Sussex Partnership NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

<Add address line 1 here>
<Add address line 2 here>
Tel:
Website:

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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)
The Harold Kidd Unit	RX240	Grove Ward	PO19 6AU
The Harold Kidd Unit	RX240	Orchard Ward	PO19 6AU
Horsham Hospital - Iris Ward	RX2C8	Iris Ward	RH12 2DR
Salvington Lodge (The Burrowes)	RX2A3	The Burrows	BN13 3BW
Lindridge	RX2Y5	Brunswick Ward	BN3 7JW
St Anne's Centre & EMI Wards	RX2K3	St Raphael Ward	TN37 7PT
St Anne's Centre & EMI Wards	RX2K3	St Gabriel Ward	TN37 7PT
Beechwood Unit	RX2L8	Beechwood Unit	TN22 5AW
Meadowfield Hospital	RX277	Larch Ward	BN13 3EF
Mill View Hospital	RX213	Meridian Ward	BN3 7HZ

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

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for acute wards for adults of working age and PICUs	Requires Improvement 
Are inpatient wards for older adults safe?	**Inadequate** 
Are inpatient wards for older adults effective?	**Requires Improvement** 
Are inpatient wards for older adults caring?	**Good** 
Are inpatient wards for older adults responsive?	**Requires Improvement** 
Are inpatient wards for older adults well-led?	**Requires Improvement** 

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

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

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

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

Summary of findings

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Overall summary

We gave an overall rating for acute older adult inpatient wards of **requires improvement** because:

- Several cleanliness and hygiene issues were identified on Burrows ward.
- Although staff had a plan to reduce the number of fixtures on the wards that could present a ligature risk, meaning patients could be at risk of suicide or self-harm, the audit had not identified all potential ligature points.
- The trust management did not ensure that learning from serious incidents was always shared with front-line staff and in particular the night staff.
- Wards did not always comply with the Department of Health gender separation requirements. This was identified by our mental health act reviewers as a breach of the Mental Health Act 1983 Code of Practice.
- On some of the wards the controlled medications were not monitored and checked in line with current legislation or best practice. Some patients had received intra-muscular injections without a clear rationale for doing so being documented in the notes.
- Some patients were physically restrained in their rooms and staff did not consider this to be a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion policy.
- Staff did not demonstrate a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. When staff did assess the mental capacity of a patient, the assessments were not sufficiently thorough.
- Staff had not received mandatory training within the timescales set by the trust.
- Staff had not received training in the use of the MCA.
- We found patients were detained unlawfully as paperwork had not been properly authorised.
- Patients were not always supported to spend time off of the wards.
- Wards were inconsistent in their approach to care planning. These did not adequately capture need and were not always up to date.
- Ward staff were not receiving regular and consistent supervision.
- Patients were not always able to access care as close to home as possible. Patients were often transferred several times before accessing care close to their home.
- Discharge was often delayed because of lack of suitable accommodation. We saw little active engagement with stakeholders to resolve the issues or establish co-ordinated pathways of care. However there are higher level meetings co-ordinated with the Local Authority and Clinical Commissioning Groups. The trust has a nominated individual who attends these meetings and a member of staff seconded to work in the accommodation team.
- Some patients were not informed of advocacy rights. Some wards did not provide advocacy information in easy to read formats and there was no evidence that staff had informed the patients of the advocacy services available to them.
- Care plans were not always signed by patients and a rationale for this had not been documented. Some patients had not received a copy of their care plans.
- There were privacy and dignity concerns on some of the inpatient wards.
- While there were memory boxes in place on some of the wards, there was no evidence that these had been used. Some of the wards were not holding community meetings for the patients.
- Some staff were unclear on the trusts vision and values.
- There were inconsistent and inadequate systems in place to monitor performance and quality assurance. We found the trust collected much data through auditing and mandatory data collection. However, there was little evidence that this information was fed back to the ward managers to enable them to improve practice.

Summary of findings

- There was a basic monthly environment audit carried out on some of the wards but this had clearly missed an environmental risk on two of the dementia wards.
- Despite the many areas that require improvement, all of the staff across all of the wards was compassionate, sensitive and kind to patients.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- Several cleanliness and hygiene issues were identified on Burrows ward, such as dirty and dusty beds. Fall cushions which were used and dirty were found in newly admitted patient's rooms. There were used toothbrushes in communal bathrooms.
- Although staff had a plan to reduce the number of fixtures on the wards that could be used by patients to tie a ligature to, the audits had not identified all potential ligature points. Until all of the risks have been identified and removed, this may present a risk of suicide or self-harm to patients. Managers on some, but not all of the wards were able to explain how they managed the ligature risks, through observation and increased staffing.
- Not all of the staff were aware of the location of ligature cutters or whether these were even kept on the ward. The manager took immediate action to ensure that the location was clearly signed for staff.
- All of the wards had incident reporting systems in place but the feedback mechanisms did not always enable full and timely feedback. The trust management did not ensure that learning from serious incidents was always shared with front-line staff and in particular the night staff. This meant that these staff members did not always benefit from the results of investigations into the incidents. Some of the wards did not have regular staff meetings which reduced the opportunities to share this information with staff. There were 17 incidents on Brunswick outstanding from May 2014 to the date of this inspection.
- Wards did not always comply with the Department of Health Gender Separation Requirements. This was identified by our mental health act reviewers as a breach of the Mental Health Act 1983 Code of Practice.
- On some of the wards the controlled medications were not monitored and checked in line with current legislation. On Iris ward the nursing staff had not checked the controlled medication in over six months and on Grove ward the nursing staff had not checked the controlled medication in two months. On Brunswick ward controlled medication had not been returned to the GP and on Burrows ward some controlled medication was out of date. On one ward the manager was

Summary of findings

checking the controlled medication alone which is not safe practice. On Larch ward patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation.

- Environmental risk assessments had not identified a patient safety risk on Iris ward. The risk assessments were not detailed and did not prompt staff to look at all areas within the ward.
- On Larch ward patients were physically restrained in their rooms and staff did not consider this to be a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion policy.
- The layout of most of the wards meant that staff could not observe patients in all parts of the ward at all times. The staff told us that they complete regular observations of all parts of the wards and monitor the whereabouts of all patients.
- The environment within St Gabriel was very tired and not dementia friendly.

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The serious issues apply to five of the ten wards inspected. On the majority of wards the staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was readily accessible. The staffing establishment on all wards was set and actively reviewed to keep people safe. Managers had the flexibility and autonomy to increase staffing numbers if the patient acuity increased. Bank and agency staff were used when needed.

While not all staff were up to date with safeguarding training, all staff we talked with knew how to make safeguarding alert. The majority of wards had clean and comfortable environments. There was good assessment and management of risks in relation to falls. Care plans in relation to falls risks had been updated and there clear risk assessments in place.

The environments at the Beechwood Unit, Burrows and Iris were dementia friendly, for example, colourful walls and posters throughout the unit. On Meridian, St Raphael, St Gabriel and Beechwood wards there were good incident reporting systems in place and there were strong feedback mechanisms in place in order to learn lessons when things may have gone wrong.

Are services effective?
We rated effective as **requires improvement** because:

Requires Improvement

Summary of findings

- Staff did not demonstrate a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. When staff did assess the mental capacity of a patient for admission to hospital and for consent to care and treatment, the assessments were often not sufficiently thorough.
- Staff had not received mandatory training within the timescales set by the trust. Staff had not received training on the correct use of the Deprivation of Liberty Safeguards.
- The quality of assessment and care planning was variable. We found the care plan documentation did not always reflect the quality of care given and was not recovery focused.
- In Meadowfield Hospital patients did not always have access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services. There was no service level agreement in place with the local community NHS trust.
- Ward staff were not receiving regular and consistent supervision. Both staff and managers confirmed that completing regular supervision sessions had been an issue. Some staff had not received supervision in over a year.
- Some concerns were raised with us by staff about the timely completion of physical health assessments on Grove ward.
- We found patients had been deprived of their liberty without the correct assessments and authorisations in place.
- The trust had used both electronic systems and paper records for recording and storing information about the care of patients. This meant that this information wasn't always readily available to doctors and nurses as patients moved between services.

Clinical staff made a comprehensive assessment of patients that were admitted. This included a good assessment of people's physical health needs. Staff completed the Medical Early Warning System (MEWS) tool which provided nurses with a guide to determine the degree of illness of a patient. Staff told us they escalated a patient's condition if their MEWS score exceeded the agreed level, which currently was at three. Assessments took place using the Health of the Nation Outcome Scales (HoNOS).

Multi-disciplinary teams and inter-agency working were effective in supporting patients. The occupation therapist told us they use the Canadian occupational performance measure (COPM). This is an

Summary of findings

evidence-based outcome measure designed to capture a patient's self-perception over time. The occupational therapist also used the PAUSE activity model which included art therapy. We observed the model being used within the wards visited.

Staff handovers in wards were person centred and ranged from good to excellent. Patients' risks were reviewed at every handover. Iris ward had very positive relationships with the neighbouring acute trust and community services which enabled prompt and effective access to specialist nursing services such as nutritional support, tissue viability, podiatry and diabetic services.

Are services caring?

Good

We rated caring as **good** because:

- Staff were kind and respectful to patients and recognised their individual needs.
- Staff explained to us how they delivered care to individuals. This demonstrated that they had a good understanding of the needs of patients.
- Through the use of the Short Observational Framework for Inspection (SOFI) we saw that staff were genuine, empathetic and compassionate towards patients. Staff defused difficult situations by speaking softly but clearly and implementing distraction techniques such as talking about something that was meaningful to the person.
- Staff demonstrated good understanding of patient's spiritual and personal needs.
- The dementia wards used 'this is me' information on patients' doors, in boxes and on walls in their bedrooms.
- The dementia wards used a Paro the seal which had received positive feedback from patients and relatives.
- Staff had dementia friendly name badges.
- Staff made sure that families and carers were involved when this was appropriate but this was not always clearly documented.
- Staff on most wards organised their working day so that a nurse could spend some 'one-to-one' time with each patient. This was not always possible because there was only one qualified nurse on some shifts. The managers told us that the trust was increasing the number of qualified nurses per shift from one to two. We saw that this was happening where possible.

Summary of findings

- We had positive feedback from carers and they told us that they felt listened to but there was limited recording about this in patient care plans.
- Some patients were not informed of advocacy rights. Some wards did not provide advocacy information in easy to read formats and there was no evidence that staff had informed the patients of the advocacy services available to them.
- Care plans were not always signed by patients and a rationale for this had not been documented. Some patients had not received a copy of their care plans.

The provider may wish to note that we saw some patients in Brunswick who had food remains on their clothes and plaster cast and a patient wandering naked up and down corridor with a lack of planning for engagement.

The involvement of patients in the care plan process was variable within the wards visited. Most of the records showed that patients had not been involved in their care planning.

Are services responsive to people's needs?

Requires Improvement

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

- Patients were not always able to access care as close to home as possible. Bed shortages across the trust meant that patients from other areas were often accommodated in whichever ward had a bed available.
- Patients were often transferred several times before accessing care close to their home. One relative told us of a negative experience that they had had where their partner had been transferred between wards up to four times.
- On Larch ward discharge was often delayed because of lack of suitable accommodation. We saw little active engagement with stakeholders to resolve the issues or establish co-ordinated pathways of care.
- The trust had implemented a new policy regarding leave beds, whereby patients going on leave were not guaranteed a bed on the same ward.
- There were privacy and dignity concerns on Burrows ward because some of the bedroom windows were exposed and faced a public walkway.
- On Larch ward the payphones were situated in communal areas which meant that patients could not make phone calls from these pay phones in private.

Summary of findings

- While there were memory boxes in place on some of the wards, there was no evidence that these had been used. Some of the wards were not holding community meetings for the patients.
- People had access to outside space but some of the wards gardens were not safe for people with dementia. For example bushes were cut in a way that meant they were sharp. One ward was seeking money to make an area suitable for patients.
- Patients were not always supported to spend time off of the wards. We found that some patients had not been off of the wards for several months and there was no evidence to indicate that these patients had been offered the opportunity to go out.
- On most of the wards there was a lack of personalisation in patients' bedrooms.
- Some of the patients under 65 years who were admitted to Meridian ward had not met the agreed criteria of the acute and urgent care services.

The trust contributed to an IBIS system which ran in conjunction with the South East Coast Ambulance Service (SECAMB). The aim of the scheme is to prevent unnecessary admission to hospital by providing information to ambulance service staff.

Staff were responsive to physical health, mental health and the spiritual needs of patients. There were spirituality advocates on some of the wards. The wards provided a range of different treatments and care. Patients could access a range of therapeutic activities. However, the provision across all of the wards was not equally accessible or available.

The staff were aware of the diverse needs of all the people who use the service and provided a range of support. Staff knew how to support people who wanted to make a complaint. There was a good choice of food and methods to offer choice to patients who were experiencing dementia. There was a good choice of snacks and drinks available to patients as and when they requested them. On Iris ward notice boards were displayed at eye level.

Are services well-led?

Requires Improvement

We rated well-led as **requires improvement** because:

- On Larch ward staff rarely received feedback from complaints and there was little analysis of themes or trends at ward level.
- On Brunswick ward there was a divide between staff and management so staff morale was low.
- Some staff were unclear on the trusts vision and values.

Summary of findings

- Ward managers had access to a range of performance indicators and other productivity metrics. However this system did not allow for the effective management and resolution of all areas of concern.
- There were inconsistent and inadequate systems in place to monitor performance and quality assurance. We found that whilst the trust collected data it did not share the findings of this data to the managers and staff at the frontline.
- There was substantive use of bank staff on Brunswick ward but they only had access to training if they had been there a long time. There was no criterion of how long bank staff have to wait before they can receive training.
- Some wards had incorrect information on the patient information boards including legal status.
- There was a basic monthly environment audit carried out on some of the wards but this had clearly missed an environmental risk on two of the dementia wards.
- Governance systems were in place to monitor the completion of documentation. However, the managers and staff informed us that these governance systems did not support the effective monitoring of the quality of care records.
- Meridian ward had experienced three ward manager changes within a one year period and this was commented on by some staff interviewed.

The hospital managers and other senior clinicians were highly visible to front line staff and patients. In some areas governance processes had identified where the services needed to improve. This had led to the improvement plan being put into place for the reduction and prevention of falls.

Arrangements for the management of medicines incidents had been carried out and acted upon promptly with individual members of staff. Staff briefing documents were circulated for staff to read. Although staff were not aware of the trust's vision and strategy they all aspired to provide high quality care for the patients in their care. The Trust had responded to staff concerns about the 12 hour shift patterns and planned to revert to a three shift pattern before April 2015.

Summary of findings

Background to the service

The inpatient wards for older adults provided by Sussex Partnership NHS Foundation Trust are part of two management structures. The dementia services are managed along with the older adult functional services which are integrated as part of the trust's acute services management structure. All of the functional older adult wards operated as "ageless" services, accepting admissions under 65 years of age alongside older people, providing specific ward criteria were met. All of the wards were mixed gender.

The Harold Kidd Unit in Chichester has two admission assessment wards. Grove ward is an admission assessment ward for older adults who experience dementia and has 10 beds. Orchard ward is an admission assessment ward for older adults experiencing functional mental health conditions including anxiety, depression and psychosis. Orchard ward has 12 beds.

Horsham Hospital in Horsham has one admission assessment ward. Iris ward is for older adults who experience dementia and has 12 beds.

Salvington Lodge in Worthing has one admission assessment ward. The Burrows is an admission assessment ward for older adults who experience dementia and has 10 beds.

Lindridge in Hove has one admission assessment ward for older adults experiencing dementia. Brunswick ward has 15 beds.

St Anne's Centre in St Leonards on Sea has two wards. St Raphael Ward is an integrated admission assessment ward for older adults experiencing functional mental health conditions including anxiety, depression and psychosis and has 14 beds. St Gabriel Ward is an admission assessment ward for older adults who experience dementia and has 15 beds.

Beechwood Unit in Uckfield is an admission assessment ward for older adults who experience dementia. Beechwood Unit has 14 beds.

Meadowfield Hospital in Worthing had one integrated admission assessment ward for older adults experiencing functional mental health conditions including anxiety, depression and psychosis. Larch ward has 18 beds.

Mill View Hospital in Hove had one integrated admission assessment ward for older adults experiencing functional mental health conditions including anxiety, depression and psychosis. Meridian ward had 19 beds. It was managed as part of the Brighton and Hove acute and urgent care services.

Our inspection team

The team that inspected the older adult inpatient wards consisted of 21 people: One expert by experience, five inspectors, one inspection manager, six Mental Health Act reviewers, six nurses, one pharmacist and one psychiatrist.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- Visited 10 wards across eight locations and looked at the quality of the ward environments and observed how staff were caring for patients
- Used the Short Observational Framework for Inspection (SOFI) to observe the interaction between staff and patients
- Spoke with 41 patients who were using the service
- Spoke with the managers or acting managers for each of the wards
- Spoke with 47 other staff members; including doctors, nurses, occupational therapists, psychologists and social workers
- Interviewed the divisional director with responsibility for these services
- Observed two ward based community meetings
- Attended and observed three hand-over meetings and four multi-disciplinary meetings.

We also:

- Looked at 71 treatment records of patients
- Carried out a specific check of the medication management on six wards
- Examined in detail the legal records in relation to people's detention under the Mental Health Act 1983
- Looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with patients and their relatives. Most were positive about their experience of care on the older adult inpatient wards. They told us that the staff were very caring and supportive. They said that the quality of the food was very good and they enjoyed mealtimes. Where patients were not able to speak with us due to their advanced dementia, we observed that patients responded positively to staff interaction and would laugh and smile with them.

People were not always involved in decisions about their care and where staff illustrated to us how they did involve people, this was not well evidenced. Some patients told us that they did not always feel involved in decisions about their care. Relatives told us that staff kept them informed but this was not always well documented.

Patients who were able to talk with us told us that they felt safe on the wards and received good care. We observed that patients with dementia were supported in a way which enabled them to feel safe. For example, the positive and calm way in which staff approached patients put them at ease.

During the inspection visit we attended carers meetings and contacted relatives over the telephone. The feedback was mainly positive. One relative told us that their partner was moved up to four times between wards during their inpatient stay.

Two patients told us that they were not able to use the garden as often as they would like.

Summary of findings

Good practice

There was evidence of excellent dementia care practice on Iris, Grove, Burrows and Beechwood wards. Iris and Grove wards had regular input from a psychologist. The psychologist was assisting the wards in developing a more person centred approach

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve the older adult acute wards

- Staff on the older adult inpatient wards must be clear about the steps they need to take to reduce the risk of ligature points to patients. Audits must be reviewed to ensure that they cover all ligature risks.
- The trust must take action to provide staff with mandatory training and timely updates.
- The trust must take action provide staff with training and timely updates in the use of the Mental Capacity Act 2005 and deprivation of liberty safeguards to ensure their effective and correct use. This is vital to ensure that staff can use the legislation with confidence to protect people's human rights.
- The trust must ensure that staff know how to complete a full and comprehensive assessment of mental capacity which adheres to the principles of the Mental Capacity Act and demonstrates every possible effort to involve and fully inform patients.
- The trust must ensure all staff have access to appropriate support, including regular supervision, annual appraisal and mandatory training.
- The trust must ensure that all informal patients are fully aware of their rights and enabled to enact those rights.
- The trust must take action to ensure that wards comply with the Department of Health gender separation requirements.
- The trust must make sure that all the older adult inpatient wards are adhering to safe practice in relation to medicines management, which follows national guidance.
- The trust must ensure that medications are not routinely prescribed to all patients on admission without clear clinical rationale or regard to individual needs.
- The trust must ensure that patients are supported to spend time off of the wards and enabled to do so in an environment that is safe.

Action the provider SHOULD take to improve the acute wards for adults of working age

- The trust should update its procedures on the use of restraint, to reflect current guidance on the use of seclusion. Staff should be fully informed of the definition of seclusion and understand when they are actually using patient's bedrooms for seclusion.
- Trust managers should ensure that learning from serious untoward incidents is shared within and across wards and teams including the night staff.
- The trust should make sure that therapeutic activities and access to occupational therapy and psychology are consistently and equally available across all older adult inpatient wards.
- The trust should ensure that its induction programme prepares new and inexperienced staff for their role.
- The trust should ensure that all of its older adult inpatient services have access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services.

Summary of findings

- The trust should support patients to access ward payphones that can be used in private. On Larch ward payphones were situated in communal areas of the wards which meant that patients could not make phone calls from these pay phones in private.
- The trust should make sure that all staff across the organisation receives feedback from complaints.
- The trust should make sure that data collected through auditing and mandatory data collection is fed back to the ward managers to enable them to improve practice. This was not evident on all wards.
- The trust should ensure that staff receive regular updates and refreshers to promote the most current and up to date practice.
- All hospitality staff should undergo breakaway and de-escalation of violence training to make sure that they are aware of the latest guidance and techniques to keep them and patients safe.
- Slips, trips and falls training should be cascaded across all older adult wards to support the pilot project on falls reduction.
- The fire evacuation timetable for 2015 should be planned and implemented at Millview Hospital.
- The trust should monitor direct admissions to Meridian ward for those patients under 65 years of age not meeting the set criteria.
- Care record documentation should reflect a holistic, person centred, recovery approach highlighting strengths of patients.
- Patients should be able to access care as close to home as possible.

Sussex Partnership NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Grove Ward	The Harold Kidd Unit
Orchard Ward	The Harold Kidd Unit
Iris Ward	Horsham Hospital - Iris Ward
The Burrows	Salvington Lodge (The Burrowes)
Brunswick Ward	Lindridge
St Raphael Ward	St Anne's Centre & EMI Wards
St Gabriel Ward	St Anne's Centre & EMI Wards
Beechwood Unit	Beechwood Unit
Larch Ward	Meadowfield Hospital
Meridian Ward	Mill View Hospital

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.

There were several issues raised by the Mental Health Act Reviewer (MHAR) on our previous visit which had not been addressed, in spite of the trust detailing what remedial action would be taken in their action plan from that visit. These are as follows:

Detailed findings

- No evidence was found that patients and carers were being offered copies of care plans.
- Community meetings were still not taking place, so there was no system in place whereby patients' views could be elicited and recorded about the general running of the ward.
- There was still no procedure in place for the Independent Mental Health Advocate (IMHA) to be notified that there were qualifying patients on the wards and no notice about how to access the service displayed in communal areas.
- Information rights leaflets were still only available on the ward in the standard format.

There was a mixed picture in relation to documentation in respect of the Mental Health Act. On most wards documentation was generally good. Paperwork about people's detentions was up to date and stored correctly. For renewals of detention, hospital managers' hearings were timely and well recorded. However, on Grove ward we could not find any statutory consultees' records of their discussions with the Second Opinion Approved Doctor (SOAD) in the file of a patient being treated under authority of a T3 certificate. We noted that the white board in the ward office on Grove ward, which was used for recording information on all patients on the ward, contained information about a patient's status under the MHA which was two weeks out of date. We were told that white board information was updated daily. We were also told that the white board was the main source of information for staff coming on the ward.

Staff routinely explained to patients what their rights are under the Mental Health Act. This happened on admission, after 10 days and thereafter every three months. There were additional reminders in respect of the rights of individuals when their particular circumstances made this necessary. Although the re-presentation of rights, including a detained patient's right to an IMHA, was regularly recorded, there was no evidence found that the information was being re-presented in a way that would overcome barriers to communication. There were no information leaflets available on the wards written in plain English or an easy-read format to aid communication.

Staff told us that no records were made of whether patients who qualified for IMHA support had been referred to the service. We were also told that qualifying patients who lacked capacity were never referred to an IMHA.

The trust's systems did not entirely support the appropriate implementation of the Mental Health Act and its Code of Practice. Administrative support was available from a team within the trust. However, not all staff had knowledge of this team. The trust carried out audits to ensure the Mental Health Act was being implemented correctly. However, this auditing process has been ineffective, with some wards having had repeated breaches of the Mental Health Act and its Code of Practice. Most staff were overdue refresher training and some staff had not received training. This reflected a mixed picture of staff understanding of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff had not received training or were overdue refresher training in the use of the Mental Capacity Act 2005. No staff had received training on the use of the Deprivation of Liberty Safeguards.

Some staff we spoke with had not heard of the Deprivation of Liberty Safeguards and most staff did not fully understand how the legislation applied to their work with patients.

However, most staff we spoke with did know who to contact in the trust for advice on the Mental Capacity Act and the Deprivation of Liberty Safeguards.

We found that Mental Capacity Act assessments completed for 'admission to hospital' and 'consent to care and treatment' were not sufficiently thorough. They did not adhere to the principles of the Mental Capacity Act 2005. We found that a number of patients were being unlawfully deprived of their liberty due to lapsed standard authorisations, inappropriate use of urgent authorisations and incomplete deprivation of liberty requests.

Managers confirmed that there was a significant deficit in the number of staff who had received training in relation to

the Mental Capacity Act or Deprivation of Liberty Safeguards. The use of the Mental Capacity Act and Deprivation of Liberty Safeguards were not effectively monitored by the wards.

On Grove ward one person was being unlawfully deprived of their liberty and had been deprived of their liberty without the correct assessments and authorisation for more than one month. On Iris Ward two standard authorisations had expired and one person had been deprived of their liberty by the inappropriate use of three urgent authorisations. This meant that three people were being unlawfully deprived of their liberty. The Mental Capacity Act Code of Practice states that only two urgent authorisations can be made, after which a best interest's assessment must be completed and a standard authorisation obtained. Both Grove and Iris wards took immediate action to rectify the concerns that we had raised.

Requires improvement

Are services safe?

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

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

Summary of findings

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

- Several cleanliness and hygiene issues were identified on Burrows ward, such as dirty and dusty beds, and we found that used fall cushions were in newly arrived patient's rooms. There were also used toothbrushes in communal bathrooms.
- Although staff had a plan to reduce the number of fixtures on the wards that could be used by patients to tie a ligature to, the audits had not identified all potential ligature points. Until all of the risks have been identified and removed, patients on the wards who have thoughts to self-harm or carry out a suicidal act will be at increased risk. Managers on some of the wards were able to explain how they managed the ligature risks, through observation and increased staffing. However, this was not the case on all of the wards and we saw that some areas were not observed.
- Not all of the staff were aware of the location of ligature cutters or whether these were even kept on the ward. The manager took immediate action to ensure that the location was clearly signed for staff.
- All of the wards had incident reporting systems in place but the feedback mechanisms did not always enable full and timely feedback. The trust management did not ensure that learning from serious incidents was always shared with front-line staff and in particular the night staff. This meant that these staff members did not always benefit from the results of investigations into the incidents. Some of the wards did not have regular staff meetings which reduced the opportunities to share this information with staff. There were 17 incidents on Brunswick outstanding from May 2014 to the date of this inspection.
- Wards did not always comply with the Department of Health gender separation requirements. This was identified by our mental health act reviewers as a breach of the Mental Health Act 1983 Code of Practice.
- On some of the wards the controlled medications were not monitored and checked in line with current legislation. On Iris ward the nursing staff had not checked the controlled medication in over six months and on Grove ward the nursing staff had not checked the controlled medication in two months. On Brunswick ward controlled medication had not been returned to the GP and on Burrows ward some controlled medication was out of date. On one ward the manager was checking the controlled medication alone which is not safe practice.
- On Larch ward patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation.
- Environmental risk assessments had not identified a patient safety risk on Iris ward. The risk assessments were not detailed and did not prompt staff to look at all areas within the ward.
- On Larch ward patients were restrained in their rooms and staff did not consider this to be a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion policy.
- The layout of most of the wards meant that staff could not observe patients in all parts of the ward at all times. The staff told us that they complete regular observations of all parts of the wards and monitor the whereabouts of all patients.
- The environment within St Gabriel was very tired and not dementia friendly.

Requires improvement

Are services safe?

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- Not all wards had the same level of access and input from staff of different disciplines. For example Burrows and Brunswick wards had less access to OT and Psychology input compared to Iris and Grove wards.

On the majority of wards the staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was readily accessible. The staffing establishment on all wards was set and actively reviewed to keep people safe. Managers had the flexibility and autonomy to increase staffing numbers if the patient acuity increased. Bank and agency staff were used when needed.

While not all staff were up to date with safeguarding training, all staff we talked with knew how to make a safeguarding alert. The majority of wards had clean and comfortable environments. There was good assessment and management of risks in relation to falls and care plans reflected this.

The environments at the Beechwood Unit, Burrows and Iris were dementia friendly, for example, colourful walls and posters throughout the unit. On Meridian, St Rapheal, St Gabriel and Beechwood wards there were good incident reporting systems in place and there were strong feedback mechanisms in place in order to learn lessons when things may have gone wrong.

Our findings

Safe and clean ward environment

- Some of the wards layouts did not enable staff to observe parts of the ward. On Grove ward a side corridor was at a right angle to the main corridor and was a blind spot. This situation was managed at night by a staff member sitting at the end of the corridor. During the day staff completed regular general observations and walked around all areas of the ward periodically. The layout of Burrows and Brunswick meant that staff could not observe patients in all parts of the ward. The Brunswick refurbishment was only 6 months old and no thought had been given to this issue. There were blind sports outside people's bedrooms and there were no clear systems in place to rectify this.
- Male and female sleeping areas were not separate on all of the older adult inpatient wards we visited. On Brunswick, Burrows, Larch, Grove and Iris wards, areas were not clearly zoned into male and female designated areas. There were no dedicated single sex designated rooms. Rooms were used on an 'as required' basis depending on who was admitted. Staff told us that gender separation was dependent on the number of male or female patients admitted and that it was not always possible to have completely gender separate areas. Some wards did not have en-suite facilities. Some wards had shared facilities and some had access to a separate male or female-only bathroom and toilet facilities. There were not separate female-only lounges on all the wards.
- Although the trust had a plan to reduce the number of fixtures on the wards that could be used by patients to tie a ligature to, the audits had not identified all of the potential ligature points.
- On Larch ward we found that the majority of high risk ligature points had been removed such as the windows. These had been replaced with mesh style windows which were safe but allowed for adequate ventilation. However, ligature risks from the hospital type beds, sink taps and door hinges remained. The risks were managed through risk assessing the individual patients. We found that the action plans to address the ligature points had been in place for some time and did not have dates for when they would be resolved.
- The ligature risk assessments had identified many high and medium level risks on all wards. However, on Brunswick ward the risk assessment failed to identify all of the risks including door closures, cables in bedrooms, handrails and door frames. Some staff did not recognise that these were potential ligature points.
- The trust had taken action to address some of the ligature risks identified. There were plans in place to conduct a larger programme of works that would address many of the existing risks. Ligature risks were being removed in order of potential risk level. However, in the intervening period there was a lack of clear guidance to help staff minimise or mitigate the risks to patients of the existing medium and high risk ligature points. Some staff we spoke with, including temporary staff, were unable to articulate, how the existing ligature risks were being managed.

Requires improvement

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- On Grove ward we asked five staff members where ligature cutters were kept on the ward. No one was able to tell us or knew whether the ward had any cutters. They were later found in the crash bag in the clinic room. A sign was produced before we left the ward which stated clearly where ligature cutters could be found. This was a concern as ligature risk points were identified throughout the ward, including in patients' bedrooms. Staff told us that the building "was not really fit for purpose" and that modifications were hampered by the fact that it was a listed building.
- Most of the wards were well-maintained and the corridors were clear and clutter free. Most of the wards were clean and people told us that standards of cleanliness were usually good. Staff conducted regular audits of infection control and prevention and staff hand hygiene to ensure that people who use the service and staff were protected against the risks of infection. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. However, these bins were not always signed and dated by staff. Several cleanliness and hygiene issues were identified on Burrows ward, such as dirty and dusty beds. There was a dirty fall cushion that belonged to a discharged patient in a new patient's bedroom and we found discharged patients used toothbrushes were in communal bathrooms.
- Emergency equipment, including automated external defibrillators and oxygen was in place. It was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices were also checked regularly. The level of staff training in life support techniques varied between wards. For example, Grove ward had seven staff trained in immediate life support, Iris ward had five staff trained and on Larch ward very few staff had received recent mandatory life support training. Staff were aware of the protocol for calling emergency assistance and told us the protocol was to call 999 and await the emergency services. This meant that patients were at risk through staff not being up to date with life support training.
- Alarms were available in each room in the wards and staff said that when the alarm was used, staff responded very quickly.
- The older adult inpatient wards did not always comply with the Department of Health gender separation requirements. The wards were mixed sex and although staff attempted to separate the genders into different corridors, depending on the sex of the patients admitted, this was not always possible. Some wards had no separate male or female lounges. However, staff told us that current shared rooms could be used for one gender only if required.
- The environment within St Gabriel was very tired and not dementia friendly.
- The environment at the Beechwood Unit was found to be dementia friendly, for example, colourful walls and posters throughout the unit. The managers and matron on Iris and Grove wards had made a concerted effort to make the wards more dementia friendly by using colourful signage, colourful toilet seats and hand rails and large staff name badges.

Safe staffing

- Staff and managers told us that the trust did not use a recognised tool to estimate the number and grade of nurses required. The manager and matron for the older adult inpatient services told us that they used a set nursing establishment based on their knowledge of safe staffing models. We reviewed the staff rotas for the weeks prior to our inspection and saw that staffing levels were in line with levels and skill mix determined as safe by the managers and matron. The staffing establishment was set locally and actively reviewed to keep people safe.
- Managers told us they were able to obtain additional staff when the needs of patients changed and more staff were required to ensure their safety. We observed that the wards ensured at least one qualified member of staff was working on each of the wards. Managers told us that it had been recognised that the older inpatient wards needed two qualified staff working per shift and recruitment for qualified staff was underway.
- Bank and agency staff were used when needed and most shifts were now being covered by two qualified staff. Managers had the flexibility and autonomy to increase staffing numbers if and when required. The ward managers and matron for the older adult inpatient services told us that they usually used the same agency

and bank nurses so they were familiar with the ward and patients. We spoke with bank nurses who told us they always worked in the same ward areas if possible and told us they had worked at the hospital for many years.

- Temporary staff, who had not worked on a ward before, were given a brief induction to the ward. This included orientation to the layout of the ward. They were provided with written guidance on the local health, safety and security procedures for the ward.
- The trust could not provide information about the number of agency staff employed over the past year because the data only recorded the use of bank staff. This meant that accurate information about the number of shifts covered by agency staff was not available and there was no formal monitoring of the use of agency staff.
- The trust's 12 hour shift pattern had been in place for over a year. The matron told us this had reduced the staffing costs but had resulted in little time allocated for staff to attend training, development or supervision. We were told that record keeping, care planning and incident reporting had also suffered as staff had little allocated time available for administrative work. We were told that although they were under budget with staffing costs the trust had agreed to revert to the original three shift pattern due to the concerns raised by staff.
- On some of the wards we were told that the majority of patients were offered and received a one-to-one session with a member of staff every day. This varied across the wards and even when staff told us that patients received a daily one-to-one, this was not always recorded in patients notes. Some patients were not able to communicate with us due to their advanced dementia and it was not possible to establish if they had received a regular one-to-one. People's records did not always demonstrate if people had been offered one-to-one time. However, we did observe staff spending time with patients on all of the wards.
- Some staff on each of the wards had been trained in the use of physical interventions. However, these staff were not clearly identified on the rota to ensure that there were sufficient staff available on each shift if required.
- Some concerns were raised with us by the medical staff about the changes that had taken place to the rota and on call system. This particular concern related to Grove ward. The medical staff told us that because of the changes to the on-call rota system, from November 2014, the foundation year two doctors had significantly less time available during the day to cover Grove ward. This had meant that reviews of patients on Grove ward had to take place sometimes without the ward based doctor being present. The medical staff told us that as a result of the changes the ward could have periods of several days when there is no regular ward based doctor available apart from the on call duty doctor. We were told that this issue had been raised with the trust senior managers by a number of consultants. The medical staff told us that the changes had implications for the provision of high quality clinical care and for the training and supervision of foundation doctors. We were told that some physical examinations of patients had not been completed for a number of days due to a doctor not being available.
- Other wards told us that there were adequate doctors available over a 24 hour period, seven days each week who were available to respond quickly on the ward in an emergency.
- We found that the majority of staff had not received mandatory training within the timescales set by the trust. This was highlighted in the NHS 2014 Staff survey and confirmed by the electronic training records kept on the wards. On Larch ward the majority of staff had not undertaken infection control, manual handling or life support training. There was a mixed picture across all of the wards but there were significant gaps in staff training on Larch, Iris, Grove, Burrows, Brunswick and Meridian wards. Staff on all of the wards required up to date training or refresher training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There was no evidence that staff competencies and skills were being monitored.

Assessing and managing risks to patients and staff

- Where patients who were not able to speak with us due to their advanced dementia, we completed detailed observations. Patients told us that they felt safe and those that we observed appeared calm and positive in their reactions to staff interaction.
- From our review of records on each ward we found that there were care plans in place that addressed the active

risks that had been identified in patients current risk assessments. Our review of care records showed that patients on all of the wards had undergone a full risk assessment within five days of admission. We saw evidence that risk assessments were reviewed as part of the multi-disciplinary care review process.

- Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of patients by staff were increased. On admission vulnerable patients were placed on close observations until no longer assessed as a risk. Individual risk assessments that we reviewed took account of patients' previous history, as well as their current mental state.
- Written handover information about patients was kept in the office and was available to all staff. We observed three handovers and each handover included discussions of individual risks to patients. Staff told us they kept patients safe through constant risk management.
- The trust had policies and procedures in place for the observation and searching of patients to ensure risks of self-harm were minimised. The policies were all available on the trust's intranet and the staff we spoke with were aware of how to access them.
- On Larch, Brunswick and Burrows wards managers and staff did not always receive timely feedback about safeguarding incidents which meant that opportunities for learning were restricted. We were told that the local authority was sometimes slow to respond and managers had to chase them for more information and confirmation on the action taken.
- All of the older adult inpatient wards had low incidents of physical restraint. On Larch ward there were less than 20 incidents of restraint in the period April 2014 and Sept14. Staff told us that restraint was only used occasionally, rapid tranquilisation rarely and face down restraint was never used.
- Most of the older adult wards did not have a separate seclusion room and did not document or report as seclusion when patients were restrained in their own bedrooms. We found that acutely disturbed patients were on occasion physically restrained in their room until their behaviour was assessed as no longer a risk to themselves or others. This was considered by the wards to be restraint rather than a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion policy.
- A number of staff across all of the wards were significantly overdue refresher training for safeguarding vulnerable adults and children, no staff were up to date with safeguarding training on Larch ward and none of the staff on Iris ward were up to date with training on safeguarding vulnerable children. Training on Burrows and Brunswick ward was significantly below the trusts targets.
- Although safeguarding training was not up to date, the staff we spoke with understood the signs of abuse and told us that they would be confident in escalating concerns and reporting through the trusts safeguarding processes. They gave examples where they had escalated concerns through the safeguarding process for example suspected financial abuse between siblings or unexpected bruising on an older person.
- The trust had a safeguarding policy in place which had been reviewed and updated in September 2013. The policy addressed key lines of accountability, the procedures for staff to follow, details of the mandatory training and how compliance with the policy would be monitored. The policy included key contact numbers and reflected the pan Sussex multi-agency safeguarding policies. We also saw safeguarding flow charts and safeguarding procedure reminders on staff notice boards.
- On some of the wards the controlled medications were not monitored and checked in line with current legislation. On Iris ward the nursing staff had not checked the controlled medication in over six months and on Grove ward the nursing staff had not checked the controlled medication in two months. On Brunswick ward controlled medication had not been returned to the GP and on Burrows ward some controlled medication was out of date. On one ward the manager was checking the controlled medication alone which is not safe practice.
- In general appropriate arrangements were in place for the management of medicines. We reviewed the medicine administration records of several patients on

each ward that we visited. We saw that the pharmacists and pharmacy technicians visited the wards daily and regularly conducted drug audits to monitor drug usage and compliance with medication policies. For example we saw that the pharmacist in Meadowfield Hospital conducted an audit of missed doses and displayed the findings in the Larch ward clinic room.

- At Meadowfield Hospital patients were routinely prescribed intra-muscular medication on admission, to be used when required regardless of patients individual needs or presentation.
- We saw that staff received medicines updates through the Drugs and Therapeutics monthly newsletter. A copy of this was placed on ward notice boards.
- Information about medicines was available to patients if they wanted it. Pharmacists and ward staff discussed changes to patients' medicines at multi-disciplinary meetings. Some patients were not able to understand information about their medicines due to their advanced dementia. The rationale for the use of certain medications was not always clearly outlined in a care plan or in care records.
- Our pharmacist inspector checked the management of medicines on Meridian ward and found that appropriate arrangements were in place. Medicines were stored securely on the ward. Temperature records were kept of the medicines fridge and clinical room in which medicines were stored, providing evidence that medicines were stored appropriately to remain fit for use.
- When patients had visits from children, this was risk assessed to ensure it was in the child's best interest. A separate visiting room away from the ward was available.
- Meadowfield Hospital operated a physically open door policy as part of their philosophy of care. Staff were committed to this and believed it reduced the risk of patients leaving the ward. Most wards had a locked door policy. The staff would unlock the doors to allow exit or entry to the wards. Staff were clear that informal patients could leave if they requested. However, not all of the wards had clear notices on their exits to inform patients, who were informally admitted, that they could leave the ward. On Iris ward we saw one informal patient had been told by staff that they could not leave the ward until they had seen the doctor, despite the patient clearly requesting to leave. Not allowing an informal patient to leave when they request to leave is effectively a de facto detention and a breach of human rights. If there is clear clinical rational for why a patient should not leave the ward due to identified risks then the appropriate legislation should be utilised to safeguard and protect patient's human rights.

Track record on safety

- There had been six serious untoward incidents across the older adult inpatient wards in the last year. These incidents related to fractures as a result of falls. The trust had a plan in place to reduce the number of falls.
- The recent incidents reported from Meridian ward involved falls by patients on the ward or whilst in the hospital grounds. There were no reported serious untoward incidents on this ward in the last year.
- There were 17 incidents on Brunswick ward outstanding from May 2014 to time of our inspection.

Reporting incidents and learning from when things go wrong

- The trust had policies and procedures in place to manage risk. Incidents were reported on an electronic system which recorded details of the incident and the action taken.
- On all of the wards we found that staff were aware of the trust's policies for reporting risk and knew how to access the system. However we found that not every incident of restraint was reported appropriately according to the Trust's policy.
- The matron told us that although they signed off each incident form, they did not keep a record of how many they had signed off in order to identify trends or themes. They told us that if there was a significant increase in the number of incidents such as restraint they would investigate. However without specific records being kept there was a risk that any changes might not be identified until it was picked up by the governance department several months later.
- Feedback was variable, with managers and staff not always receiving timely feedback following incident investigation. The ward manager was responsible for ensuring that learning was fed back following an

Requires improvement

Are services safe?

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incident investigation. The process was that individual staff would usually receive feedback during supervision. However, we noted that few staff had received supervision in the past year.

- The only formal feedback staff usually received was through the trust's quarterly 'Report and Learn' Bulletin. This contained key learning points for staff and sharing of best practice. Although this was a useful tool for disseminating information it did not provide staff with timely feedback following the reporting of any incident, safeguarding or complaint.
- We saw that where staff were informed of incidents, action was taken to address the situation. For example the ward received an alert about benches being a climbing hazard. Although this was not so much a risk for older people on the wards, the benches were removed from the garden and a new seating arrangements were being sourced.
- The ward managers received a monthly report of the number of incidents but this did not identify trends or capture themes. We were told that the governance department was responsible for analysing the data and would feed back if there was an issue or in the quarterly governance report which provided an overview of the Trust.
- We found that staff rarely met to discuss any feedback. When it occurred feedback happened through informal handovers or may have occurred through the trust's bulletins which came out some time after the original incident. Feedback when it happened was not planned or part of the governance cycle of individual incidents. Some staff told us that learning from incidents was not as good as it could be.
- The trust had emergency planning policies and procedures in place to deal with unforeseen events such as adverse weather and unforeseen staff shortages. We saw the policies addressed issues such a bomb threat and hospital evacuation plans and included a disaster recovery plan along with key contacts.
- We viewed actions put in place to reduce the occurrence of falls which included: zoning patients to show acuity based on need and risk assessments, nursing staff to be aware of the role of the unit co-ordinator and to seek their assistance, compliance with falls assessments on admission and falls pilot project to focus on active reduction in the level of falls. We noted that there was no training available to staff on Meridian ward on slips, trips and falls.

Are services effective?

Requires Improvement

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

Summary of findings

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

- Staff did not demonstrate a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. When staff did assess the mental capacity of a patient for admission to hospital and for consent to care and treatment, the assessments were often not sufficiently thorough.
- Staff had not received mandatory training within the timescales set by the trust. Staff had not received training on the correct use of the Deprivation of Liberty Safeguards.
- Not all of the wards had clear notices on their exits to inform patients, who were informally admitted, that they could leave the ward. This constitutes a de facto detention and a breach of human rights.
- The quality of care plans was variable. We found the care plan documentation did not always reflect the quality of care given and was not recovery focused.
- Patients did not always have access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services as the trust did not have a service level agreement with the local community NHS trust.
- We found across the wards that staff were not receiving regular and consistent supervision. Some concerns were raised with us by staff about the timely completion of physical health assessments on Grove ward. Staff informed us that since the change in the trainee doctors' on-call rota, physical assessments were sometimes not being completed upon admission due to the ward doctor not being available.
- The trust used both electronic systems and paper records for recording and storing information about the care of patients. This meant that this information wasn't always readily available to doctors and nurses as patients moved between services. This also led to variances in the quality of care recorded.

Clinical staff made a comprehensive assessment of patients that were admitted. This included a good assessment of people's physical health needs. Staff completed the Medical Early Warning System (MEWS) tool which provided nurses with a guide to determine the degree of illness of a patient. Staff told us they escalated a patient's condition if their MEWS score exceeded the agreed level, which currently was at three. Assessments took place using the Health of the Nation Outcome Scales (HoNOS).

Multi-disciplinary teams and inter-agency working were effective in supporting patients. The occupation therapist told us they use the Canadian occupational performance measure (COPM). This is an evidence-based outcome measure designed to capture a patient's self-perception over time. The occupational therapists also used the PAUSE activity model which included art therapy.

We observed the model being used within the wards visited. Staff handovers in wards were person centred and ranged from good to excellent. Patients' risks were reviewed at every handover. Iris ward had very positive relationships with the neighbouring acute trust and community services which enabled prompt and effective access to specialist nursing services such as nutritional support, tissue viability, podiatry and diabetic services.

Our findings

Assessment of needs and planning of care

- The trust was using a mainly paper based system of recording the care given. Although some records were kept electronically the majority of records were paper-based. This led to variances in the quality of care recorded. Care record documentation was not easy to navigate. The trust had plans to introduce electronic record keeping for older peoples' services later in 2015.
- We found that care plan documentation was generally good. Most of the care plans that we reviewed contained up to date, personalised and holistic information. Some of these records clearly documented the patients' views. This was not always the case. For example, on Meridian ward, care plans did not highlight the personalised, holistic and recovery based approach that we observed staff delivering throughout our time spent on the ward. On Brunswick ward care plans were not always kept up

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to date and they did not always capture and reflect patient's progress, in particular patients' fluid intake was recorded but there was not a plan in place to address shortfalls.

- On Grove ward where diet and fluid intake was indicated as requiring monitoring, we found that diet and fluid charts were not clear or consistently completed. For example, one person appeared to have had no fluids or no more than 200mls of fluid on some days and it was impossible to measure the amount of food consumed due to arbitrary statements including 'ate half a meal'. The manager and staff told us that this was not an accurate reflection of what the patient would have actually had. This meant that it was not possible to accurately monitor the patient's diet and fluid intake even when a clinical need to do so had been identified.
- In Meadowfield Hospital patients did not always have access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services as the trust did not have a service level agreement with the local community NHS trust.
- In general most patients' needs were assessed and care was delivered in line with their individual care plans. Records showed that risks to physical health were identified and managed effectively on most wards. Assessments included a review of the person's physical health on at least a weekly basis. Where physical health concerns were identified, care plans were put in place to ensure the person's needs were met and clinical observations were made more frequently.
- Some patients were able to give us examples of how their individual needs were met. Staff on Grove ward described how a clear and comprehensive management plan had been put in place for one patient with complex and difficult needs. This had been shared with all staff and had resulted in a consistent approach which led to a reduction in the patient's level of distress. We observed staff using the plan during our visit. The positive effects on the person were clear and this was a marked improvement from their previous reviews.
- Although patients could not remember seeing their care plans they told us they felt involved in their care and listened to.
- Patients received a physical health check on admission and their health was actively monitored throughout their stay in hospital.

Best practice in treatment and care

- Most of the wards offered psychological therapies as recommended by NICE. Patients were able to access psychological therapies as part of their treatment. We were told that psychologists were available as part of the ward team and offered staff reflective practice opportunities, although this was seldom taken up. There was active psychology input on Grove and Iris wards. The psychologist was working closely with the staff to develop best practice in the care of people who had dementia. This included supporting staff to complete training in dementia care mapping and the use of more person centred care documentation such as 'this is me' care plans.
- We saw there were a range of therapeutic activities available to patients. This ranged from talking therapies to art, crafts, exercise and vocational support. Some of the hospitals had a gym and encouraged meaningful and purposeful activities to develop patients coping mechanisms, well-being and self-esteem.
- Meadowfield Hospital employed a personal trainer who organised exercise and physical fitness sessions. We found that patients revived occupational and therapeutic interventions from passionate and committed staff.
- Patient feedback indicated there were a lot of good and worthwhile activities and therapies to get involved in but there was less to do at the weekends. Managers acknowledged that there were more limited resources available at the weekends.
- The occupation therapist told us they use the Canadian occupational performance measure (COPM). This is an evidence-based outcome measure designed to capture a patient's self-perception over time. The occupational therapist also used the PAUSE activity model which included art therapy. We observed the model being used within the wards visited.
- Staff completed the Medical Early Warning System (MEWS) tool which provided nurses with a guide to determine the degree of illness of a patient. Staff told us they escalated a patient's condition if their MEWS score

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exceeded the agreed level, which currently was at three. The wards also monitored health through the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions.

- On Larch ward patients did not always have access to prompt specialist nursing services such as podiatry, tissue viability, nutritional or diabetic support. This was because of historical differences in the provision of these services across the county and the trust did not have a current service level agreement with the local community NHS trust. Staff told us that the services were usually organised through the district nursing services rather than direct with the healthcare professional. This sometimes meant a delay in the care patients received.
- NICE guidance was not always followed in the prescribing of medication. At Meadowfield Hospital patients were routinely prescribed intra-muscular medication on admission, to be used when required, regardless of patients individual needs or presentation. For example, we found one patient aged over 100 who had been prescribed an intramuscular sedative on admission. There was no documented rationale for why it was required.
- At Mill View Hospital we saw that an acute and urgent care governance meeting was held monthly. This was chaired by the acute care clinical lead. We saw that Meridian ward was represented at the meeting. Areas of best practice discussed included, medication and associated protocols, the Mental Health Act, engaging family and friends through the use of the triangle of care, bed management, a recent audit on use of seclusion, physical healthcare and an interim report on the CQUIN key performance indicators.
- The older adult wards used a number of measures to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis. On all the wards we visited we saw examples of audits of planned activities for patients, such as infection control and prevention measures and physical health checks. Information from completed audits was not always fed back directly to the staff because supervision and team meetings were not happening regularly. The information was being reported to the trust governance teams. The trust told us the information was used to identify and address changes needed to improve outcomes for patients.

- **Skilled staff to deliver care**

- All of the wards had a multi-disciplinary team which included a ward manager, consultant psychiatrist, junior doctors, registered mental health nurses, nursing assistants, occupational therapists, therapeutic activity workers, pharmacists and housekeeping staff. Some wards had more access to occupational therapy and psychology than others.
- The wards held separate staff training records electronically. There was no link with the trust's training department who collated training information separately. On Larch ward the infection control training was categorised as non-essential training. We queried this with the matron. The system on all of the wards did not alert managers when staff had completed any e-leaning and we were told that it was difficult to maintain a current picture of staff's training and development needs. The staff and managers told us that the trust did not have a centralised system to monitor training.
- Staff told us that the training had improved with the availability of e-learning as they didn't have to leave the ward to do the training. However, some staff and managers told us that there was an expectation to complete this training without being given the required time to complete it. Some staff told us that they did not learn as much from the e-learning as they would from a dedicated face to face lesson.
- The majority of staff had not received any supervision, appraisals or undertaken reflective practice in line with the trust's policy. Many staff had not received any formal support in the past year. Staff we spoke with told us that they can go quite a while without any formal support but that support does happen in other ways.
- The trust had identified that staff training, learning and development was a concern and had a strategy in place to address the issues. This included launching a new induction programme, to redefine core training, commission a learning management system and ensure that the majority of staff completed core training within the next eighteen months.

Are services effective?

Requires Improvement

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

- Team meetings did not happen regularly. However, most staff felt well supported by their manager and colleagues on the wards. Many staff commented on how good team work as one of the best things about their ward.

Multi-disciplinary and inter-agency team work

- Assessments on all of the wards were generally multidisciplinary in approach. Patient's records showed that there was effective multidisciplinary team working taking place. Care records included advice and input from different professionals involved in people's care. We saw evidence that patients were supported by a number of different professionals on the wards. Some wards had better access to physical health professionals than others. For example Iris ward had very good links with the neighbouring acute trust but Larch and Grove did not.
- Patients met with their consultant psychiatrist on a weekly basis at a clinical review and were visited during the week by a junior doctor. Medical staff raised concerns regarding the changes to the doctor's rota and on call system having had a negative impact on Grove ward. We were told that junior doctors are not as available on the ward as they were under the previous rota and on call system. There was always a doctor on call throughout the day and night for urgent medical issues with a senior nurse practitioner available in the hospital.
- We observed four multidisciplinary meetings and found they were effective in sharing information about people and reviewing their progress. Different professionals worked together effectively to assess and plan people's care and treatment.
- We observed holistic, effective and knowledgeable hand overs between shifts and healthcare professionals where information was presented and discussed. Staff used a printed handover sheet which identified the patient, their diagnosis, past and present risks, any comments and things to do during the shift.
- On Larch ward a daily ward planning meeting was held with patients and staff. This was an informal meeting over a cup of tea or coffee where staff and patients met to plan the activities and groups for the day. This was also an opportunity for patients to discuss any issues in an open environment. Separate times were tabled for one to one meetings with staff for therapeutic discussions. Community meetings did not occur on all of the wards. This was highlighted as a concern by our mental health act reviewers.
- We saw that the Crisis teams, care coordinators and local authority social services were involved in the assessment, planning and delivery of people's care and treatment.

Members of the Crisis Teams visited the wards regularly and helped in co-ordinating patients discharge home arrangements. This was important as the trust had identified that the number of patient suicides within three days of discharge from hospital in 2013/2014 was an elevated risk.

Adherence to the MHA and MHA Code of practice

- The trust had informed CQC that 100% of records for all Mental Health Act event episodes had errors. This was identified as a reporting error and flagged as an elevated risk as data quality had a direct impact on health and social care.
- On most wards we found the legal paperwork was generally in good order. The Approved Mental Health Professional reports were available and there was evidence that patients had had their rights discussed with them on admission and regularly afterwards on most wards. Section 17 leave forms were generally in good order. However, on Grove ward only two patients out of the five whose documents were scrutinised seemed to have been granted section 17 leave. The leave authorisations did not record whether the patient and other relevant people had been offered a copy.
- The section 17 leave documentation at St Anne's Centre did not specify leave parameters. For example, whether the escort should be male or female, qualified or unqualified. This contravened the Code of Practice 21.17 which states "the parameters within which this discretion may be exercised must be clearly set out by the responsible clinician."
- At Mill View Hospital good conditions of Section 17 leave were being recorded and reviews of risk carried out prior to leave. Capacity and consent was being assessed and recorded on admission and within the first three months

Are services effective?

Requires Improvement

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

prior to the statutory requirement to do this which was felt to be good practice and in line with the code of practice. Section 132 rights were found in most cases being given and recorded in line with the trust policy.

- The trust had flagged difficulties in arranging GP services for detained patients as a risk at Meadowfield Hospital. We found that this was a particular problem where patients were accommodated out of area.
- Not all staff were up to date with training on the Mental Health Act and the Code of practice. Most staff were due refresher training.
- Information on the rights of people who were detained was displayed in most wards and independent advocacy services were readily available to support people. Where signs were not displayed the managers took immediate action to rectify this. Staff were aware of the need to explain patient's rights to them. Some patients were not able to confirm that their rights under the Mental Health Act had been explained to them. Records showed that staff had attempted to inform people of their rights. However, there was little evidence that patient's rights had been offered to them in other formats.
- Staff knew how to contact the Mental Health Act office for advice when needed.

Some patient's files contained completed Do Not Attempt Resuscitation (DNAR) forms. The information on the forms was very sparse. We were unable to find details in the patient's clinical notes of the discussions which had taken place around these decisions. We could not locate any assessments where patients were recorded as not having capacity. Although one of the forms stated that the patient was recorded as having capacity to make the decision, the patient's notes indicated that capacity fluctuated. One member of the multi-disciplinary team was listed as having been involved in the decision making process but there were no references found as to whether any relatives or an advocate had also been involved. This is not in line with the trust DNAR policy and in accordance with current guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.

Good practice in applying the MCA

- Most staff did not demonstrate a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. When staff did assess the mental capacity of a patient for admission to hospital and for consent to care and treatment, the assessments were often not sufficiently thorough. The assessments did not adhere to the principles of the Mental Capacity Act 2005 for example they would record that the person had dementia and that they did not have capacity but there was no record of an actual assessment. Staff confirmed that the forms that we looked at were the assessments that they used. We checked patient's records and found an equally brief summary as to why the patient did not have capacity.
- On some of the wards we found that awareness of the Mental Capacity Act was better with staff using a single assessment document (FACE) to document the capacity decision making process.
- The ward manager on Larch ward told us that deprivations of liberty safeguards were rarely used. They told us that because they were rarely used they were not familiar with them and would discuss with the trust's deprivation of liberty safeguards team. They told us they had not received recent deprivation of liberty safeguards update training.
- Staff had not received training on the correct use of the Deprivation of Liberty Safeguards. On Grove ward one person was being unlawfully deprived of their liberty and had been deprived of their liberty without the correct assessments and authorisation for more than one month. On Iris Ward two standard authorisations had expired and one person had been deprived of their liberty by the inappropriate use of three urgent authorisations. This meant that three people were being unlawfully deprived of their liberty. The Mental Capacity Acts accompanying code of practice states that only two urgent authorisations can be made, after which a best interest's assessment must be completed and a standard authorisation obtained. Both Grove and Iris wards took immediate action to rectify the concerns that we had raised.
- Staff were not aware of any audits taking place to monitor the use of the Mental Capacity Act and deprivation of liberty safeguards.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- Staff were kind and respectful to patients and recognised their individual needs.
- Staff explained to us how they delivered care to individuals. This demonstrated that they had a good understanding of the needs of patients.
- Through the use of the Short Observational Framework for Inspection (SOFI) we saw that staff were genuine, empathetic and compassionate towards patients. Staff defused difficult situations by speaking softly but clearly and implementing distraction techniques such as talking about something that was meaningful to the person.
- Staff demonstrated good understanding of patient's spiritual and personal needs.
- The dementia wards used 'this is me' information on patients' doors, in boxes and on walls in their bedrooms.
- The dementia wards used a Paraseal which had received positive feedback from patients and relatives.
- Staff had dementia friendly name badges.
- Staff made sure that families and carers were involved when this was appropriate but this was not always clearly documented.
- Staff on most wards organised their working day so that a nurse could spend some 'one-to-one' time with each patient.
- We had positive feedback from carers and they told us that they felt listened to but there was limited recording about this in patient care plans.
- Some patients were not informed of advocacy rights. Some wards did not provide advocacy information in easy to read formats and there was no evidence that staff had informed the patients of the advocacy services available to them.
- Care plans were not always signed by patients and a rationale for this had not been documented. Some patients had not received a copy of their care plans.

The provider may wish to note that we saw some patients in Brunswick who had food remains on clothes and plaster cast.

The involvement of patient's in the care plan process was variable within the wards visited. Most of the records showed that patients had not been involved in their care planning. This was confirmed by patients we spoke with. Most care plans had not been signed by patients and there was no rationale written as to why. We did see some good examples of involvement on some of the wards where quotes from patients had been included in their care plans.

Our findings

Kindness, dignity, respect and support

- In general we saw that staff were kind and compassionate when interacting with patients, offering appropriate emotional and practical support where necessary. We noted that on all of the wards the staff were visible and actively engaging in a friendly manner with patients.
- Patients in general were genuinely happy with the care they received from the nursing and support staff. Patients told us the staff were wonderful and caring.
- We attended Holy Communion with a group of patients from Meadowfield Hospital. Patients told us they found the service uplifting and very helpful. Staff demonstrated an understanding of personal, cultural and religious needs of patients.
- Staff explained to us how they delivered care to individuals. This demonstrated that they had a good understanding of the needs of patients.
- Through the use of the Short Observational Framework for Inspection (SOFI) we saw that staff were genuine, empathetic and compassionate towards patients. Staff

Good

Are services caring?

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

defused difficult situations by speaking softly but clearly and implementing distraction techniques such as talking about something that was meaningful to the person

- The provider may wish to note that we saw some patients in Brunswick who had food remains on clothes and plaster cast and one patient wandering up and down corridor with a lack of planning for engagement. Also we saw a female patient wandering naked in the corridor and she was visible to male patients.

The involvement of people in the care they receive

- All of the wards had a welcome pack which gave an introduction to the hospital and useful information to help patients on their first few days following admission. We saw that there was an admission process that informed and orientated the patient to the ward.
- We saw an information booklet given to all patients on admission to Meridian ward. This included contact information on local advocacy services and MIND in Brighton and Hove who provided a once monthly meeting on Meridian ward to discuss any concerns any patients may wish to raise.
- Friends, families and advocates were actively involved as appropriate and in accordance with the patients' wishes. However, this was not always well recorded. Relatives, partners and carers were able to attend clinical reviews with the patient's agreement.
- We saw staff actively involved patients in their care and support. Although this was not always well documented, some patients confirmed that the staff supported them in making decisions when needed.
- Larch ward had facilitated monthly meetings of an independent mental health charity where patients were encouraged to meet and give feedback on their experience. The meetings were led by volunteers with no hospital staff present. Anonymous feedback was given to the hospital matron following the meetings if indicated.
- Most wards had information posters and literature on the advocacy services available for patients. We spoke with the Independent Mental Health Advocate who regularly spent time at Meadowfield Hospital. They visited the hospital on a weekly basis and supported patients in their dealings with the trust.
- There were feedback boxes for patients and visitors to leave comments on the hospital and care provided. These were not used on some of the wards.
- We found that staff were kind, caring and built positive relationships with patients, their families and carers. All the patients we spoke with told us they felt involved in their care. On Larch ward we saw minutes from patients meetings which confirmed that patient's felt they were supported to remain in contact with their families.
- The hospital told us they worked collaboratively with families and carers in supporting patients. Part of this included working with the local carer support group. Carers groups were held at Meadowfield Hospital on a monthly basis. However one manager we spoke with did not have local knowledge about local self-help groups or what was available. There were no minutes of these meetings available or information on display about their work.
- The occupational therapist on Beechwood ward ran a weekly carers clinic which looked at improving carers' experience. This included a training course for carers and staff about mental health, the role of a carer and how to keep going.
- On Meridian ward we saw evidence that patients were encouraged to join the recruitment process to appoint substantive staff.
- We saw that Meridian ward was implementing the triangle of care initiative to ensure a carer champion was visible and in good communication with families and friends. We also noted a carer information board in the main corridor of Mill View.
- During our inspection we were asked to join a multi-disciplinary discharge planning meeting where the views and wishes of the patient were discussed with them. Options for discharge planning were given to the patient to consider.

Requires Improvement

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

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

- Patients were not always able to access care as close to home as possible. Bed shortages across the trust meant that patients from other areas were often accommodated in whichever ward had a bed available.
- On Larch ward discharge was often delayed because of lack of suitable accommodation. We saw little active engagement with stakeholders to resolve the issues or establish co-ordinated pathways of care.
- The trust had implemented a new policy regarding leave beds whereby patients going on leave were not guaranteed a bed should they need to return to the ward.
- On Larch ward the payphones were situated in communal areas which meant that patients could not make phone calls from these pay phones in private.
- While there were memory boxes in place on some of the wards, there was no evidence that these had been used. Some of the wards were not holding community meetings for the patients.
- People had access to outside space but some of the wards gardens were not safe for people with dementia. For example bushes were cut in a way that meant they were sharp. One ward was seeking money to make an area suitable for patients.
- Patients were not always supported to spend time off of the wards.
- On most of the wards there was a lack of personalisation in patient's bedrooms.

There were spirituality advocates on some of the wards. The wards provided a range of different treatments and care. Patients could access a range of therapeutic activities. However, the provision across all of the wards was not equally accessible or available. The staff were very aware of the diverse needs of all the people who use the service and provided a range of support. Staff knew how to support people who wanted to make a complaint. There was a good choice of food and methods to offer choice to patients who were experiencing dementia. There was a good choice of snacks and drinks available to patients as and when they requested them. On Iris ward notice boards were displayed at eye level.

Our findings

Access, discharge and bed management

- Patients were not always able to access care as close to home as possible. Bed shortages across the Trust meant that patients from other areas were often accommodated in Larch ward. On the day of our inspection Larch ward was accommodating working age adult patients. Although the Larch ward was full, few patients were people detained under the Mental Health Act 1983 (MHA). For example on the day of our inspection of the 18 patients admitted only six were patients were subject to detention.
- Meridian ward was at full capacity when we inspected. We saw that two female patients were in en-suite bedrooms on the corridor specified for men. We were told this was avoided if at all possible but due to bed pressures and in order to avoid referring to the private sector.
- We saw an audit which had been carried out retrospectively from 2011 through to 2013 which showed that 23% of total admissions over the two-year period did not meet the trust criteria for admission onto the older persons ward.
- The number of patients placed out of Sussex for emergency mental health treatment had increased in recent years. The number had increased from 90 in 2012 / 2013 to 227 patients transferred out of county due to no suitable place of treatment closer to home in 2013 / 2014.
- The matron told us that they received daily updates on the number of patients out of area. On the day of inspection there were no out of area patients on Larch ward.
- The information on length of stay in hospital indicated that patients in Meadowfield Hospital were discharged on average two days over the optimal stay of 28 days.

Requires Improvement

Are services responsive to people's needs?

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

The Trust reported that 28 wards across 12 sites had an average bed occupancy rate of 93%. The Royal College of Psychiatrists recommend an average occupancy rate of 85%. The matron for Meadowfield Hospital confirmed that bed turnover was high.

- The trust data indicated that there were 346 readmissions across 14 locations within 90 days of discharge between April to September 2014. Meadowfield Hospital was flagged for having over 20 readmissions in the past six months.
- We found that patients were often moved between wards or transferred between locations several times before accessing appropriate care close to their home. Staff told us this was due to a lack of suitable beds across the region.
- On Larch ward discharge was often delayed because of lack of suitable accommodation. We saw little active engagement with stakeholders to resolve the issues or establish co-ordinated pathways of care. On Iris ward the manager told us that delays in discharge were often due to the very limited number of suitable homes available in the area that would be able to meet the needs of patients.
- On Brunswick ward references were made to discharge in the daily notes but there were no written discharge plans. On most of the wards discharge planning started too late in the process and allocation of a care co-ordinator did not happen until the patient was ready for discharge. This was recognised by staff as one potential factor in the discharge delays. Following an audit of bed use in 2013, the trust had identified delayed discharge as a concern. One of the outcomes of this audit was to create new posts for dedicated discharge staff. This had not been put into practice across the trust.
- On the wards at St Anne's Centre and Beechwood Unit we found the records viewed were difficult to navigate. For example, discharge plans were incorporated within the client review documentation which made it difficult to find and track. Some records had not been updated to reflect current discharge planning.
- In the six months to September 2014 the trust reported 132 delayed discharges from 22 wards. Brunswick Ward had a total of 29 delayed discharges in this period, the most of any ward in the trust. The trust had identified that the most common areas contributing to delayed transfers of care in the past 12 months were; availability of residential care home placement, housing difficulties and completion of assessment. We spoke with members of the crisis team, ward managers and the Independent Mental Health Advocate who confirmed that lack of suitable accommodation was a serious concern. However we did not see how this was being addressed with other agencies.
- The proportion of patients followed up within seven days of discharge was in line with the England average of 97%. Patients valued the contact following discharge.
- The service partook in a phone call each afternoon to review the admissions within the last 24hours and assess the bed availability within the wards.
- The trust worked in partnership with the South East Coast Ambulance Service (SECAMB). The aim of the scheme is to prevent unnecessary admission to hospital by providing information to the ambulance service.

The ward optimises recovery, comfort and dignity

- We found that most wards provided a full range of therapeutic rooms and equipment to support treatment and care. For example, they had art and therapy rooms, a spiritual room, laundry and kitchen facilities, a gym, a family room together with clinical treatment rooms and quiet rooms. Some hospitals also had a café available for the use of patients, staff and visitors.
- Most of the ward environments were in good repair and provided a therapeutic environment. Some wards including those at St Anne's Centre were tired and not designed in a way that benefits patients with dementia. Not all of the wards had bedrooms that were en-suite. This meant that some wards had shared toilet and bathroom facilities.
- All of the wards had quiet areas where patients could meet visitors. In addition Meadowfield Hospital had therapeutic areas off the ward where patients could socialise, engage in therapeutic activities or meet visitors if their condition allowed.
- We found the ward payphones were situated in communal areas of the wards which meant that patients could not make phone calls from these pay phones in private.

Requires Improvement

Are services responsive to people's needs?

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

- All patients had access to outside areas for therapeutic activities and fresh air. However, some of the wards gardens were not safe for people with dementia. For example bushes were cut in a way that meant they were sharp. One ward was seeking money to make an area suitable for patients.
- Patients were not always supported to spend time off of the wards. We found that some patients had not been off of the wards for several months and there was no evidence to indicate that these patients had been offered the opportunity to go out. Care plans were not in place to support patients in accessing regular time off of the ward and some patients who were subject to a deprivation of liberty safeguards did not have conditions set which required the staff to ensure that patients had time off of the ward.
- We saw that there was a range of information available on treatments, medication, the services offered at the hospital and local services together with information on patients' rights and how to complain. However, this was not consistent across all wards and information wasn't always available in easy to read formats.
- Patients told us the food was good. The wards provided breakfast, light lunch and an evening meal. Some wards had a patient's pantry where patients had access to hot drinks and snacks throughout the day and night if needed. All wards provided a range of snacks and drinks that could be accessed throughout the day.
- Daily and weekly activities were advertised and available on Meridian ward. In addition Mill View hospital had a good range of activities and groups available to patients from Meridian ward. The activities were varied, recovery focussed and aimed to motivate patients. We saw that the activities programme covered the weekend periods.

Ward policies and procedures minimise restrictions

- We found that in general blanket restrictions were only used when justified. Meadowfield Hospital was open with an unrestricted access policy. We observed how this was managed in practice with staff using therapeutic relationships to maintain safety. This meant that informal patients could access the café and activities off the ward as indicated by their risk assessment and care plan. However, a number of wards operated a locked door policy and exits were not always clearly signed.
- On most wards we saw little evidence of patients personalising their rooms although there were pin boards available in the bedrooms. However, we noted that the length of stay in most hospitals was short. Personal effects could be brought into the hospital and people were able to personalise bedrooms. The advice for patients coming into hospital was not to bring too many belongings as storage space was minimal.
- On Larch ward, visiting times for family and friends was 10.00am to 8.00pm seven days a week. This meant that patients who had relatives, friends and carers who lived nearby were able to maintain contact with them. Most wards had flexible and open visit times.
- Patients had unrestricted access to their bedrooms. On some of the wards bedrooms were kept locked during the day to prevent people from wandering in by accident. Staff informed us that they would open rooms upon request.

Meeting the needs of all people who use the service

- We saw that information leaflets were available in different languages and staff told us how they were able to access interpreters if required. For example, we saw information about medication with advice that information in other languages was available. However, we saw little information about local services in the community for people with mental health problems.
- Some of the wards had a sacred space or multi-faith spiritual room and a Chaplin trained to support people with mental health problems. The Chaplin was also able to arrange for members of other faiths to visit and provide spiritual support.
- We saw that the weekly menus provided a choice of food which met the dietary requirements of religious and ethnic groups. Staff confirmed that special diets could be catered for and gave examples of providing gluten free or halal meals. Menus were available in dementia friendly formats to optimise choice.

Listening to and learning from concerns and complaints

Requires Improvement

Are services responsive to people's needs?

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

- The patients we spoke with all knew their rights and how to raise a complaint. Details on how to make a complaint was included in the welcome handbook given to each patient on admission. We saw there were also information leaflets available on the wards about making complaints. The trusts' website included information on the Patient Advice and Liaison Service (PALS) which supported patients in raising concerns.
- Community meetings were not held on all of the wards. This meant that not all patients in the trust had the same opportunities to raise concerns or complaints. On Larch ward community meetings were held on the ward each morning and this was an added opportunity for patients to raise concerns. Patients told us they were listened to and gave examples where they had made a complaint and positive action was taken. Staff told us that most issues were resolved informally and these concerns were not documented.
- The staff we spoke with told us that they rarely received feedback from complaints. There was little analysis of themes or trends at ward level. We saw the monthly information received by the ward managers and this related to the timeliness of their response to the complaint and did not include feedback about the type of complaint, identify themes, details of any investigation or outcomes for both patients and staff.
- We saw that 'Report and learn' bulletins were sent to staff giving information about some of the complaints but this was general in nature and appeared sometime after the event.

Are services well-led?

Requires Improvement

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

Summary of findings

We rated well-led as **requires improvement** because:

- On Larch ward staff rarely received feedback from complaints and there was little analysis of themes or trends at ward level.
- Some staff were unclear on the trusts vision and values.
- Ward managers had access to a range of performance indicators and other productivity metrics. However, this system did not allow for the effective management and resolution of all areas of concern. For example there were no centralised systems for monitoring the progress and updates in staff training. There were significant gaps in mandatory training and supervision.
- There were inconsistent and inadequate systems in place to monitor performance and quality assurance. We found the trust did data through auditing and mandatory data collection. However, there was little evidence that this information was fed back to the ward managers to enable them to improve practice.
- There was substantive use of bank staff on Brunswick ward but they did not always have access to training.
- Some wards had incorrect information on the patient information boards including legal status.
- There was a basic monthly environment audit carried out on some of the wards but this had clearly missed an environmental risk on two of the dementia wards.
- Governance systems were in place to monitor the completion of documentation. However, the managers and staff informed us that these governance systems did not support the effective monitoring of the quality of care records.
- Meridian ward had experienced three ward manager changes within a one year period and this was commented on by some staff interviewed.

Our findings

Vision and values

- In 2013 the trust held focus groups with staff who informed them the trust's values and vision were unclear. Following this the trust started an initiative to promote their business objectives through publications and leadership development initiatives. We found that those staff we spoke with were not aware of the Trust's vision and strategy; however they all aspired to provide high quality care for the patients in their care. We spoke with managers, who were undertaking the leadership programme. These staff were aware of the trust's objectives.
- Staff spoke highly of their individual teams and the support they got from their colleagues.
- Staff we spoke with told us that members of the senior management team and executive members of the trust board had visited their service. Managers told us that the senior management team and directors of the trust understood what was happening at the frontline as they get reports and visit the various wards and services.

Good governance

- The trust's own governance arrangements had identified the majority of issues found at inspection and had action plans in place to address the issues. For example the trust had identified the detrimental effect the 12 hour shift pattern had had on staff training, support and supervision. It had plans in place to revert to a three shift system as soon as possible. We saw that actions had been taken such as recruiting additional staff to the ward vacancies. However we noted that although staff supervision, appraisals and training had been flagged as a risk, resources had not been allocated to mitigate the effect of the 12 hour shift pattern and allow staff to attend training or receive supervision.
- The trust's governance arrangements had identified issues with the data collection and processing of incidents. However, we identified that staff were not always recording all incidents as required in the trusts incident policies. The managers told us wards were focussed on reporting falls as an identified risk for older people.
- There were mechanisms to learn from incidents, complaints and patient feedback such as the Trust bulletins and information on notice boards. However,

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staff told us this information often was passed on some time after the events in question and they rarely received direct feedback from any incident they reported or were involved in.

- Managers told us of the various meetings and groups they attended to monitor the local risks both within the trust and the wider community. For example, the leadership team meetings where all the heads of departments met to discuss risk management at the A&E liaison group. The reports from these meetings fed into the divisional leadership meetings and from there to the trust board.
- The trust identified six extreme risks. These included improving services for people that used mental health services, maintaining financial performance, meeting contracted levels of performance, improving satisfaction with premises, reduce backlog of maintenance and reducing agency staff. Control measures were in place for each risk. However, there were no timescales identified.
- The trust acknowledged that the outdated information technology systems had impacted on the quality of information available. The trust reported a number of reporting and recording errors with the data sent through to the Care Quality Commission. This included the recording of professional registration for pharmacists, training data and the use of agency staff. The poor quality of data available impacted on reporting information, the learning and development information for workforce planning and the trust's understanding of the quality of care given. A recent staff survey also identified outdated information technology as a key concern.
- We were told of the trust's plan to undertake a large scale modernisation of their information technology infrastructure during 2015.
- We found that the ward managers had sufficient authority and autonomy to effectively manage their service.

Leadership, morale and staff engagement

- The managers confirmed that there were some sickness and absence issues which had a knock on effect with the staff covering becoming exhausted. They told us that this was exacerbated by the 12 hour shift pattern and they were working to implement the new system as soon as possible.
- The staff we spoke with told us they felt able to raise concerns without fear of victimisation. They gave us examples of raising concerns with their immediate line managers and the action that was taken. However, on Brunswick ward there was a divide between staff and management, so staff morale was low.
- Most staff we spoke with told us they happy to work for the trust. Several members of staff had worked for the trust for some time and told us how much they enjoyed their job. Others told us that their teams were good to work for and that they always supported each other.
- Junior staff and healthcare assistants told us that the senior staff on the ward consulted with them and listened to their opinion. They told us they felt valued and that their opinion mattered.
- Meridian ward had experienced three ward manager changes within a one year period and this was commented on by some staff interviewed.

Commitment to quality improvement and innovation

- We found that the Trust collected much data through auditing and mandatory data collection. There was little evidence at ward level that this information was fed back to the ward manager to enable them to improve practice.
- The wards undertook a number of quality monitoring audits such as monthly records audits and the early warning scoring system (MEWS) audit. The managers told us that these local audits were useful in highlighting poor practice. For example if staff scored less than 85% on the MEWS audit it had to be undertaken monthly. The audits had identified that there was good completion following admission but this tended to fall off after 72 hours. This information helped managers address the issues with individual staff. We saw that over the past four months, compliance with the MEWS observations were generally improving across the wards. However the results from these local audits were not fed into the trust's governance information systems and weren't reported on.

Are services well-led?

Requires Improvement

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

- We saw that the wards were using the NHS National Safety thermometer to record and identify safety themes. The matron told us that since the information became available in electronic form this had helped with the monitoring individual ward compliance. We were told that Larch ward consistently collected the information and displayed the results on the ward notice boards.
- The trust placed a high value on research and developing best practice, encouraging staff innovation. There was a research and development department who worked with the local university. The Trust was undertaking 36 studies and published more than 100 studies each year.
- The workforce was relatively settled and where staff had been in post for some time. We found a lack of contemporaneous practice, which was exacerbated by a lack of training. For example, many staff had little working knowledge of recovery focused care and had not included this model of care into their working practices.
- Ward managers had access to a range of performance indicators and other productivity metrics. However, this system did not allow for the effective management and resolution of all areas of concern. For example there were no centralised systems for monitoring the progress and updates in staff training. There were significant gaps in mandatory training and supervision.
- There were inconsistent and inadequate systems in place to monitor performance and quality assurance.
- At the time of this inspection the wards were not participating in a national quality improvement programme such as Accredited Inpatient Mental Health Service (AIMS.)

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although numerous ligature risks had been identified on all the older adult admission wards some staff were not able to articulate how they were being managed or mitigated on a day to day basis. Audits did not capture all potential ligature risks. Trust governance systems had not effectively assessed and monitored the quality of services provided. The trust did not have an effectively operating system to share learning from incidents in a timely manner in order to make changes to peoples care in order to reduce the potential for harm to service users. This was in breach of regulation 10(1)(a)(b) and (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Relates to Grove, Iris, Larch, Brunswick and Burrows wards.**

Regulated activity	Regulation

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9: Person-centred care The trust had not taken proper steps to ensure that each patient using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe. At one hospital, all patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation. This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Relates to Larch ward.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11: Need for consent The trust did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people or where that did not apply for establishing and acting in accordance with people's best interests. Mental capacity assessments lacked explanation of how capacity had been assessed. Many staff had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Requirement notices

This was in breach of regulation 18 (1)(a)(b) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relates to Grove and Iris wards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13: Safeguarding service users from abuse and improper treatment

The trust did not have suitable arrangements in place to protect patients against the risk of unlawful control and restraint. On two wards patients were being unlawfully deprived of their liberty.

This was in breach of regulation 11(1)(a) (2)(a) (3)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relates to Grove and Iris wards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12: Safe care and treatment

Requirement notices

The trust did not protect patients against the risks associated with unsafe use and management of medicines. Two wards had not been monitoring the storage of controlled drugs and one ward had not disposed of or returned out of date controlled drugs. One ward had not used covert medication in line with trust policy because a pharmacist had not been involved in the process.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relates to Grove, Iris, Burrows and Brunswick wards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15: Premises and equipment

The trust did not ensure that patients were protected from the risks associated with unsafe or unsuitable premises. Five wards did not comply with Department of Health gender separation requirements. Two of the older adult inpatient wards had unsuitable garden designs and layouts for use by dementia patients.

This was in breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relates to Grove, Iris, Burrows, Brunswick and Larch wards.

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance The trust did not ensure that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Care plans were not signed by patients and there was no rationale given as to why they had not signed. It was not evident that copies had been given to patients. Diet and fluid charts were not completed clearly or consistently despite being identified as a clinical need. This was in breach of regulation 20(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Relates to Grove, Iris, Burrows and Brunswick wards.** **(The diet and fluid charts only relate to Grove ward.)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing The trust did not have suitable arrangements in place to ensure that staff had received appropriate training, professional development, supervision and appraisal.

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10: Dignity and respect Informal patients were not always fully informed of their right to leave the ward and on one occasion an informal patient was advised that they could not leave the ward until they had seen a doctor. This would constitute as de facto detention. Other patients had not been supported to spend time off of the wards and they did not have care plans in place to ensure that staff provided people with an opportunity to leave the ward and access the community. This was in breach of regulation 17(1)(a)(b) (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Relates to Grove and Iris wards.**

This in breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relates to Grove, Iris, Burrows, Brunswick, Meridian and Larch wards.