Care Quality Commission

Avon and Wiltshire Mental Health Partnership NHS Trust

Acute Admission Wards

Quality Report

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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)
Callington Road Hospital	RVN4A	Lime Silver Birch	BS4 5BJ
Fountain Way	RVN9A	Beechlydene	SP2 7EP
Green Lane Hospital	RVN6A	Imber	SN10 5DS
Hillview Lodge	RVN2A	Sycamore	BA1 3NG
Longfox Unit	RVN4B	Juniper	BS23 4TQ
Sandalwood Court	RVN8A	Applewood	SN3 4WF
Southmead AWP	RVN3N	Oakwood	BS10 5NB

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Avon and Wiltshire Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health Partnership NHS Trust.

Summary of findings

Ratings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The acute admission wards are based in seven hospitals sites across Bristol, Weston Super Mare, Bath, Swindon, Devizes and Salisbury. All provide inpatient mental health services for adults.

Overall, we found that adult acute services required improvement and we are concerned about the safety of the care that patients receive within some acute adult wards at this trust.

Staff understood their responsibilities regarding safeguarding; however we found that incidents had not always been reported, investigated or learnt from. Risks were usually assessed, though this did not always translate in to changes in practice.

Overall, we saw good multidisciplinary working and found staff who were compassionate and caring. However a number of units had significant staff shortages and environmental challenges which may have impacted on patients' care and safety.

People we spoke with were mainly positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them.

The availability of beds appeared to be a trust-wide issue, with acute care beds always in demand. This meant that occasionally people may have been discharged early or managed within an inappropriate service. People were not always being treated within their local area and sometimes had been moved during their care, which would have an impact on their recovery.

We found that both staff and patients knew how to make a complaint and many were positive regarding the response they received.

The trust's board and senior management had a clear vision with strategic objectives, though staff knowledge of this varied. Staff generally felt supported by the managers at ward level, however leadership from above ward level was not visible to all staff.

There is a trust-wide governance and information system called IQ and governance processes are in place; however these had not always led to positive changes in practice.

Summary of findings

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

Are services safe?

We are concerned about the safety of the care that patients receive within acute wards for adults at this trust.

Staff understood their responsibilities regarding safeguarding and knew how to report concerns. However, while there is a process in place for reporting, investigating and learning from incidents, we found that this had not always been followed.

Assessments of people's individual risks were generally carried out; however this was not always reviewed and updated following incidents of concern or changes to people's care needs.

A number of units had significant staff shortages which may have had an impact on patients' care and safety.

We found a number of challenges within the ward environment, including potential ligature risks and poor design, which was affecting patients' safety and dignity.

The management, administration and storage of medication requires improvement and we found that checks required to make sure that medicines are kept properly had not been fully undertaken.

We also found a number of issues regarding the management of processes and maintenance of equipment – for example, for life support, lifting and fire safety.

Are services effective?

Overall, we found that the trust needs to improve services to make sure they are effective.

People's needs, including physical health needs, were assessed and care and treatment was planned to meet them. Overall we saw good multidisciplinary working. However, people's knowledge and involvement in their care plans varied across the services.

Most staff had received their mandatory training but had been unable to access more specialist training. Overall, most staff had received regular supervision and appraisal.

Systems were in place to ensure that the service complied with the Mental Health Act (MHA). However, we found that staff did not always recognise and manage people's seclusion within the safeguards set out in the MHA Code of Practice.

Summary of findings

We found that the environment and equipment in a number of units did not reflect good practice guidance and had an impact on people's safety, dignity or treatment.

Are services caring?

Overall, we saw that staff were kind, caring and responsive to people and were skilled in the delivery of care.

We observed staff treating patients with respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments.

People we spoke with were mainly positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them.

Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed.

Are services responsive to people's needs?

Overall, we found that improvements are needed to the responsiveness of this trust.

The availability of beds appeared to be a trust-wide issue, with acute care beds always in demand. Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However, a lack of available beds meant that occasionally people may have been discharged early or managed within an inappropriate service.

We also found that bed availability had an impact on people being treated within their local area. Some people told us that they had been moved during their care, which had an impact on their recovery.

We found that both staff and patients knew how to make a complaint and many were positive about the response they received.

Are services well-led?

Overall, leadership and local governance arrangements require improvement at this trust.

The trust's board and senior management had a vision with strategic objectives, though staff knowledge of this varied.

Summary of findings

Staff generally felt supported by the managers at ward level and they also valued the support of their team. However leadership from above ward level was not visible to all staff.

There is a trust-wide governance and information system called IQ. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards.

Several meetings were held by the trust focusing on current provision and identifying concerns. However, it was clear that some issues were raised without any action being taken to remedy the situation.

Staff we spoke with were aware of their roles and responsibilities on the ward.

Summary of findings

Background to the service

The acute admission wards are based in seven hospital sites across Bristol, Weston Super Mare, Bath, Swindon, Devizes and Salisbury. There are also a further six rehabilitation wards at Bristol, Weston Super Mare and Swindon. All provide inpatient mental health services for adults.

Avon and Wiltshire Mental Health Partnership NHS Trust has been inspected 28 times since registration in April 2010. Out of these, there have been 12 inspections to 7 locations that have looked at adult acute wards.

At the time of our visit there were a number of compliance actions in place that we reviewed during this inspection. These were:

- Hillview Lodge – we had last visited this location in November 2013 and it was found to be non-compliant in five areas. These were: Respecting and involving people who use services, meeting nutritional needs, safety and suitability of premises, staffing, and records.
- Callington Road – we had last visited this location in February 2014 and it was found to be non-compliant in two areas. These were: Assessing and monitoring the quality of service provision and records.

Our inspection team

Our inspection team was led by:

Chair: Prof. Chris Thompson, Consultant Psychiatrist

Team Leaders: Julie Meikle, Head of Inspection

Lyn Critchley, Inspection Manager

The team included CQC managers, inspection managers and inspectors and a variety of specialists including: consultant psychiatrists, specialist registrars, psychologists, registered nurses, occupational therapists, social workers, Mental Health Act reviewers, advocates, governance specialists and Experts by Experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience 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?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits between 9 and 13 June 2014. During the visits we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and allied staff. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We also carried out unannounced visits between 24 and 26 June 2014.

Summary of findings

What people who use the provider's services say

Most people told us that staff treated them really well and were caring. They confirmed that staff treated them with dignity and respect.

People told us they usually felt safe, but sometimes there were not enough staff to maintain this. They did however praise the staff for managing some very difficult situations.

Most people we spoke with felt involved in planning their care and treatment. Most people were aware of their care plans and some said they had contributed to them.

Patients told us staff listened to them and that they were well trained and knowledgeable. Some people were concerned at the lack of time staff had to spend with them.

In some units, people told us that the environment did not promote their safety, dignity or wellbeing.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that ligature and environmental risks are addressed.
- The trust must ensure that all acute units meet guidance on mixed sex accommodation.
- The trust must ensure that emergency lifesaving equipment is readily available and fit for purpose.
- The trust must ensure that there are clear procedures for managing fire safety and that equipment is readily available.
- The trust must ensure that there are sufficient staff to safely meet the needs of patients.
- The trust must ensure that individual patient risk assessments are reviewed and updated following changes in people's needs and risks.

- The trust must ensure that the medication management and administration procedures are safe and effective and that checks are undertaken to ensure the integrity of medication.
- The trust must work with commissioners to ensure that there are sufficient beds or alternatives to hospital so that people receive the right treatment at the right time.
- The trust must ensure that local governance arrangements lead to positive changes in practice.
- The trust must ensure that seclusion is recognised and managed within the safeguards set out in the Mental Health Act Code of Practice.
- The trust must ensure that there is no restrictive practice leading to a deprivation of liberty.

Care Quality Commission

Avon and Wiltshire Mental Health Partnership NHS Trust

Acute Admission Wards

Detailed findings

Locations inspected

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

Mental Health Act responsibilities

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

We reviewed the application of the Mental Health Act and the Code of Practice at all of the acute wards that we visited. We found that legal paperwork was in place and in order.

Staff confirmed that they had received training in the Mental Health Act and had access to advice where required.

In the patient records we reviewed, assessments of a patients capacity to consent to treatment was carried out at regular intervals and to a satisfactory standard. All treatment appeared to have been given under an appropriate legal authority. However improvement was needed in the recording of discussions with the Second Opinion Appointed Doctor (SOAD) by the statutory consultees and recording by the responsible clinician of the patient being informed of the outcome of the SOAD assessment.

Detailed findings

There was evidence that patients were regularly presented and re-presented with their rights under the Mental Health Act. This included their right to an independent mental health advocate (IMHA). There was generally a good advocacy presence on the wards however we were told that at one service the use of advocacy was not actively promoted.

A standardised system was in place for authorising and recording section 17 leave of absence. However we found that leave authorisation and records were not always fully completed and those pre-leave risk assessments were not always undertaken. At Fountain Way we found a local process had been put in place for managing the leave of informal patients meaning that they could only leave the ward following authorisation. This may lead to a restriction on a person's liberty.

Seclusion is practiced at a number of the services we visited. Generally seclusion paperwork was completed and indicated that the safeguards required within the Mental Health Act Code of Practice had been adhered to. However at Hillview we found staffs' understanding about the practice of seclusion to be lacking and evidence of practices that may amount to seclusion without the necessary safeguards being in place.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made public commitment to reviewing provider adherence to MCA and DoLS.

Staff said they were aware of the Mental Capacity Act and the implications this had for their clinical and professional practice. Staff had received training on this Act. Capacity assessments were usually being completed appropriately and reviewed as required. However we found arrangements at Fountain Way in respect of authorising leave for informal patients that may lead to a restriction on a person's liberty.

Are services safe?

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

Summary of findings

We are concerned about the safety of the care that patients receive within acute wards for adults at this trust.

Staff understood their responsibilities regarding safeguarding and knew how to report concerns. However, while there is a process in place for reporting, investigating and learning from incidents, we found that this had not always been followed.

Assessments of people's individual risks were generally carried out; however this was not always reviewed and updated following incidents of concern or changes to people's care needs.

A number of units had significant staff shortages which may have had an impact on patients' care and safety.

We found a number of challenges within the ward environment, including potential ligature risks and poor design, which was affecting patients' safety and dignity.

The management, administration and storage of medication requires improvement and we found that checks required to make sure that medicines are kept properly had not been fully undertaken.

We also found a number of issues regarding the management of processes and maintenance of equipment – for example, for life support, lifting and fire safety.

Our findings

Callington Road – Lime and Silver Birch
Track record on safety

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an online electronic system to report and record incidents and near misses. Where serious incidents had happened we saw that investigations were carried out.

Learning from incidents and Improving safety standards

Some learning had taken place from a series of incidents of patients going absent without leave. There are outstanding compliance actions for the Callington Road Hospital in relation to this. Operating procedures and staff practices had been reviewed with some changes made to reduce the likelihood of a similar incident. The new policy on patients being absent without leave had been shared with staff. We saw some specific care plans for patients and risk assessments regarding absence without leave but this was not consistently the case for patients on Silver Birch ward. The height of the external fence in Silver Birch ward had been increased but the design and layout of garden furniture still enabled patients to exit the garden area and so become absent without leave. There had been three recent instances of patients going absent without leave on this ward prior to our visit.

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

Systems were in place for keeping people safe and safeguarded from abuse. We saw that staff had completed training in safeguarding vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and knew how to raise any safeguarding concerns. We noted however that documented evidence regarding the behaviour of a male patient and vulnerable female patient had not been identified correctly by staff as a safeguarding issue. This was raised with staff during our visit who then made a safeguarding alert.

We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

Most people told us they felt safe on the wards. One person on Lime Ward said, "I feel safe here so I don't go out for long". However some people raised concerns regarding safety on Silver Birch ward. One person said, "I find it really difficult when the other patients are kicking off. I know I am OK but I feel scared". Another person said, "They're extremely short staffed, I could disappear and they wouldn't notice".

All staff carried safety alarms and we observed that they were quick to respond when required. Staff on Alder and

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

Are services safe?

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

Larch told us that they used de-escalation techniques in response to any episodes of challenging behaviour but if restraint or seclusion was needed the person was transferred for management in a more acute environment.

People told us they were able to lock their room, when risk assessed as appropriate, and had access to personal lockable space. We saw that sleeping areas for male and female patients were segregated with all bedrooms having ensuite toilet and shower facilities.

We were concerned to observe potential ligature points on Lime and Silver Birch wards. Examples included taps in bathrooms and bedroom ensuites. We also observed that drawing pins were used for notices in communal areas. We were informed that a patient had died using a ligature on Lime ward recently. We raised these potential risks with the trust on the day of our visit.

We saw that medicines were stored securely on Lime Ward. A clinical pharmacy service was provided daily. Checks on controlled drugs were in place and staff were aware of when and how to report medicine errors and the action required. Self-administration of medicines by patients was risk assessed.

We found that the temperature of the room where medicines were stored on Lime ward was not recorded. The temperatures of the medicines refrigerators were being recorded daily but had been over the required temperature for the six days prior to our visit with no report or action taken. There were also four unexplained gaps on one prescription chart.

Assessing and monitoring safety and risk

Daily ward meetings took place. These were well planned and organised with staff and used effectively to share relevant information about the patients to ensure continuity and safety of care.

Risk assessments were carried out and management plans developed for patients. Staff spoke about patients with respect and demonstrated a good understanding of their needs and assessed risks.

Staffing levels and skill mix had been set and reviewed. The number of nurses had been increased on Lime Ward to reflect the increased acuity and needs of patients being admitted to the ward. Staff told us the planned staffing levels could be increased on the wards if the needs of patients required this. Bank staff who knew the units well

were used to fill the gaps where ever possible however the management told us that the use of staff who were unfamiliar with the dynamics of the units and the needs of people who use the service could have an adverse impact on people's safety and well-being. As a result the manager acknowledged that at times they made the decision to work under the set staffing levels after balancing the needs of people in the unit against the risks of using new staff.

Fountain Way - Beechlydene
Track record on safety

Staff had access to a secure online reporting system used to report and record incidents. Staff were able to describe their role in the reporting process. However incident reporting was not sufficiently detailed or investigated in a timely manner which meant incidents were recurring and risks remained unaddressed.

We witnessed staff completing incident forms and submitting them online for investigation by the unit manager. This information then went verbally into handover to be shared with the staff team. When asked, one member of staff told us "I have to do that as it takes ages for the manager to do their bit". It was noted by the inspectors that the manager had a lengthy list of incident forms awaiting their attention, some dating back several weeks. Medical staff told us that the delay in investigation was a concern to them and that reporting systems were not robust enough to protect patients from harm.

When we returned during an unannounced visit, we saw the backlog had been addressed and a system put in place to ensure the review of incident forms was not delayed.

Learning from incidents and Improving safety standards

Patients and staff told us incidents kept recurring. Staff gave the example of a patient setting small fires in their bathroom. We looked at the incident reporting for this and found the forms lacked detail and the risk assessments had not been reviewed or additional safeguards put in place. This was a recurring theme in the majority of the incident reporting we looked at. The care plans and risk assessments were not up to date. This remained the same on our return unannounced visit. However staff explained the new system that had been put in place since out first visit. Staff had protected time to complete a review of care plans at a weekend which were then checked by the management.

Are services safe?

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

Lack of staffing was identified as a concern both by patients, staff and the manager. Staff told us they did not have enough time to complete paperwork, engage effectively with patients on a one to one basis or take detained patients on escorted leave. Staff told us it was a regular occurrence that they did not get any breaks during the day. We observed staff were not always available for patients when they requested help.

When we entered the ward on one occasion, there were no staff to be seen for several minutes. A patient told us that they went to the nurses' station when they were feeling very unwell and there was no one there to support him. Staff told us that staff sickness was not always covered, leaving the ward unsafe and increasing the pressure on the remaining staff.

One patient told us that the staffing problems appeared worse at night. They described a situation when the night medication was delayed by approximately 90 minutes due to the staff nurse having to manage a situation elsewhere. The patient added that delays in medication rounds were a common problem. This information was put to the manager during the inspection and they agreed this was not acceptable but may not have happened as described. We noted that on our return visit, this issue had been escalated to senior management for further consideration.

Staff told us they had reported their concerns around safe staffing levels to management but did not feel they were listened to or their opinions valued. On our return visit, the matron had escalated the issue to the senior trust management and we saw an email confirming a planned meeting to look in to these issues.

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

The unit had policies in place relating to safeguarding and whistleblowing procedures. Staff we spoke with were able to describe situations that would constitute abuse and relate these to their work.

The trust policies and procedures were accessible via the trust's intranet site.

Staff were passionate about providing high quality care in a challenging environment. They told us that they did their best but they knew there were problems. Staff believed the problems stemmed from lack of staff and no sickness cover in addition to the high pressure nature of the client group.

Patients told us that on occasion they did not feel safe on the ward due to the lack of visible staffing and staff being overloaded with paperwork. They did however praise the staff for managing some very difficult situations. Staff also told us that the ward did not feel safe at times. We also observed the ward staff managing some very complex situations whilst remaining calm and positive. The staff told us they were proud of how they manage complex conditions and how interesting but challenging that made their work.

On our initial visit medication management was of concern. The room temperature of the clinic room was excessively high. The manager acknowledged this was an issue but nothing had been done to remedy this situation. On our return visit, a thermometer was in place and monitoring had begun. An air conditioning unit had been installed as a temporary measure.

We noted there was no recording system for the receipt or management of stock medicines on the ward. This meant that medicine could be missing without anyone's knowledge. There was no evidence of auditing of medication related paperwork. On our return visit, we were informed the pharmacist had begun a weekly audit of all medicines on the ward.

We looked at the medication charts and found recording errors including missing signatures. These had not been reported as incidents and had not been investigated. Open bottles of liquid medication had no dates on them meaning that the ward could not ensure they were disposed of within the recommended timescale. Patients were not being protected from the risks associated with unsafe management of medicines.

Assessing and monitoring safety and risk

Staff told us the ward was not safe at times as there could be a lack of staff. One patient told us "there was no-one there when I needed someone". This had been partly addressed by our return visit as two admin staff had been identified to be stationed in the ward office meaning care staff could concentrate on patient needs.

We attended a handover between shifts where a very unwell person was discussed briefly and current risks were identified. Communication was good, the language respectful, and the level to detail was sufficient to provide a basis for providing care.

Are services safe?

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

We found that care plans and risk assessments were not up to date. No risk assessments were undertaken when a patient had leave, although they were screened prior to leaving the ward. We were told by staff that they did not have enough time to deal with this. One staff member said "Things are haphazard and not as organised as we would like it to be".

After incidents, risk assessments were not being reviewed consistently. Information was not recorded fully on the computerised record system leaving potential for miscommunication and misunderstanding. This meant that staff were not fully informed of the changes to care plans and risk assessments or recent events, leaving both patients and staff at increased risk of harm.

Green Lane Hospital - Imber

Track record on safety

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. Staff had access to a secure online reporting system used to report and record incidents. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an online electronic system to report and record incidents and near misses. Where serious incidents had happened we saw that investigations were carried out.

Learning from incidents and improving safety standards

The manager told us that they used the trust 'IQ dashboard' system and risk register to identify and monitor risks. The trust held data on a wide range of safety processes. Staff were confident that they could use these processes and action would be taken to ensure that people who used the service were safe.

Investigations, incidents, safeguarding and staffing were standing agenda items for discussion at the weekly governance meeting. All learning points were fed back to staff through their team meetings or at one to one supervision, and action plans were put in place to improve safety.

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

The unit had policies in place relating to safeguarding and whistleblowing procedures. Most staff had received their mandatory safeguarding training and knew about the relevant trust-wide policies relating to safeguarding. Safeguarding guidance was available to staff. We observed

comprehensive discussion regarding safeguarding concerns during the focus groups we attended during this visit. Staff we spoke with were able to describe situations that would constitute abuse and relate these to their work.

The trust policies and procedures were accessible via the trust's intranet site.

Assessing and monitoring safety and risk

There were procedures in place to identify and manage risks to people who used the service.

Comprehensive risk assessments were carried out with people who use the service and these were formulated though to the care plans and reviewed regularly. We saw evidence that risks were managed positively. Effective handovers took place between the staff in order to share relevant information and maintain continuity and safety of care.

Staffing levels and skill mix were set and reviewed however we were told that staffing levels were not always sufficient. This was said to be due to recruitment issues blamed on the recent trust restructure.

We saw evidence that regular health and safety checks of the environment were undertaken and these included ligature checks and control of substances hazardous to health risk assessments.

The trust had a policy for the assessment of environmental ligatures in inpatient settings (reviewed July 2012). The policy required that ligature risk assessments must be reviewed annually, on significant change or after a serious adverse event involving suicide or attempted suicide involving a ligature. The policy also required that daily inspections take place to check for any new ligature points, risks or loss of safety controls.

However we observed there to be safety issues in the seclusion suite. These included potential ligature points in the seclusion suite bathroom area. There was no connecting door between the seclusion room and toilet and no method of communicating between the lounge and seclusion room other than shouting through the door. The observation window was small and high. Some staff would have been required to stand on tip-toes to be able to observe the patient inside. The blind was on the inside of

the window and staff did not know how to control it. There were also blind spots in the room. This facility does not meet Royal College of Psychiatry or Mental Health Act Code of Practice requirements.

Doctors we met with in a focus group told us that nurses do not regularly undertake baseline observations and required further training to ensure they could detect any physical health deterioration of patients. They also provided examples of where health issues had been missed by ward staff.

Staff demonstrated a good understanding of confidentiality and information governance issues.

Hillview Lodge - Sycamore
Track record on safety

Staff had access to a secure online reporting system used to report and record incidents. Staff were able to describe their role in the reporting process and were encouraged to do so. However incident reporting was not sufficiently detailed or investigated in a timely manner which meant incidents were recurring and risks remained unaddressed.

There were three serious incidents on the ward between April 2013 and March 2014 including two deaths. Following these incidents there had been investigations undertaken or underway. One investigation report identified a number of risks which, whilst not directly affecting the outcome, may have been contributory factors. These included the application of the observation policy, management of ligature risks, provision and checking of emergency equipment and staff training and awareness.

Learning from incidents and Improving safety standards

Staff told us that risks relating to specific patients were discussed at handover meetings. More generic risks such as environmental risks were discussed at ward meetings. However at the time of our visit these meetings had not taken place for approximately six weeks.

Staff told us they had received debriefing following the two recent deaths on the ward but expressed frustration that they had not been informed of the progress of or any learning from the investigations. They told us that the paperwork they used to record patient observations had been amended but apart from this, they could not describe any action or learning that had taken place following the incidents.

Our findings were consistent with feedback provided to the ward following a recent quality visit by senior management on 19 May 2014. It had been reported that there was a positive reporting culture on the ward but staff did not receive feedback about actions that resulted from the incident.

Staff told us about a recent incident on the ward where a patient had climbed a tree in the garden and climbed on to the roof. They told us that the tree had already been identified as both a ligature risk and a means of escape. We did not consider this risk was being adequately managed as we found that prompt action had not been taken to remove or cut back the tree to eliminate this risk. We noted on several occasions during our visit that the garden, which was being well used because of the warm weather, was not closely monitored by staff. In particular, we observed that on one occasion, the patient who had previously climbed the tree was not being supervised in the garden. We also noted that observation records were inconsistent meaning we could not be assured that staff were being sufficiently vigilant to manage identified risks. We were informed the week after our visit that work would commence imminently to remove shrubbery and over-hanging branches.

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

The staff identified to us that the physical environment on the ward was the most significant safety risk. The layout of the ward meant that patients could not be easily observed as there were a number of "blind spots" where patients were not in sight of staff. Staff told us that the layout of the ward made observation very challenging. The position of the nurses' station in relation to the three "anti-ligature" rooms meant that vulnerable patients were not closely observed.

Patient observation was one of the ways in which staff mitigated risks of patients harming themselves or others. We observed that observation practice did not meet the trust's own policy or guidance set out by the National Institute for Health and Care Excellence (NICE). We asked how the ward monitored compliance with the policy. Staff were not aware of any system used to monitor this practice. Issues that we found included variation from the prescribed level of observation, record keeping and a lack of training.

The investigation following the patient death in March 2014 had identified problems with the accuracy record keeping

in respect of observation. The standard of record keeping had not improved since this time. We also found that for patients with a history of self-harming there were no observations records in respect of patients' mental state, behaviours and wellbeing. Staff told us they were aware of and understood the risks the patients posed, although these were not well documented on the observation form. We saw that for these individuals there were also no specific care plans which would indicate to staff the level and nature of observation required and how to manage the identified risks.

There was a clinic room on the ward where medicines were stored and an emergency. The temperature of the room was not measured therefore we could not be assured that medicines were stored at the correct temperature. Controlled drugs were appropriately secured and had been regularly checked. Medicine administration charts had been completed correctly and were accompanied by a National Early Warning Score (NEWS) physical observation chart. We found that prescribing of anti-psychotic medicine was within the limits recommended by the British National Formulary (BNF). The drugs fridge was maintained at the correct temperature but was not locked, although the room itself was secure.

We checked emergency resuscitation and safety equipment. We found some items were out-of-date in the crash trolley, even though the records showed that the trolley had been checked on a daily basis. In addition to the crash trolley, there were two 'grab bags' containing emergency equipment. According to staff these were no longer used and we saw that they had not been regularly checked but they remained available. We were concerned that they may present confusion for staff, particularly temporary staff, in an emergency situation. There were three bags containing emergency drugs. All were stored in the bottom of the crash trolley. Two of them were not sealed to prevent tampering and one bag had expired. Ligature cutters were available in the clinic room and the staff we spoke with were able to locate these. However they were not stored with the other emergency equipment, posing the risk that they may not be collected swiftly in an emergency.

The investigation following the patient death in March 2014 had highlighted that weekly checks of the resuscitation equipment on the ward were not accurate and that some items of equipment were out-of-date or missing. The report

stated that action had been taken to standardise resuscitation equipment on Sycamore ward in order to avoid any confusion about what should be taken to the scene of an emergency. We found that potential for confusion still existed.

Assessing and monitoring safety and risk

Risk assessments of individual patients were undertaken on admission and were discussed and recorded at staff handover meetings.

The locality maintained a risk register however this contained only two risks and we questioned whether it was comprehensive or up-to-date. The most significant risk was identified as difficulties with senior clinical leadership, with difficulties experienced in recruiting to the consultant, ward manager and matron posts, although the latter two had now been appointed. A number of the concerns we found including the ward environment had not been the risk register.

Staffing levels on the ward were not consistently maintained at optimum levels. A review had recently been undertaken and the staff establishment had been increased to reflect the number and acuity of patients and the level of risk however a high level of staff long term absences and number of vacancies meant that temporary bank and agency staff were regularly used to achieve the required levels of staff.

At our previous visit, staff and patients told us that staff shortage impacted on the care and support they received. Patients complained that their leave from the ward was often disrupted or cancelled because there were insufficient staff to facilitate escorted leave. Staff shortage continued to be a problem on the ward. Some staff told us that it was sometimes difficult to facilitate escorted leave and sometimes ward based activities could not take place, although they could not quantify this. There was no system in place to capture the number of times that leave was cancelled due to a lack of staff, despite the fact that we had raised this as a concern when we last visited the ward. Similarly there was no system in place to monitor the provision and up take of staff patient one to one time, another important quality indicator.

The matron told us that staffing issues had a huge impact on the ward and that staff were exhausted. They told us that staff did not have time to spend meaningful with patients and that observation was "just observation" and

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did not involve interaction with patients. This was confirmed to us by a patient who had recently stayed on the ward. They told us during their stay, staff had made few efforts to engage with them or even to ask them how they were feeling. They stressed to us that they did not think staff were uncaring, just too busy.

Lack of staff continuity had also been a problem we identified at our previous visit. At this visit medical staffing was still reliant on locum staff. A locum consultant had provided some continuity but the trust had not begun the recruitment process to fill the substantive position. A middle grade doctor position was also filled by a locum.

Staff told us that some shifts were short of staff because temporary staff were not available. This was estimated to be between five and ten shifts per week. Several staff reported ongoing problems with the system used to book temporary staff. Staff told us that if a critical incident occurred and the ward was under staffed, safety would be compromised and there was little back up because the ward was stand alone. Medical staff expressed concerns about nurse staffing levels and the number of bank staff employed. They also voiced concerns about poor communication with regard to medication, tests and observations not being communicated or consistently carried out by nursing staff.

Handovers took place at the start of each nursing shift. Patient histories were shared and discussed. Information included reason for admission, admission status (informal or formal) and observation level, outstanding issues, risks, physical health and feedback following the weekly ward round.

The ward was locked, with entry and exit controlled by staff. Staff carried personal alarms and these were offered to patients and visitors. There were call bells throughout the ward so that staff or patients could summon assistance.

Patients leaving the ward for periods of escorted or unescorted leave were signed in and out by staff so that their whereabouts were known. Staff recorded the purpose of the leave, the expected duration and what the patient was wearing when they left the ward. We looked at the leave log and found that records were incomplete with 21 out of 67 returns to the ward not being recorded. We were concerned that this indicated a lack of vigilance.

There were facilities and systems in place to manage and prevent violent and aggressive behaviour of disturbed patients.

There was a high care area which staff told us they used as a de-escalation area. There was a protocol for the use of the high care area which emphasised that the area was a comfortable space which could be used as "a therapeutic area" but should not be used as a seclusion room. We found from discussion with staff that there were situations where de-escalation may have become de-facto seclusion. The area was clean, appropriately furnished and comfortable. There was access to a small outside space, if patients wanted to access fresh air or to smoke. There was also a seclusion room within the high care area and a separate procedure was in place defining and regulating its use. Staff were required to report all use of seclusion as an adverse incident. We were provided with figures for the use of seclusion but no detailed information analysis to support this figure to enable us to judge whether seclusion was being used appropriately.

Use of restraint was also a measure of last resort and was defined as reportable incident in order that it could be monitored. Such incidents would be discussed and monitored at safety and risk meetings. We saw that two incidents had taken place during April 2014. A report had recently been submitted to the trust's Quality and Standards Committee outlining the trust's response to the Department of Health's recently published 'Positive and Proactive Care: reducing the need for restrictive interventions'. It was noted that the trust had recently re-established an expert violence reduction group.

The trust had a policy for the assessment of environmental ligatures in inpatient settings. The policy required that ligature risk assessments must be reviewed annually, on significant change or after a serious adverse event involving suicide or attempted suicide involving a ligature. The policy also required that daily inspections take place to check for any new ligature points, risks or loss of safety controls. These checks should be recorded in the ward security log. We requested a copy of the ward security log but this was not provided.

A ligature risk assessment had been undertaken on 23 March 2014, one week after a patient death. The assessment showed that a number of areas in the ward

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had a high or medium residual risk recorded however there were no actions arising from this. The trust had commenced a trust-wide ligature review at the time of our visit.

Longfox unit - Juniper

Track record on safety

The trust had in place a system for the reporting of incidents and staff were able to describe their role in the reporting process. We saw that staff had access to an online electronic system to report and record incidents and near misses. Adverse incidents are documented and then forwarded for review by the manager.

The governance facilitator showed us a database she had set up to log all incidents on the unit that had occurred since February 2014. She described that this information was beginning to be used to consider trends and enable learning from incidents. We were made aware of increasing number of incident reports. The head of professional staff for the locality was analysing the data to distinguish whether this was an increase in active reporting or a rising incident rate.

However we found occasions were incidents had not been appropriately reported, or where reported there was no apparent learning or action taken as a result.

Learning from incidents and Improving safety standards

We found occasions were incidents had not been reported appropriately. For example records stated that two patients had been found engaging in intimate relations on the ward. There was no evidence that this had been reported as an incident or referred to the local adult safeguarding team. We found additional incidents referred to in people's care records that had not resulted in incident reporting.

There have been two critical incidents recorded over the last two months on Juniper ward. Additionally there were eight episodes of absence without leave over this period. The incidents had been escalated but there was no clear evidence of lessons learned.

Since February 2014 there had been numerous incidents were people had attempted self-harm by tying ligatures however we found that the unit contained numerous potential ligature risks. A ligature risk assessment was undertaken on 27 March 2014. We were concerned to note that actions identified did not appear to have been completed and remained outstanding. We also noted that

not all ligature points had been included in the risk assessment. For example, the overhead door closure on the door between the main corridor and the female bedroom area.

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

The unit had policies in place relating to safeguarding and whistleblowing procedures. Staff had undertaken safeguarding training, and were able to describe situations that would constitute abuse and relate these to their work.

The trust policies and procedures were accessible via the trust's intranet site.

Staff all carry alarms to activate in an emergency. We found that the seclusion room is used infrequently and instead there is a focus on de-escalation in the extra care suite.

The trust had a policy for the assessment of environmental ligatures in inpatient settings (reviewed July 2012). The policy required that ligature risk assessments must be reviewed annually, on significant change or after a serious adverse event involving suicide or attempted suicide involving a ligature. The policy also required that daily inspections take place to check for any new ligature points, risks or loss of safety controls.

We were told that the ward had some anti-ligature bedrooms available. We looked at two of these bedrooms and found that although anti-ligature taps were fitted there were still ligature points on the windows and window handles. We were concerned that there was some complacency amongst the staff team in respect of ligature risk. For example we found the laundry, which contained ligature points and the means to ligature such as electric flex, was unlocked. Staff confirmed that the laundry should be locked and patients have accompanied access. Additionally the disabled bathroom was also left unlocked. We noted a high number of ligature points on trees in the ward garden which were screened by bushes and some staff told us they were worried about patients harming themselves in this area.

We observed that there were waste bins in the garden overflowing with rubbish, which presented a potential fire hazard as they were in a smoking area.

We were very concerned to find that the fire extinguishers had been removed from the wall in the female bedroom area. There was no sign telling people what they should do

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if they discovered a fire in that area. In addition, the fire signage throughout the ward was inaccurate and indicated that should a fire be discovered, then a button should be pressed to make the alert. However, there were no buttons to press, and instead there was a box where a key could be inserted to raise the alarm. We discussed this with the ward manager as a matter of urgency and asked that immediate actions be taken to ensure the ward was safe.

We were concerned that the layout of the unit did not facilitate clear gender separation. During the visit, we observed a male patient entering the female bed area. He was unchallenged because there was no staff presence. Nursing staff in the office had to be alerted by the inspection team.

We looked at the arrangements in place for the management of medicines and found that medicines were stored securely. A clinical pharmacy service was provided daily for medicines reconciliation and the supply of medicines. Emergency medicines including crash drugs were available. However we also identified some concerns. The clinic room was found to be very warm and the room temperatures were not recorded. Medicine refrigerators temperatures were not being recorded daily. Controlled drugs were not being checked daily in line with trust policy. Staff told us they do not assess competency of staff for medicines administration but were planning to bring this in. Staff also told us that the recent change in pharmacy supply meant that obtaining medication was now time consuming and lengthy. This change was blamed for the concerns we identified.

Assessing and monitoring safety and risk

We found that the skill mix of nursing staff was satisfactory at the time of the inspection. We observed that staff were very busy and were managing some patients with extremely complex needs. We looked at staff rotas and found that for the week from 16 June to 22 June 2014 57% of shifts had been below staffing numbers and that the majority of these shifts had only one qualified nurse on shift rather than two. The week of 9 June to 15 June 33% of shifts were below the required number of staff.

The junior doctors expressed concern about potential poor care at Juniper out of working hours due to limited nursing cover. This limitation had resulted in lack of qualified nurses to liaise with following an acute admission. On two occasions over the last two months, staff had been distressed due to being unable to contact the on-call

manager overnight. They also told us about their concerns over breaches in the European Working Time Directive (EWTD) when they did not get a six hour break after 48 hours of continuous duty. They told us that they had reported these concerns to management but were yet to receive a response. The trust subsequently provided us with details of how they had been able to address this issue.

We were told that there is no occupational therapist (OT) employed on the ward, although this post has been advertised. A member of the nursing team was tasked daily to carry out an activity programme. Although an activity programme covering seven days was displayed on the ward notice board, there was limited evidence that people were engaged in meaningful activities. We were told that an extra member of staff was available to work an 'OT shift' to cover activities. Rotas we looked at showed that a member of staff had been identified on the rota to do this on seven occasions since April.

We were concerned to find that a patient who had been recently re-admitted to the ward from another trust location had not had their risk assessment updated or reviewed since admission, nor was there a new care plan. In the records we reviewed we found that risk plans were not reviewed regularly and did not always reflect incidents that had occurred. We found that there was also limited evidence of active discharge planning.

Sandalwood Court – Applewood
Track record on safety

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. Staff had access to the trust safety alerts and resources on the intranet. Staff had access to a secure online reporting system used to report and record incidents. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an online electronic system to report and record incidents and near misses. Where serious incidents had happened we saw that investigations were carried out.

Learning from incidents and improving safety standards

We were told that the service used the trust 'IQ dashboard' system and risk register to identify and monitor risks. The

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trust held data on a wide range of safety processes. Staff were confident that they could use these processes and action would be taken to ensure that people who used the service were safe.

Investigations, incidents, safeguarding and staffing were standing agenda items for discussion at the weekly governance meeting. All learning points were fed back to staff through their team meetings or at one to one supervision, and action plans were put in place to improve safety.

Staff on Applewood ward told us about safety alerts that had been received and stated that they had been acted upon. However staff told us they would like more fire safety drills as these were not being facilitated at the time of our visit.

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

The unit had policies in place relating to safeguarding and whistleblowing procedures. Most staff had received their mandatory safeguarding training and knew about the relevant trust-wide policies relating to safeguarding. Safeguarding guidance was available to staff. We observed comprehensive discussion regarding safeguarding concerns during the focus groups we attended during this visit. Staff we spoke with were able to describe situations that would constitute abuse and relate these to their work. All staff spoken with told us that they were aware of the signs of abuse and demonstrated knowledge of how to report it.

The trust policies and procedures were accessible via the trust's intranet site.

Assessing and monitoring safety and risk

There were procedures in place to identify and manage risks to people who used the service. However we saw that observation practice under the national early warning scoring system (NEWS) were not being fully monitored in accordance with guidelines at Applewood ward.

Comprehensive risk assessments were carried out with people who use the service and these were formulated though to the care plans and reviewed regularly. We saw evidence that risks were managed positively. Effective handovers took place between the staff in order to share relevant information and maintain continuity and safety of care.

Staffing levels and skill mix were set and reviewed however we were told that staffing levels were not always sufficient on Applewood ward. This was said to be due to recruitment issues blamed on the recent trust restructure. This had meant that patients had been denied their section 17 leave. Staff and patients told us this was leading to high levels of patient stress.

There was a defibrillator on site, which was checked regularly. Staff were aware of an emergency procedure and where equipment was located.

We saw evidence that regular health and safety checks of the environment were undertaken and these included ligature checks and control of substances hazardous to health risk assessments.

Southmead - Oakwood
Track record on safety

Arrangements for reporting safety incidents and allegations of abuse were in place. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an online electronic system to report and record incidents and near misses. Where serious incidents had happened we saw that investigations and root cause analyses were carried out.

Learning from incidents and Improving safety standards

Learning had taken place from a recent serious incident on the ward. Operating procedures and staff practices had been reviewed with some changes made to reduce the likelihood of a similar serious incident. This has resulted in the observation practice of the ward being changed at night.

The provider shared learning from incidents elsewhere in the trust. Following an incident where a patient had gone absent without leave a new policy had been put in place. We were told that this had been discussed with staff in meetings. Staff we spoke with were aware of the contents of the policy. Recently the height of the external fence had been raised to reduce the risk of patients going absent without leave. We saw specific care plans for patients who had been assessed as a risk of going absent without leave. However we found that risk assessments were not always completed prior to a patient going on section 17 leave.

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

Systems were in place for keeping people safe and safeguarded from abuse. We saw that staff had completed training in safeguarding vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and knew how to raise any safeguarding concerns.

We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

We saw that sleeping areas for male and female patients were segregated with all bedrooms having ensuite toilet and shower facilities. The seclusion facility was located in the male sleeping area. Staff had identified the potential risks to safety and dignity with actions that were used to mitigate these risks if a female patient needed to be secluded.

People told us they felt safe on the ward and that staff intervened effectively if concerns were identified, for example in relation to the mixed sex environment. People told us they were able to lock their room, when risk assessed as appropriate, and had access to personal lockable space.

We noted that sharp items were not allowed on the ward for patient safety reasons. However we observed that drawing pins were used for notices in communal areas, the outside metal table was damaged leaving sharp edges, a broken pot remained outside with sharp edges, and pens had been left in the de-escalation area. We raised these potential risks to patient safety with staff on the day of our visit.

Assessing and monitoring safety and risk

We observed a nursing handover. We saw that this was well planned and organised with staff sharing relevant information about the patients to ensure continuity and safety of care. Staff spoke about patients with respect and demonstrated a good understanding of their needs and assessed risks. All staff were clearly allocated tasks for the shift ahead, in order to use their time effectively and ensure key tasks were completed.

Staffing levels and skill mix had been set by the trust under the safer staffing initiative. The number of more senior nurses had been increased to six for the ward to reflect the increased acuity of patients being admitted to the ward.

We were concerned that arrangements for medical cover on the ward were affecting patient care. The ward is covered by one consultant psychiatrist. We saw that due to shortages in medical cover 32 summaries, which must be sent to the patient's GP at discharge, had not been completed. One had been outstanding for two months before our visit. Staff told us that no doctor had been available to assess any patients who might have been admitted on two separate days recently. We saw that not all risk assessments had input from medical staff. We were told that when the consultant psychiatrist was away cover was provided by another consultant psychiatrist who could be located nine miles away. Medical staff had raised concerns about the level of medical staffing on the ward to senior managers of the trust but did not feel action had been taken or that they had been listened to.

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

Overall, we found that the trust needs to improve services to make sure they are effective.

People's needs, including physical health needs, were assessed and care and treatment was planned to meet them. Overall we saw good multidisciplinary working. However, people's knowledge and involvement in their care plans varied across the services.

Most staff had received their mandatory training but had been unable to access more specialist training. Overall, most staff had received regular supervision and appraisal.

Systems were in place to ensure that the service complied with the Mental Health Act (MHA). However, we found that staff did not always recognise and manage people's seclusion within the safeguards set out in the MHA Code of Practice.

We found that the environment and equipment in a number of units did not reflect good practice guidance and had an impact on people's safety, dignity or treatment.

Our findings

Callington Road – Lime and Silver Birch

Assessment and delivery of care and treatment

People's needs were assessed and care and treatment was planned to meet identified needs. People we spoke with were aware of their care plans and some said they had contributed to them. Care plans considered all aspects of the person's circumstances and were centred on them as an individual. They were regularly reviewed and updated to reflect changing needs.

We found good evidence of regular assessment of people's capacity to consent to their care and treatment. People were supported to make informed choices and decisions about their care and treatment and were able to access the independent advocacy service if needed.

We saw that people's physical health needs were identified. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward. Nurses and health care assistants

were completing baseline physical health checks on patients although this practice was inconsistent for some patients on Silver Birch ward. Any abnormal readings were reported to medical staff for further investigation. Staff told us and we saw from records that specialist healthcare could be accessed for patients when needed.

Outcomes for people using services

Some performance information, such as patient readmissions, was used to help improve the quality of the service. Staff had access to the trust's electronic IQ system that allowed them to look at their performance as a ward and compare that to other areas of the trust.

Staff, equipment and facilities

All staff received an induction programme when beginning employment with the trust. We saw that all staff had received their mandatory training. The majority of staff told us that they had been unable to access more specialist training.

We saw that most permanent staff had received regular supervision. Staff told us they found the supervision sessions helpful. Staff told us they had annual appraisals and most were clear about what was expected of them in their role and said they found their work rewarding.

All of the ward environments were clean and well maintained.

In the acute wards there were large garden areas that patients had access to. These contained a smoking shelter. All bedrooms had ensuite facilities and a separate lounge was available for men and women. Patients were able to get a cold or hot drink and healthy snacks between meals. The wards had their own laundry and patients were encouraged and supported to use these.

A wide range of activities were available on and off the ward for those who had section 17 leave. Information about these was displayed on the ward. People were positive about the activities available. One person said, "There are loads of really good groups and sessions."

Multi-disciplinary working

We saw good multi-disciplinary working, including daily ward meetings and weekly multi-disciplinary meetings to discuss patient care and treatment. There were effective handovers with the ward team at the beginning of each shift and a multidisciplinary review of each person was

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carried out each week which people were involved in if they chose. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved.

We noted that social workers were now working within the local authority and not based in the trust. We saw that staff from the trust were covering social care tasks in order to provide personalised comprehensive care for their patients.

Mental Health Act (MHA)
Good systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. Legal documentation was routinely scrutinised within the trust. We reviewed a sample of records for patients who were detained under the MHA. All paperwork was in place and in order. All treatment appeared to have been given under an appropriate legal authority. We saw good evidence of regular testing of capacity to consent. However improvement was needed in the recording of discussions with the Second Opinion Appointed Doctor (SOAD) by the statutory consultees and recording by the responsible clinician of the patient being informed of the outcome of the SOAD assessment.

We saw that staff had regularly explained their rights to detained patients. People we spoke with were aware of their rights under the MHA. A standardised system was in place for authorising and recording Section 17 leave of absence.

Fountain Way - Beechlydene
Assessment and delivery of care and treatment
Patients told us they were not always involved in the initial care planning but were aware of the care plans and reviews. They told us staff listened to them but they had to ask for support as one to one time was very dependent on staffing levels.

The care records we looked at showed that some care plans had not been completed and a patient told us that they had not been asked to sign a care plan and didn't know what it was. Documentation we looked at had not consistently been signed by patients. We noted that admission paperwork was not fully completed. Staff told us completing paperwork could take up to five hours of their shift. They expressed frustration about this saying they should spend that time with the patients.

Patients were reviewed regularly by the consultant and we saw documentation of this. We saw that close observation records were being kept for some patients and the ones we sampled were completed fully.

Outcomes for people using services
Staff said they didn't have time to engage as much as they wanted to with patients. The manager told about the lifestyle group which included bringing in professionals from other services to speak with people about topics such as sexual health, dental hygiene, healthy eating and food. We saw a timetable of activities but patients told us they don't always happen.

There was an occupational therapy department where we were told a lot of activity happened. Patients told us that lack of staff prevented them from accessing this on occasions. One patient told us that there were no activities at the weekend. They described this as having a negative impact on people's mental state because "at least in the week the ward is busy and you can watch what is happening. There's nothing to distract you from your illness at the weekends". On our return, we saw that activities had been timetabled for weekends.

Staff, equipment and facilities
Every staff member we spoke with on the ward said they really enjoyed working on the ward and with the patient group. Staff told us about the pressure they were under due to poor staffing and how this impacted on them receiving supervision. They told us they felt overwhelmed at times and the current managerial supervision arrangements were poor and ineffective as meetings were reliant on being able to leave the ward. Some staff expressed they did not feel supported through this supervision and sickness levels continued to rise as a result. However they described a weekly meeting with the psychologist during which they felt was very supportive and valuable to them in managing their stress levels.

Lack of staffing was identified as a concern both by patients, staff and the manager. Staff told us they did not have enough time to complete paperwork, engage effectively with patients on a one to one basis or take detained patients on escorted leave. Staff told us it was a regular occurrence that they did not get any breaks during the day. We observed staff were not always available for patients when they requested help.

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.

Patients told us they felt the staff were well trained and knowledgeable. Staff told us there was not enough training and some were out of date with mandatory training. One member of staff who had been working on the ward for several months told us they had not completed their mandatory training due to time pressures and access to the computer at work. Issues of travel and time were stated as barriers to accessing some training as face to face training occurred on other sites in the trust which were difficult to access. Training data supplied by the trust confirmed that there was poor compliance with mandatory training in this locality.

Multi-disciplinary working

We saw that community teams attended discharge planning meetings and patients told us this was really beneficial to them, making the process of leaving the ward feel safer. The consultant and medical staff were a regular presence on the ward and were present during our inspection. We observed good interaction between the ward staff and medical teams on the ward and visiting professionals from the community.

Staff told us the 24hour crisis team were very supportive and would come to the ward if they needed extra assistance out of hours or were managing the section 136 place of safety suite.

The psychologist visited weekly which patients told us was helpful to them. However they felt that one and a half days a week was not enough as it was such a beneficial service. There was an occupational therapist attached to the ward but we did not see them there during our first visit. On our return visit, we saw they were on the ward engaging with the patients.

Mental Health Act (MHA)

We sampled a proportion of the Mental Health Act paperwork for patients detained on the ward. The MHA scrutiny process was good. We identified some concerns including that statutory consultees were not always recording their discussion with the second opinion appointed doctor (SOAD) on the notes. When they did record their involvement they did not always include any detail of the actual discussion. Capacity and consent issues were also not always addressed,

We saw section 17 leave forms detailing escorted and unescorted leave and observed staff undertaking a short risk assessment before any leave was taken. We were however not able to see documented evidence of this.

Patients who were detained told us they were aware of their rights under the Mental Health Act.

We were informed about times when a lack of staff meant that detained patients were unable to take their escorted leave or had to wait a very long time. During our inspection, one person was made to wait for several hours for their leave. We raised this with the nurse in charge who agreed that this situation is unacceptable but informed us that they did not have enough staff to escort the person due to staff sickness.

We found out that special arrangements have been put in place for patients who are informal and wanted to leave the unit. An informal patient who has capacity should be able to leave the ward at any time. The ward had a process whereby the amount of leave is agreed with the doctor. We noticed that with one informal patient it said that they could have one hour escorted leave. One of the consultants confirmed the use of this process and said that this form had been agreed by the mental health legislation committee of the trust following on from the death of an informal patient from Beechlydene. We are concerned that this restrictive practice does not meet the guidance regarding the management of informal patients set out in the Mental Health Act code of Practice.

Patients detained under the Mental Health Act have a right to an independent mental health advocate. Providers are obliged to provide detained patients with information about and access to advocacy services. The advocate we spoke with expressed concerns about the staffs' knowledge about the advocacy services and so the availability of information for patients. Some of the patients and staff we spoke with knew of the service but did not understand what they were for. Others did not know anything about the service. There is training available within the trust about the service but it appears not to be as effective as it should be.

Of concern was the advocate informing us they felt that some medical staff had been obstructive to them in their role. Meeting times had been changed and ward reviews

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cancelled at the last minute without informing them despite the patient specifically requesting their attendance. This was put to the modern matron and ward manager during our visit.

Green Lane Hospital - Imber

Assessment and delivery of care and treatment

We found that staff assessed and planned care in line with the needs of the individual. We saw that care plans reflected the individual's needs and choices as far as possible. Service users were offered a copy of their care plan, people we spoke with confirmed this and that they had been involved in their reviews. Records showed that risks to physical health were identified and managed. However doctors told us they felt nurses required more training to help facilitate this.

Outcomes for people using services

The trust had a range of audit systems and performance targets in place which monitored team performance. However delayed discharges were clearly apparent. Staff told us this was mostly due to onward housing and bed availability. The Mental Capacity Act (MCA) was not clearly understood amongst nursing staff and advance directives were not evidenced.

Staff, equipment and facilities

The manager had an overview of mandatory training requirements for the team and most staff were found to be up to date. Some staff told us that opportunities for training and professional development other than core mandatory training had been reduced for more than twelve months. Doctors told us that nurses needed training in understanding and performing physical observations.

Multi-disciplinary working

There was evidence of effective multidisciplinary team working. People`s health, safety and welfare were protected when more than one provider was involved in their care and treatment. The multi-disciplinary team discussed all referrals and agreed a treatment plan with the individual.

Mental Health Act (MHA)

We reviewed a sample of case files for detained patients. Legal paperwork was in order. Staff told us that they had access to social workers to provide guidance on the Mental Health Act. The staff told us they did not clearly understand the Mental Capacity Act We noted that there was frequent discussion with patients regarding their rights under section 132 and found that patients were very involved with the planning of their care and medication.

Hillview Lodge - Sycamore

Assessment and delivery of care and treatment

Care plans were not consistently complete, up-to-date or personalised. This was consistent with our finding at our previous inspection in November 2013. In particular, we previously found that patients were not screened for nutritional risk and for those who had been identified as being at risk, monitoring of food and fluid intake was not adequate. The RCA report following a patient death in March 2014 reported that the patient had not had a nutritional screen undertaken. They had been identified as having risks related to self-neglect and controlling their food intake and were supposed to be subject to food and fluid monitoring but records to evidence this taking place were incomplete. It was concluded that a lack of adequate nutrition would have impacted on the patient's mental state and emotional vulnerability. An internal audit of compliance which was undertaken on Sycamore ward in May 2014 found that a nutrition screen had been completed for only one of four patient records selected. The trust told us that the audit had been repeated the week before our inspection and had improved to full compliance.

Care plans were not personalised, and did not express people's views and goals. We saw that one patient had been given a copy of care plan which related to their last period of admission. Other patients had care plans where sections had been lifted word for word from previous care plans. Two care plans were not signed and there was no reason recorded for this or evidence that the patients had been offered copies. We noted that one patient had a crisis plan dated 10 February 2014, which had been written at the time of a previous admission.

People were given opportunities to participate in structured and therapeutic activities, including one to one time with staff but we thought opportunities were limited. There was an activity programme displayed on the ward, which showed a range of activities arranged Monday to Saturday. Some activities took place off the ward, such as a weekly visit to Bath City Farm, facilitated by volunteers. There were no structured activities available on Sundays and some patients complained of boredom.

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.

We looked at activities provided over a four week period, including the week of our visit and noted that activities did not take place consistently every day. We also noted that there were few activities aimed at older people. The ward independent advocate told us patients had regularly complained about limited activities and limited access to one to one time with staff. We noted a negative comment from a patient who had recently completed the friends and family test. They said "there were not enough group activities or varied things to do, for example, sport." The ward did not routinely capture information on attendance/ take up of activities but provided us with some information for the four week period in question. This showed 24 to 30 attendances per week. The Mental Health Act Code of Practice states that boredom and lack of environmental stimulation is a factor which may contribute to disturbed behaviour.

Patients had access to psychological therapies and occupational therapy. Psychology services included individual psychological assessment and treatment, a regular compassionate mind group and arts psychotherapy. Several staff told us they thought that access to psychology was inadequate, although we were told that psychologist input to the ward had recently increased. Information was not available to show how accessible these services were or uptake of the services. We were told that 13 patients at the time of our visit had referrals to psychological therapies, with approximately four patients attending the compassionate mind group each month and five patients attending the arts psychotherapy group over the last two weeks.

Outcomes for people using services
Performance information was used by the local delivery unit to assess effectiveness and report performance to the board and to its commissioners. The trust used a performance dashboard known as the Integrated Quality (IQ) system which reported performance against a range of RAG rated local and national key performance indicators.

In the friends and family test the in-patient services had achieved scores of 13, 42 and 0 for March, April and May 2014 respectively (the range of possible scores is -100 to +100, where the more positive score the better).

Most of the national and local KPIs were met, with the exception of seven day follow-up to discharge, which was rated red.

The ward received few complaints. Three complaints were received from January to May 2014. Themes included insufficient notice of transfer to another area and attitude of staff.

Some audit had taken place. Audits included discharge planning standards, physical healthcare checks, legal scrutiny and nutritional screening. We were also provided with an audit programme for 2014/15.

Staff, equipment and facilities
Permanent staff were appropriately qualified and supervised. Training data showed that most staff had received recent supervision and an annual appraisal. We did not receive any information with regard to the training, supervision and appraisal status of temporary staff and therefore could not be assured of their competence.

The design and decoration of the ward did not support a therapeutic environment. We had previously reported a sterile and unwelcoming environment on the ward. Although some new furniture had been purchased and some artwork displayed, we saw little improvement in the environment. Staff told us that patients and visitors were not happy about the environment. This was supported by comments made in the friends and family test (FFT) in May 2014.

Prior to our inspection we received feedback from a patient who had recently stayed on the ward regarding a lack of privacy and a stressful and challenging environment. Patients also complained that bedrooms were too small and confined, and there was a lack of private space on the ward. Two out of six patients who completed feedback forms for us commented negatively on the environment. A visit by the trust's senior management team had recently commented on the visitors' seating area at the entrance to the ward which was felt to be to be unwelcoming. They also commented on "the tired appearance and cleanliness of the environment", which was consistent with our judgement.

Multi-disciplinary working
A weekly care pathway meeting took place attended by ward medical and nursing staff, psychology and representatives from community recovery and intensive services.

Are services effective?

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The ward staff reported good support from pharmacy, with regular visits from pharmacists or pharmacy technicians. Patients were able to access advice form a pharmacist about their medication and its effects.

Mental Health Act (MHA)

We met with two detained patients in private and looked at their detention records. Paperwork was in place and detention appeared lawful. We noted one error on a transfer authorisation form which was incorrectly dated. This was forwarded for correction by the MHA administrator.

Both patients had had their rights explained to them and this had been repeated in accordance with section 132 of the MHA. Medication was covered by consent to treatment certificates which were in order. Section 17 leave forms were clearly set out and one of the two forms was signed by the patient. For the second patient there was no evidence that they had been offered a copy of their leave form.

Longfox unit - Juniper

Assessment and delivery of care and treatment

Care plans were generally in place but were not always updated and did not always evidence patients' involvement. We were also concerned to find that a patient who had been recently re-admitted to the ward from another trust location had not had their risk assessment updated or reviewed since admission, nor was there a new care plan. In the records we reviewed we found that risk plans were not reviewed regularly and did not always reflect incidents that had occurred. We found that there was also limited evidence of active discharge planning.

We saw that physical health problems were identified and treated appropriately and staff carried out regular monitoring of basic observations such as blood pressure, temperature and weight. However it was also reported to us by both staff and patients that the pathway into acute care for patients requiring treatment for physical care was unclear and difficult to access.

We were concerned to find that leave beds were being used to accommodate additional patients taking the ward numbers above the number of beds actually available. Staff told us that six current patients were from other areas covered by the trust and outside the immediate locality such as Bristol.

Outcomes for people using services

Staff had access to the trust's electronic IQ system that allowed them to look at their performance as a ward and compare that to other areas of the trust. We met with the local governance facilitator who told us about a range of measures being developed to consider patients outcomes.

We were told that there is no occupational therapist (OT) employed on the ward, although this post has been advertised. A member of the nursing team was tasked daily to carry out an activity programme. Although an activity programme covering seven days was displayed on the ward notice board, there was limited evidence that people were engaged in meaningful activities. We were told that an extra member of staff was available to work an 'OT shift' to cover activities. Rotas we looked at showed that a member of staff had been identified on the rota to do this on seven occasions since April.

The ward had access to a gym and we were told that this is regularly used. We saw one member of staff playing a game of table tennis with a patient but this was the extent of the activities for the morning we were on the ward.

Staff, equipment and facilities

Staff told us they were able to attend a reflective group facilitated by the clinical psychologist which was highly valued. Students on the ward said they felt well supported. Appraisals were found to be up to date as was all mandatory training. Duty rotas had been written up to the end of July.

The ward environment was not satisfactory. Some of the walls and doors were in need of redecoration. It was identified during a Mental Health Act visit in December 2013 that the seclusion suite was not cleaned to a satisfactory standard. Although this area has now been added to the cleaning schedule, the toilet and wash hand basin were dirty and the ceiling in the toilet was water marked. In the main lounge the wall behind the door was damaged. In the dining room, the water boiler was noted as out of order. All the radiator covers were unclean and the walls above the radiator were dirty. This was also identified during the MHA visit and had not been addressed. We found that the radiator cover in the female bathroom was not attached to the wall. The bedroom doors were fitted with a clear glass panel for observation and not all were fitted with a means of ensuring that people's privacy and dignity was respected.

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.

We found that some communal areas were drab and institutional. The modern matron told us they had involved patients in painting some areas of the ward. One area was the patient lounge. Whilst this room had been painted it had no pictures on the walls, no curtains and felt bare and institutional. The modern matron acknowledged that improvements could be made to the environment.

We found a number of safety issues relating to the environment including potential ligature points and unclear fire management procedures. We were also concerned that the layout of the unit did not facilitate clear gender separation or easy observation of patients. These are detailed within the safety domain of this report.

Multi-disciplinary working

We saw multidisciplinary working on the ward, including weekly multi-disciplinary meetings to discuss patient care and treatment.

Mental Health Act (MHA)

Overall the Mental Health Act documentation was in good order. However, we were concerned about the recording of leave taken under section 17. For six patients reviewed four records had not been comprehensively completed and did not reflect the recording on the electronic record This was previously highlighted at the most recent Mental Health Act monitoring visit in December 2013. On reviewing the AWOL (absence without leave) records, we were concerned to find that for each of last three months, there was on average five instances of patients going AWOL from the ward.

In the patient records we reviewed, assessments of a patients capacity to consent to treatment was carried out at regular intervals and there was evidence that patients were regularly presented with their rights under the Mental Health Act. This included their right to an independent mental health advocate (IMHA).

Sandalwood Court – Applewood
Assessment and delivery of care and treatment

We found that staff assessed and planned care in line with the needs of the individual. We saw that care plans reflected the individuals person`s needs and choices as far as possible. Service users were offered a copy of their care plan and were given full involvement with both their care and medication. The patients we spoke with confirmed this and that they had been involved in their reviews. All care plans seen were patient focused and patient lead. We saw evidence of advance directives in place. Records showed that risks to physical health were identified and managed. Good usage of advance patient directives was apparent.

Outcomes for people using services

The trust had a range of audit systems and performance targets in place which monitored team performance. The team worked closely with both the memory and psychological services to provide comprehensive assessment and psychological interventions.

Multi-disciplinary working

There was evidence of effective multi-disciplinary team working. People`s health, safety and welfare were protected when more than one provider was involved in their care and treatment. The multidisciplinary team discussed all referrals and agreed a treatment plan with the individual.

Staff told us that they worked collaboratively with other professionals, for example, the wards and other community mental health teams, using the care programme approach process.

Staff, equipment and facilities

There were good staff interactions with patients and staff attitudes were good. Patients had good access to advocacy and were treated with respect and compassion. However staff told us that section 17 leave was not always granted due to staff shortages.

The manager had an overview of training mandatory requirements for the team and most staff were up to date. The manager told us that all staff were released for personal and professional development training and said that the staff all had training opportunities which were identified and discussed through supervision. Staff confirmed that they received regular clinical and management supervision and we saw some supervision records. Some staff told us that opportunities for training and professional development other than core mandatory training had been reduced for more than 12 moths.

Staff told us that they had reported difficulties that they experienced with the computer system crashing but it was still a frequent issue.

Mental Health Act (MHA)

We reviewed a sample of case files for detained patients. Legal paperwork was in order. We noted that there was

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frequent discussion with patients regarding their rights under section 132 and found that patients were very involved with the planning of their care and medication. However we found that section 17 leave was not always granted as authorised.

Southmead - Oakwood

Assessment and delivery of care and treatment

People's needs were assessed and care and treatment was planned to meet identified needs. People we spoke with were aware of their care plans and some said they had contributed to them. Care plans considered all aspects of the person's circumstances and were centred on them as an individual. They were regularly reviewed and updated to reflect changing needs.

A range of activities were available on and off the ward for those who had section 17 leave. Information about these was displayed on the ward.

We saw that people's physical health needs were assessed regularly. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward. Nurses and health care assistants were completing baseline physical health checks on patients weekly and time had been set aside for this. Any abnormal readings were reported to medical staff for further investigation. A senior nurse had been identified as the lead for physical health for the ward to ensure standards were met. Staff told us and we saw from records that specialist healthcare could be accessed for patients when needed.

Outcomes for people using services

Some performance information, such as patient readmissions, was used to help improve the quality of the service. Staff had access to the trust's electronic IQ system that allowed them to look at their performance as a ward and compare that to other areas of the trust.

Staff, equipment and facilities

All staff received an induction programme when beginning employment with the trust. We saw that all staff had received their mandatory training. Some staff told us they found the e-learning courses less useful and found it difficult to find the time to complete these when working on shift. Staff told us that the matrix containing information about which staff had received which training was emailed to them so they could check for accuracy and also be aware of training they still had to complete. Staff told us that they had been unable to access more specialist training.

We saw that all staff currently working on the ward had received regular supervision. Some supervision sessions were on a group basis. Staff told us they found the supervision sessions helpful, and that they felt able to raise any issues and were supported by these.

The ward environment was clean, although staff told us there had been some consistency issues recently as one member of cleaning staff was off sick. This was being discussed with the provider of the cleaning services. There was a large garden area that patients had access to. This contained a smoking shelter. All bedrooms had ensuite facilities and a separate lounge was available for men and women. Patients were able to get a cold or hot drink and healthy snacks between meals. People told us the food was generally good. The ward had its own laundry and patients were encouraged and supported to use this.

Multi-disciplinary working

We saw multidisciplinary working on the ward, including weekly multi-disciplinary meetings to discuss patient care and treatment. This was however limited by a lack of psychology input to the ward and reduced medical cover. We noted that social workers were now working within the local authority and not based in the trust. We saw staff from the trust were covering traditional social work tasks in order to provide personalised comprehensive care for their patients.

There was proactive engagement with other health bodies to co-ordinate care and meet people's needs. Examples include close work with dieticians and the local acute healthcare provider.

Mental Health Act (MHA)

Good systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. Legal documentation was routinely scrutinised within the trust. We reviewed a sample of records for patients who were detained under the MHA. Paperwork was in place an all appeared in order. All treatment appeared to have been

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given under an appropriate legal authority. However improvement was needed in the recording of the discussion about and person's capacity to consent to treatment.

We saw that staff had regularly explained their rights to detained patients. People we spoke with were aware of their rights under the MHA.

A standardised system was in place for authorising and recording section 17 leave of absence. An assessment of risk however was not always completed prior to the patient going on leave.

The door to the ward was locked. There was no information displayed for patients and visitors on how to enter and leave the ward. This was raised with staff and was rectified on the day of our visit.

Are services caring?

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

Summary of findings

Overall, we saw that staff were kind, caring and responsive to people and were skilled in the delivery of care.

We observed staff treating patients with respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments.

People we spoke with were mainly positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them.

Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed.

Our findings

Callington Road – Lime and Silver Birch
Kindness, dignity and respect

Staff appeared kind with a caring compassionate attitude. They put a significant effort into treating patients with dignity. We observed staff treating patients with respect and communicating effectively with them. Generally people we spoke with were very positive about the staff. One person said, "It's brilliant here. Everyone is so helpful and caring". Another person said "They treat me with respect. They make me feel at ease". However some people were concerned at the lack of time staff had to spend with them. One person said, "There are so many really good nurses, but they are so busy, you can't see them". Another said, "Protected time doesn't happen, there's not enough staff". We were however told of one individual who had been quite blunt towards a person who uses the service. We were informed that this had been escalated up as an incident, indicating that the trust does not tolerate disrespectful attitudes from staff towards people who use the service.

People using services involvement

People we spoke with told us they were involved in their care and treatment. They were aware of their care plans and were able to take part in the regular reviews of their care. One person said, "The ward rounds are put on a chart so you know when yours is coming up. All the changes are written up and I sign my care plan." Patients were given a copy of their care plans unless they refused this. We saw evidence that some people had the opportunity to input their own requests into their CPA report. In addition on one unit we saw that each patient held a personal care folder in their room which, people we spoke with about it, said they valued and were fully aware of its contents. We were shown one and saw it contained essential information including their care plan, signed care agreement, information about the unit, and their therapy sheet together with contact details of the advocacy service and PALS and MHA information with a list of solicitors able to provide MHA advice.

People we spoke with were able to discuss their medication and its use. Patient information leaflets about the range of medications were available. One person said, "I know all my meds and have information on them, they're good like that".

Staff we spoke with were aware of the need to respect confidentiality at all times and we saw that the units had a number of rooms available for private consultations.

Patients had access to advocacy including an independent mental health advocate (IMHA) and there was information on the notice boards on how to access this service.

Emotional support for care and treatment

Everyone we spoke with told us that they had regular one to one time with their key workers and knew who to go to if they had any concerns or questions about their treatment. People told us the staff listened to them. One person said "They try and find out ways of helping us, they try and motivate me and they are always supportive". We saw evidence that carers also appreciated the support provided by staff and noted the comments in a recent letter of thanks received. 'How well you liaised with us and took our feelings and comments on board and involved us in our relative's treatment. We always felt you were there to listen to any concerns and give us reassurance and advice'.

Are services caring?

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

People were supported to manage their own care and maintain their independence. There was a programme of activities which included art therapy, exercise groups, drug and alcohol sessions and occupational activities.

Visitors to the ward were encouraged and information on visiting times was displayed. Where necessary visiting times were arranged at a time to suit them.

Fountain Way - Beechlydene
Kindness, dignity and respect
Staff we spoke with showed they were caring and respectful towards patients and demonstrated their knowledge that decisions made during admission could have a significant impact on the patient's experience of the ward. They showed the desire to provide high quality care despite the challenges of staffing levels.

Patients told us the staff were very good and always tried to be helpful. We observed staff behaving in a supportive manner towards patients during our inspection.

People using services involvement
Patients told us they were not always involved in the initial care planning but were aware of the care plans and reviews. They told us staff listened to them but had to ask as one to one time was very dependent on staffing levels. The care records we looked at showed that some care plans had not been completed and one patient told us that they had not been asked to sign a care plan and didn't know what it was.

We looked at records and found that in some cases ongoing care planning and reviews were not consistently involving patients. This was confirmed by both staff and patients. Staff told us they did not like having to do this but it did happen sometimes due to the time pressure.

There were daily meetings on the ward for patients. The manager told us these were implemented to assist patients to raise concerns, to arrange to see medical staff and to help people know what activities and events were happening that day. Patients told us these meetings were happening regularly however they did say that issues they raised were not always dealt with. An example of these were when objects on the ward were broken and needed replacing. One patient commented things are more likely to happen from the meetings if it doesn't cost money.

Emotional support for care and treatment
Patients told us that staff do listen to them in one to one sessions and generally around the ward. The patients we spoke with felt supported by their named nurse and the carers. However patients did say that they felt that the staff appeared stressed and needed to be supported more by the senior management.

We saw that patients' families were able to visit. We noted a comment that it often took a long time to gain access to the ward even if there were staff visible in the nurses' station. We experienced this during our inspection. On our return visit, we saw that administration staff had been allocated to be at the nurse's station every day.

Green Lane Hospital - Imber
Kindness, dignity and respect
People using the services told us they were treated with dignity and respect and did not raise concerns about how staff treated them. We observed staff discussing people in a caring and respectful manner.

However we found that patient's privacy and dignity was being compromised due to a bathroom window facing a playing field having clear glass and no curtains opposite a playing field.

People using services involvement
Detailed information packs were given to service users and carers. We saw a range of information available in the waiting area. This includes accessible information about the service available to them and the range of needs the service supports. We saw that patients also had good access to advocacy including independent mental health advocates (IMHA).

There was evidence that carers were involved where possible. The team undertook carer`s assessment and carers we spoke with confirmed that they get care and support from the team.

Emotional support for care and treatment
Service users we spoke with were generally positive that they received the support they needed and were involved with their care. Staff told us that people's carers were involved in their assessment and care, and the carers we spoke with confirmed this. People who use the service were sent a letter clearly outlining the outcome of their assessment and the agreed plan. However there was a lack of appointments for care co-ordinators which was leading to delays in patient discharges. We also received a written

Are services caring?

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complaint from a patient on the ward stating that there was not enough one to one time to discuss issues. Another patient told us that activities were very limited or tended to stop at weekends.

Hillview Lodge - Sycamore
Kindness, dignity and respect

All of the patients we spoke with during our inspection described the staff as caring, friendly and understanding. However prior to our inspection we received feedback from a patient who had recently stayed on the ward. They told us that while some staff were caring and understanding some could be patronising.

All patients had their own bedrooms, in which they had access to a lockable space so that staff could observe them discretely without disturbing them. We noted that some of the bedrooms occupied by women were overlooked by the garden/courtyard areas, accessed to men and women, and their privacy could not be maintained unless they drew the curtains.

We saw a female patient wandering along the corridor in her underwear, in full view of male patients. She remained unnoticed in this undignified state by staff for several minutes before we drew it to their attention. Staff then acted quickly to assist her.

During our previous visit to Sycamore ward in November 2013, patients and visitors complained about the lack of private space to meet. This continued to be a problem. There was a quiet room, but this was a very confined space which people did not like. It was also cold and unwelcoming. A visitor told us "it is often hard to talk in private and the ward is sometimes so loud". There was a family room located in the same building but off the ward, which could be booked for meetings with visitors. However staff told us this was not always available and was not practical for those patients who needed to be supervised.

At our previous visit we also raised concerns that patients could not use the pay phone in private as this was located in the corridor. This was still the case. A staff member told us that a mobile phone had been made available but this had been broken and not replaced. Staff assured us that patients were allowed to use an office phone if they needed to contact family members or their solicitor. However patients told us that this did not always happen.

People using services involvement

Patients told us they were shown around the ward on admission and introduced to staff. There was a picture board at the entrance to the ward showing photographs of ward staff. There was a ward information booklet which described the facilities on the ward. There was also a range of information on mental health issues and services. There were regular visits from mental health advocacy services and this service was publicised on the ward. The trust's patient advice and liaison service (PALS) was also publicised and patients knew how to complain. Most of the patients we spoke with had copies or had been offered copies of their care plan and had signed them to indicate their agreement with the contents.

Most of the patients we spoke with understood the reason for their admission, any restrictions which applied and their rights to appeal against these restrictions. The ward was locked and entrance to and exit from the ward was strictly controlled. Patients whose admission was informal were able to leave the ward with assistance from staff and there was a notice on the ward to advise them of this right.

Patients attended weekly reviews of their care, although some reported that they found this to be a frightening or intimidating experience due to the number of people present at these meetings. There were regular ward (community) meetings where patients could discuss their views about the ward. There was a service user engagement officer who facilitated monthly meetings where patients and carer representatives could provide feedback on services.

Emotional support for care and treatment

We attended a carers' event and carers were mainly positive about the efforts the trust was making to listen to their views. However visitors' we spoke with on the ward and over the telephone were not so positive. One carer told us that staff were rude and dismissive of their views and their desire to be actively involved in their relative's care. Another carer told us they had limited opportunities to speak with staff and felt their views were not listened to. They also complained about the lack of private space to meet their relative.

Longfox unit - Juniper
Kindness, dignity and respect

We observed staff interacting with patients in Juniper ward. These interactions were seen to be sensitive, timely and

Are services caring?

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appropriate. One patient on the ward described his care by staff as very supportive and that his wishes were being listened to compared to the rehabilitation unit he had just left.

We found that the sleeping areas on the ward were segregated with separate corridors for male and female bedrooms however a social area with a pool table was located next to the entrance to the female bedroom area. We observed this area was mostly occupied by male patients which meant vulnerable female patients had to walk past this area to access their bedroom and lounge areas. During the visit, we observed a male patient entering the female bed area. He was unchallenged because there was no staff presence. Nursing staff in the office had to be alerted by the inspection team.

The bedroom doors were fitted with a clear glass panel for observation and not all were fitted with a means of ensuring that people's privacy and dignity was respected. Some female bedrooms were shared occupancy with only a curtain for privacy. Staff told us that the shared rooms compromised privacy and dignity and that female patients often complained of being affected by their roommate's mental distress.

We found that some communal areas were drab and institutional. The modern matron told us they had involved patients in painting some areas of the ward. One area was the patient lounge. Whilst this room had been painted it had no pictures on the walls, no curtains and felt bare and institutional. The modern matron acknowledged that improvements could be made to the environment.

People using services involvement

Members of staff informed us that community meetings take place twice a week. However, the minutes of these meeting were not on display in a communal area. When we reviewed the folder for these minutes, there was one set of minutes for a meeting held the day prior to our visit. There was no evidence that regular meetings are held.

The ward is included in the friends and family test. We found detailed information regarding this displayed in the ward which indicated a good level of patient and carer satisfaction.

The ward has information packs and leaflets available for patients.

Emotional support for care and treatment

Patients we spoke with were positive about the staff team and consistently described them as caring. Patients told us they felt safe.

However, the junior doctors expressed concern about potential poor care at Juniper out of working hours due to limited nursing cover. This limitation had resulted in lack of qualified nurses to liaise with following an acute admission. On two occasions over the last two months, staff had been distressed due to being unable to contact the on-call manager overnight.

Sandalwood Court – Applewood

Kindness, dignity and respect

We saw good staff interactions with patients. Staff attitudes were good and patients were being treated with compassion and respect. We observed all staff discussing people in a caring and respectful manner. People using the service told us they were treated with dignity and respect and did not raise concerns about how staff treated them.

A patient told us that meal portion sizes could be on the small side depending on which member of staff was serving them.

People using services involvement

All care plans seen were patient focused and patient led. We saw evidence of advance directives in place.

Detailed information packs were given to service users and carers. We saw a range of information available in the waiting area. There was evidence that carers were involved where possible. The team undertook carer`s assessment and carers we spoke with confirmed that they get care and support from the team. The passion of the staff was clear.

Emotional support for care and treatment

Service users we spoke with were generally positive that they received the support they needed. Staff told us that people's carers were involved in their assessment and care. Carers we spoke with confirmed this. People who use the service were sent a letter clearly outlining outcome of assessment and agreed plan.

Southmead - Oakwood

Kindness, dignity and respect

Staff appeared kind with a caring compassionate attitude. We observed staff treating patients with respect and communicating effectively with them. People we spoke

Are services caring?

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

with were very positive about the staff. One person said, "They are brilliant". Another person told us that staff were very helpful and that they trusted them but would like more time with them as they were so busy.

Staff did put a significant effort into treating patients with dignity. For example, they knocked before entering a bedroom. However the patient status board in the nursing office that included details of the patient's MHA status could be observed from outside the office by other patients and visitors. This was raised with staff on the day of our visit.

People using services involvement

People we spoke with told us they were involved in their care and treatment. They were aware of their care plans and were able to take part in the regular reviews of their care. Patients were given a copy of their care plans unless they refused this.

People we spoke with were able to discuss their medication and its use. Patient information leaflets about the range of medications were available.

Patients had access to advocacy including an independent mental health advocate (IMHA) and there was information on the notice boards on how to access this service.

Emotional support for care and treatment

Visitors to the ward were encouraged and information on visiting times was displayed. Where necessary visiting times were arranged at a time to suit them. There was a private space for visits. This room could be accessed directly by vulnerable adults or children without having to come into the entrance area for the ward. Some toys were available for children who visited.

People were supported to maintain their independence. There was a programme of activities that included exercise groups and occupational activities. People were supported to do their own laundry and to shop for personal items.

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

Overall, we found that improvements are needed to the responsiveness of this trust.

The availability of beds appeared to be a trust-wide issue, with acute care beds always in demand. Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However, a lack of available beds meant that occasionally people may have been discharged early or managed within an inappropriate service.

We also found that bed availability had an impact on people being treated within their local area. Some people told us that they had been moved during their care, which had an impact on their recovery.

We found that both staff and patients knew how to make a complaint and many were positive about the response they received.

Our findings

Callington Road – Lime and Silver Birch
Planning and delivery of services
We were told that referrals were taken from a number of health and social care providers, both within primary care services and secondary mental health services. Staff reported it was difficult to find a local bed if a person needed to be admitted to hospital.

Right care at the right time
Bed availability appeared to be a trust-wide issue with acute psychiatric beds always in demand. On the day of our visit three acute beds allocated to a patient on section 17 leave were being used by another patient. Staff told us this was a common occurrence.

Care Pathway
Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However staff told us that bed availability in the intensive care units meant that there had been delays on occasion in transferring a patient who needed intensive care. We were told that moving people back from beds provided outside the trust was a priority. We observed that one patient was transferred to Silver Birch Ward from a non NHS mental

health provider at 00.20 hours due to a delay in accessing patient transport. This was potentially disruptive to the patient concerned and others on the ward. Staff told us that at times the transfer process does not get completed fully due to the amount of transfers taking place.

Once ready for discharge people moved to one of a range of settings within the community, depending on their needs and preferences, including residential care, supported housing and independent living. Discharge plans were clearly discussed with people who use the service. Arrangements for discharge were also discussed and planned with other involved care providers.

We saw that the chaplain visited weekly and additional chaplaincy and spiritual care was provided when requested. The service responded to individual's spiritual and cultural needs. We saw that menus took account of people's dietary, cultural and religious needs. One person told us, "I have special food and they do a good job bringing it in."

Learning from concerns and complaints
Information about the complaints process was clearly displayed in the wards with leaflets available for patients or visitors to take away and read privately. People we spoke with knew how to make a complaint and said that they felt able to talk to staff if they had a concern. Staff we spoke with were aware of the trust's complaint policy. Staff knew the process for receiving complaints and told us that learning took place in their staff meetings. We saw that new complaints were regularly discussed at the matrons and ward managers meetings each week and the trust board continued to hear complaints at public meetings. People we spoke with told us they felt able to raise any concerns in the community meetings and that they felt listened to.

Fountain Way - Beechlydene
Planning and delivering services
The manager told us the average length of stay on the ward was four weeks. Staff and patients told us the ward was always busy with new patients being admitted seemingly daily. Patients did not express any concerns about this affecting their care, but did express concern for the staff with such high stress levels. The staff were adaptable and flexible to the demands of the ward. They had a positive working relationship with other services both allied to the ward and community based. This helped with efficient discharge process. The ward has a very positive working relationship with the other wards onsite, the crisis team

Are services responsive to people's needs?

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

and local community services. Patients told us they felt the ward worked well with the community teams to help during the discharge process. Bed availability appears to be a trust-wide issue.

Right care at the right time

Bed availability appears to be a trust-wide issue. Staff told us they occasionally had to admit people in beds where the patient is on leave. One person described it as a "juggling act" and said "you are always worried that if the person on leave needs to come back, you haven't got a bed for them".

During our inspection, several senior staff spoke about the challenges posed by the geographical area of the trust. They told us that patients are often long distances away from their home area due to bed availability and this impacted on the care provided and the potential for families to visit. It is worth noting that throughout the discussion, repatriating people to the home area was stressed as a high priority.

The ward is also the designated place for people aged 16 to 18 years needing acute admission following crisis in the community. We were told that these patients are moved into children's service beds as soon as possible, usually within 24 hours. The modern matron told us about a young person who had spent four days on the acute ward waiting for a bed to become available in the children's service, which is provided by a different organisation. We were told this was over a bank holiday weekend. They acknowledged that it is a problem but not a common occurrence. This meant that, due to the delay, young and vulnerable patients were not always being cared for in the best possible environment to meet their needs.

Care Pathway

The ward worked with other services to provide all aspects of care. These included social services, psychological therapies, physiotherapy, occupational therapy, community teams and the crisis team. Together they worked with the patient towards discharge from early on in the patient's admission. One patient told us the team began planning discharge within days of being admitted. They told us that although this relieved the fear of being stuck in the ward for a long time, it was too early for them as they knew they needed treatment and felt like the ward was trying to get rid of them quickly.

Ward rounds happen regularly to review care, and medical staff were available daily to assist staff to overcome any challenges that arose.

Learning from concerns and complaints

Patients told us they knew to speak to the staff if they were not happy with anything. The morning meeting was a means of expressing their views, although some patients did not feel comfortable speaking out. Staff told us they know how to support patients and their relatives to make complaints. We found staff and patients to be very open with their views throughout the inspection.

Medical staff told us in a focus group that the delay in incident investigation was a concern to them and that reporting systems were not robust enough to protect patients from harm. We saw evidence of incident reporting of risks not being addressed and the same incidents recurring frequently, placing both patients and staff at risk. On our return visit, we saw that a system had been put in place to address this. We could not say how effective this was as it had only just begun to be used.

Green Lane Hospital - Imber
Planning and delivering services

We were told that referrals were taken from a number of health and social care providers, both within primary care services and secondary mental health services. Staff reported it was difficult to find a local bed if a person needed to be admitted to hospital.

Right care at the right time

Bed availability appears to be a trust-wide issue meaning patients could frequently be moved from ward to ward. We were told by doctors and staff that there had been issues with night-time admissions, particularly when patients had been admitted after midnight, which was not in the patient's best interest. We were also informed of delays in completing Mental Health Act Assessments due to a lack of bed availability.

Care Pathway

Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However staff told us that bed availability had meant that there had been delays on occasion in transferring a patient who needed intensive care.

Staff told us they felt under pressure to discharge patients early due to other patients in the community needing an acute psychiatric bed.

Are services responsive to people's needs?

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

Learning from concerns and complaints

Information about the complaints process was given when people first started working with the service. We found that the ward manager actively encouraged. People who use the service told us that they knew how to make a complaint and felt able to do so if they needed to. There were patient satisfaction audits and a "You Said We Did" board. There were systems in place to learn from complaints and we saw evidence that this had resulted in changes in practice.

Hillview Lodge - Sycamore
Planning and delivering services

The provider failed to deliver services that were responsive to the different needs of people served. Some people did not receive care as close as possible to their home because beds were not available on the appropriate ward. Staff reported concerns about the high level of out of area admissions. This meant that patients were sometimes admitted to a ward which was not close to their home, their friends and their family. This usually meant that they were subsequently transferred or repatriated, which was sometimes disruptive to the continuity of their care.

We were told that between 4 November 2013 and 9 June 2014 only 54 out of 121 admissions were local patients. A person who had recently stayed on Sycamore ward told us that they had been admitted to a hospital in Bristol for two days because a bed was not available in Bath. They were subsequently moved to Sycamore ward and found this to be upsetting and disruptive to their care. A complaint had recently been received from a patient who had been repatriated to their area of residence with only 30 minutes' notice and they felt this had set their recovery back. One current patient had been transferred twice and was still out of area.

A staff member employed in the complex intervention team (CIT) for older people in BaNES told us that they spent a lot of time trying to find appropriate in-patient beds for older people because provision in Bath was inadequate. They told us that patients were sometimes admitted to units as far away as Weston Super Mare.

Staff were also concerned about the appropriateness of older people being cared for on Sycamore Ward, because their specific needs could not be met on a ward primarily for adults of working age with acute mental illness. They told us that older patients, some of whom were very frail with limited mobility, were sometimes intimidated by younger adults and could become isolated. We noted that there were few age appropriate activities for older people and the environment did not adequately support people who may have age related impairments such as mobility, vision and hearing. We observed there to be a mix of younger and older adults during our visit.

The environment in which patients received care was unsuitable. We had raised concerns that the premises were not fit for purpose at our last visit. The trust had accepted these concerns and was actively engaged in securing finances and authority to re-provide the service. In the short term they had committed to making improvements to the environment. This had included the provision of some new furniture and art work. We thought that the artwork was positive step and we received positive comments from patients and visitors about the pictures. The ward remained a neglected and unwelcoming environment. It was poorly maintained and the poor lighting, tired décor and furnishings did not support a therapeutic environment. Although some new furniture had been purchased and some artwork displayed, we saw little improvement in the environment.

Two out of six patients who completed feedback forms for us commented negatively on the environment and most of the patients and carers we spoke with commented negatively about the environment.

Bedroom, toilet and bathroom accommodation was arranged so that male and female patients were accommodated in separate corridors. There was also a separate lounge for women only. However, we were concerned that people's privacy and dignity was at times compromised. There were three rooms, known as 'swing rooms' which could accommodate either gender depending on the demand for the accommodation. At the time of our visit these rooms were occupied by female patients. Bedrooms did not have en-suite facilities so in order to access the toilet or bathroom in the female section of the ward women had to walk through the communal area of the ward, occupied by men and women. Staff told us that this was explained to patients when they were admitted to these rooms and if they objected, staff would make every effort to move them when an appropriate room became available. However, these three rooms were also designated as 'anti ligature' for the use of vulnerable patients who were at risk of self-harm. Staff told us that this

Are services responsive to people's needs?

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risk would outweigh that somebody's privacy and dignity was compromised. The use of this accommodation for female patients does not meet the MHA code of practice or department of health guidance.

Access to outside space was limited. The garden was primarily used by smokers and was strewn with cigarette ends. A staff member told us that they regularly swept this area but we saw no evidence of this. There was evidence that a wall mounted receptacle for cigarette ends had been removed and not replaced. This was what we had found in November 2013 and had not been acted upon.

Access to the outside space was via the garden room, which remained an unofficial smoking area for people who did not want to go outside. Smoking indoors was not adequately monitored or controlled. As a result, the garden room often smelled of smoke and deterred people from using it for any purpose other than to smoke. There were plans to move the beverage station to this room to make it a more sociable 'café style' space and to provide some more soft furnishings however the smoking issue had not been resolved and this environment remained unacceptable. We were told that a smoking cessation officer visited the ward for several hours per day to encourage and support patients with their smoking and that smoking care plans had been developed. We were also told that areas of the ward frequently used by smokers were subject to ten minute observations. Despite this we saw evidence throughout our visit that patients were smoking on the premises.

Staff told us that patients were encouraged to care for themselves and engage in daily activities such as making themselves drinks and snacks, cleaning their bedrooms and doing their own laundry. There was a laundry room on the ward, although one of the machines was out of order and had been for a few days. This was also the position when we last visited.

The beverage station was unclean. Although there were notices reminding people to clean up after themselves, invariably they did not. The sink and surround were grimy and the cupboard under the sink was being used to store crockery, which we felt was inappropriate and unhygienic. We saw evidence that the fridge temperature had been monitored regularly but it was not adequately clean.

Toilets and bathrooms were also not maintained to an acceptable standard. On the first day of our visit the toilet in the female shower room was out of order. The cleaner told us it had been out of use for a few days. There was no notice in place to prevent its use. A patient told us there were no plugs in the sinks or baths. We found two bins in female bathrooms, overflowing with sanitary products. Twice we were told by staff that they would attend to these but this did not happen and the bins remained full the following day. We spoke with a cleaner about this who told us that it was not their responsibility and that contractors emptied these bins approximately every three months. A senior ward staff member told us that the receptionist could arrange for the bins to be emptied but there seemed to be no ownership of the problem.

Patients were provided with a choice of food and drink. There was a rolling menu with several choices of hot and cold food, including vegetarian option. Fresh fruit and drinks were available for people to help themselves. Staff told us that the needs of patients with special dietary requirements could be met.

Right care at the right time

Prior to our inspection we received feedback from a patient who had recently stayed on Sycamore Ward. They told us they did not feel that that the service was responsive to their needs. They thought this was partly due to workload and partly due to staff attitude.

Care Pathway

There was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services. The ward team worked closely with both intensive services and recovery teams to ensure continuity of care when patients were discharged from hospital. However some staff expressed concerns about patients from out of area who received few visits from their care coordinator. A staff member told us that one patient from North Wiltshire had been an in-patient for seven weeks and had received only one visit from their care coordinator.

Learning from concerns and complaints

Patients were given information which told them how to complain about the service. This was contained within the ward information booklet and included information about how to contact the patient advice and liaison service (PALS).

Are services responsive to people's needs?

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

The ward also used the friend and family test (FFT) to measure patient feedback. Questionnaires were given to patients on discharge. The ward displayed a "you said, we did" message to show how it was responding to patients' feedback.

Complaints were discussed at risk and safety meetings. Reports detailed the nature of complaints and a summary of actions taken in response. The timeliness of investigation and response to the complainant were not reported on within this report. We saw no evidence that there was learning at ward level following complaints. None of the staff we spoke with had any awareness of the themes of complaints received about the ward or other inpatient units within the trust.

The ward had received a complaint from a relative who had raised concerns that the ward had not been able to facilitate some periods of escorted leave. The relative was informed that the trust was introducing a process on every ward to record the number of times that escorted leave could not be provided and why. The lack of such a process and information had been raised by CQC at previous visits to trust inpatient units but had not been acted upon. None of the staff we spoke with were aware of such a process. The matron developed a new recording form on the day of our visit so that staff could begin to capture this information.

Longfox unit - Juniper
Planning and delivering services
The ward is allocated to cover the north east area of Somerset. Staff told us that six current patients were from other areas covered by the trust and outside the immediate locality such as Bristol. This means that not all patients on the ward are as close to home as possible.

Right care at the right time
Bed availability appeared to be a trust-wide issue with acute psychiatric beds in demand. We were concerned to find that leave beds were being used to accommodate additional patients taking the ward numbers above the number of beds actually available.

Care Pathway
Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However staff told us that bed availability in the intensive care units meant that there had been delays on occasion in transferring a patient who needed intensive care.

Staff told us they felt under pressure to discharge patients early due to other patients in the community needing an acute psychiatric bed.

Learning from concerns and complaints
Information about the complaints process was displayed in the ward with leaflets available for patients or visitors to take away and read privately. People we spoke with knew how to make a complaint and said that they felt able to talk to staff if they had a concern. Staff we spoke with were aware of the trust's complaint policy.

Sandalwood Court – Applewood
Planning and delivering services
We were told that referrals were taken from a number of health and social care providers, both within primary care services and secondary mental health services. We saw good therapeutic relationships between patients and staff.

Staff reported it was difficult to find a local bed if a person needed to be admitted to hospital and there were some delayed discharges due to housing problems and move on bed availability.

However we found that there was a good use of external agencies such as with the housing department and the voluntary sector in relation to community discharge.

Right care at the right time
Bed availability appeared to be a trust-wide issue particularly for acute psychiatric beds. On the day of our visit to Applewood ward was full and it included patients from outside of area

Care Pathway
Staff worked with other services in the trust to make arrangements to transfer or discharge patients.

We saw evidence that patients were fully involved in their care and medication pathways. We were told that doctors explain all medication and side effects when asked. We saw good recording on notes regarding capacity and consent to treatment.

At Applewood ward patients were positive about the care and treatment received but we were told that there was not always enough staff to facilitate section 17 leave.

Are services responsive to people's needs?

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

Learning from concerns and complaints

Information about the complaints process was given when people first started working with the service. People who use the service told us that they knew how to make a complaint and felt able to do so if they needed to. There were systems in place to learn from complaints.

Southmead - Oakwood
Planning and delivering services

The ward takes admissions from two different geographical areas covered by the trust. Admissions are also taken on occasion from other geographical areas covered by the trust when an acute psychiatric bed is not available in their allocated acute unit. This means that not all patients on the ward are as close to home as possible.

Right care at the right time

Bed availability appeared to be a trust-wide issue with acute psychiatric beds always in demand. On the day of our visit to this ward one bed allocated to a patient on section 17 leave was being used by another patient. Staff told us this was a common occurrence. They also told us that concern about pressures on bed availability meant that at times patients were not given leave as staff were concerned they may need to return early and their bed would be allocated to another patient in their absence.

Care Pathway

Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However staff told us that bed availability in the intensive care units meant that there had been delays on occasion in transferring a patient who needed intensive care. On one occasion this meant the patient had to be nursed in seclusion throughout the day whilst waiting for a bed. Staff felt this put additional pressure on them and the service provided.

Staff told us they felt under pressure to discharge patients early due to other patients in the community needing an acute psychiatric bed.

The service responded to individual's spiritual and cultural needs. For example one patient had been provided with a mat for prayer and information about the appropriate place to site this in their room. Staff were supporting the patient to have the right time for prayer and to use the multi faith facilities at the local acute hospital on the same site as the ward.

Learning from concerns and complaints

Information about the complaints process was clearly displayed in the ward with leaflets available for patients or visitors to take away and read privately. People we spoke with knew how to make a complaint and said that they felt able to talk to staff if they had a concern. Staff we spoke with were aware of the trust's complaint policy.

Community meetings were held daily between staff and patients. These were recorded. People we spoke with told us they felt able to raise any concerns in the community meetings and that they felt listened to.

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

Overall, leadership and local governance arrangements require improvement at this trust.

The trust's board and senior management had a vision with strategic objectives, though staff knowledge of this varied.

Staff generally felt supported by the managers at ward level and they also valued the support of their team. However leadership from above ward level was not visible to all staff.

There is a trust-wide governance and information system called IQ. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards.

Several meetings were held by the trust focusing on current provision and identifying concerns. However, it was clear that some issues were raised without any action being taken to remedy the situation.

Staff we spoke with were aware of their roles and responsibilities on the ward.

Our findings

Callington Road – Lime and Silver Birch
Vision and strategy
Staff we spoke with had varying levels of awareness about the vision and values of the trust. Staff received a weekly newsletter with information about the trust via the intranet.

Responsible governance
There is a trust-wide governance and information system called Integrated Quality (IQ). This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards. Local audits of documentation were carried out by the managers on a regular basis to ensure that areas for improvement were identified and addressed. Managers attended weekly governance meetings and they told us that information from these was passed to the teams via their team meetings and at supervision.

No audits of the use of and practice in seclusion had been conducted within the acute wards.

All staff we spoke with were aware of their roles and responsibilities.

Leadership and culture
Staff we spoke with felt supported by the ward managers who demonstrated good leadership skills. They also felt supported by the consultant psychiatrists. Staff also valued the support of the team who worked well together and were motivated to promote good outcomes for people and try to ensure least restrictive practice.

Staff told us that leadership from above the ward level was not visible to staff. Staff did not understand the triumvirate leadership arrangements and had limited knowledge of who senior staff in Bristol and the wider trust were.

Engagement
We saw that regular staff meetings were held and minutes were available so all were aware of what had been discussed and agreed.

The pending retendering of acute services and uncertainty about the future had impacted negatively on staff morale.

We were told in the consultant psychiatrists' focus group for Bristol that senior managers were not responsive to the consultants' concerns about the service. They told us they did not feel supported in their role by the trust. There was no forum for the consultant psychiatrists to meet with the triumvirate leadership team in Bristol or Medical Director and no medical staff committee for the trust where they could share and discuss their views and concerns.

People who use the service gave very positive feedback about it and said that staff listened to them. Each of the wards had regular community meetings which gave them the opportunity to express their views, make suggestions for change and be involved in how the unit was run. We saw that changes were made as a result of these meetings.

Performance Improvement
Staff told us that they were aware of their professional objectives and these were reviewed regularly at supervision and appraisal.

The trust had an Integrated Quality (IQ) system in place to monitor and audit the care management records and the quality records in line with the outcomes set by the Care

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.

Quality Commission. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards.

Fountain Way - Beechlydene
Vision and strategy

Staff we spoke with had varying levels of awareness about the vision of the trust. The senior management and consultants on site had a very clear vision and passion for the trust and its purpose and development. It was clear that this did not filter through to ward level, where there was a sense of just coping on a daily basis and not knowing the senior trust managers or what their vision was for the trust.

Staff received information about the trust via email and intranet. They told us they didn't often have time to read emails and there were issues about being able to access a computer at work to read emails.

Staff told us they knew the onsite management well and most felt they had a good working relationship with them. Some staff were concerned that the manager was not visible enough on the ward. Staff told us they would probably not recognise the senior trust management if they came on the ward. Most could name the chief executive but no other management personnel.

Responsible governance

Staff we spoke with were aware of their roles and responsibilities on the ward. They told us that if they were not sure of anything, they would ask the manager or matron for advice. They demonstrated a depth of understanding of the challenges faced by the trust but also a frustration that trust-wide issues, such as training provision and staffing levels, were not being addressed with any urgency.

There is a trust-wide governance and information system called IQ. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards. Local audits of documentation were carried out by the managers on a regular basis to ensure that areas for improvement were identified and addressed. Managers attended weekly governance meetings and they told us that information from these was passed to the teams via their team meetings and at supervision.

The ward was divided into three teams for auditing purposes. Audits included care planning, legal documentation, health and safety issues and medication. We sampled the audits from each team and found inconsistency in the quality of these across the teams. Some were very detailed and up to date whilst others were vague and lacking in detail.

Leadership and culture

We received varying reports about the support from the ward manager. Some staff reported they felt very supported and valued whilst others said they rarely saw the manager on the ward. The manager's office is situated upstairs away from the ward. Staff expressed that this separated them from their leader and meant that the manager was often not there to assist when staff needed help. One member of staff commented that the management cannot be in touch with what is happening on the ward if they are not there to experience it themselves.

Engagement

Patients told us that staff engaged with them as much as they were able to under the high demands of the ward. They said they saw their professional team regularly and most felt included in their care on a daily basis. However we did find that patients were not always involved in care reviews and some did not have copies of their care plans.

Staff told us they felt they worked closely as a team at ward level but felt isolated within the trust. Communication came to them via email or on the intranet. This was not easily accessible due to lack of computers and time to be able to sit a read correspondence.

Performance Improvement

We saw evidence from several meetings focusing on current provision and identifying concerns. These meetings were well attended and showed that some issues were being addressed. However it was clear that some issues, in particular training, staffing and ward improvements, were spoken about each time with little if any action being taken to remedy the situation. There appeared that trust-wide issues and concerns were not being highlighted or escalated assertively enough to trust level management for attention.

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.

Green Lane Hospital - Imber

Vision and strategy

Staff we spoke with were aware about the vision and values of the trust. Staff received a weekly newsletter with information about the trust via the intranet.

Responsible governance

The manager reported that the trust IQ governance system allowed them monitor quality and assurance at a local level. There was a locality Quality and Safety meeting where governance information was shared and discussed. We saw that there were some regular team audits undertaken to monitor quality.

Leadership and culture

We found that the Imber ward was well led. Staff told us that they felt supported and were encouraged to share concerns and ideas. The ward manager was supportive and accessible. The staff felt listened to and that concerns were acted on by the senior management team. We saw that staff were passionate about their work and showed a genuine compassion for people.

Staff told us that there had been too many trust and policy changes and there were many vacant posts that they had been unable to fill. We also heard complaints from staff that all but basic mandatory training had been cut which was potentially affecting their PDR's and prospects of promotion. Staff told us these issues had been raised with management.

Engagement

Staff positively engaged with service users and carers and asked for regular feedback. People who use the service and carers told us that they felt well informed about their treatment and communication with staff was clear. Good quality information was given to carer`s and individuals throughout their time with the team.

Staff we spoke with were generally aware of the trust's whistleblowing policy, and felt confident to report to their team management any concerns they had.

Performance improvement

Staff we met with understood their aims and objectives in regard to performance and learning. We saw that the team meeting focussed on team objectives and direction particularly through ensuring the service was needs led and person centred. Staff told us that they had good support and had an opportunity to reflect on any performance or learning outcomes in management supervision. We saw that there were some regular team audits undertaken to monitor quality.

Hillview Lodge - Sycamore

Vision and strategy

Staff we spoke with were aware about the vision and values of the trust. Staff received a weekly newsletter with information about the trust via the intranet.

Responsible governance

Performance information was used by the local delivery unit (LDU) to assess effectiveness and report performance to the board and to its commissioners. The trust used a performance dashboard known as the Integrated Quality (IQ) system which reported performance against a range of local and national key performance indicators. A quality and safety plan monitored improvements against targets set where performance was below target.

Three LDU governance meetings took place monthly. Risk and safety meetings were chaired by the clinical director and attended by the managing director, head of professions and practice and team and service managers. Items discussed included incidents, complaints, safeguarding and safety alerts. Management performance meetings discussed staffing and financial issues, whilst a quality and safety meeting discussed feedback from service user engagement groups.

Leadership and culture

The ward had experienced numerous changes in ward management over the last two years which had caused instability and uncertainty. A new ward manager had recently been appointed but had not yet commenced employment. There had been a vacancy for approximately six weeks. A new modern matron had also been in post for approximately eight weeks and staff were very positive about the impact this individual had made on staff management and morale, and were optimistic about the future.

The trust had attempted to recruit a substantive consultant psychiatrist however had been unsuccessful. The post was currently filled by a locum who was an associate specialist doctor employed for one year until October 2014. Although this doctor was highly regarded by staff and patients, concerns were expressed about the prospect of further change and instability.

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.

Staff were familiar with the senior management team, who were visible and accessible. They reported that they had received emotional support following two deaths on the ward which had been devastating for them. They also appreciated a visit by the trust's chief executive following one if these incidents. Staff felt that systems, processes and performance management were all starting to improve. For example, there was clear process and accountability for supervision and mentorship.

Junior doctors felt well supported by consultants. Medical staff in general felt that the locality service as a whole was well led, and worked well with commissioners.

Staff employed in housekeeping and administration felt that communication was poor. They said that they were not treated with courtesy by other staff roles and were not listened to. They felt that they were undervalued as a staff group.

Engagement

An involvement co-ordinator had been appointed and they chaired the local people's group which captured views from patients and carers. Feedback was reported to the locality quality and standards meeting. A project called 'experienced based design' was being piloted on the ward to capture patient and staff experiences.

Performance Improvement

The trust had failed to act promptly to concerns raised at our previous visit in November 2013. Their most recent internal compliance visit had concluded that two of the areas we found non-compliant at our last visit remained non-compliant. We found further evidence that the ward had been slow to implement improvements. We continued to have serious concerns with regard to the environment, staffing and record keeping.

Longfox unit - Juniper
Vision and strategy

Staff we spoke with were aware about the vision and values of the trust. Staff received a weekly newsletter with information about the trust via the intranet.

Responsible governance

There is a trust-wide governance and information system called 'Integrated Quality' (IQ). This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to

compare the performance of individual wards. Local audits of documentation were carried out by the managers on a regular basis to ensure that areas for improvement were identified and addressed.

On our second visit we met with the recently appointed Governance facilitator who showed us the reporting systems which she had established on the unit in February 2014. These included a range of risk assessments and indicators dealing with staffing levels, environmental issues, incidents and complaints. We also saw the annual ligature risk assessment had been undertaken by the health and safety representative. This included a rating scale, action plan including remedial work and review dates. This assessment is sent to the trust's health and safety committee who prioritise expenditure.

We were also told by the facilitator how the units' governance arrangements are planned to change later this year. This will involve creating a monthly report to the directorate's management which details all incidents which have occurred on the unit. These will then be reviewed by them and the modern matron to identify any trends and themes.

Leadership and culture

Staff from the ward and the junior doctors we met with described a lack of visibility of senior managers for this service. The junior doctors said they were concerned for their nursing colleagues as they observed poor morale and general tiredness. During our visits we observed that the ward was extremely busy and we were concerned that staff seemed to have limited time to interact with all patients due to the complex needs of some patients present on the ward. Nevertheless we observed that the team was working very hard to manage this and that staff were very dedicated despite managing in a very challenging environment.

Staff told us they were able to attend a reflective group facilitated by the clinical psychologist which was highly valued. Students on the ward said they felt well supported. Appraisals were found to be up to date as was all mandatory training.

Engagement

Members of staff informed us that community meetings take place twice a week. However, the minutes of these

Are services well-led?

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meeting were not on display in a communal area. When we reviewed the folder for these minutes, there was one set of minutes for a meeting held the day prior to our visit. There was no evidence that regular meetings are held.

The ward is included in the friends and family test. We found detailed information regarding this displayed in the ward which indicated a good level of patient and carer satisfaction. The ward has information packs and leaflets available for patients.

Staff we spoke with were generally aware of the trust's whistleblowing policy, and felt confident to report to their team management any concerns they had.

Performance Improvement
Staff told us that they were aware of their professional objectives and these were reviewed regularly at supervision and appraisal.

The trust had an Integrated Quality (IQ) system in place to monitor and audit the care management records and the quality records in line with the outcomes set by the Care Quality Commission. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards.

The governance facilitator showed us a database she had set up to log all incidents on the unit that had occurred since February 2014. She described that this information was beginning to be used to consider trends and enable learning from incidents. We were made aware of increasing number of incident reports. The head of professions and practice for the locality was analysing the data to distinguish whether this was an increase in active reporting or a rising incident rate.

However there did not appear to be any learning from the significant number of incidents and AWOLs over the last few months.

Sandalwood Court – Applewood
Vision and strategy
Staff we spoke with were aware about the vision and values of the trust. Staff received a weekly newsletter with information about the trust via the intranet.

We found that the ward was well led. Staff told us that they felt supported and were encouraged to share concerns and ideas. The manager was supportive and accessible. The

staff felt listened to and that concerns were acted on by the senior management team. We saw that staff were passionate about their work and showed a genuine compassion for people.

Responsible governance
The manager reported that the trust IQ governance system allowed them monitor quality and assurance at a local level. There was a locality Quality and Safety meeting where governance information was shared and discussed.

Leadership and culture
Most staff told us that they felt supported and were encouraged to share concerns and ideas through regular supervision. However two staff members told us that there was a culture of racism on the ward. They told us that they did not want to take and further action regarding this as both members of staff had decided to leave. Most staff spoken with said the ward manager was supportive and accessible. Generally the staff felt listened to and that concerns were acted on by the senior management team.

Engagement
Staff positively engaged with patients and carer`s and asked for regular feedback. The manager told us that they treat each other with respect and look after each other in a supportive manner. People who use the service and carers told us that they felt well informed about their treatment and communication with staff was clear. Good quality information was given to carer`s and individuals throughout their time with the team.

Staff we spoke with were aware of the trust's whistleblowing policy, and felt confident to report to their team management any concerns they had.

Performance improvement
Staff we met with understood their aims and objectives in regard to performance and learning. We saw that the team meeting focussed on a culture of praise and positivity. Team objectives and direction particularly through ensuring the service was needs led and person centred. Staff told us that they had good support and had opportunity to reflect on any performance or learning outcomes in management supervision. We saw that there were some regular team audits undertaken to monitor quality.

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Southmead - Oakwood

Vision and strategy

Staff we spoke with had varying levels of awareness about the vision and values of the trust and told us they did not feel they had had any input into them. Staff received a weekly newsletter with information about the trust via the intranet.

Responsible governance

There is a trust-wide governance and information system called Integrated Quality (IQ). This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards. Local audits of documentation were carried out by the managers on a regular basis to ensure that areas for improvement were identified and addressed. Managers attended weekly governance meetings and they told us that information from these was passed to the teams via their team meetings and at supervision.

No audits of the use of and practice in seclusion had been conducted within the acute wards.

All staff we spoke with were aware of their roles and responsibilities.

Leadership and culture

Staff we spoke with felt supported by the ward manager who demonstrated good leadership skills. Staff also valued the support of the team who worked well together and were committed to 'going the extra mile' to provide the service.

Leadership from above the ward level was not visible to staff. Staff did not understand the triumvirate leadership arrangements and had limited knowledge of who senior staff in Bristol and the wider trust were.

Engagement

Staff we spoke with felt isolated as a service within the trust and did not feel that their views were encouraged. They told us they had raised concerns about medical staffing levels but did not feel listened to or that appropriate action had been taken.

The pending retendering of acute services and uncertainty about the future had impacted negatively on staff morale.

We were told in the consultant psychiatrists' focus group for Bristol that senior managers were not responsive to the consultants' concerns about the service. They told us they did not feel supported in their role by the trust. There was no forum for the consultant psychiatrists to meet with the triumvirate leadership team in Bristol or Medical Director and no medical staff committee for the trust where they could share and discuss their views and concerns.

Performance Improvement

Staff told us that they were aware of their professional objectives and these were reviewed regularly at supervision and appraisal.

The trust had an Integrated Quality (IQ) system in place to monitor and audit the care management records and the quality records in line with the outcomes set by the Care Quality Commission. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards.

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 Treatment of disease, disorder or injury	The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care. How the Regulation was not being met: • On some units there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety and dignity of patients. • On Juniper ward we evidenced a male patient enter the female bed area. • Individual patient risk assessments had not always been reviewed and updated following incidents of potential or actual harm. • Observation practice did not meet the guidance set out by the National Institute for Health and Care Excellence (NICE). • We found that seclusion was not always recognised and managed within the safeguards set out in the MHA Code of Practice. • There is inadequate provision of appropriate activities on Sycamore Ward and Juniper Ward as recommended by the Mental Health Act Code of practice. • There was inadequate provision of structured activities on some units as required by the MHA Code of Practice meaning some patients complained of boredom. Regulation 9 (1) (b) (ii)(iii)
Regulated activity	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person did not have suitable arrangements to protect patients from the risk of unsafe or unsuitable equipment: How the Regulation was not being met:

Compliance actions

- At Hillview Lodge emergency life support equipment was not properly maintained and suitable for its purpose.

Regulation 16 (1) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not safeguarded the health, safety and welfare of service users by taking appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity: How the Regulation was not being met: - A number of units were experiencing significant staff shortages which may have impacted on patient care and safety. - Arrangements for medical cover were not always sufficient Regulation 22

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines: How the Regulation was not being met: - On a number of units we found that there was not appropriate procedures in place for the administration, management and audit of medications - On additional units we found that temperature checks necessary for ensuring the integrity of medications had not been undertaken Regulation 13

Compliance actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by regularly assessing and monitoring the quality of the services provided and identifying, assessing and managing risks relating to the health, welfare and safety of service users and others: How the Regulation was not being met: • We found occasions where the trust had not taken prompt and appropriate action to manage risks identified by serious incidents and concerns • The trust has failed to have regard to reports prepared by CQC relating to their compliance following a CQC visit to Hillview Lodge in November 2013 Regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person must had not ensured that suitable arrangements were in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities by receiving appropriate training, professional development, supervision and appraisal; • Staff at Hillview Lodge had not received training in the application of the observation policy and observation practice • Not all staff at Hillview Lodge had received training in advanced life support • Staff told us that they do get access to mandatory training but there is a lack of developmental training Regulation 23

Enforcement 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
Treatment of disease, disorder or injury	The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises How the Regulation was not being met: At Hillview lodge we found: • The ward did not meet the required level of cleanliness and the design and decoration of the ward did not support a therapeutic environment • Potential ligature risks that had not been effectively mitigated or managed • The garden was not well maintained and contained overgrown trees and shrubs that may have posed a ligature risk or a means of escape • Shower and bathroom facilities were in a poor state of repair • Areas of the ward and grounds were staff could not easily observe patients • The design of the unit did not promote privacy or dignity. Regulation 15(1)