Care Quality Commission

Camden and Islington NHS Foundation Trust

Psychiatric intensive care units and health-based places of safety

Quality Report

Tel: 0203 317 3500
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Date of inspection visit: 27-30 May 2014
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Highgate Hospital	TAF72	Coral Ward	N19 5JG
St Pancras Hospital	TAF01	Psychiatric liaison services providing services to places of safety	NW1 0PE

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

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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Overall summary

Camden and Islington NHS Foundation Trust psychiatric intensive care inpatient services (PICU) are provided in one ward based at the Highgate Centre for Mental Health. This accommodates 12 men (aged 18 to 65 years). There are no female PICU beds within the service.

The trust also provides liaison services to three health-based places of safety (PoS). These are located in the accident and emergency (A&E) departments of the Whittington Hospital, University College Hospital and the Royal Free Hospital.

Psychiatric intensive care unit (PICU)

In January 2014, the trust initiated a 'rapid improvement plan' for Coral Ward as through trust wide quality assurance processes it was recognised that urgent improvements were needed. At the time of our inspection, the ward had an interim ward manager in place, as well as a project group who had prepared an action plan. A team development day was planned to take the team forward.

People's experience of care varied. While they were actively involved in planning their care, they told us that they felt unsafe on the ward because of drug use and thefts. Staff treated people with care and respect and were responsive in addressing people's needs.

People's physical health needs were met. Staff were aware of patients' physical health needs and responded promptly.

The progress on the rapid improvement plan was being overseen by a project group which included the Chief Operating officer and Associate Divisional Director. However, it was hard to tell if areas that were identified as needing improvement were always followed-up in a timely manner.

Strong structures for staff supervision and appraisal have been in place since April 2014. In addition, all staff were updating their training based on a list of core competencies.

Staff reviewed and managed risk on the PICU at a daily multidisciplinary meeting.

The service monitored its compliance with the Mental Health Act 1983 and addressed any gaps found. Staff's knowledge and application of the Mental Health Act was good, but their knowledge and use of the Mental Capacity Act 2005 needed to be improved.

Health-based place of safety (PoS)

The trust has strong joint policies and procedures in place. These made sure that the three acute trusts providing accommodation for the PoS had an effective liaison service. The staff working in this service were appropriately qualified and worked as a multidisciplinary team.

Summary of findings

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

Are services safe?

Psychiatric intensive care services

The service provided did not always protect people from known risks to their health, safety and welfare. Staff and patients told us that they were concerned about the use of illegal drugs on the ward.

Staff knew about a previous serious incident on the ward and lessons from the incident and action plans had been shared. Some staff were not able to tell us what these lessons were and how these were being put into practice.

The multidisciplinary team were working well to evaluate risk and provide people with person-centred support.

We found that there were a lot of temporary staff on the ward because of vacancies, sickness and other contributory factors. This is challenging for such a complex service.

Health-based places of safety

Procedures in the health-based places of safety kept people safe. Staff arranged for people to be transferred to inpatient services when needed.

Are services effective?

Psychiatric intensive care services

We saw that the unit was using a range of assessments.

In general, medicines were well managed. However, observations needed to be recorded after the use of rapid tranquilization.

Patients' physical health care needs were assessed. The Modified Early Warning Signs (MEWS) was being used and staff were aware of how to recognise the signs when a patient's condition was deteriorating.

There was ongoing staff training and development to help develop an effective service. This was in line with a list of core competencies that were based on good practice guidelines.

The ward's multidisciplinary team worked well together.

Although there were some good activities provided for people, there were not enough available.

Are services caring?

Psychiatric intensive care services

Staff were caring, respectful and kind in the way they treated people.

Although temporary staff were caring, they need more guidance and support to improve the way they interact with people.

Summary of findings

Health-based places of safety
Staff in the health-based places of safety were very professional and supported people well.

Are services responsive to people's needs?
Psychiatric intensive care services
The trust only provides male psychiatric intensive care beds, so women have to be treated outside the trust's catchment area.

Staff understood how to respond to complaints and these were being addressed as needed.
Health-based places of safety
The health-based places of safety liaison team were able to arrange for people to be assessed for detention under the Mental Health Act. People were admitted to hospital when needed.

Are services well-led?
Psychiatric intensive care services
The unit has a 'rapid improvement plan' in place, which is overseen by a project team. However, it was not clear when targets were expected to be met.

The senior management team, including the modern matron, supported the interim manager to makes sure that changes were well managed.

Staff told us that they have recently become engaged taking service development plans forward.

People were also engaged through ward community meetings, and on an individual basis with their named nurse.
Health-based places of safety
The health-based places of safety services were operating effectively and were well led.

Summary of findings

Background to the service

Camden and Islington NHS Foundation Trust is the largest provider of mental health and substance misuse services to residents within the London boroughs of Camden and Islington. They also provide substance misuse services in Westminster and substance and psychological therapies services in Kingston-upon-Thames.

Services are provided to adults of working age, adults with learning disabilities and to older people.

The trust has three registered locations. These are their two main inpatient facilities at the Highgate Mental Health Centre and St Pancras Hospital. They have also registered a nursing home for older people at Stacey Street. The trust provides community-based services throughout the boroughs of Camden and Islington. Those located in Camden fall under the registration at St Pancras and those in Islington fall under the registration at the Highgate Mental Health Centre.

The people who use the services provided by the trust come from diverse ethnic and social backgrounds encompassing the extremes of wealthy and deprived areas. They also serve a large immigrant population speaking over 290 languages and a transient population of young adults.

The trust works with partner agencies and the voluntary sector to provide a range of services. The services are delivered through five divisions:

- Acute division.
- Rehabilitation and recovery division (psychosis services).
- Community mental health division (non-psychosis services).
- Services for ageing and mental health division.
- Substance misuse division.

Camden and Islington NHS Foundation Trust has been inspected on nine occassions4. At the time of this inspection there was non-compliance at two locations. Stacey Street Nursing Home was non-compliant with outcome 9: management of medicines. St Pancras Hospital was non-compliant with outcome 2: consent to care and treatment and outcome 4: care and welfare. We followed up this non-compliance as part of our inspection and found the trust had made the necessary improvements.

Camden and Islington NHS Foundation Trust psychiatric intensive care inpatient services (PICU) are provided in one ward based at the Highgate Centre for Mental Health. This accommodates 12 men (aged 18 to 65 years). There are no female PICU beds within the service.

The trust also provides liaison services to three health-based places of safety (PoS). These are located in the accident and emergency (A&E) departments of the Whittington Hospital, University College Hospital and the Royal Free Hospital.

Our inspection team

Our inspection team was led by:

Chair: Dr Steve Colgan, Medical Director, Greater Manchester West NHS Foundation Trust

Team Leader: Jane Ray, Care Quality Commission (CQC)

The team of 35 people included: CQC inspectors, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors which included consultant psychiatrists, psychologists, senior nurses, junior doctors and social workers.

We were additionally supported by four Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected the psychiatric intensive care unit (PICU) and health-based place of safety (PoS) services included a CQC inspector and a variety of specialists: a consultant psychiatrist, a senior registered mental health nurse, a Mental Health Act commissioner, an Expert by Experience and a head of mental health policy.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme. This trust was selected to enable CQC to test and evaluate its methodology across a range of different trusts.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

The inspection team always inspects the following core services at each inspection:

- Acute admission wards.
- Health-based places of safety.
- Psychiatric intensive care units (PICU)
- Services for older people.
- Adult community-based services.
- Community-based crisis services.

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

Before our inspection, we met with five different groups of people who use the services. We also met with two carers groups from the two boroughs of Camden and Islington. They shared their views and experiences of receiving services from the provider.

We undertook site visits at all the acute inpatient services and crisis teams for adults of working age. We also visited the psychiatric intensive care unit (PICU) at the Highgate Centre, and went to two of the three places of safety. These are located in the accident and emergency (A&E) departments at University College Hospital and the Whittington Hospital. We also inspected the inpatient and some community services for older people and visited a sample of the community teams.

During our visit the team:

- Held focus groups with different staff members such as nurses, student nurses and healthcare assistants, senior and junior doctors, allied health professionals and governors.
- Talked with patients, carers, family members and staff.
- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Interviewed staff members.
- Reviewed information we had asked the trust to provide.
- Attended multidisciplinary team meetings.
- Collected feedback using comment cards.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

What people who use the provider's services say

We spoke with people who use the service. However, no carers were available at the time of our visit to the psychiatric intensive care unit (PICU).

In the PICU, most people we spoke with were positive about their experience of care. However, they were frustrated by the lack of facilities available, such as the

Summary of findings

ward phone. This had not been working for several weeks and people were only had restricted access to the office phone. People on the unit said that they enjoyed the activities, but that they were limited.

People told us that they were well supported when they had attended a health-based place of safety.

Good practice

Psychiatric intensive care services

- We observed a good level of input from occupational therapy services. We were also told that there is a proposal to improve therapy services further to meet National Association of Psychiatric Intensive Care and Low Secure Unit (NAPICU) standards.

Health-based place of safety

- The multi-agency policies and procedures in place for the psychiatric liaison team were well developed, with skilled staff undertaking individual and responsive care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Psychiatric intensive care unit:

Action the provider MUST take to improve

- The trust must ensure that learning that from incidents is understood by staff working on Coral Ward.
- The trust must ensure that staff are applying their training in the Mental Capacity Act 2005 correctly.
- The trust must ensure that the action plan, which is part of the 'rapid improvement plan', is kept up to date so that it is clear when targets have been met, and that there are deadlines for outstanding work. This is to ensure the actions are completed quickly so that people using the service are safe and receive the appropriate care and treatment.

Summary of findings

Action the provider SHOULD take to improve

- The trust should continue to ensure that there are adequate arrangements in place to make sure people are safe, for example in relation to the management of illegal drugs on the ward. The provider should review its implementation and management of illegal substances procedures.
- The trust should continue to recruit permanent staff to reduce dependency on temporary staff.
- Staff should enter the seclusion room when needed to make sure that observations are carried out safely
- Staff should all update their training on the use of restraints, to make sure that they are using the latest guidelines to minimize the use of face down restraint.
- Where rapid tranquillization is used, patient observations should be consistently recorded.
- Staff should continue to complete the training identified in the competency assessment.
- The trust should ensure there are enough activities available on the ward to meet the people's needs.
- People using the service should have regular access to one-to-one support in line with the trust's own targets.
- Where issues are raised at the ward community meeting, such as a broken public telephone, this should be addressed quickly.

Detailed findings

Camden and Islington NHS Foundation Trust

Psychiatric intensive care units and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Coral ward – psychiatric intensive care unit	Highgate Mental Health Centre
Health-based places of safety	Whittington Hospital, University College Hospital, and the Royal Free Hospital.

Mental Health Act responsibilities

The use of the Mental Health Act was mostly good in acute admission wards. Mental health documentation reviewed was mostly found to be compliant with the Act and the Code of Practice in the records of people detained under the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff working in the psychiatric intensive care unit were not assessing people's capacity to make decisions about their care and treatment appropriately. Staff were inconsistent in their understanding and application of the Mental Capacity Act 2005.

There was a good understanding and application of knowledge about the Mental Capacity Act within the liaison team working at the places of safety.

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

Summary of findings

Psychiatric intensive care services

The service provided did not always protect people from known risks to their health, safety and welfare. Staff and patients told us that they were concerned about the use of illegal drugs on the ward.

Staff knew about a previous serious incident on the ward and lessons from the incident and action plans had been shared. Some staff were not able to tell us what these lessons were and how these were being put into practice.

The multidisciplinary team were working well to evaluate risk and provide people with person-centred support.

We found that there were a lot of temporary staff on the ward because of vacancies, sickness and other contributory factors. This is challenging for such a complex service.

Health-based places of safety

Procedures in the health-based places of safety kept people safe. Staff arranged for people to be transferred to inpatient services when needed.

Our findings

Psychiatric intensive care unit

Track record on safety

The service reported all incidents on an electronic system that was accessed and monitored by relevant teams within the trust. Staff we spoke with knew how to report incidents on the system and we saw these reports contained an appropriate level of detail about the event and any injuries sustained.

The trust collated and monitored incidents and where needed provided a "patient safety alert".

Learning from incidents and improving safety standards

The trust shared with us their report on incidents for the last quarter of year 2013/14.

Coral Ward had a death on the unit in June 2012 and the trust responded to the coroner in January 2014 with details of the lessons learnt. Whilst we were able to see from records of team meetings that the findings of this investigation had been shared with the staff team so that improvements could be made, some of the staff we spoke with were unable to articulate the learning from this incident.

They were aware of the rapid improvement plan and were working to improve safety standards through training, supervision and developing practices.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff we spoke with understood their responsibilities to raise safeguarding concerns. They had access to written safeguarding processes to refer to and these were up to date and in line with current guidance. Ward managers had good links with the safeguarding team and actively sought advice from them.

Assessing and monitoring safety and risk

Staff were aware of the needs of people using the service and were able to explain how they were supporting people with the risks they presented. A multidisciplinary 'board round' took place each morning which focused on managing risk.

When a person was admitted to a ward a comprehensive package of assessments were completed within 72 hours. This included undertaking a number of risk assessments. Where a risk was identified plans were put in place to support the person. In the last quarter of 2013/14. the ward was red rated as not meeting the target for completing these risk assessments within the five-day period. The ward should ensure it meets the target for the timely completion of risk assessments.

We observed the multidisciplinary ward review and this included a discussion of risk factors for the people on the ward and how to support people in the least restrictive manner.

The wards were generally well maintained but some repairs were outstanding for a considerable amount of time for

example the telephone was broken. Corridors were clear and not used for storage and clinical spaces were tidy. Outdoor space was available and open to people with supervised access and was the wards smoking area.

Staffing levels on the ward was clearly defined and comprised of three qualified and three unqualified staff during the day and two qualified and two unqualified staff at night. Staffing levels were increased according to the needs of the people being supported on the ward. There were approximately 20% staff vacancies on the ward resulting in a significant use of temporary staff to maintain the staffing levels. In the last quarter of 2013/14, 45% of the shifts had been covered by temporary staff. The unit had an interim consultant psychiatrist and an interim manager in post.

Coral Ward had two seclusion rooms. These were suitably equipped. We looked at the records of seclusion and found that these contained the necessary information in line with the Mental Health Act code of practice. Staff can observe people in seclusion through the use of CCTV cameras and two-way audio equipment. We were told that staff did not enter the seclusion room to carry out observations, but we were concerned that if a person was lying down and was still it would not be possible to tell if they were breathing without entering the room. Staff should enter the room where needed to carry out safe observations.

Staff had been trained in the use of physical interventions by the Middlesex University and understood that these should only be used as a last resort. When an incident of violence occurred on the ward we saw that staff responded calmly and respectfully preventing further escalation. We looked at the quality of the records of restraint, which are recorded as an incident and saw that these had improved from the previous inspection of the trust. Staff told us they were still using face down restraint but when their training was updated they were learning alternative approaches. Staff should all be provided with refresher training that reflects recent guidance on reducing the use of face down restraint.

Understanding and management of foreseeable risks

Equipment used in an emergency was available and checked regularly. Staff were able to explain how they would respond in the event of an emergency and how to access the resuscitation team, if required. We looked at the ligature cutters and found that there were several different types. These were kept in different places on the ward and staff were not always clear where they were.

Following a previous serious untoward incident, all the smoke detectors on the ward had been changed as one had been used as a ligature point. There were plans in place to conduct a larger programme of works which would address many of the existing ligature risks. These were subject to board approval in July 2014.

Staff told us there was a problem with illegal drugs coming onto the unit. This was confirmed by some people using the service. There was a programme of work led by the Trust Local Security Management Specialist. This has included the use of drug sniffer dogs and also support from the local safer Neighbourhood Team. This had been successful to a degree but staff were aware that drugs continued to come onto the wards but they did not know how. The trust had a policy in place in respect of searching premises, patients and/or their property which had last been revised in 2010. The date for reviewing the policy was December 2013 and was therefore overdue. The policy described the search procedure and the use of drug dogs in inpatient settings as a form of drug detection. The policy stated that 'all patients have the right to receive care in a safe environment, free from drug and alcohol use.' Whilst there has been some progress this is still an ongoing issue.

Health-based places of safety

Track record

There was a clear system for recognising and reporting notifiable incidents.

Managers were notified of any safety alerts through bulletins from the trust and these were cascaded to staff.

Staff were aware of policies about lone working and other procedures to support the safety of patients and staff.

Learning from incidents and Improving safety standards

Staff described to us how learning from incidents was a key aspect of their role. This had informed the clear working protocols between the emergency department staff, police and the liaison team.

Are services safe?

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

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff were aware of safeguarding policies and safeguarding was discussed individually in supervision and was also an agenda item at team handover meetings. The trust had both detailed guidance and protocols along with "quick reference" flow charts and staff were aware of how to access local and trust policies and contacts and were aware of referral processes.

Assessing and monitoring safety and risk

Within each of the A&E units there was dedicated and private area for the places of safety and people admitted to the unit. There was a dedicated entrance for people who were coming to the unit supported by the police and staff were alerted in advance of this by the emergency department.

Staff were trained in managing people with complex presenting behaviours and had excellent communication skills.

Strategies were in place to ensure people's safety. When we reviewed people's records we saw that risks were identified by the person, their carer or relative and the service. These risks were then addressed as part of the person's care plan.

Are services effective?

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.

Summary of findings

Psychiatric intensive care services

We saw that the unit was using a range of assessments.

In general, medicines were well managed. However, observations needed to be recorded after the use of rapid tranquilization.

Patients' physical health care needs were assessed. The Modified Early Warning Signs (MEWS) was being used and staff were aware of how to recognise the signs when a patient's condition was deteriorating.

There was ongoing staff training and development to help develop an effective service. This was in line with a list of core competencies that were based on good practice guidelines.

The ward's multidisciplinary team worked well together.

Although there were some good activities provided for people, there were not enough available.

Our findings

Psychiatric intensive care unit

Assessment and delivery of care and treatment

When we checked medications we found they were managed in a safe manner. Medicines were stored in a locked clinic room and all medicine cupboards and refrigerators were tidy and locked. The keys were kept by a nurse. Fridge temperatures were monitored and were within the guidelines for maintaining the effectiveness of medicines but the room temperature was reported as being too hot for use on a regular basis.

The pharmacy inspector visited this unit to review the use of rapid tranquilisation, which is the use of medication to calm violent or aggressive patients. We reviewed prescription charts to see when rapid tranquilisation had been used, and we cross-checked people's electronic care records to see whether staff had made a record of when and why it had been used. We saw that one patient had received rapid tranquilisation four times since 19 May 2014, once on Amber Ward, before being transferred to Coral Ward, and three times on Coral Ward. Staff on Coral Ward had made notes to explain why this had been used.

Staff were not able to provide evidence that physical observations, or a debrief, had been carried out following the use of rapid tranquilisation, which is required by trust policy. Not carrying out physical observations after rapid tranquilisation can place a person at risk. This evidence was backed up by the trust own rapid tranquilisation audits, which stated that significant improvements were needed in the recording of physical observations and debriefs after people received rapid tranquilisation.

When we reviewed care records we saw that physical healthcare checks were completed.

The service had also recently introduced the Modified early Warning Score (MEWS) as a method of identifying, assessing and responding to any signs of deteriorating physical health. When we looked at the care notes for people we saw this was completed. .

Most staff had undertaken training and demonstrated a reasonable level of understanding of the Mental Capacity Act. Capacity was discussed in the ward round and documented. However, capacity assessments were generally considered in respect of the Mental Health Act 1983 rather than the Mental Capacity Act 2005 and usually consisted of a short confirmation of whether or not the person was considered to have capacity.

Outcomes for people using services

The service as part of its "rapid improvement plan" was being closely monitored and this included the completion of a range of audits as well as the trust wide performance dashboard. This was enabling the progress of the ward to be monitored through a project group that was meeting on a monthly basis. The trust is also using guidance and support through the National Association of Psychiatric Intensive Care to ensure their work is in line with best practice.

Staff, equipment and facilities

The medical and nursing team were experiencing a period of transition and had an interim ward manager and a locum consultant in post.

As part of the rapid improvement plan a competency framework had been developed to ensure staff had the necessary core skills and to identify their training and support needs. Staff were updating their training in line with this framework.

Are services effective?

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.

During our inspection we saw some excellent therapeutic activities provided by the occupational therapist, but for much of the time there were no activities taking place and the record of activities showed that frequently these were cancelled. The trust monitors the access to activities on the ward and this showed that people were being offered four activity sessions a week. However having also looked at the minutes of the ward community meetings people were asking for more leisure activities. We were also told that the occupational therapist had evaluated the therapeutic activities provided on the ward to ensure they were the most appropriate to meet the needs of the people using the service.

Multidisciplinary working

When we reviewed people's care pathways we saw that practitioners and clinicians from a wide range of disciplines were involved in the assessment, planning and delivery of people's care and treatment. When people's needs were assessed and a care plan reviewed this information was presented at the weekly team meetings with the aim of keeping everyone informed.

People care's was coordinated by a nurse. A range of other disciplines then made up the team such as psychologists who provided both clinical contact to people using the service and an advisory function.

The services had developed strong relationships with the forensic services and had good links with other key agencies to facilitate discharges from the unit.

Mental Health Act (MHA)

The use of the Mental Health Act was good. MHA documentation reviewed was compliant with the Act and the Code of Practice.

Detention renewals were timely and appropriate. Each ward was monitoring when renewals where due and ensuring they were completed as appropriate. Section 132 papers were present in most cases regarding ongoing treatment.

Capacity assessments were recorded in most records we reviewed (T2 papers present) but the details were often limited to "has capacity to consent".

Medication was given in accordance with appropriate authorisations in most of the notes we assessed. The documentation of use of medication was good.

Standardised leave authorisations were in evidence on the files we assessed.

Information on the rights of people was recorded and audited as undertaken but there was little information available in the ward to support detained patients. Section 17 leave forms were completed and documented.

Health-based places of safety

Assessment and delivery of care and treatment

Staff from the liaison team completed assessments in line with good practice guidance. Patients' needs were individually considered and responded to.

When people required specialist support to manage their physical health needs they were receiving this support. Staff, from the liaison team, were able to work with colleagues in the acute emergency department if needed.

Nursing and medical staff told us that they had received recent training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and they were not clear about their legal responsibilities.

The service was using a number of indicators to measure the effectiveness of its service. Critical targets were being monitored and reported.

Staff, equipment and facilities

The two services we visited provided an appropriate environment for people to be assessed in private and for the liaison team to work. The areas were well supported with staff and had a quiet area for relatives and access for people with mobility difficulties.

Staff we spoke with told us they felt supported in their roles and had good access to training and supervision.

Multidisciplinary working

During our visits we were told about the effective working relationships not just between multidisciplinary staff from within the trust but also of strong multi-agency work to support people attending the place of safety. The positive work between the liaison team, police and staff in the emergency department was noted.

Mental Health Act (MHA)

Staff demonstrated an outstanding knowledge of the Mental Health Act and it application. Documentation was completed correctly.

Are services caring?

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

Summary of findings

Psychiatric intensive care services
Staff were caring, respectful and kind in the way they treated people.

Although agency staff were caring, they need more guidance and support to improve the way they interact with people.

Health-based places of safety
Staff in the health-based places of safety were very professional and supported people well.

Our findings

Psychiatric intensive care unit

Kindness, dignity and respect

On the PICU unit we undertook a considerable period of observation of interactions. We observed the staff supporting people with respect and care.

We saw staff responding calmly and respectfully to multiple requests and demands on their time and facilitate successful outcomes in difficult situations.

We also saw regular staff support other agency staff when necessary.

People using services involvement

When we spoke with people using the service most told us they had a care plan but were not always in agreement with its content. They said that issues such as their rights and leave arrangements were explained to them. They had regular multidisciplinary reviews to discuss their care and treatment.

A life events checklist was used to inform people's care. They tried to support people's choices in their care for example in their choices for their activity programme but were limited by the environment and facilities available.

Independent Mental Health Advocates (IMHA) were available. We saw that advocates had been involved in some decisions and this was documented.

Emotional support for care and treatment

The ward had protected engagement time (PET) from 11.30am until 1pm where staff focussed on working with people either in group or in one to one activities. In practice we saw little evidence of this as staff were busy with other duties such as carrying out observations of people on the unit. The trust monitors whether people are offered a one-to-one session with a staff member each day and for the last quarter of 2013- 14 this was red rated for Coral Ward, meaning that one-to-one meetings were not happening in line with trust targets.

Staff told us how much they recognised the value and positive impact this had on people who use the service. However, they also reported that it was a challenge to provide this time.

We observed a ward round which considered the care arrangements and future plans of people who use the service. People were invited and supported to attend the meeting, relatives also were welcomed but none were present during our visit.

There was limited information available for people or their carers although we were told that a more comprehensive information board was being developed.

Health-based places of safety

Kindness, dignity and respect

Feedback from people who used the service and colleagues was extremely positive about staff's approach and skills. People we saw were very positive about the care they received and the information and involvement they had whilst in the service.

We saw an admission being facilitated and the nurse carried this out in a respectful and responsive manner and accompanied the person and their carer to the hospital and supported them to choose their mode of transport. People in the unit said that they were involved and informed about all aspects of their care.

Emotional support for care and treatment

People were provided with a recovery model of care with access to critical care staff, medical and nursing professionals all of whom were described as being very professional and helpful. A full physical and psychiatric assessment had taken place with sensitivity and inclusion.

Are services responsive to people's needs?

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

Summary of findings

Psychiatric intensive care services

The trust only provides male psychiatric intensive care beds, so women have to be treated outside the trust's catchment area.

Staff understood how to respond to complaints and these were being addressed as needed.

Health-based places of safety

The health-based places of safety liaison team were able to arrange for people to be assessed for detention under the Mental Health Act. People were admitted to hospital when needed.

Our findings

Psychiatric intensive care unit

Right care at the right time

The PICU service within the trust was a male only ward. Female patients need to be cared for outside the trusts catchment area.

An admission criteria checklist is in place to ensure appropriate admissions to the unit. The service had performance targets. For example the completion of full risk assessments within five days of admission.

Care was led and delivered through the multidisciplinary team, and we saw that when people required care interventions it was provided promptly, for example in supporting people with their personal care. They were also respectful of people choices regarding their personal care.

Care pathway

The length of stay in inpatient areas was monitored by the trust. The ward model of care gives a clear pathway for admissions and discharges. We were told by staff that there were people experiencing a longer length of stay on the unit due to a lack of appropriate step down services or readmissions.

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Local faith representatives visited people on the ward and could be contacted to request a visit. Interpreters were available to staff and were used to assist in assessing people's needs and explaining people's rights as well as their care and treatment. Leaflets explaining people's rights under the Mental Health Act 1983 were available in different languages. During our review of people's healthcare records on the wards we noted that interpreters had accompanied people to multidisciplinary meetings when the person did not speak English well.

A choice of meals was available. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to access appropriate meals.

Learning from concerns and complaints

The trust had a complaints procedure the guidance of which was summarised and advertised on the ward. Staff knew how to respond if they received a complaint. A summary of complaints was available and these had been addressed appropriately although in some cases had taken a longer period to resolve.

Place of safety

Right care at the right time

Clear response times were in place for the liaison team and they were conscious of delays and the impact of these on the person and their family and for the service. Care was seen to be considered and individual and timely.

Care pathway

The service was developing its pathway for admission and discharge and included a time frame for assessments and admissions.

Admissions were via the bed management team who had a good knowledge of the services and managed these effectively. Prison referrals were managed by the senior PICU clinician.

Are services well-led?

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.

Summary of findings

Psychiatric intensive care services

The unit has a 'rapid improvement plan' in place, which is overseen by a project team. However, it was not clear when targets were expected to be met.

The senior management team, including the modern matron, supported the interim manager to makes sure that changes were well managed.

Staff told us that they have recently become engaged taking service development plans forward.

People were also engaged through ward community meetings, and on an individual basis with their named nurse.

Health-based places of safety

The health-based places of safety services were operating effectively and were well led.

Our findings

Psychiatric intensive care unit

Vision and strategy

Staff we spoke with knew the trust's vision of the best possible recovery within available resources. Everyone spoke about being committed to people who use the service. Staff spoke to us about how the changes had affected the service and the people that used them (both positive and negative).

Responsible governance

The unit has a 'rapid improvement plan' in place. An action plan is in place and this is overseen by a project team that meets on a monthly basis. We asked to see copies of the most recent action plan and records of the monthly meetings. We were given an action plan dated February 2014. It was not clear when some targets were completed or expected to be completed. Staff we spoke to on the ward were also not clear about progress with meeting targets. As this ward is undergoing such significant changes, which could impact on patient safety, and care clarity would be expected.

Leadership and culture

Leadership on the ward was in a period of transition with an interim ward manager in post. There was also a practice development nurse working two days a week supporting the changes on the ward. The manager was not available during our inspection, however the matron was available to support the team.

The medical team were being led by a locum consultant who was readily available on the ward.

Some staff told us that they found the pace of change hard and did not always feel engaged in the process.

A team development day using external facilitators has been agreed. The focus of the development day was to be on moving the team forward with a shared vision of the future.

Engagement

The views of people using the service were collected on an ongoing basis through using an 'electronic patient experience' tool. The issues raised by patients on Coral Ward were reported as being personal safety, safety of property, the use of illicit drugs and environmental risks.

A regular community meeting was undertaken on the ward to gather the views of people using the service. This enabled people to discuss what was happening on the ward including issues such as food, activities and leave. But staff and patients were frustrated at the slow response to issues raised (for example the time taken to repair the telephone).

Health-based places of safety

Vision and strategy

Staff told us they knew about the trusts vision and providing best services within its resources. Staff were positive about the service and felt that they were equipped with the skills needed to provide a quality service. Where issues were raised they felt that these were addressed in a positive and open manner.

Responsible governance

There were clear lines of accountability and responsibility within the teams and staff described to us who they would seek advice and guidance from. There were weekly team meetings where incidents and learning points were discussed and robust supervision structures in place.

Are services well-led?

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.

Leadership and culture

Staff told us they felt very well supported locally. Staff told us that they enjoyed working in the team and were proud of the range of services they provided. The team leaders were available and responsive and staff felt that they were well informed of issues.

Staff told us they felt very well supported through their line management structures, with supervision described as "excellent" and they felt they had opportunities to develop their skills further. Managers described senior management as "transparent" and said that they were provided with clear information.

We were impressed with the level of enthusiasm and pride staff took in the service they provided. We saw that there was good teamwork and staff commented how they enjoyed working within a supportive and varied team.

Performance improvement

Staff were aware of team and performance targets for their area of work and told us that these were discussed and monitored by their manager through team meetings and individual supervision sessions.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated activities) Regulations 2010** **Assessing and monitoring the quality of service** The trust did not have an effectively operating system to share learning from incidents in order to make changes to people's care in order to reduce the potential for harm to service users. This was in breach of Regulation 10(2)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated activities) Regulations 2010** **Consent to care and treatment** The trust did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people or where that did not apply for establishing and acting in accordance with people's best interests. Many staff in inpatient areas had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and this meant that decisions were being made that might not take into account people's human rights. This was a breach of Regulation 18 (1)(a)(b) (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated activities) Regulations 2010** **Assessing and monitoring the quality of service**

Compliance actions

The trust did not have a clear rapid improvement action plan on the Psychiatric Intensive Care Unit showing when targets were completed or expected to be completed. Staff we spoke to on the ward were also not clear about progress with meeting targets. As this ward is undergoing such significant changes which could impact on patient safety and care clarity would be expected.

This was in breach of Regulation 10(2)(c)