access to their rooms and communal areas on the ward. For example, all bedroom doors were locked from 10:00am to 12:30pm and from 2:00pm to 6:00pm each day. These meant patients' were unable to seek privacy in their rooms for substantial parts of the day. The ability of a patient to electively seek privacy or take "time out" can be important in developing coping mechanisms and promoting recovery, as psychiatric wards can by their nature be very stressful environments.
- The dining room was locked except at mealtimes. Patients told us that they were not allowed to eat snacks in their bedrooms and this was confirmed by staff. This meant that patients had less freedom to self-cater and develop other independent living skills.
- When we brought these restrictions to the attention of ward staff, we were told that they were possibly in place to encourage participation in activities on the ward during the day. However staff also told us that the restrictions had been in place for a number of years without review as to their effectiveness and purpose. This meant that patients were subject to restrictions that were likely to be unnecessary and would fail to promote their recovery and rehabilitation.
- Risk assessments for patients using this service were poor. Some staff described using a recognised risk assessment tool, but there was no evidence of this in the care plans that we reviewed. The risk assessments we reviewed were completed by nursing staff without input from other members of the multi-disciplinary team. This meant that the team were not able to identify risks and monitor if their interventions were effectively managing and reducing risks to the patient.
- However most patients we spoke with told us they felt safe on the ward.

Track record on safety

- In the six months prior to the inspection there had been no serious incidents reported relating to the patients using this service. We discussed safety issues with patients and staff, and they were not aware of any incidents that should have been reported.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were clear on the process for reporting incidents and concerns. Nursing and care staff were able to cite examples of incident reviews that had been discussed in team meetings.
- We saw records of "risk notes" sent via email to ward staff sharing learning from incidents and complaints elsewhere in the Trust. These also included action points and any changes to policy and practice as a result of the complaint or incident.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- Computer based care plans had a wide range of domains for assessments relating to patients' needs. However, in many of the plans we reviewed some key domains were not completed or dated before admission to the ward. That is they had been completed on an acute ward before transfer. In one case a key component of a care plan had not been updated since four months before the patient's admission to the ward.
- Patients told us that they had little one to one time with their named nurses in order to plan their care. This was reflected in the care plans where we found few had evidence of patient involvement.
- Less than half of the care plans we reviewed had evidence of discharge planning for the patient. On a rehabilitation ward this should be a priority for every patient.
- Overall the care plans did not reflect care which was holistic, person centred and recovery orientated.
- The electronic recording of patient notes was a relatively new system. We found that staff were not always recording information in the correct part of the record. This made it difficult to access information in a timely manner.
- Paper records of care and treatment plans were being phased out, but recording in these was good.

Best practice in treatment and care

- The management of medicines was of a high standard and followed NICE guidelines. There was a clear system in place for reviewing and monitoring patients following administration of high dose antipsychotics. Regular physical health checks were recorded in all the care plans we reviewed so the medical team were aware of any adverse effects of the patient's treatment.
- The range of psychological therapies offered was well tailored to the needs of the patient group. We attended a Hearing Voices group meeting attended by six patients. The content was clearly related to NICE guidelines on therapies for schizophrenia. Patients we spoke with after the group said it was important and effective for them as part of their recovery.
- The Occupational Therapy and Psychology teams had created a comprehensive program of activities in response to peoples assessed needs. This included tailored cookery sessions and sessions on managing medication, delivered with the pharmacy team.

Skilled staff to deliver care

- The multi-disciplinary team had a wide range of professionals that worked solely within this service. This included an occupational therapy team able to provide activities seven days a week, a psychology team and a psychiatry team.
- A pharmacist visited the ward at least twice a week with additional availability to speak to patients on a one to one basis.
- Nursing and care staff received regular one to one supervision and an annual appraisal. We saw staff records that showed that all nurses and healthcare assistants had received an appraisal in the preceding twelve months. We saw records of regular staff meetings for the ward.

Multi-disciplinary and inter-agency team work

- We observed a multi-disciplinary meeting. It was attended by all the professionals involved with the patient's on-going care and treatment.
- The service had access to a hospital based social work team to liaise with community services and take part in discharge planning.
- Over a six month period the ward reported only one readmission of a patient within 90 days of discharge. This shows an effective system of partnership between the ward and the community team to achieve a timely and safe discharge for the patient.

Adherence to the Mental Health Act and Code of Practice

- Detention papers were available for scrutiny and they were all found to be in order. In the documents of some patients, we were unable to find evidence of explaining of the rights on an on-going basis. In the documents of two patients, we found no record of a discussion of rights following the renewal of detention.
- The Mental Health Act (MHA) administration team were effective at supporting the ward staff to manage the legal aspects of the MHA.

Are services effective?

Requires improvement

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

- All permanent ward staff had recent training on the new MHA Code of Practice. Staff we spoke with had good knowledge of the principles of the code of practice. We were not able to review training records for agency staff.
- There was input from independent mental health advocacy (IMHA) services. The IMHA attended the ward on a regular basis. Information about the IMHA service was available on the ward.
- Section 17 leave was authorised through a standardised system and included specified conditions. Expired leave forms had been removed or crossed through. Patients informed us that escorted section 17 leave had been cancelled from time to time due to staff shortage.
- Informal patients were aware of their right to leave the hospital. Signs on the ward informed patients of this right.
- Consent to treatment provision on the ward was found to be reasonably good. All patients were assessed for capacity to consent to treatment at the first administration of a medicine.
- All the prescribed medicines were covered by consent form T2 or form T3 where patients refused consent or were unable to give consent.

Good practice in applying the Mental Capacity Act.

- Staff completed online training on the Mental Capacity Act (MCA). We were not able to access up to date records of the uptake of training specific to this ward.
- Staff we spoke with had poor knowledge of the MCA. The principles of the MCA were on display around the ward, and staff could quote these but were often unable to describe examples of how they would use the MCA in practice, for example in creating a discharge plan with a patient.
- The Ward had not made any applications under the Deprivation of Liberty Safeguards. However, none of the patients we met and whose notes we reviewed would have required such an application.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed many interactions between staff and patients throughout our two visits to the ward. Most of these were positive and caring.
- Patients reported good experiences of care and said when they had complained about negative experiences, that things had improved.
- Patients' bedrooms all had signs on the doors reminding staff to knock before entering. Observation windows on bedroom doors were kept closed between observations.
- We observed a multi-disciplinary meeting with a patient. We observed that the patient was fully involved in the meeting and that when the team decisions were challenging for the patient, that the team members were supportive and empathetic. This helped patients understand why the decision was made.
- We saw that patients were able to decorate their rooms with personal items, within the rules of the ward requiring a safe environment. Several patients told us they were pleased with their rooms.

However:

- The dining room on the ward was locked between meal times. We observed people queuing in the corridor before lunch, many of them sitting on the floor. We asked them why they were queuing and they said that they expected the dining room to be unlocked soon, but did not know exactly what time it would happen. We discussed this with staff who told us that this often happens. There was a general acceptance of this behaviour by staff and we did not observe any staff intervening to offer an activity or open the dining room. This showed a lack of dignity and respect for the patients and in the case of those sitting on the floor was degrading to the patients.
- During lunch, we observed a staff member was standing in the dining room watching the patients eat. They did not seek to engage the patients in conversation or otherwise contribute to the dining experience. Again, this showed a lack of respect for the patients' dignity and privacy.

The involvement of people in the care they receive

- The ward had a member of staff who took the lead for carer issues. A carers' forum was organised for the ward recently, but cancelled due to low levels of interest. A hospital wide carer's forum was being organised at the time of the inspection in order to attract a wider number of people.
- Patients told us they had contact with family and that family could visit the ward. Some preferred to meet their family off the ward, and this was enabled by the care team through leave arrangements.
- There was input from independent mental health advocacy (IMHA) services. The IMHA attended the ward on a regular basis. Information about the IMHA service was available on the ward.
- People were not always involved in the planning of their care when they were able and willing to be involved. Care plans had little evidence of patient involvement. Some patients also told us that they had very little time with their primary nurse to discuss their care or to plan for meetings with the multi-disciplinary team. Half the patients told us they had a copy of their care plan or had been offered, but declined a copy.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Senior hospital staff told us that beds on the ward were used for acute patients when rehabilitation patients were away from the ward on overnight leave. This enabled the acute bed to be made available for an admission. Hospital staff told us they tried to minimise this and ensure that acute patients return to the appropriate ward as soon as possible. However in 25 out of 26 of the week's up to and including the inspection, there was at least one such admission per week. This meant that ward occupancy was frequently over 100% and if patients had to return early from leave then a bed would not be available.
- We reviewed the hospital "patient flow" chart. This showed that they were aware patients were moved between wards for non-clinical reasons at times when beds were needed for admissions. However, there was no measure of the impact on patients' well-being or of the impact on the other patients of such frequent admissions and discharges to a rehabilitation ward. This meant that vulnerable patients were moved twice in a short space of time in the interests of hospital administration rather than the clinical needs of the patient.
- The ward admitted patients on a long-term basis to beds still allocated to patients on extended leave (that is they were away from the hospital for up to 28 days to assess if they were ready for discharge to the community). Again, this meant that if a patient's leave was not successful and they needed to return, then their bed would not be available.
- Data from the provider on bed occupancy over a six-month period showed that it averaged 110% when figures included people on leave.
- A patient told us that they were concerned that other people were admitted to their room while their property was still there. The staff assured the patient that their personal property was removed before another patient was admitted. However, it was clear that the patient was unsettled by the way the ward managed admissions.
- Staff we spoke with told us that discharge of patients takes place in a planned way, working with community teams that operate seven days a week. The occupational therapy team on the ward offer follow up support to patients for up to four weeks after discharge.
- The ward reported no delayed discharges to the community for a six-month period.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients did not have keys to their bedrooms. Staff told us that the same key opens all locked doors on the ward, so patients could not be provided with a key to their room for security reasons.
- A cupboard was used to securely store patients' personal items. This included items that would be considered dangerous such as razors.
- The ward had a range of communal rooms that the patients could use including a games hub, a TV lounge and two quiet sitting rooms. There was a designated women's lounge, however during our inspection visits we only saw male patients using this room. Segregated areas are a requirement of the Mental Health Act code of practice, so use of this lounge should have been monitored more closely by ward staff.
- The occupational therapy team had a well equipped kitchen and an activities room on the ward for use for therapeutic activities. Both these rooms could only be accessed with supervision by occupational therapy staff.
- A small kitchen area was accessible for making hot drinks.
- The ward had a comfortably furnished treatment room where patients could meet nurses or doctors for consultations and physical health checks in privacy.
- Male and female patients were accommodated on separate corridors with single sex bathing facilities on each.
- Patients were able to access a large garden during the day, as this was part of the ward they did not require leave arrangements to be made.
- The seclusion suite on the ward had CCTV in all the rooms, including the bathroom. This could only be viewed by staff supervising the use of the suite. This ensured the person's privacy and dignity were protected as far as possible while ensuring their safety.

Meeting the needs of all people who use the service

- The ward was on a single level and was accessible from the rest of the hospital building without the use of steps, ramps or elevators.

Are services responsive to people's needs?

Requires improvement

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

- One bedroom on each corridor was designed for wheelchair access. Extra floor space was available in both the bedroom and bathroom to use hoists or other mobility aids.
- We saw information on accessing interpreters for patients that did not speak English as their first language. The staff had used this service for families of patients.
- There were many noticeboards in communal areas that had information on making a complaint, accessing advocacy services, explaining key points of the Mental Health Act and explaining patients' rights.
- Some patients told us they were able to have their spiritual needs met on the ward or within the hospital through the chaplaincy.

Listening to and learning from concerns and complaints

- The ward had a weekly "Have Your Say" meeting for patients to raise concerns. One notice board on the ward is titled "What You Said – What We Did." This gave examples of actions taken following "Have Your Say" meetings.
- The ward had no recorded formal complaints in the year preceding the inspection.
- One patient put in writing concerns about how their symptoms were managed when they were unwell and aggressive. This was discussed with the multi-disciplinary ward team and a new care plan agreed to the patient's satisfaction. This was recorded on the patients care plan.
- We saw records of "risk notes" sent via e-mail to ward staff sharing learning from incidents and complaints elsewhere in the Trust. These also included action points and any changes to policy and practice as a result of the complaint or incident.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Some staff told us they would like to see more rehabilitation work on the ward. They felt this work had been impacted by staff shortages. They told us that more of this work had taken place since staff levels improved, such as the managing medicines group. Staff were mostly confident that they could provide a good quality service to patients.
- The work of the ward reflected the organisations values and objectives, though ward staff were not always able to articulate them. All staff were dedicated to a high standard of patient care. However the ward did not have an ethos of care that promoted rehabilitation.

Good governance

- There was no plan in place to monitor and assess the impact of moving patients between wards and to plan how to reduce such moves. The unit manager and modern matron responsible for the service told us at the time of the inspection that such moves were "occasional", but ward records we received and reviewed later showed that these moves were frequent, typically more than once a week. This demonstrated a lack of oversight by managers responsible for the service.
- Maintenance and environmental risk audits took place but these failed to address the ongoing maintenance issues with regard to the drains and leaking roof
- The trust has monitoring systems in place to keep track of staff training. They provided inspectors copies of their reviews and their on-going plans to improve staff attendance of skills training and professional development. However staff training records still included many ex-staff and it was not possible to obtain accurate reports on training for the team employed at the time of the inspection.
- The trust also has effective systems for monitoring appraisals and supervision.

Leadership, morale and staff engagement

- The psychiatry team on the ward told us they were very dissatisfied with the policy of moving patients between wards, as they were often not consulted in the process. They told us that this had been raised with the unit manager, but the response had been slow.
- The ward manager was "acting up" in their role from the substantive post of deputy ward manager on another ward. We discussed the support they were given in the role. They told us that the modern matron and service manager for the ward gave support when asked and had occasionally visited the ward. This was in addition to regular supervision from the modern matron and service manager. Given the level of the problems faced on the ward in relation to staffing levels, management of new care note systems and the acknowledged bed pressures, senior managers on site should have been taking a more direct interest in the running of the ward.
- Nursing staff were positive about the leadership on the ward. They told us that low staffing levels had made the ward more stressful in the past, but this had improved and they felt positive about the future. They described a range of ways staff were able to give ideas about improving the service.
- Staff felt that planning was collaborative between professionals and patients, helping them to establish activities and engage with patients.
- Staff of all grades felt they had opportunities for personal and professional development. The Trust had established a training program with a university to enable nurses to manage their Continuous Professional Development to maintain their registration.

Commitment to quality improvement and innovation

- The service achieved Accreditation for Inpatient Mental Health Services (AIMS) from the Royal College of Psychiatrists in March 2015. This required meeting a wide range of standards for patient care. The ward achieved an 'Excellent' rating.
- The nursing staff we spoke with on the ward did not have involvement in clinical audits.

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 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good Governance The trust did not take action to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users when moving patients between wards to create beds for other users. The Trust did not ensure that sufficient information about these patients was handed over between staff after they moved wards. The trust did not maintain accurate care plans for the patients on the ward, both for formally admitted patients and those staying temporarily. This is a breach of regulation 17.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 Premises and equipment

This section is primarily information for the provider

Requirement notices

The trust did not keep accurate records of maintenance issues and did not maintain the premises to an appropriate standard of hygiene for the purpose required.

This led to service users staying in bedrooms that were not fit for use due to the smell of sewage from blocked drains and a leaking roof.

This is a breach of regulation 15

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13

Safeguarding service users from abuse and improper treatment

Blanket restrictions were in place on the ward in relation to access to rooms and access to food and drink. This resulted in service users sitting on the floor outside the dining room waiting for mealtimes.

The restrictions were not proportionate to the risk of harm posed to the service users and were degrading for the service users.

This is a breach of regulation 13:4 b and c