Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Ridge Lea Hospital

Quernmore Road, Lancaster, LA1 3JR

Tel: 01524550500

Date of Inspections: 23 October 2013
22 October 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Lancashire Care NHS Foundation Trust
Overview of the service	Ridge Lea Hospital (Lancaster Ward) is a 17 bed acute mental health inpatient admission ward. They provide care and treatment for up to 10 male patients and seven female patients whose bedroom areas are separated on one corridor. Patients are provided with their own bedroom area and some of the female bedrooms have en-suite facilities. The hospital has a seclusion facility/extra care suite. The hospital is located in a rural area outside Lancaster in Lancashire.
Type of services	Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 October 2013 and 23 October 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We observed patients in Ridge Lea hospital being treated with respect and dignity and were involved and participated in making decisions whilst on the ward.

Patients were able to express their views about their care and treatment. We saw staff supported patients in a calm relaxed way, encouraging them to carry out tasks and activities. One patient told us, "Within half an hour of arrival I had relaxed, definitely been good for me". Another patient commented, "I have not had support before to make decisions about my future, but I have here" and "I have a pathway to a rehab unit".

We reviewed records; spoke with seven patients and three relatives of patients who were on the ward. We saw that patients experienced safe, appropriate care and treatment. We also found patient identified risk issues were addressed and reviewed on a daily basis and this was intended to ensure patients were safe whilst in the hospital.

Patients, relatives and carers felt that staff provided good care and support. One patient said, "Staff are quite helpful and do listen. I've seen the doctor twice in two weeks, could be more often" and "All in all quite a good place and it is run properly". Another patient told us, "Staff coaxed me out of my room and have encouraged me to eat, which I was not doing".

All of the seven patients spoken with told us they felt safe on the ward. Patients told us they had no concerns and any problems they had they would talk through with their named nurse or any other member of staff. We found patients were protected from abuse and suitable arrangements were in place to respond to any allegations of abuse. We found restraint was being used on this ward infrequently and this was being monitored by the trust with suitable arrangements in place to protect and support patients against the risks associated with the use of control and restraint.

We found staff were supported in their responsibilities to be able to deliver care and treatment to the patients safely. We spoke with five staff about being supported in their work. All of the staff we spoke with said they felt supported. One staff member told us they, "I feel supported by the management on the ward and by other team members". Another staff member told us, "We are more supported now than we were a few years ago".

There were established and effective systems in place to monitor the quality and safety of the service. We found the trust had implemented improvements by learning from unfortunate events that had taken place on this ward.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected and people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

We observed patients in Ridge Lea hospital being treated with respect and dignity. Staff supported patients in a calm relaxed way, encouraging them to carry out tasks and activities. One patient told us, "Within half an hour of arrival I had relaxed, definitely been good for me." Another patient commented, "I have not had support before to make decisions about my future, but I have here" and "I have a pathway to a rehab unit".

We saw that routines in the hospital were flexible and patients were encouraged to make their own decisions about their daily routine. Individual and group activities were in place to encourage patients to get involved in meaningful occupation and interaction.

We saw staff encourage patients to make choices about their care and support where possible. Where this was not possible we saw staff supporting people sensitively and explaining the reasons for any restrictions placed on them.

Our expert by experience spoke with seven patients and carried out telephone interviews with three relatives of patients. This is a person who has personal experience of using or caring for someone who uses this type of care service.

The patients told us that staff were polite and respected their privacy. One patient told us, "Staff always knock on the door and close the treatment room door when I have injection, everything explained". They also said that staff gave people enough time to manage their difficulties. One patient said, "I have been told I won't be going anywhere until I feel safe and ready. The staff seem to know what I am going through".

We saw there was information on notice boards for patients, their families and carers. This included advocacy information, patient meetings information and the complaints procedure. This assisted people in knowing where to get help and advice and to direct any concerns. Patients and relatives knew where this information was but one relative told us they were not given the information leaflet usually provided to carers to inform them about

patients who were admitted to hospital.

Patients also received a welcome/recovery pack on admission. This information included a booklet about the Lancaster unit and what to expect when staying on the unit. There was also a recovery folder for the patients to record their own notes. The pack also had information about the rights of patients and advocacy support.

We saw that where possible, patients had been involved in developing their care plans. Each plan described the difficulties the patient was having prior to and during their admission. They also recorded the care and support people felt they needed and the support they felt care staff should give them. Following this the planned care agreed with the patient was detailed. One patient told us, "I have care plan and was involved in its preparation and review".

Views were mixed from relatives about how staff involved them in their family members care. One relative told us how they had been asked about her family member and was involved with meetings. They told us their family member did not tell her a lot, adding, "But staff do" and "I feel he is safe".

Other families we spoke with felt they could have been involved more and contributed more towards their family members care. One relative said, "I only get information if I ask and responses depend who is on duty". Another relative said, "We were not really given much information about our family member's progress, as the staff seem to be too busy". However they both expressed satisfaction with the care and treatment their family members were receiving.

There were weekly patient meetings where people were able to voice their concerns and bring up any issues or discuss matters that were important to them. These meetings were organised and delivered by the, 'volunteer service'. This service involved patients who had previously used mental health services and some who had previously been an inpatient on Lancaster ward.

Patients had open access to their rooms. Bedrooms were lockable so patients could lock their doors if they wished to maintain their privacy. A master key could override locks in an emergency.

Advocacy services were in place. Staff told us that one of the advocacy services visited the unit every week to check if anyone wanted to speak with them. Other advocacy services were available as needed. One patient said, "An advocate came in to see me and left a phone number, but I do not feel I need her at the moment". Another patient confirmed that they had an advocate.

We saw that patients were supported to make choices about the meals provided. There were several alternatives available at each meal. We saw that hot and cold drinks and fresh fruit were available at any time.

We found patients were offered the opportunity to participate in activities on the unit. Dependent on the patients assessed risk, outside activities and leave were also available. One patient said, "I have developed my confidence and staff trust in me. Initially I was escorted into the grounds but now I can go into the grounds on leave on my own".

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

During the inspection we observed some of the care and support provided to patients. We saw one patient was involved in baking cakes supported by a member of staff. They told us they often cooked on the unit and enjoyed this. We saw that other people went out on planned escorted leave. This had been risk assessed prior to the activity.

We saw staff supporting one patient who was detained under the Mental Health Act (MHA). This person was upset about their detention and wanted to discuss this at regular intervals. We observed staff supporting the person, explaining the reasons for the detention and discussing this with them. They supported the person to write down their feelings about this in a letter to the doctor involved in the person's care.

Patients and their relatives and carers felt that staff provided good care and support. One patient said, "Staff are quite helpful and do listen, I've seen the doctor twice in two weeks, It could be more often" and "All in all quite a good place and it is run properly". Another patient told us, "Staff coaxed me out of my room and have encouraged me to eat, which I was not doing".

Patients said that they saw senior staff regularly and were able to speak with them.

A named nurse system enabled staff to work on a one to one basis with people in order to develop and review care plans and risk assessments. Patients confirmed they had a named nurse who they discussed their care with. They knew who their named nurse was and that they were the person they contacted first to discuss their care. One patient said, "I have a named nurse and I wait for her if I want to talk about things". Other patients told us, "I have a named nurse and a health care assistant who I trust". Relatives were not always sure who their family members named nurse were. One relative said, "I am not sure who the named nurse is or if I was told".

The named nurse system meant staff were more familiar with the patients they were named nurse for and knew their care needs as well as their likes and dislikes. However some staff felt that the 'long days' shift system sometimes reduced its effectiveness as staff were sometimes off for several days at a time.

Some patients were admitted to the unit on a voluntary basis, others were detained under the Mental Health Act. We looked at the care records for four patients. We saw information relating to any detentions and section 17 MHA leave was in place and up to date. Senior staff carried out regular audits to ensure that detentions were lawful and that records were completed correctly.

An electronic patient record system was in place. This system was accessible to all staff within the trust, regardless of the location. It was available to community and hospital based staff which enabled all staff to access and write in the patients' records at all stages of their care pathway. We saw that physical health checks were completed for all patients admitted to the ward and checks were also in place to monitor any weight issues or malnutrition.

The care records provided staff with enough information to make day to day decisions around patients' care needs, risks and choices. However we found the system was unwieldy and difficult to navigate around. This made it difficult to find information relating to specific incidents. As part of the inspection we looked for information about specific changes to a person's care and the reasons for this. It took some time and several conversations with various staff to find this information.

There was a structure in place for the planning and reviewing of patients' care and treatment. Care plans were developed at multi-disciplinary Care Programme Approach (CPA) meetings. A CPA meeting is a formal process in which the members of the multi - disciplinary team and other appropriate health care practitioners meet together with the patient to clarify the care and treatment that is to be provided. One relative said they had not been invited to any care meetings. However other relatives said they had been to all or part of the meetings for their family member.

We found patient daily reviews were in place and these were attended by the multidisciplinary team at the hospital. This meant that patients were reviewed daily and any issues around their care, treatment and any risk issues were discussed and documented.

Records clearly showed how the patient wanted their care delivered and reflected any changes in support needed. We saw informative daily records which provided a picture of the patients care, support and welfare. Changes in health were noted, the information acted upon and treatment carried out. We saw that as well as treatment on the unit, staff supported people on health appointments out of the unit.

The main areas of the records we saw had all been completed and were informative and up to date. However the provider should note that some of the documentation had not been completed. This was information that only required completion of a tick box or yes or no answer. We checked some of this information and saw that it was available elsewhere in the documents. But this meant staff needed to scroll through more information to find it.

Risk assessments had been completed in each patient's safety profile to identify potential risk of accidents and harm. This assisted staff in providing appropriate care and support.

Leave care plans were in place for all patients regardless of whether they were voluntary or detained patients. We looked at three leave plans. Documentation in regards to each period of leave was in place. Each leave plan had information about the frequency and length of any leave. Also whether the leave was escorted or unescorted. The reasons for these decisions were recorded.

Actions to be taken prior to any leave and direction for staff if the patient did not return at the expected time were in place. There was also evidence that these had been discussed with the patient at the time the leave care plan was completed and prior to any leave. Several patients explained how leave was arranged and how they agreed a return time and how they should let the unit know if they were late. Relatives we spoke with said leave arrangements for their family member and any restrictions had been explained to them.

Patients on the ward all had access to the restart and recovery team and psychology. The restart and recovery team consisted of occupational therapists (OTs) and technical instructors. Patients were seen on the ward and were provided with individual support. They also organised individual and group activities on and off the ward where possible. Activities on the ward were reviewed regularly and patients were consulted with about their interests and goals. The team also linked into the community OTs to ensure patients who were due for discharge continued to receive input in the community where an identified need had been highlighted.

Patients were seen by the psychologist on the ward and again they linked into the community teams providing support and guidance to staff and care coordinators to assist them in working with patients more effectively. We were told that although access to psychology on the ward was available, when patients required specialist psychological input in the community there was a likelihood they would be placed on a waiting list.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We spoke with seven patients during our visit; all of the seven patients who spoke with us told us they felt safe on the ward. Patients told us they had no concerns and any problems they had they would talk through with their named nurse or any other member of staff. One relative we spoke with told they felt their relative was, "fairly safe".

We spoke with three staff members about safeguarding and all were able to confirm who the trust lead was for safeguarding was on the ward. The staff we spoke with about safeguarding told us they had received updated safeguarding training about protecting adults and children. They were all able to explain what is meant by abuse and were able to detail the appropriate procedure to be followed in the event that they had any concerns, regarding the care or welfare of a patient using the service. All staff who we spoke with were fully aware of the trust's safeguarding policy and procedure. They were able to identify the reporting structures in place within the trust to escalate any safeguarding concerns.

We found that staff were aware of the whistle blowing policies (internal reporting of bad practice) and procedures and most staff told us they would not hesitate in reporting concerns about the operation of the hospital and about the way patients were treated.

We looked at incident recording and reporting on this ward for July 2013, we were told by the ward manager that this was a pilot currently being trialled by selected wards within the trust. (This is called the Safety Thermometer). We found incidents were being recorded, reviewed and analysed as well as information being submitted at ward level via a computerised system (datix). The tool reported on trends, patterns and any hotspots of increased incidents. The information was used to review and analyse incidents on the wards to improve and reduce violent or aggressive incidents on the ward. This tool had been implemented in place of the matron's weekly checks on this ward.

We also reviewed a safeguarding log dated September 2012- September 2013. This was a record of all incidents that had taken place on the ward and any actions the ward staff had taken. We saw that 15 incidents of safeguarding had been documented with actions taken to minimise and safeguard patients whilst on the ward.

Records and audits we looked at confirmed that people's capacity to consent to their care and treatment was being reviewed, documented and audited. Staff training records confirmed that over half of the staff team had not completed their Mental Capacity Act 2005 (MCA 2005) mandatory training identified by the trust. We saw that staff had signed to confirm they had received a copy of a briefing document about the MCA 2005. This provided staff with information about their responsibilities and actions required when considering capacity and best interest decisions. The training records we reviewed did not tell us when staff had last completed their training and we were unable to verify what date the training was due. This meant that although records were provided we were unable to confirm up to date training and supervision that staff had received.

Staff training records we reviewed, told us that all of the staff on the Lancaster unit had received safeguarding adults training as well as safeguarding children. These records also told us most of the staff had completed the management of violence and aggression training (MOVA) and identified which staff required update training.

Staff we spoke with told us they had two staff who were responsible for training staff in the restraint of patients should this be required. They also told us that staff returning to the ward after a period of absence and/or new staff completed a five day course followed by a full day workshop incorporating the trust values.

Staff were able to tell us how they used restraint as a last resort to manage violence and aggression of patients on the ward. They also told us that body maps were used to identify the hold positions of the restraint and records were also maintained to identify the reasons for restraint being used and identified staff who were involved in the restraint. They also told us that if restraint was used a medical doctor was always requested to review the patient. Restraint practices continued to be monitored and reviewed by the trust and reporting mechanisms were in place at the trust.

We asked patients about physical restraint being used on the ward and all confirmed that they had not been restrained nor had they witnessed anyone else being restrained.

Patient electronic records we reviewed told us that all patients had a safety profile completed and safeguarding information had also been completed where any safeguarding issues had been identified. One patient record we reviewed told us that staff had documented a recent safeguarding concern and this had been reported effectively via the internal systems and records confirmed the appropriate external authorities had been informed.

Records we looked at told us that a violence reduction, practice reflection and debriefing sessions had recently been organised for patients. Six patients had attended this meeting and it was held every two weeks. This meant that patients were able to share and comment on any concerns they had whilst on the ward and were able to provide input to improve the ward environment by discussing any issues relating to their safety and experiences.

We reviewed quarterly safeguarding children, young people & vulnerable adults' committee meetings. These had taken place with safeguarding leads from the local authority representatives and service commissioners. This meant the trust was working collaboratively with local services in relation to safeguarding issues to protect people who used their services.

During our visit we observed that an identified staff member was allocated on each shift,

who was responsible for the safety and security (SAS) on the ward. We saw that written records were maintained to identify the whereabouts of all patients.

We also found leave records had been completed, these told us that following two serious untoward incidents on the ward improvements had been made to ensure the safety and whereabouts of patients. These included the types of leave the patients had and checks were made against their leave of absence care plans.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We spoke with five staff about being supported in their work. All of staff we spoke with said they felt supported. One staff member told us, "I feel supported by the management on the ward and by other team members". Another staff member told us, "We are more supported now than we were a few years ago".

We found staff had received email updates from the trust via 'Team Talk'; this was a briefing to all staff. This informed staff of any updates staff needed to be aware of. Items included in this briefing provided information to staff about the progress of the new inpatient mental health unit being built as well as informing staff about the quality. We found various trust quality initiatives were in place across the trust. The briefing also contained information about the Francis Report (Public enquiry into the issues raised about Mid Staffordshire Hospital) and the trust staff survey results. This meant staff were kept informed and updated about local and national drivers within the NHS to seek to improve patient care and experiences.

We reviewed five staff supervision records completed by the ward manager in August and September 2013. These records told us that procedural issues and trust updates were discussed with staff as well as professional development and training. Topics such as safeguarding, medication, record keeping, care planning and case load management were also discussed. We found 'any other issues' were also discussed with staff and these included personal issues, roles and expectations and reflective practices after serious untoward incidents (SUIs). These told us that processes were in place to support staff and update them on any trust issues.

One staff member told us they attended weekly group supervision. They also told us, "Staff on the ward sometimes experience difficulties getting off the ward, and attendance is determined by staffing levels on the ward". We looked at these weekly supervision records. We found this group provided staff with a safe place to reflect and discuss the impacts of clinical practice at a service and team level. We found staff from all disciplines who worked on the ward had attended the meetings.

Staff also told us that they received individual supervision and appraisal on a regular basis. Records we reviewed told us most of the staff had received personal development

planning/appraisal (PDP).

Staff told us they had access to training and some of this was on line. One staff member told us, "It is sometimes difficult to complete the online training as it has to be done within your shift".

The provider may wish to note, that most staff we spoke with told us about the difficulties handing over information about the current patients on the ward at the end of their 12 hour shift. Most staff told us fifteen minutes in the morning and half an hour in the evening was insufficient, with staff often staying behind to complete the handover. We were also told that due to the current shift patterns staff had long periods of time off from the ward and this caused a difficulty for the staff to 'catch up' on pertinent information about the patients on the ward.

We asked staff about support they had received following the SUIs on the ward. Staff told us the trust had supported them well providing debriefing, support contact telephone numbers and additional supervision.

Staff told us about the changes implemented by the trust following the SUIs on this ward. We found team meetings had been arranged to discuss changes to practice. Staff had received email correspondence about the updated changes to the policies and procedures such as leave, risk assessments and records. We found information readily available throughout the ward advising all staff of their responsibilities and duties when ground or day leave was agreed for patients. We found arrangements had been made to share learning with the staff team following the SUI, this learning event addressed notifying families and carers of missing patients and highlighted specific actions required by staff to address and implement the action plans devised following the SUI. It included staff from the ward and the access and crisis teams within the community. This meant staff had an awareness of what they were required to implement and what checks they needed to put in place to protect the safety and wellbeing of the patients.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

When we spoke with seven patients on the Lancaster ward during our inspection we asked their opinion of the overall quality of the care and service provided.

All of the seven patients made positive comments about the staff and their treatment on the unit. These included, "Staff are quite helpful and do listen, an advocate came into see me and left a telephone number, but I do not feel I need them at the moment" and "All in all quite a good place and it is run properly". One patient told us, "I have been told I won't be going anywhere until I feel safe and ready, they seem to know what I am going through" and another patient told us, "I have a named nurse, but they are all easy to talk to".

We found the trust had an internal complaints team (customer care team) which was responsible for managing complaints received. We found that when a complaint was made the trust acknowledged the complaint and allocated a person to review and investigate the complaint. We were told the chair of governors and the interim director of nursing had recently introduced a system of sampling complaints responded to by the trust. This was to ensure lessons could be learnt and improvements made when dealing with patient complaints.

We had also previously looked at the trust's quality account for 2012 to 2013 which documented the quality of their services delivered from April 2012 to March 2013 and sets out their priority areas for improvement for 2013 to 2014. This plan is available to the public, providing an overview of the services the trust provide and their performance for the previous year. It also provided an overview of systems being used to monitor and improve the services provided by the trust.

Quality monitoring mechanisms were used in all divisions and directorates to provide information on the performance of the trust. These included a variety of auditing and reporting systems. The audits, subsequent reports and action plans were designed to demonstrate practices were being monitored with the aim of driving improvements. These audits and action plans were routinely reviewed in the service line locality governance groups (SLLGG) which reported through to the trust board of governors.

We also found the trust were piloting new safety checks (Thermometer checks) on specific wards throughout the trust to monitor ward level incidents. This was then reported to the harm free steering group that then reported to the executive quality committee who reviewed all the information and reported back about any improvements needed to address the data analysed.

Information we reviewed told us that the process for overseeing the management of incidents and risks within the trust were fed into the clinical business unit risk management group and to the executive risk management committee who were also informed. Serious incidents were recorded on the datix system with associated action plans and lessons learnt fields completed. The information we reviewed told us that any serious incident investigations, where necessary, were escalated onto the trusts risk register which was monitored by the executive team.

We saw evidence that the trust had a clinical governance structure in place for all services provided by Lancashire Care NHS Foundation Trust. The governance systems used at this trust facilitated a continuous flow of information, from patients and frontline staff to managers and then senior managers and vice versa to ensure quality and safety was monitored at all levels within the organisation. This structure was used to monitor, review and improve risk management as well as to review service development, performance management, workforce performance, development and policy implementation as well as service user experience. We also found systems had been implemented to improve mental health inpatient services and community services. The trust were responding to emerging themes and trends by analysis of data collected as well as monitoring any action plans produced throughout the trust.

The trust had implemented a quality improvement strategy. This strategy, reviewed on a previous inspection, described actions necessary to improve the quality of the care the trust provided. We previously reviewed the trusts quality master plan for 2013 to 2014. The plan also made reference to the recent Mid Staffordshire NHS foundation Trust Public enquiry report (February 2013, Francis report) recommendations. The recommendations had been linked to this plan as well as the quality governance audits needed to monitor the trust's progress in implementing the plan.

We saw evidence that a self-assessment tool had been completed on Lancaster ward in relation to safety, effectiveness, experience and leadership (SEEL). This assessment tool was an on-going assessment and was to be reviewed at regular intervals to monitor improvement and progress at team level. We reviewed the evidence generated from the use of this tool which told us that staff, patients and carers had been consulted with. This provided an overview of where improvements were needed against the current Health and Social Care Act 2008 Regulations and associated Care Quality Commission guidance.

We also reviewed the recommendations the Mental Health Act (MHA) commissioners had made follow their visit in July 2012. We found most of the recommendations made had been implemented. However, we found that guidance had not been issued to the Responsible Clinicians (RC) confirming where the record of capacity would be maintained after three months of detention under the MHA.

The ward has a seclusion suite which is used when a patient requires additional nursing support. The trust confirmed the bed had been used over the weekend period to admit a patient as an emergency inpatient bed. We discussed this with the director of nursing and the medical director. They told us this was not usual practice and all other trust bed

provisions and care services had been considered to minimise the risk to the patient. We were told that the risks presented by the patient required urgent admission to this bed as there were no other available beds throughout the trust. The trust told us that all executive directors met weekly to review and monitor the use of inpatient beds and occupancy levels.

It was reported that audits were routine on the ward and undertaken at least on a weekly basis. The audit process for care was led by the practice development nurse. They told us the audits/checks they completed included checks on the safety profiles, health and social care needs, record keeping, care plans, reviewing of care plans and also included checks on patients' physical health needs and gender specific care planning. Records we looked at confirmed that this was taking place.

We found the process was not simply checklist driven. The audits looked into the content of the processes to establish the quality of the care and or intervention. Care plan content was checked by routine discussion with patients and subsequent cross-checking that the care plans were appropriate to the perceived care need. Patients were interviewed to check that care plans had been constructed with their input and acknowledged their views and aspirations.

We found daily checks had been completed by the matron and the nurse in charge. These included a situation report review, environmental checks, staffing checks, activities monitoring and service user and carer views. Other weekly checks included the monitoring of staff supervision, auditing records, Mental Health Act audits and checks on the ward to meet agreed actions. These checks were used to monitor and improve services.

We also found ligature point audits had been completed throughout all the inpatient facilities of the trust and ligature review and patient safety meetings had taken place to identify actions and recommendations to address any identified risks. These meetings were reported through to the inpatient clinical business unit risk management meetings.

We looked at improvement plans developed to improve the electronic patient record systems being used (eCPA). Staff used the record to capture information about the patients and individuals to whom they provided a service to within mental health services. We found that the trust had established a 'task and finish' group and action plans we reviewed showed us that improvements and some system updates had been implemented. We also found news letters were available for staff to update them on the changes made and to provide them with information about forthcoming electronic learning and user guides. This meant that the trust had reviewed and implemented improvements to their electronic systems.

We saw that the, 'Bluelight' (a method of sharing information quickly from incidents across the trust) initiative had been issued to staff following any learning from serious incidents. We saw that actions from post incident review (PIR) investigation recommendations were disseminated to all ward managers to inform and implement them with the ward staff.

We also saw the trust had used a number of different methods, such as thematic analysis, staff communication bulletins and sharing the learning and guidance to disseminate the learning from serious incidents. This meant that appropriate changes and improvements were made to the delivery of patients' treatment and care and this was reflective of the analysis of the incident.

We saw evidence that incidents that happened on the ward and throughout the trust were reported through their incident reporting systems (Datix). Information was provided and cascaded to teams and staff in relation to any lessons learnt from these incident reviews.

Staff were given the opportunity to provide the trust with feedback about the quality of services, by means of access to the NHS staff surveys, individual and group supervision and appraisal as well as team meetings. Staff also had access to a whistle blowing procedure should they wish to raise any concerns about the organisation anonymously or outside of their line management arrangements.

We found patient involvement initiatives had been implemented on the ward we visited. These included weekly meetings on the ward run by volunteers some of who were previously patients on the ward who met with current inpatients to discuss any issues whilst on the ward.

We found the ward had recently introduced a 'violence reduction' initiative group for patients on the ward to access. This provided patients with the opportunity to discuss their experiences and any observations they had made in relation to the management of violence or harm reduction on the ward. These meeting also provided additional support and debriefing sessions for patients to be able to discuss and reflect on violence reduction whist in the ward environment. They also allowed patients to share ways in which things could be improved on the ward to make their inpatient stay safer for them.

We had asked the trust for clarification and assurance of their checks and processes in place to ensure their nursing staff were qualified and registered. The trust provided information to ensure us there was a clear process in place which provided assurance and checks that their qualified nurses were on the nursing and midwifery council register (NMC). The trust had processes in place to ensure that where nursing staff had not re registered then they did not work as a nurse within the trust.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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