Surrey and Borders Partnership NHS Foundation Trust

Psychiatric intensive care units and health-based places of safety

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Langley Wing Epsom General Hospital	RXX87	Fenby psychiatric intensive care unit	KT18 7EG
Langley Wing, Epsom General Hospital	RXX87	Fenby ward place of safety	KT18 7EG
Ridgewood Centre	RXX20	Wingfield ward place of safety	GU16 9QE
St Peter's site	RXXW1	Blake ward place of safety	KT16 0AE

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

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

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

Summary of findings

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

Contents

Summary of this inspection

Page

Overall summary 4

The five questions we ask about the service and what we found 5

Background to the service 8

Our inspection team 8

Why we carried out this inspection 8

How we carried out this inspection 8

What people who use the provider's services say 9

Good practice 10

Areas for improvement 10

Detailed findings from this inspection

Locations inspected 11

Mental Health Act responsibilities 11

Mental Capacity Act and Deprivation of Liberty Safeguards 12

Findings by our five questions 13

Action we have told the provider to take 21

Summary of findings

Overall summary

Surrey and Borders Partnership NHS Foundation Trust provides health and social care services for people with mental health problems, drug and alcohol problems and learning disabilities in Surrey and North East Hampshire.

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

The trust has 24 locations registered with CQC. Thirteen locations are registered to provide social care to children and adults with learning disabilities. The remaining locations are registered to provide a range of healthcare services. Acute and older people's inpatient beds are provided at a number of locations: Farnham Road Hospital, West Park Epsom, Mid Surrey Assessment & Treatment Service, Ridgewood Centre, St Peters Site, and Willows, Woking Community Hospital. Services for people with learning disabilities are provided at Bramdean and April Cottage. Margaret Laurie House provides inpatient rehabilitation services. Community based services are registered to the trust headquarters in Leatherhead.

The trust was formed in 2005 and became a foundation trust in May 2008. It employs 2,300 staff across 56 sites, including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. The trust is currently undertaking a programme of work costing £64m to replace, modernize or maintain its building stock which is a significant programme of change for the trust.

The trust serves a population of 1.3 million people. Deprivation in the population is lower than the national average, although some areas of deprivation do exist. Life expectancy is 6.3 years lower for men and 4.0 years lower for women in the most deprived areas of Surrey than in the least deprived areas. In Surrey, 9.7% of the population is non-White.

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

- Mental Health Services for Adults of Working Age
- Mental Health Services for Older People and Specialist Services
- Services for People with Learning Disabilities
- Services for Children and Young People

Surrey and Borders Partnership Foundation NHS Trust's locations have been inspected on 51 occasions since registration across 29 of its locations. Reports of these inspections were published between April 2011 and March 2014. At the time the comprehensive inspection was undertaken the trust was non-compliant for at least one regulation at 20 of its locations. Of these locations 12 were non-compliant for the safety and suitability of their premises and 10 for the care and welfare of people who use services. Two locations were compliant for all regulations. Seven locations were no longer registered to provide services. This non-compliance was followed up across the relevant locations as part of this comprehensive inspection.

The trust has one psychiatric intensive care unit based on Fenby Ward at Epsom General Hospital. There are three hospital based places of safety provided by the trust at Epsom General Hospital, Blake ward on the St Peters site and at the Wingfield ward at the Ridgewood Centre.

Summary of findings

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

Are services safe?

Staff on the psychiatric intensive care unit recognised the need to report serious incidents and lessons were being learnt from these events.

Staff were not clear about when the use of interventions constituted seclusion. This meant that the necessary safeguards were not put in place to keep people safe.

The emergency equipment available for resuscitation was not being checked on a weekly basis as stipulated by the trust to ensure it was always ready to use.

Whilst staff had received safeguarding training, they could not clearly explain what actions they would take in response to an allegation of abuse.

Many of the staff who were working on the psychiatric intensive care unit were temporary. The trust provided safe staffing levels and recruitment was ongoing. More permanent staff are needed to improve the consistency of care.

The places of safety had access to staff as needed. At the Ridgewood Centre some of the recommended actions following a previous serious incident had not been implemented.

While the physical environment of the place of safety on Blake Ward at St Peters site had been improved, we found that the trust needed to review the other two places of safety at the Ridgewood Centre and Epsom General Hospital to ensure they safely met the needs of the patients.

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Summary of findings

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Are services effective?

Permanent staff on the psychiatric intensive care unit had received training and received regular supervision.

Significant numbers of temporary staff were working in the service and some were supporting other staff to carry out physical interventions, such as restraint, without having completed the appropriate training. We were also told that some agency staff were working on the ward without an induction to the service.

The use of the Mental Health Act was mainly appropriate, but patients detained on a section 2 did not have a record of having their rights explained to them on a weekly basis.

Activities did not always take place as planned and some people told us that they did not find them engaging.

Are services caring?

On the psychiatric intensive care unit we saw that staff interacted with patients briefly and in a task-focused way. Staff tended to watch the patients rather than actively engage with them. Staff did not always respond to patients' requests for assistance in a timely manner.

In the places of safety we found staff generally engaged in a positive manner with people and recognised the stress and anxiety they were feeling.

Are services responsive to people's needs?

The psychiatric intensive care unit at the time of the inspection had three bedrooms which were not in use as they were being refurbished.

It was positive to note that the trust's places of safety do accept patients who are intoxicated if they are assessed as being physically

Summary of findings

stable. Some patients are spending long periods of time in the places of safety, up to 29 hours, waiting for their Mental Health Act assessment to be completed and where needed a bed to be available.

Are services well-led?

The psychiatric intensive care unit did not have strong leadership in place to ensure the service provided a high standard of care at all times.

The recent internal quality assurance processes (periodic service review) used by the trust had not highlighted the challenges being faced by the service and the need for improvements to take place.

Staff working within the places of safety felt that the leadership of these services had improved.

Summary of findings

Background to the service

Psychiatric intensive care unit (PICU)

We found that the leadership of the unit needed to improve in order for people to receive a consistently good quality service.

People using the service were not always getting the support they needed from staff in a timely manner and staff did not actively engage with patients and interacted with them in a task-focused way.

Emergency equipment for resuscitation was not being regularly and thoroughly checked, which could have compromised people's safety.

Staff did not always recognise when they were secluding people, which could affect their rights and safety. Also agency staff were restraining people without having the correct training.

Internal quality assurance processes had not always identified the need for improvements to be made and there were areas where this was needed.

Places of safety

We found that the leadership of these services has improved.

The physical environment that services are provided in at Epsom General Hospital and the Ridgewood Centre needs to be improved to ensure patients are cared for in a safe place that preserves their dignity.

Some people are spending long periods of time in the place of safety waiting for a Mental Health Act assessment to be completed and where needed for a bed to be made available.

Our inspection team

Our inspection team was led by:

Chair: Sheena Cumiskey Chief Executive Officer at Cheshire & Wirral Partnership NHS Foundation Trust

Team Leader: Jane Ray, Care Quality Commission

The team of 50 people included CQC Inspectors, Mental Health Act Reviewers, and an analyst. We also had a variety of specialist advisors which included a consultant psychiatrist, nurses, junior doctors and social workers.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

The inspection team inspected the following core services, which are inspected at each trust:

- Acute admission wards
- Health-based places of safety
- Psychiatric Intensive Care Unit
- Services for older people
- Adult community-based services
- Community-based crisis services
- Child and adolescent mental health services
- Services for people with learning disabilities or autism
- Long stay/rehabilitation services

We also inspected the Specialist eating disorder services provided by the trust.

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

Before the inspection visit took place, we met with five different groups of people who use the services provided by the trust. We also met with the trust's council of governors. They shared their views and experiences of receiving services from the provider.

Before and during the week of the inspection we undertook separate inspections at 10 social care services provided by the trust: Ashmount, Beeches Bungalow, Court Hill House, Derby House, Ethel Bailey & Oak Glade, Hillcroft, Larkfield, Redstone House, Rosewood and The Shieling. These inspections are reported on separately, although their findings are included in the 'well-led' section of this report.

We inspected all the acute inpatient services and crisis teams for adults of working age. We visited the psychiatric intensive care unit on Langley wing at Epsom hospital. We went to the three places of safety located in Langley Wing, Epsom General Hospital, Wingfield ward, Ridgewood Centre, Frimley and St Peter's Hospital.

We also inspected the inpatient and some community services for older people. We visited a sample of community teams across a range of services, including services for adults, services for people with learning disabilities, and services for people with eating disorders,

During our visit the team:

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

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

What people who use the provider's services say

Psychiatric intensive care services

The ward had nine patients admitted at the time of our inspection, and we spoke with four of them. Comments about care received were generally negative. People told us they often had to wait a long time for staff to respond to their requests. People also told us that activities, such as cookery sessions, are frequently cancelled.

Places of safety

People we spoke with told us they felt supported and respected by staff even though they may be unhappy about the need for an admission. People said they had their rights explained to them and were offered food and drink. They expressed frustration about the length of time they had to wait for a Mental Health Act assessment.

Summary of findings

Good practice

- The trust places of safety did not exclude people due to intoxication and there were policies in place to ensure they could meet the needs of these patients. There were also specific procedures in place for the care of people under the age of 18 years.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

Psychiatric intensive care unit

- Staff working in the service must respond promptly to people's requests for help and engage proactively with them.
- The resuscitation equipment must be maintained and monitored. Staff must be able to identify the equipment accurately.
- Staff must be clear about when the use of interventions constituted seclusion and ensure the necessary safeguards are in place.
- Patients detained under Section 2 of the Mental Health Act must have their rights explained to them on a weekly basis and recorded. The documentation given to patients must include details of how to access advocacy services and how to contact the Care Quality Commission.
- Agency staff must be trained to an appropriate standard in the use of restraint before using this physical intervention.
- The internal quality assurance processes used by the trust (periodic service review) must be completed correctly so it accurately reflects the service being reviewed.

Places of safety

- While the physical environment of the place of safety on Blake Ward at St Peters site had been improved, the other two places of safety used by the trust must have their physical environments reviewed to ensure they safely meet the needs of the patients.

Action the provider SHOULD take to improve

Psychiatric intensive care unit

- Staff should be able to explain what actions they would take in response to allegations of abuse.
- There should be a clear record of people entering and leaving the ward.
- The accuracy and detail of documentation should improve – especially incident forms, restraint forms, documentation of rapid tranquilisation and people's involvement in their care plans.
- Agency staff should complete a ward induction before caring for patients on the unit.
- Activities provided on the ward should be reviewed to ensure they reflect the interests of people using the service.
- Recruitment should continue to provide more permanent staff on the ward and improve consistency of care.
- Leadership should improve to provide a consistently high quality service.

Places of safety

- The Ridgewood Centre place of safety must ensure that where recommendations are made following serious incidents and the recommendations are fully implemented.
- The trust should work with other stakeholders to reduce the time spent by some patients in the places of safety waiting for a Mental Health Act assessment or where needed a bed – especially out of hours.
- The provider must ensure that all documentation relating to the use of the places of safety is accurate and fully completed.

Detailed findings

Surrey and Borders Partnership NHS Foundation Trust

Psychiatric intensive care units and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Fenby psychiatric intensive care unit	Langley Wing, Epsom General Hospital
Fenby place of safety	Langley Wing, Epsom General Hospital
Wingfield ward place of safety	Ridgewood Centre
Blake Ward place of safety	St Peter's 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 systems in place to ensure the effective operation of the Mental Health Act that met legal requirements.

Section 17 leave was recorded and reviews of risk carried out prior to leave, with a copy of the leave form being given to the patient, carer or others to meet requirements of the Code of Practice.

One patient had been transferred to another hospital for medical treatment and the legal authority was not in place for the transfer. This was resolved immediately when highlighted to the consultant.

The giving of section 132 Rights information was not completed in accordance with trust's own policy. For example patients detained under Section 2 had no clear records that their rights had been explained on a weekly

basis. Also as an old form was being used it was not possible to confirm if patients had been given details of accessing advocacy services or how to contact the Care Quality Commission.

The use of the Mental Health Act was generally well managed in the places of safety. Patients were having their rights explained to them on admission as well as receiving the written information.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Capacity and consent were assessed on admission to the place of safety and were discussed and reassessed at ward reviews for inpatients.

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

Staff on the psychiatric intensive care unit recognised the need to report serious incidents and lessons were being learnt from these events.

Staff were not clear about when the use of interventions constituted seclusion. This meant that the necessary safeguards were not put in place to keep people safe.

The emergency equipment available for resuscitation was not being checked on a weekly basis as stipulated by the trust to ensure it was always ready to use.

Whilst staff had received safeguarding training, they could not clearly explain what actions they would take in response to an allegation of abuse.

Many of the staff who were working on the psychiatric intensive care unit were temporary. The trust provided safe staffing levels and recruitment was ongoing. More permanent staff are needed to improve the consistency of care.

The places of safety had access to staff as needed. At the Wingfield Unit some of the recommended actions following a previous serious incident had not been implemented.

While the physical environment of the place of safety on Blake Ward at the St Peters site had been improved, we found that the trust needed to review the other two places of safety at the Ridgewood Centre and Epsom General Hospital to ensure they safely met the needs of the patients.

Our findings

Fenby psychiatric intensive care unit

Track record on safety

Staff who worked at the unit regularly were able to recognise incidents that had arisen in their work and knew how to report incidents using the trust's electronic incident forms. We did note the level of detail contained on incident reporting forms was not consistent.

Learning from incidents and improving safety standards

Following a recent serious incident on the unit, we saw additional security checks had been implemented. The service manager told us what actions had been taken immediately following the incident to ensure patient safety.

Risks relating to the patients were discussed in weekly reviews with risk assessments updated accordingly. Risk assessments were being undertaken prior to any leave being approved for detained patients. We looked at the care records and risk assessments relating to the most recent serious incident. We noted that the patient's risk assessment in their notes had not been updated since the incident. We raised this with senior staff on the ward and found that this was a recording error. Risk had been reassessed in a ward review, recorded on the progress notes but not linked to the individual patients risk assessment. Senior staff said that this would be raised as a reminder to staff at the next staff meeting.

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

Records showed staff were up to date with safeguarding training and the staff we spoke with could describe the different types of abuse; however they were not able to explain how they would use this knowledge and respond to allegations of abuse. Staff did not know the name of the trusts safeguarding lead but told us they would speak to a manager if they felt they needed to report anything.

We were asked to sign the visitor book on our arrival and departure from the ward on a couple of occasions but this was not consistent. The book was outside the ward and, on one occasion, a member of domestic staff let us out of the ward. Staff did not always know who was on the ward and where they were which could potentially place patients and visitors at risk.

Assessing and monitoring safety and risk

The ward used the trust-wide risk rating scale to identify and monitor the levels of risk relating to patients. The ward had assessed each of the rooms and made improvements to ensure the environment of the bedrooms presented the lowest risk possible. Patients' level of risk was assessed and those with the highest risk rating had bedrooms nearest the nursing office.

Are services safe?

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

Every patient had individual risk assessments covering aspects of their health including physical health, medication, psychological therapies, meaningful activities and mental health. These were updated at ward reviews or reactively after incidents.

The ward often required additional staff to maintain safe staffing levels. Senior staff explained that they use NHS Professionals agency as a preference but also had to regularly use staff from other agencies. They tried to use the same agency staff to maintain continuity of care. During the week of the inspection the rota split was 51% permanent staff and 49% agency staff excluding the band 6 and 7 nurses. We were told that this use of temporary staff was greater than usual as one person was requiring acute hospital care.

We were informed by senior staff on the unit that they do not use seclusion as a physical intervention for managing challenging behaviours. However we found records which showed that seclusion had been used three times this year. Documentation was not fully completed and lacked key assessments such as a medical assessment. Staff we spoke to had different understandings of what they called the de-escalation space and seclusion.

We also looked at the use of restraint on the unit. We noted the recording of the use of restraint was incomplete and not easy to understand. For example, we read a document for a patient, which stated that a staff member had restrained the person's legs but did not say where the patient had been held. We spoke with the staff and were told the patient may have been restrained on their bed but this was not recorded on the form. We also found that when physical restraint had been used patients had not been given an opportunity to give their account of the episode in line with the Mental Health Act 1983 (MHA) code of practice.

On the first day of our inspection we found the female lounge locked on our arrival. Staff explained this had recently been cleaned and would be opened straight away. We found it locked again the following day. We highlighted this to the manager who immediately reminded staff of the importance of that room remaining available to the female patients. When we checked on the final day of our inspection, the room was open.

Understanding and management of foreseeable risks

The ward had three bedrooms out of use at the time of our inspection. The environment was stark and felt institutionalised with several areas showing damage. The ward manager and service manager spoke with us about the challenges of the environment. They told us the ward had to regularly be repaired. One problem they had identified was damage to the walls. We were shown that the walls had been redecorated with material that could be wiped clean rather than having to be repainted. There was an extensive programme of improvements underway. Staff showed an awareness of the risks posed by the ward environment and systems had been put in place to attempt to ensure patient safety.

We checked the resuscitation equipment. The ward manager was the physical health lead for the ward and informed us the resuscitation emergency bag was checked every week. We found from looking at the records that checks were only being carried out approximately once a month. There also appeared to be inconsistency in the identification of the equipment for the completion of the checklist. For example one member of staff could not clearly show, which oxygen masks related to those listed on the checklist.

Places of safety

Track record on safety

Incidents in the places of safety were reported and findings were shared in team meetings.

We were concerned that at the Ridgewood centre place of safety, the recommendations from a previous incident (hostage situation in March 2013) relating to the provision of a clock were not followed through, and there was a lack of clarity regarding responsibility to ensure that actions were taken. A clock was provided as soon as this was identified during the inspection.

Assessing and monitoring quality and safety

The places of safety operated by the trust were coordinated by a manager based at the Fenby Unit at Epsom General Hospital. A paper copy of the policy and procedures for the places of safety were available at the Fenby Unit and were also accessible on the trust's website. At the Ridgewood centre we found that staff were not clear about how to

access guidance about what steps they should take for patients brought to the unit by the police (section 135 or 136) which raised concerns about whether staff were fully aware of how to use the procedures for the service.

Staffing levels were monitored using the trusts system of safe staffing and the wards had enough staff to respond to admissions to the places of safety. The nurses in charge of the shift were responsible for the local management of the places of safety. Additional staffing could be arranged as required. The police remained in attendance for as long as was needed to ensure the safe handover of care to the qualified nursing staff.

Understanding and management of foreseeable risk

The Fenby Unit place of safety was located behind the psychiatric intensive care unit with a separate entrance. The room was stark with little furniture. This had already been ordered and was being replaced following our inspection. There was a separate bedroom area (which doubled as the seclusion room used by the ward) with an interconnecting door to a ligature-free toilet. The viewing mirrors allowed staff to monitor the person whilst in the bedroom and toilet area. The window in the bedroom door was high up and in a position which was not easy for staff to observe through for long periods.

There was no clock in the area. There was no communication system in place to allow people to communicate with staff whilst in the bedroom area. To support people using the toilet, staff had to enter the toilet via a door from the main area and unlock the interconnecting door. This placed the staff at risk. The doors to the bedroom, interconnecting door and toilet to main area were old and showed damage and repair. We noted the hand push plate had a sharp corner which a person could potentially injure themselves on. We highlighted these issues to the acute service manager who addressed the concerns that could be dealt with immediately and added the remaining concerns to the agenda for the next service meeting.

The place of safety in the Wingfield Unit was a converted quiet room with no ensuite toilet facilities or panic alarm (a hand held panic alarm system was in place for staff use). The furniture consisted of a bed and sofa, and no clock was present.

The physical environment of the place of safety on Blake Ward place had been significantly improved as a result of previous inspections. There was separate access and some improvements had been made to the environment. The suite had been refurbished and had two single rooms with a bathroom.

Are services effective?

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

Summary of findings

Permanent staff on the psychiatric intensive care unit had received training and received regular supervision.

Significant numbers of temporary staff were working in the service and some were supporting other staff to carry out physical interventions, such as restraint, without having completed the appropriate training. We were also told that some agency staff were working on the ward without an induction to the service.

The use of the Mental Health Act was mainly appropriate, but patients detained on a section 2 did not have a record of having their rights explained to them on a weekly basis.

Activities did not always take place as planned and some people told us that they did not find them engaging.

Our findings

Fenby psychiatric intensive care unit

Assessment and delivery of care and treatment

The management of medicines was in line with trust policies and procedures. We noted the temperature of the clinic room was very high, regularly over 30 degrees. There was a small air conditioning unit in place and we were told that the new air conditioning unit was due for installation within a few weeks.

We looked at records relating to the use of rapid tranquilisation medication. Rapid tranquilisation had been recorded as being used 13 times in 2014. This should have been reviewed afterwards with the patient. Records of this had not been fully completed and so it was not possible to tell if this review had taken place.

We looked at a sample of care records. We found basic assessments of mental and physical health needs. Risk assessments were individualised and current. Ward reviews were weekly and we saw evidence of discussions about the effectiveness of care plans and risk assessments as part of these.

Staff had received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). Capacity and consent was discussed during ward reviews and documented as such. The deputy ward manager was the mental capacity lead for the ward. All patients in the ward were detained under the MHA.

Staff, equipment and facilities

The majority of permanent staff had been trained in de-escalation techniques and the use of physical interventions. We found that some agency staff had not completed this training. At the time of the inspection there were significant numbers of agency staff working on the unit. NHS Professionals provide all the temporary staff to the trust either from their own bank or from vetted agencies. As part of this contract temporary nursing staff are required to have break-away training if they work in mental health services. We spoke with five agency staff. Four of them informed us they had been involved in restraining patients on the ward and had little or no training. One person who worked regularly on the ward told us they were regularly involved in undertaking restraints and had not received any form of training. The other person told us they had undertaken a two day course in restraint. They said they would only help with a physical intervention as a last resort when permanent staff were not available.

Permanent staff were mostly up to date with mandatory training and supervision. We spoke with staff and found varying levels of understanding of the topics and application of the knowledge to the patients they cared for. A significant amount of training was undertaken via the online learning system. Staff told us they occasionally had trouble accessing this.

New permanent staff underwent an induction period. This involved attending a corporate induction, learning the ward and trust policies and a period of shadowing existing staff before working alone. We were told that agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. We did witness a brief induction of a member of agency staff however we were approached by another member of agency staff who was concerned that they had not been given any form of induction or handover before beginning one to one observations with a patient. This was confirmed by other agency staff we spoke with.

There was a full programme of activities available on the unit, provided by a dedicated therapy service. This

Are services effective?

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

included provision for the weekends and evenings. Patients gave generally negative comments about the service. They told us they always ended up doing art. One person told us cooking groups rarely happen. We spoke with the occupational therapy staff who told us it was very difficult to engage the patients and accessing activities off the ward was hard as this relied on accessing staff support to accompany patients.

We observed the "project group" activity during our visit. The group was listed as two hours long. Only two patients went to the group and did some art work whilst listening to background music. Other patients told us they did not go as it was "boring". Staff arrived at 10.50am, the group started at 11am and the group had finished and staff left the ward by 11.40am. We did not observe additional activities being offered to other patients or to group attendees once they had finished their projects.

Multi-disciplinary working

Daily meetings were held on the wards. These were attended by ward staff, doctors and the therapy service. There were ward reviews weekly and patients were involved regularly.

The manager felt they had a good relationship with the acute wards.

Mental Health Act (MHA) 1983

There were systems in place to ensure the effective operation of the MHA that met legal requirements.

Section 17 leave was recorded and reviews of risk carried out prior to leave, with a copy of the leave form being given to the patient, carer or others to meet requirements of the Code of Practice.

One patient had been transferred to another hospital for medical treatment and the legal authority was not in place for the transfer. This was resolved immediately when highlighted to the consultant.

The giving of section 132 Rights information was not completed in accordance with trust's own policy. For example patients detained under Section 2 had no clear records that their rights had been explained on a weekly basis. Also, as an old form was being used, it was not possible to confirm if patients had been given details of accessing advocacy services or how to contact the Care Quality Commission.

Places of safety

Staff, equipment and facilities

Staff supporting patients at the Fenby and Ridgewood centre places of safety were trained in the management of aggression and use of physical interventions. We were concerned that some staff had not completed the training needed to restrain a patient on the Blake Ward place of safety on the St Peter's site. The ward manager had escalated this as an issue and training was due to take place in July 2014.

Are services caring?

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

Summary of findings

On the psychiatric intensive care unit staff interactions with patients were observed to be brief and task focused. Staff tended to watch the patients rather than actively engage with them. Staff did not always respond to patients requests for assistance in a timely manner.

In the places of safety we found staff generally engaged in a positive manner with people and recognised the stress and anxiety they were feeling.

Our findings

Fenby psychiatric intensive care unit

Kindness, dignity and respect

We spoke with the patients on the ward and observed how staff interacted with patients throughout the three days of our inspection. We saw that staff were not responding promptly to patients' needs when they were asking for help. We had also been told this by several patients.

We used a tool to carry out an observation of interactions called a short observation framework for inspection (SOFI). The language we heard between staff was functional but generally positive. However, one member of staff was heard to say to another staff member "you need to be careful around (patient) – they're playing up".

In the handover we observed, staff were reminded to ensure that patients had one to one time. During our specific observation of approximately three hours, we did not observe any meaningful interactions between care staff and patients. Interactions tended to be brief and task-focused. We did not observe any one to one time occurring. Staff appeared to be watching the patients without positively and actively engaging with them.

People using services involvement

Patients were involved in their ward reviews on a weekly basis. The care records we looked at showed an inconsistency in the recording of the involvement of patients in the care planning process. When patients were not involved, we could not find documentation as to why not.

There was information available about the advocacy service and the advocate visited the ward regularly. They were also available to attend the ward reviews if the patient requested them.

Emotional support for care and treatment

Patients' relatives were involved in care planning and review as much as they could and from what the patient allowed. Being the only intensive care unit in the trust meant that some relatives had to travel significant distances to come to the ward.

A chaplaincy service was available to patients and representatives of other faiths and belief systems could be accessed through them.

Places of safety

Kindness dignity and respect

We spoke with one person whilst they used the Fenby place of safety. They were complimentary about their treatment and we observed staff behaving in a respectful and dignified manner. We saw that efforts were made to include the person in decisions and help them to understand the process and what was happening to them.

People using services involvement

We witnessed some good practice with a person being given rights verbally as they were unable to read or write. This was then documented on the paperwork

Emotional support for care and treatment

Staff working in the trust's places of safety appeared caring and compassionate with an understanding of the distress caused by and during an admission. Families and carers were involved and supported throughout the process.

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

The psychiatric intensive care unit at the time of the inspection had three bedrooms which were not in use as they were being refurbished.

It was positive to note that the trust's places of safety do accept patients who are intoxicated if they are assessed as being physically stable. Some patients are spending long periods of time in the places of safety, up to 29 hours, waiting for their Mental Health Act assessment to be completed and where needed a bed to be available.

Our findings

Fenby psychiatric intensive care unit

Right care at the right time

During our inspection, there were three bedrooms out of use due to building improvements that were taking place. There was a system in place where patients were identified who could be transferred to the acute wards should a bed be required on the intensive care unit. Where a bed was required, and there were no patients ready for transfer out, a private bed would be used out of area until a bed was available.

Care pathway

Patients expressed concern about the inconsistency of staffing and the use of agency staff. The ward reviews were attended by the consultant, therapy staff, ward staff as well as the patients and their relatives. Patients did not express any concerns to us about being delayed in their transfer in or out of the ward.

Learning from concerns and complaints

The service utilised the trust complaints system. Patients were given information about the complaints process. The service manager told us they discussed any complaints in team meetings and changes to practice were discussed and implemented as a result.

Places of safety

Right care at the right time

The Fenby Unit coordinated the place of safety services across the trust and collated the data for analysis.

The trust policy stated that a risk assessment should be completed within 30 minutes and an assessment by the duty doctor and home treatment team practitioner within an hour. A MHA assessment was required to be completed within four hours (within daytime working hours) and eight hours (outside normal working hours). The Royal College of Psychiatrists' recommend a three hour maximum assessment time. Section 136 documentation was used to monitor and record the use of the places of safety. We reviewed this and found that in general the level of detail was poor. For example some records did not say the time the person arrived, when the professionals were contacted and subsequently arrived to carry out an assessment.

We looked at the records kept for the service across the trust and noted the delays in Approved Mental Health Professionals (AMHP) and Section 12 approved doctors attendance times, particularly out of hours. We were told this has been acknowledged as an issue in service meetings. Causes were thought to be a lack of staffing amongst these services and the increased demands out of hours as they had to cover safeguarding concerns across the trust. This resulted in people regularly being in the place of safety for over four hours. We found stays of up to 29 hours in some locations which can be due to waiting for a bed where needed to be available.

The service did not exclude people on the grounds of intoxication which can in some cases delay their assessment. If a person was intoxicated, they would only be excluded after an assessment on grounds of physical ill health. The Fenby suite coordinated the service and a system was in place to prioritise assessments should demand outweigh provision.

Are services well-led?

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

Summary of findings

The psychiatric intensive care unit did not have strong leadership in place to ensure the service provided a high standard of care at all times.

The recent internal quality assurance processes used by the trust (periodic service review) had not highlighted the challenges being faced by the service and the need for improvements to take place.

Staff working within the places of safety felt that the leadership of these services had improved.

Our findings

Fenby psychiatric intensive care unit

Vision and strategy

Staff we spoke with appeared aware of the trust's values but it felt removed from its everyday work. There was information on staff noticeboards about the vision and values of the trust but this was covered up by other notices.

Responsible governance

We looked at the latest periodic service review which is a key part of the trusts internal quality assurance process, undertaken in June 2014. This produced some very positive findings which did not reflect some of the issues identified during the inspection. Staff were unable to tell us how their service was monitored and what areas there were for improvement according to service audits.

Information from the trust board was communicated through emails and newsletters. The service manager told us they ensured that staff were aware of important changes, accepting the difficulty of keeping staff aware when working nights and using agency staff. The trust board undertook visits to the services; however staff we spoke with were unable to tell us when the trust board last visited the ward.

Leadership and culture

There did not appear to be a strong sense of leadership on this ward. Information we were told by the service manager and ward manager did not reflect the actual practice we found. For example, we were told there was a strict rule that agency staff did not get involved in restraining patients. However, we were informed on several occasions, by a number of different agency staff, that they were involved in restraints on the ward.

During our inspection on the ward, it was not always clear who was in charge and leading the shift, which made the ward feel chaotic and unsafe at times. Patients told us on each day of our inspection that they did not feel safe on the ward.

Engagement

The trust had a variety of means of engaging patients to obtain feedback and opinions about care provision. Despite the sometimes challenging nature of the patient's conditions, there did not appear to be a focus on gaining their views on the ward. Patients were involved in care reviews but we did not see evidence of actions being taken to gain feedback on general service provision.

Performance improvement

There was a leadership programme which managers could access if they felt they needed additional training. The ward manager was additional to the staff numbers when on duty.

Places of safety

Responsible governance

The multi-agency police liaison group met on a monthly basis to review incidents, address highlighted concerns and risks and to plan further improvements.

We had concerns about how the activity of the services was being monitored and the impact of that on the quality and accuracy of the data used and the audit and development of the service provision trust wide.

Leadership and culture

On a day to day basis, the suites appeared well managed. Staff felt supported and their work was valued. Staff said they felt they were moving in the right direction and that the places of safety were, on the whole, a good place to work

At the Blake Ward place of safety, staff spoke highly of the manager who had been in post nine months. There was recognition of the changes that they had made in improving staffing levels, completely revamping the suite and changing the culture and ways of working on the ward.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated activities)** **Regulations 2010** **Respecting and involving people who use the service** The registered person must so far as reasonably practicable make suitable arrangements to treat service users with consideration and respect. The service must treat people with respect and engage proactively. Patients told us their needs were not attended to in a timely fashion and were consistently told to wait, with their request not always being attended to. Our observations found poor engagement levels between staff and patients. **Regulation 17(2)(a)**

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 2008 (Regulated Activities) Regulations** **2010** **Safeguarding service users from abuse** **How the regulation was not being met:** Seclusion is being used without suitable arrangements in place to protect service users against the risk of physical interventions being excessive, as the use of seclusion is not being recognised as such so its use can be correctly recorded and monitored. This was a breach of Regulation 11(2)(b)

Regulated activity	Regulation

Compliance actions

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 2008 (Regulated activities)** **Regulations 2010** **Respecting and involving people who use the service** **How the regulation was not being met:** The trust is not making arrangements to enable patients to be involved in decisions about their care and treatment by ensuring that patients detained on section 2 of the Mental Health Act are regularly informed of their rights in relation to the treatment they are receiving. This was a breach of Regulation 17 (1)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated activities)** **Regulations 2010** **Assessing and monitoring the quality of service** **How the regulation was not being met:** The trusts internal quality assurance system (periodic service review) had not been completed in a way that identified the areas for improvement in the psychiatric intensive care unit to ensure timely improvements were put into place. This was in breach of Regulation 10(2)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated activities)** **Regulations 2010** **Safety, availability and suitability of equipment** **How the regulation was not being met:** The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of

Compliance actions

unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is properly maintained and suitable for its purpose.

The resuscitation equipment was not regularly monitored in line with trust policy and documentation demonstrated staff appeared unable to identify the equipment accurately.

This was in breach of Regulation 16(1)(a)

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 22 HSCA 2008 (Regulated activities)** **Regulations 2010** **Staffing** **How the regulation was not being met:** In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Agency staff informed us they were regularly involved in restraining patients and had little or no training. This was a breach of regulation 22

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
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 2008 (Regulated activities)** **Regulations 2010** **Staffing** **How the regulation was not being met:** The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of— (a) suitable design and layout;. The Wingfield place of safety was housed within a converted day room. There were no ensuite facilities in the suite. The entrance is via the main reception and ward area. People are able to view inside the area from the garden. There was an unlocked door through to a small corridor with two locked rooms from it posing a risk to staff undertaking 1-1 observations. At the Fenby place of safety the window in the bedroom door was high up and in a position which was not easy for staff to observe through for long periods. There was no communication system in place to allow people to communicate with staff whilst in the bedroom area. To facilitate people using the toilet, staff had to enter the toilet via a door from the main area and unlock the interconnecting door. This placed the staff at risk. The doors to the bedroom, interconnecting door and toilet to main area were old and showed damage and repair. We noted the hand push plate had a sharp corner which a person could potentially injure themselves on. This was a breach of regulation 15(1)(a)