Requires Improvement

Sheffield Health and Social Care NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

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)
The Longley Centre	TAHCC	Rowan Ward Maple Ward Intensive Treatment Service	S5 7JT
Michael Carlisle Centre	TAHFC	Stanage Ward Burbage Ward	S11 9BF

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care 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.

Summary of findings

Where applicable, we have reported on each core service provided by Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care 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 psychiatric intensive care units	Requires Improvement 
Are acute wards for adults of working age and psychiatric intensive care units safe?	**Requires Improvement** 
Are acute wards for adults of working age and psychiatric intensive care units effective?	**Requires Improvement** 
Are acute wards for adults of working age and psychiatric intensive care units caring?	**Good** 
Are acute wards for adults of working age and psychiatric intensive care units responsive?	**Good** 
Are acute wards for adults of working age and psychiatric intensive care units well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

There were issues with the management of medicines with recording of medication administration, medication storage and rapid tranquilisation requiring attention. There was high use of seclusion on the PICU and it was not always clear that seclusion was used as a last resort or for the shortest possible time. There continued to be some environmental safety and ligature risks across the acute wards and the risks were not always fully mitigated.

The acute wards were clean. Risk assessments were in place to assess and manage risks to individuals.

The wards were utilising the productive ward initiative to make them more effective. There were good Mental Health Act systems but there were issues with adherence to the Act and Code of Practice particularly around recording of rights, capacity to consent, and seclusion recording.

Overall the trust was providing a caring service for patients across the acute wards. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. Patients commented favourably on the quality of care and support they received. The service had good practice examples of providing comprehensive information to patients through touch screen computers.

The service was responsive to patients' needs. Restrictions were usually kept to a minimum. Patients' individualised needs were met. Complaints were managed to ensure that where patients commented or complained the trust listened and responded.

We found that the service was well led with effective management of the service through regular audit and a commitment to provide high quality care and continuous improvement in line with the trust's stated values and strategy.

We found good practice in relation to information through touch screen technology piloted on one ward and good psychology input. We found a breach of regulations relating to the management of medicines, records in relation to the Mental Health Act and the suitability of premises. We have issued compliance actions.

Summary of findings

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

Are services safe?

Requires Improvement

We rated safe as requires improvement because:-

- There were issues with the management of medicines with recording of medication administration, medication storage and rapid tranquilisation requiring attention across all locations.
- There was high use of seclusion on the PICU ward and it was not always clear that the safeguards for seclusion were being met. There were environmental safety issues including within the seclusion rooms, and identified ligature risks across acute services.
- We found ligature risks within some of the ward environments, some of which had not been identified by the service. It was not always clear that ligature risks were being fully mitgated.

The acute wards were clean. Incidents were reported and investigated and lessons were learnt and shared to prevent them happening again. Staff knew about potential risks to patient's health and safety, and how to respond to them and manage them. Risk assessments were in place to assess and manage risks to individuals. Staffing levels were generally safe and there was on-going recruitment to fill staff vacancies. There were clear systems in place for reporting safeguarding concerns and staff understood what they had to do.

Are services effective?

Requires Improvement

We rated effective as requires improvement because:-

- There were good Mental Health Act systems but there were issues with adherence to the Mental Health Act Code of Practice particularly around significant delays in recording of rights, capacity to consent for treatment for mental disorder and seclusion recording. Many of these issues had been raised on MHA monitoring visits but we continued to find issues.
- The planning of care was affected by staffing issues such as cancelled or curtailed leave and activities and there were no clear systems to monitor the impact on patient care

Services were evidence based and focused on the needs of patients. The trust completed audits and had implemented changes to improve the effectiveness and outcomes of care and treatment. The wards were utilising the productive ward initiative to make them more effective. We saw some examples of good collaborative working and innovative practice.

Summary of findings

Staff were working within the Mental Capacity Act to ascertain if the patient was agreeable to, or had capacity, to consent to care and treatment required for significant decisions.

Patients were supported to make decisions and choices about their care and treatment.

There was good multidisciplinary working on wards. Patients on the acute wards had timely access to psychology input, with psychologists embedded within the multi-disciplinary teams.

Are services caring?

Good

We rated caring as good because:-

Overall the trust was providing a caring service for patients across the acute wards and the PICU. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients was generally positive about their experiences of the care and treatment provided by the staff on the acute wards and the PICU.

Staff were knowledgeable about patients' needs and showed commitment to provide patient led care. Patients had access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act. Patients felt that they were involved in their care. However some patients told us that they were not always able to participate fully in ward rounds due to the new ways that the multi-disciplinary team meetings operated. The service had good practice examples of providing comprehensive information to patients through touch screen computers.

Are services responsive to people's needs?

Good

We rated responsive as good because:-

Patients were able to access beds in their local acute psychiatric service within reasonable timescales. Whilst there were some pressure on beds this did not significantly adversely affect patient care. The service was responsive to patients' needs. Restrictions were usually kept to a minimum. Patients' individualised needs were met.

Patients told us they felt involved in their care and treatment. The trust provided interpretation services to ensure that where there was a barrier for patients to communicate effectively, these were overcome using different approaches. The acute wards had a well equipped multi-faith room to enable patients with religious beliefs.

Summary of findings

Patients felt they would know how to make a complaint. Staff tried to and resolved concerns with patients before they became a formal complaint.

Are services well-led?

Good

We rated well led as good because:

We found that the service was well led with effective management of the service through a commitment to provide high quality care and continuous improvement in line with the trust's stated values and strategy. Staff we spoke with were aware of their roles and responsibilities and staff had knowledge of the trust's values and objectives.

Staff reported that they felt well supported by their managers. Staff felt that the executive and senior management of the trust were accessible.

Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings. Generally audits identified and addressed issues to ensure continuous improvement. Where we found issues which had not been picked up or addressed by the trust's own systems, we were assured that managers were already developing plans to address these in better ways to properly identify, address or manage the risks to patients.

Summary of findings

Background to the service

Sheffield Health and Social Care NHS Foundation Trust provided inpatient services for men and women aged 18 years and over with mental health conditions.

The acute admission wards are based on two hospital locations; The Longley Centre and the Michael Carlisle Centre. They provided inpatient mental health services for adults aged 18-65 years. Each location had two acute admission wards and provided inpatient mental health services for adults who were admitted informally and patients compulsorily detained under the Mental Health Act.

The Longley Centre had two acute admissions inpatient wards and a psychiatric intensive care unit:

Maple ward was a 23 bed mental health acute ward. It provided assessment and treatment for working age males and females with acute mental health needs. Maple ward also has a health based place of safety (HBPOS) attached to the ward staffed by Maple ward. We report on the health based places of safety in the core service report relating to crisis services and HBPOS.

Rowan ward was a 24 bed mental health acute ward. It provided assessment and treatment for working age males and females with acute mental health needs.

The Intensive Treatment Service was an 8 bed psychiatric intensive care unit (PICU) ward for male and female patients. It provides high intensity care and treatment for people whose illness means they cannot be easily or safely managed on an acute ward. People will normally stay in a PICU for a short period of time and will usually be transferred to an acute ward once the risks have reduced.

The Michael Carlisle Centre has two acute admissions inpatient wards:

Stanage ward was a 24 bed mental health acute ward. It provided assessment and treatment for working age males and females with acute mental health needs.

Burbage ward was a 24 bed mental health acute ward. It provided assessment and treatment for working age males and females with acute mental health needs. The 24 beds included five beds for people to receive care and support when they were detoxifying from drug or alcohol problems

Sheffield Health and Social Care NHS Foundation Trust have been inspected on a number of occasions since registration. The acute in-patient services have previously been inspected by the CQC at the Longley Centre and the Michael Carlisle Centre in September 2011. At the inspection of the Longley Centre we looked at regulations relating to consent, care and welfare, cleanliness, premises and records. At the inspection of the Michael Carlisle Centre we looked at regulations relating to consent, care and welfare, staffing levels and records. We found that the trust was compliant in all the regulation we looked at both the Longley and Michael Carlisle centres in September 2011 inspections.

We have also carried out regular Mental Health Act monitoring visits to the acute wards and PICU at both of these locations with all of the wards having had a MHA monitoring visit within the last 18 months of this inspection. Where we found issues relating to the MHA on these monitoring visits, the trust has provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice.

Our inspection team

Our inspection team was led by: Chair: Alison Rose-Quirie, Chief Executive Officer, Swanton Care

Team Leader: Nicholas Smith, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission.

The team looking at the acute wards and psychiatric intensive care units included a CQC inspection manager, a Mental Health Act reviewer, and a pharmacist inspector. We also had a variety of specialist advisors which included a consultant psychiatrist, senior nurses, social workers and a psychologist.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about acute admission wards and psychiatric intensive care units and asked other organisations to share what they knew. This included speaking with local Healthwatch, Independent Mental Health Advocacy Services and other stakeholders. We also reviewed comment cards left by patients.

We carried out an announced visit over three days between 30 September and 2 October 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and allied health professional. We talked with people who used services who shared their views and experiences of the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed care or treatment records of people who used services. We reviewed Mental Health Act documentation. We spoke with senior managers and looked at the environment of the wards.

We inspected the acute admissions services in Sheffield including the Psychiatric Intensive Care Unit (PICU). We spoke with 24 patients and three carers, 24 staff. Looked at 16 sets of patients' notes and at the MHA documents including seclusion records and medicine charts for more patients. We looked at the patient environment, the availability of equipment, cleanliness and information provided to patients. We observed a number of clinical interventions and meetings including MDT meetings and handovers.

What people who use the provider's services say

Overall, patients we spoke with told us that staff treated them with dignity. Patients said they could approach staff with any issues they had and staff treated them with respect and care. Patients told us staff respected their privacy and dignity.

Good practice

We found the following areas of good practice:

- Patients on Stanage ward had access to innovative touch screen technology providing information on a range of subjects including the ward services, Mental Health Act rights, medication information and services available to the patients in hospital and in the community.
- Patients on the acute wards had timely access to psychology input, with psychologists embedded within the multi-disciplinary teams.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

The trust must ensure that standards of record keeping is improved in the following areas:

- Observations following the use of rapid tranquilisation
- The recording of benzodiazepines to effect safe use
- The recording of fridge and room temperature where medication is stored to ensure that medication is stored in appropriate environments
- The recording of episodes of seclusion including the appropriate rationale for seclusion to ensure that it is only used as a last resort and time the doctor attended seclusion and the cogent reasons if there is a delay in attendance
- The recording of rights to detained patients including refusals and attempts made and action where a patient does not understand despite repeated attempts
- The recording that qualifying patients are informed of the Independent Mental Health Advocacy service
- The recording of consent and capacity to consent on administration of treatment for mental disorder
- The availability of legal authorisations (T2 and T3 forms)

The trust must address identified environmental issues including within the seclusion rooms, and continue to address and mitigate the identified ligature risks across acute services.

Action the provider SHOULD take to improve:

- The trust should continue to address staff vacancy rates and sickness levels and improve the monitoring of its impact on patient care by measuring care and treatment which has been cancelled or curtailed (leave of absence, one to one nursing sessions, activities, access to fresh air).
- The trust should address identified cleanliness issues including within the seclusion room on Burbage ward and ensure better systems for cleaning between use of seclusion.
- The trust should ensure that there is improved governance systems to ensure on going adherence to the MHA and MHA Code of Practice.

Sheffield Health and Social Care NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rowan ward Maple ward Intensive Treatment Service (Psychiatric Intensive Care Unit)	Michael Carlisle Centre
Stanage Ward Burbage ward	The Longley Centre

Mental Health Act responsibilities

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

We reviewed care and treatment of patients detained under the Mental Health Act. We found the service did not always adhere to the Mental Health Act Code of Practice.

We found there were good systems in place to support the operation of the Mental Health Act. However staff were not completing the appropriate records to evidence adherence to the Mental Health Act. These included:

- There was a lack of proper recording relating to consent to treatment for decisions around treatment for mental disorder given to detained patients.

Detailed findings

- Some records did not show that patients had been told about their rights under the Mental Health Act which could have impacted on their understanding of how to appeal against their detention.
- Some records did not show that patients had been told about how to obtain the services of an Independent Mental Health Advocate (IMHA) to support them.
- The recording of episodes of seclusion including the time the doctor attended seclusion and the cogent reasons if there is a delay in attendance.
- The legal authorisations (T2 and T3 forms) for treatment were not kept with the medicines charts.

We have found many of these issues before when we carried out MHA monitoring visits and despite promised improvements we are continuing to see the same issues reoccurring.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

For example we saw staff in a handover discussing the need for a capacity assessment when there were doubts whether the patient had capacity to make the decision. Patients had been encouraged to draw up advance statements and subsequently their wishes on future treatment were being respected. This showed that staff ensured they respected patients' capacitated decisions and that staff understood the legal framework to follow to when patients may lack capacity.

Staff reported that they had received MCA training when the MCA was first implemented but there had been limited further or refresher training.

We were told that staff on Burbage ward had recently made an application for a Deprivation of Safeguard (DoLS) for one patient. On checking our records following the inspection, it does not appear that we were notified of the application and the outcome as a notifiable incident.

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:-

- There were issues with the management of medicines with recording of medication administration, medication storage and rapid tranquilisation requiring attention across all locations.
- There was high use of seclusion on the PICU ward and it was not always clear that the safeguards for seclusion were being met. There were environmental safety issues including within the seclusion rooms, and identified ligature risks across acute services.
- We found ligature risks within some of the ward environments, some of which had not been identified by the service. It was not always clear that ligature risks were being fully mitigated.

The acute wards were clean. Incidents were reported and investigated and lessons were learnt and shared to prevent them happening again. Staff knew about potential risks to patient's health and safety, and how to respond to them and manage them. Risk assessments were in place to assess and manage risks to individuals. Staffing levels were generally safe and there was on-going recruitment to fill staff vacancies. There were clear systems in place for reporting safeguarding concerns and staff understood what they had to do.

Our findings

The Longley Centre – Rowan and Maple wards

Safe and clean ward environment

The wards provided clear lines of sight for the observation of patients.

The wards were clean and during our visit the housekeeping team busy doing cleaning tasks. Patients and staff commented favourably on the cleanliness of the wards and the dedication of the housekeeping staff.

There had been attention to addressing some of the ligature risks which could be or have been used to cause serious self harm to patients but there continued to be ligature risks across the unit. For example taps in bathrooms were not anti-ligature taps. The door hinges in the wardrobes were not piano-style hinges which meant that again they could be used as a fixing for a ligature. The door hinges were not seen as a risk on the environmental risk assessment. Risks were managed through individual assessment.

The wards felt relaxed and comfortable.

Patients told us that they felt safe and whilst some patients had caused issues on the wards, patients felt that staff did what they could to keep patients safe.

An electronic prescribing and medicines administration system was in place on all wards and helped support safe and effective prescribing. Pharmacists were fully integrated into multi-displinary teams (MDTs) for inpatient services to support and ensure best outcomes from the use of medicines. Patients and their carers were provided with information about their medicines and a pharmacist was available to support this. The clinic room used to dispense medication was clean and tidy.

However we found:-

- Ward treatment rooms and refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature. This meant there was a risk that medicines were stored at the wrong temperature and might not be safe to use.
- On Maple ward there were regular small discrepancies in controlled drug stock (benzodiazepines) which had been identified but it was not always clear what action had been taken. These discrepancies were not always reported in line with the trust policy to ensure that they were properly investigated. Entries in the controlled drug register did not always include the signature of the witness observing administration and sometimes the dose given was not recorded.
- Despite systems of reminders, there was also a delay in considering consent and capacity to consent issues for

one detained patient leading to an avoidable late application for a second opinion appointed doctor and the need to use emergency powers under section 62 to authorise treatment for mental disorder.

We were told that regular pharmacist support to Maple ward had been suspended for three months recently because of long term sickness. Ward staff and the Chief Pharmacist told us that this had led to reduced monitoring of medicines management during this period.

Risk assessments were carried out by staff during patients' initial assessment and reviewed or updated during care review meetings or if patients' needs changed. We looked at care records and saw there were appropriate risk management plans for patients.

The wards had a relaxation and de-escalation room where patients could come and relax which offered diversional activities such as pampering sessions and relaxing music. The use of restraint and seclusion was minimal.

Safe staffing

The wards displayed the expected and actual staffing levels on each ward. The actual staffing levels matched the expected staffing levels. Ward managers told us they were empowered to take professional decisions about the staffing needs of the patients in their care, for example if patients were in seclusion or required higher levels of observation.

Whilst the wards were holding higher levels of staff vacancies and sickness, these issues were generally managed through utilising overtime, bank and agency staff to manage the need of the wards. There were very limited occasions when staffing may have fallen slightly below expected levels due to unexpected sickness and when this occurred an incident record was completed to highlight this.

Whilst staffing levels were kept safe the higher use of bank and agency staff did cause difficulties at times because not all tasks could be delegated to these staff members. Qualified nursing staff on Maple ward were also expected to staff the health based place of safety for Sheffield which involved supporting assessments 24 hours a day and 7 days a week. This involved one or two members of nursing staff liaising with the police who bring people to the health based place of safety and supervising the patient until an appropriate assessment was completed. There were occasions when the health based place of safety could not be used due to the number of staff available on the ward to manage the clinical presentation of patients or due to other staffing issues on Maple ward.

Assessing and managing risk to patients and staff

Overall, the ward had effective systems to assess and monitor risks to individuals. We found that risk assessments were comprehensive and holistic. Risk assessments were carried out by staff during patients' initial assessment and most reviewed or updated during care review meetings or if patients' needs changed.

Staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring. There was information posters for patients informing them about raising safeguarding issues. During the inspection staff told us about current safeguarding issues and alerts that had been made to safeguard vulnerable patients.

Records of seclusion showed that many of the safeguards and reviews required when seclusion was used were met. The reasons for seclusion were clearly recorded. However, some seclusion records kept at ward level were difficult to read due to the ward keeping the carbonated copy. In addition, it was also not clear that the MHA 1983 code of practice requirement that a doctor attended immediately following a period of seclusion was being met. Many of the seclusion records either did not record the time the doctor was informed and attended or did not explain the reasons why the doctor was not able to attend immediately. This meant that it was unclear if patients placed in seclusion received a timely medical review.

The wards had systems to deal with foreseeable emergencies including medical emergencies. We saw the emergency equipment were accessible. Staff were trained in the prevention and management of violence and aggression. Records showed that emergency equipment was checked regularly to ensure it was fit for purpose. Staff were equipped with alarms and would use these to call for assistance from other team members and there were systems in place for responding to an emergency.

Reporting incidents and learning from when things go wrong

The wards had a system in place to capture incidents and accidents and to learn from them when things went wrong.

Requires improvement

Are services safe?

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

Staff explained to us the process they used to report incidents through the trust's reporting systems. Staff felt that incidents were reduced by the therapeutic relationship they had with patients such as knowing patients well, reducing triggers and identifying early warning signs.

We saw that when incidents occurred there was a reflective session which looked at what led up to the incident. The reflective sessions were led by psychology and helped them consider issues that had arisen, how staff reacted and how things could be done differently next time.

The Longley Centre – Intensive Treatment Service (PICU)

Safe and clean ward environment

The ward provided a clean environment for the care of patients within a psychiatric intensive care environment. There had been attention to addressing some of the ligature risks which could be or have been used to cause serious self harm to patients but there continued to be ligature risks across the unit for example taps in bathrooms were not anti-ligature taps.

The wards felt relaxed and comfortable. The ward was clean and well maintained, having recently been redecorated. Patients commented favourably on the cleanliness of the wards. Patients told us that they felt safe. Patients told us that they felt that staff did what they could to keep other patients safe when patients presented with management issues on the wards. Patients did comment on some of the restrictions placed on them whilst on the PICU.

Access and exit from the ward and the unit was controlled by staff. Exit from the unit was through an air lock door which helped to ensure patients were kept safe. The wards had access to outside space which had the appropriate level of fencing. There had been low numbers of incidents of patients going absent without agreed leave from the ward and absence without leave episodes whilst on agreed escorted or unescorted leave were minimal.

The clinic room was clean and tidy. However, we found:-

- There were issues regarding the appropriate arrangements in place for storing medicines appropriately. Ward treatment rooms and refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature. The record of the fridge temperatures had significant gaps where no record or check had been made. This meant there was a risk that medicines were stored at the wrong temperature and might not be safe to use.
- On occasions patients may be prescribed medicines to help with extreme episodes of agitation, anxiety and sometimes violence known as rapid tranquillisation. We saw information about the use of rapid tranquillisation and the trust had an up to date policy covering this type of treatment. Following rapid tranquilisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate. However, when we checked the care records for patients on two occasions who had been given rapid tranquillisation, we found that it was not clear that these observations had been recorded.

Risk assessments were carried out by staff during patients' initial assessment and reviewed or updated during care review meetings or if patients' needs changed. We looked at care records and saw there were appropriate risk management plans for patients.

Staff were aware of their responsibilities to undertake searches and checks on patients balancing the need to promote patients' dignity and safety. Staff told us they felt safe on the wards and supported by colleagues to maintain appropriate relational and actual security arrangements.

We viewed the seclusion area which consisted of a locked seclusion room and separate toilet area. There was a clock outside of the seclusion room so that patients that were secluded could remain orientated to time. There was no way of controlling the lights which were either on or off and there were no integrated blinds or coverings at the window so the light levels could not be adjusted. The heating was controlled from a panel in the nursing office but this was not very effective. The viewing panel in the seclusion room door was securely covered by a Perspex sheet but this of the patient very difficult as it was opaque due to scratches. There was another viewing window from the toilet area but blind spots in the seclusion room remained. The taps in the sink of the seclusion room were not anti-ligature. The mattress in the seclusion room was a thin 'crash mat' type mattress which would not afford comfort especially during longer periods of seclusion.

Requires improvement

Are services safe?

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

The wards and service had an environmental risk register which identified risks and how these risks were managed or addressed. However many of the identified risks had been on the risk register for a significant number of months with no proper plans on how these risks would be fully mitigated.

Safe staffing

The wards displayed the expected and actual staffing levels on each ward. The actual staffing levels matched or exceeded the expected staffing levels. Ward managers told us they were empowered to take professional decisions about the staffing needs of the patients in their care, for example if patients were in seclusion or required higher levels of observation.

Whilst the wards were holding higher levels of staff vacancies and sickness, these issues were generally managed through utilising overtime, bank and agency staff to manage the need of the wards. There were very limited occasions when the number of staff may have fallen slightly below expected levels due to unexpected sickness and when this occurred an incident record was completed to highlight this. Whilst staffing levels were kept safe, the higher use of bank and agency staff did cause difficulties at times because not all tasks could be delegated to these staff members.

Assessing and managing risk to patients and staff

Overall, the ward had effective systems to assess and monitor risks to individuals. We found that risk assessments were comprehensive and holistic. Risk assessments were carried out by staff during patients' initial assessment and most reviewed or updated during care review meetings or if patients' needs changed. However we noted that there was one female patient on the PICU and their risk assessment had not been updated to reflect that the patient was a lone female and subject to higher levels of observations.

The service had a good system to ensure risks were reviewed or undertaken prior to a detained patient commencing leave from the ward.

Staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring. There were information posters for patients informing them about raising safeguarding issues.

There was significant use of seclusion on the intensive treatment service – the trust reported that 93 episodes of seclusion occurred in the six months between February and July 2014. Seclusion records continued to show regular episodes of seclusion since July 2014. Many seclusion episodes were for significant periods. For example, in one case seclusion lasted 284 hours and for one patient there were many episodes of seclusion which occurred which lasted over 100 hours.

The new temporary ward manager was starting to look into the relatively high use of seclusion including looking at the reasons, frequency, duration and key characteristics such as ethnicity of patients placed in seclusion but there had been no formal audit or written report produced. The trust had also recently introduced a restrictive practices review which aimed to reduce seclusion through the following initiatives:

- visible leadership;
- improved training, development and debriefing of staff,
- better use of data, and
- increasing use of involving service users.

Some of the initiatives were further progressed than others for example staff had received new de-escalation and the management of violence and aggression training called RESPECT. Also, he trust board has approved a significant investment to build a new Intensive Treatment Service ward to improve the environment and work was underway at the time of our inspection.

Records of seclusion showed that many of the safeguards and reviews required when seclusion was used were not always met. The reasons for seclusion were clearly recorded. However it wasn't always clear that the Code of Practice requirements that seclusion was used as a last resort or for the shortest possible time. For example we saw that in one record that it was stated that "if the patient causes any more disruption on the ward, they will be secluded again at least until overnight". In another record the requirements for ending seclusion were recorded and followed by a statement which stated: "any contravention of the above will result in a return to seclusion". This meant that patients were at risk of being placed in seclusion for longer than necessary or for reasons other than the management of severely disturbed behaviour likely to pose a risk to other people.

Requires improvement

Are services safe?

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

It was also not clear that the MHA 1983 code of Practice requirement that a doctor attended immediately following a period of seclusion was being met. Many of the seclusion records either did not record the time the doctor was informed and attended or did not explain the reasons why the doctor was not able to attend immediately. Where longer episodes of seclusion or segregation occurred the regular reviews were not always adhered to. This meant that it was unclear if patients placed in seclusion received a timely medical review.

The wards had systems to deal with foreseeable emergencies including medical emergencies. We saw the emergency equipment were accessible. Staff were trained in the prevention and management of violence and aggression. Records showed that emergency equipment was checked regularly to ensure it was fit for purpose. Staff were equipped with alarms and would use these to call for assistance from other team members and there were systems in place for responding to an emergency.

Reporting incidents and learning from when things go wrong

The wards had a system in place to capture incidents and accidents and to learn from them when things went wrong. Staff explained to us the process they used to report incidents through the trust's reporting systems. Staff felt that incidents were reduced by the therapeutic relationship they had with patients such as knowing patients well, reducing triggers and identifying early warning signs.

We saw that when incidents occurred there was a reflective sessions which looked at what led up to the incident. The reflective sessions were led by psychology to help them consider issues that had arisen, how staff reacted and how things could be done differently next time.

Michael Carlisle Centre – Stanage and Burbage wards

Safe and clean ward environment

The ward provided clear lines of sight for the observation of patients.

There had been attention to addressing some of the ligature risks which could be used to cause serious self harm to patients but there continued to be ligature risks across the unit for example taps in bathrooms were not anti-ligature taps. The door hinges in the wardrobes were not piano-style hinges which meant that again they could be used as a fixing for a ligature. The door hinges were not seen as a risk on the environmental risk assessment so it was unclear that these risks were always being mitigated.

The wards felt relaxed and comfortable.

The ward was clean and well maintained with the exception of the seclusion room. Patients commented favourably on the cleanliness of the wards. Patients told us that they felt safe and whilst some patients had caused management issues on the wards, patients felt that staff did what they could to keep patients safe. Patients did comment on the incidents of disturbed behaviour of other patients on the ward and how this made them feel uneasy but stated that staff tried to keep them safe.

An electronic prescribing and medicines administration system was in place on all wards and helped support safe and effective prescribing. Pharmacists were fully integrated into MDTs for inpatient services to support and ensure best outcomes from the use of medicines. Patients and their carers were provided with information about their medicines and a pharmacist was available to support this. The clinic room used to dispense medication was clean and tidy.

However we found:-

- Ward treatment rooms and refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature. This meant there was a risk that medicines were stored at the wrong temperature and might not be safe to use.
- On Stanage ward there were regular small discrepancies in controlled drug stock (benzodiazepines) which had been identified but it was not always clear what action had been taken. These discrepancies were not always reported in line with the Trust policy to ensure that they were properly investigated.
- There were issues regarding the appropriate arrangements in place for managing medicines appropriately. Whilst many of the consent to treatment provisions were being met, we saw that ward staff did not have ready access to a copy of the current legal authority approving treatment for mental disorder (for example T2 or T3) attached. This meant that it was not always clear that nurses were checking whether they

Requires improvement

Are services safe?

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

had the appropriate legal authority to administer medication for mental disorder to detained patients as required by the MHA Code of Practice. The treatment for one detained patient receiving high dose antipsychotic medicines was not properly authorised and for a second patient the category of one medicine being administered did not match the entry on the consent form for their treatment for mental disorder.

- On occasions patients may be prescribed medicines to help with extreme episodes of agitation, anxiety and sometimes violence known as rapid tranquillisation. We saw information about the use of rapid tranquillisation and the trust had an up to date policy covering this type of treatment. Following rapid tranquilisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate. However, when we checked the care records for patients on two wards who had been given rapid tranquillisation, we found examples where it was not clear that these observations had been recorded.

Risk assessments were carried out by staff during patients' initial assessment and reviewed or updated during care review meetings or if patients' needs changed. We looked at care records and saw that there were appropriate risk management plans for patients.

The wards had a relaxation and de-escalation room where patients could come and relax which offered diversional activities such as pampering sessions and relaxing music. The use of restraint and seclusion was minimal.

We saw that the seclusion rooms did not meet many of the requirements of the MHA Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others. The seclusion room on Burbage ward was not particularly clean with stained walls, an unclean floor and a mattress and the toilet was not fully cleaned. The seclusion room was cleaned during our visit. However, it was therefore not clear that the seclusion room was systematically cleaned between use so that it was always ready for the management of patients presenting with disturbed behaviour. The heating of the seclusion room on Burbage ward was controlled from a panel outside of the room but it was broken so that this was not very effective in controlling the temperature. A clock was situated outside the room but was not working so that patients in seclusion could not orientate themselves to the time. The seclusion room on Burbage had a blind spot in one corner where a patient could not be observed. The seclusion room on Stanage ward did not allow clear observation into all areas of the room. The blind spots could be addressed by installing a parabolic (curved) mirror. The manager of the wards agreed they would look into this.

Safe staffing

The wards displayed the expected and actual staffing levels on each ward. The actual staffing levels matched or exceeded the expected staffing levels. Ward managers told us they were empowered to take professional decisions about increasing the staffing levels to provide appropriate care of patients for example if patients were in seclusion or required higher levels of observation.

Whilst the wards were holding higher levels of staff vacancies and sickness, these issues were generally managed through utilising overtime, bank and agency staff to manage the need of the wards. There were very limited occasions when staffing may have fallen slightly below expected levels due to unexpected sickness and when this occurred an incident record was completed to highlight this. Whilst staffing levels were kept safe, the higher use of bank and agency staff did cause difficulties at times because not all tasks could be delegated to these staff members.

Assessing and managing risk to patients and staff

Overall, the ward had effective systems to assess and monitor risks to individuals. We found that risk assessments were comprehensive and holistic. Risk assessments were carried out by staff during patients' initial assessment and most reviewed or updated during care review meetings or if patients' needs changed. The service had a good system to ensure risks were reviewed or undertaken prior to a detained patient commencing leave from the ward.

Staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring. There were information posters for patients informing them about raising safeguarding issues.

The wards had systems to deal with foreseeable emergencies including medical emergencies. We saw the emergency equipment was accessible. Staff were trained in

Requires improvement

Are services safe?

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

the prevention and management of violence and aggression. Records showed that emergency equipment was checked regularly to ensure it was fit for purpose. Staff were equipped with alarms and would use these to call for assistance from other team members and there were systems in place for responding to an emergency.

Reporting incidents and learning from when things go wrong

The wards had a system in place to capture reporting incidents and learning from when things go wrong. Staff explained to us the process they used to report incidents through the trust's reporting systems. Staff felt that incidents were reduced by the therapeutic relationship they had with patients such as knowing patients well, reducing triggers and identifying early warning signs.

We saw that when incidents occurred there was a reflective sessions which looked at what led up to the incident. Staff had reflective sessions led by psychology to help them consider issues that had arisen, how staff reacted and how things could be done differently next time. We observed a reflective session on Burbage ward where staff had an opportunity to discuss the psychological impact of events over the last week including a recent restraint episode. The meeting was well attended, with contributions from all staff. Staff found the sessions to be beneficial; senior staff were able to offer support and assurance to more junior members of staff.

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:-

- There were good Mental Health Act systems but there were issues with adherence to the Mental Health Act Code of Practice particularly around significant delays in recording of rights, capacity to consent for treatment for mental disorder and seclusion recording. Many of these issues had been raised on MHA monitoring visits but we continued to find issues.
- The planning of care was affected by staffing issues such as cancelled or curtailed leave and activities and there were no clear systems to monitor the impact on patient care

Services were evidence based and focused on the needs of patients. The trust completed audits and had implemented changes to improve the effectiveness and outcomes of care and treatment. The wards were utilising the productive ward initiative to make them more effective. The PICU was a member of the National Association of PICU care. We saw some examples of good collaborative working and innovative practice.

Staff were working within the Mental Capacity Act to ascertain if the patient was agreeable to, or had capacity, to consent to care and treatment required for significant decisions.

Patients were supported to make decisions and choices about their care and treatment.

There was good multidisciplinary working on wards. Patients on the acute wards had timely access to psychology input, with psychologists embedded within the multi-disciplinary teams.

Our findings

The Longley Centre – Rowan and Maple wards

Assessment of needs and planning of care

We saw evidence of well documented care plans that described how individual needs were met on admission and at each stage of patient care. Care plans were recovery focused and helped patients receive support to address the symptoms of mental disorders. Feedback from patients across the wards confirmed they felt involved in decisions about their care. Patient needs and care were reviewed on a regular basis at multi-disciplinary meetings.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward.

The wards were operating with higher levels of sickness levels and some staff vacancies. The impact of these issues was being managed by holding recruitment days and utilising additional bank staff and occasional agency staff. Patients on the wards commented on the curtailment or cancellation of agreed leave and reduced access to fresh air. The situation was exacerbated on Maple ward by the additional duties to staff the health based place of safety. Ward managers told us they managed patient needs – however they accepted that patients may be impacted on occasions, for example patients may not be able to access section 17 leave due to lack of staff to facilitate leave. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks. There was no developed system to monitor, record or co-ordinate information on the impact of ongoing staffing issues on the planning of patient care such as the impact on leave, fresh air or activities. On occasions where the impact was deemed to be critical then an incident record would be completed. It was therefore unclear what impact these staffing issues were having on patient care.

Best practice in treatment and care

Patients had access to the full range of NICE guidelines through a comprehensive leaflet rack. Care plans included relapse prevention and crisis planning.

We found evidence which demonstrated the acute wards had implemented best practice guidance within their clinical practice. This included implementation of the National Institute of Clinical and Health Excellence (NICE) guidance for the psychological treatment of a range of mental illness conditions such as psychosis, depression, anxiety and bipolar disorder. The service was able to offer information and support to people using the service to cognitive behavioural and psychological therapies as guided by NICE. Patients had good access to psychology

Are services effective?

Requires Improvement

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input with psychologists embedded within the multi-disciplinary teams. Patients with personality disorder had access to dialectical behavioural therapy (DBT) as recommended by NICE guidelines.

On the wards we visited we saw patients participating in on and off ward activities. There was an active occupational therapy team which engaged patients who were socially isolated to develop self-belief, hope and engagement in activities which can continue on discharge. The focus was on mental wellbeing and recovery. There were a range of initiatives that patients could get involved in including volunteering the patients' shop; the Hillsborough walled garden initiative and cycling for health. Occupational therapy support was available six days a week.

Skilled staff to deliver care

We spoke with a number of staff including the consultant psychiatrist, ward managers, registered and student nursing and non-registered nursing staff and other professionals including the psychologists. Staff we spoke with was positive and motivated to provide quality care.

Staff received appropriate training, supervision and support. Staff on the wards commented favourably on the support and leadership they received from the ward manager. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision.

Training for staff consisted of mandatory and more specialist training. The trust monitored the staff in relation to compliance with mandatory training. We saw that where staff were overdue training, systems were in place to provide prompts to ensure this occurred.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input from managers, medical staff, registered nursing and non-registered nursing staff and other professionals including occupational therapists and psychologists. Patients on the acute wards had timely access to psychology input, with psychologists embedded within the multi-disciplinary teams.

Multi-disciplinary meetings occurred on a daily basis. However following a recent change towards business type MDT meetings; and patients were not usually invited into the MDT meeting but were instead offered time with any professional on an individual basis on request. This meant that it was not always clear that patients were fully participating in their care and discussions about patients could be made without them being involved and for detained patients, it was not clear how such structures accorded with the MHA Code of Practice participation principle.

We observed a multi-disciplinary meeting and a handover and there was comprehensive information on each patient to ensure that all members of the nursing and multi-disciplinary team were kept up to date on current issues with patients and to inform decisions about future holistic care needs.

Adherence to the MHA and the MHA Code of Practice

The ward had good systems in place to ensure that the responsibilities of the Mental Health Act 1983 (MHA) were being followed, including reminders to clinicians for consent to treatment provisions, patient rights and renewals.

Whilst the MHA papers were available in the electronic records, we saw shortfalls including:

- Approved Mental Health professional reports not available alongside the detention papers on any of the files viewed,
- delays in considering consent and capacity in one case and patient rights not always recorded appropriately.
- We saw an example of continued repeating rights for incapacitated patients where it was unlikely that a patient would ever understand their rights, with no appropriate consideration of the patient's best interests to assist the patient to exercise their rights and involve Independent Mental health Advocacy Services.
- We also examples where there were no records or delays in giving of patient rights with one example of a patient not being given information on their rights until 14 days after admission on a section 3 and another not given their rights on admission on a section 3.

Many of these were regular issues we report on during MHA monitoring visits. It is disappointing to note that we continue to find issues with adherence to the MHA despite the action detailed by the trust in response to our MHA monitoring reports.

Good practice in applying the Mental Capacity Act (MCA)

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever

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.

possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

Staff were aware of the recent ruling (known as the Cheshire West case) and the implications of this decision for caring for patients who lacked capacity.

The Longley Centre – Intensive Treatment Service (PICU)

Assessment of needs and planning of care

We saw evidence of well documented care plans that described how individual needs were met on admission and at each stage of patient care. Care plans were recovery focused and helped patients receive support to address both the symptoms of mental disorder and the issues that led them to be admitted to the PICU. Feedback from patients across the wards confirmed that they felt involved in decisions about their care. Patient needs and care were reviewed on a regular basis at multi-disciplinary meetings and at allocated Care Programme Approach (CPA) meetings.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward.

Most of the wards were operating with higher levels of sickness levels and some staff vacancies. The impact of these issues was being managed by holding recruitment days and utilising additional bank staff and occasional agency staff. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks, for example agency staff could not provide escorts for leave beyond the hospital grounds.

Best practice in treatment and care

Care plans included relapse prevention and crisis planning.

On the wards we visited we saw patients participating in on and off ward activities. Patients had access to an activities programme led by a full time activities co-ordinator; and an occupational therapy (OT) input five half day sessions a week. The activities were determined by patients on the ward in planning sessions and patients commented favourably on the range of activities.

The PICU was an active member of the National Association of PICU care which meant that staff had an opportunity to share good practice with other PICUs across England.

Skilled staff to deliver care

We spoke with a number of staff including the ward managers, registered and student nursing and non-registered nursing staff and other professionals including the activities co-ordinator and psychologists. Staff we spoke with were positive and motivated to provide quality care.

Staff received appropriate training, supervision and support. Staff on the wards commented favourably on the support and leadership they received from the new interim ward manager. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision. Samples of records confirmed this.

Training for staff consisted of mandatory and more specialist training. The trust RAG monitored the staff in relation to compliance with mandatory training. We saw that where staff was overdue training, systems were in place to provide prompts to ensure this occurred.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input from managers, medical staff, registered nursing and non-registered nursing staff and other professionals including occupational therapists and psychologists. The consultant psychiatrist that provided overall care was a locum consultant psychiatrist.

We observed a multi-disciplinary meeting and a handover. There was comprehensive information on each patient to ensure that all members of the nursing and multi-disciplinary team were kept up to date on current issues and to inform decisions about future holistic care needs.

Adherence to the MHA and the MHA Code of Practice

The ward had good systems in place to ensure that the responsibilities of the Mental Health Act 1983 (MHA) were being followed, including reminders to clinicians for consent to treatment provisions, patient rights and

Are services effective?

Requires Improvement

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renewals. MHA documentation was in good order with evidence of appropriate detention documentation being in place and consent to treatment provisions being adhered to.

Whilst the MHA and MHA Code of Practice was being followed in most areas, we saw issues with the recording of patient rights. For example for one patient there was no records of patient rights being given to the patient when first detained. For another patient where it was not clear whether the patient was informed of their right to see the appropriate Independent Mental Health Advocacy (IMHA) Service to ensure they were aware of their rights whilst detained and help and support to exercise their rights.

Good practice in applying the Mental Capacity Act (MCA)

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

All of the patients on the PICU were detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were made under the legal framework of the MHA. Staff understood the limitations of the MHA, for example that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues. We saw completed capacity assessments when important decisions needed to be made, for example, one patient was waiting for decisions on funding for a specialist placement and staff were seeking support as there were doubts about the patient's capacity to consent to the decision to move to the specialist placement.

Michael Carlisle Centre – Stanage and Burbage wards

Assessment of needs and planning of care

We saw evidence of well documented care plans that described how individual needs were met on admission and at each stage of patient care. Care plans were recovery focused and helped patients receive support to address the symptoms of mental disorder. Feedback from patients across the wards confirmed they felt involved in decisions about their care. Patient needs and care were reviewed on a regular basis at multi-disciplinary meetings.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward.

The wards were operating with higher levels of sickness levels and some staff vacancies. The impact of these issues was being managed by holding recruitment days and utilising additional bank staff and occasional agency staff. Patients on the wards commented about the lack of activities stating they were bored, commented on the curtailment or cancellation of agreed leave and reduced access to fresh air. Ward managers told us they managed patient needs – however they accepted that patients may be impacted on occasions, for example patients may not be able to access section 17 leave due to lack of staff to facilitate leave. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks. There was no developed system to monitor, record or co-ordinate information on the impact of ongoing staffing issues on patient care such as its' impact on leave, fresh air or activities although patients were encouraged to complain. Several fast track complaints on Stanage ward related to issues regarding short staffing and/or leave being cancelled. On occasions where the impact was deemed to be critical then an incident record would be completed. It was therefore unclear fully what impact these staffing issues were having on patient care.

Best practice in treatment and care

Patients had access to the full range of NICE guidelines through a comprehensive leaflet rack. Care plans included relapse prevention and crisis planning.

On the wards we visited we saw patients participating in on and off ward activities. Patients on Stanage ward had access to an activities programme led by an activities co-ordinator. The activities co-ordinator was shared between Stanage and Burbage ward. We heard on Burbage ward that activities were limited to when staff were available to provide these and patients commented on feeling bored.

The wards operated the productive ward and 15 steps challenge initiatives. The productive ward initiative focuses on improving ward processes and environments to help nurses spend more time on patient care and at the same time improve levels of safety and efficiency. This involved reviewing specific ward areas and processes with

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.

improvements agreed and tested. The '15 steps challenge' encourages patients and staff to work together to identify improvements evident from taking the first 15 steps onto the ward. It looks to which enhance the patient experience, highlighting what is working well and what might be done to increase patient confidence.

Skilled staff to deliver care

We spoke with a number of staff including the consultant psychiatrist, ward managers, registered and student nursing and non-registered nursing staff and other professionals including the psychologists. Staff we spoke with were positive and motivated to provide quality care.

Staff received appropriate training, supervision and support. Staff on the wards commented favourably on the support and leadership they received from the ward managers. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision. Most staff had received an annual appraisal, for example on Burbage ward 28 out of 30 staff had received an appraisal, with plans to ensure the outstanding two members of staff received an appraisal.

Training for staff consisted of mandatory and more specialist training. The trust monitored the staff in relation to compliance with mandatory training. We saw that where staff were overdue training, systems were in place to provide prompts to ensure this occurred.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input from managers, medical staff, registered nursing and non-registered nursing staff and other professionals including occupational therapists and psychologists. Patients on the acute wards had timely access to psychology input, with psychologists embedded within the multi-disciplinary teams.

Multi-disciplinary meetings occurred on a daily basis. However following a recent change towards business type MDT meetings; patients were not usually invited into the MDT meeting but are instead offered time with any professional on an individual basis on request. This meant that it was not always clear that patients were fully participating in their care and decisions about patients could be made without them being involved and for detained patients, it was not clear how such structures accorded with the MHA Code of Practice participation principle.

We observed a multi-disciplinary meeting and a handover and there was comprehensive information on each patient to ensure that all members of the nursing and multi-disciplinary team were kept up to date on current issues and to inform decisions about future holistic care needs.

Adherence to the MHA and the MHA Code of Practice

The ward had good systems in place to ensure that the responsibilities of the Mental Health Act (MHA) were being followed, including reminders to clinicians for consent to treatment provisions, patient rights and renewals. Mental Health Act documentation was in good order with evidence of appropriate detention documentation being in place and consent to treatment provisions being adhered to.

Whilst the MHA and MHA Code of Practice was being followed in most areas, we saw examples where there were no records or delays in giving of patient rights. For example one patient had not been given information on their rights until 19 days after admission on a section 3 and another not given their rights until 25 days after admission on a section3. This meant that the patient was not made aware of their right to lodge an appeal to a first tier tribunal. Shortfalls in the giving of patient rights are regular issues we report on during MHA monitoring visits. It is disappointing to note patients are not being given information on their rights in a timely manner when subject to compulsory powers despite the action detailed by the trust in response to our MHA monitoring reports.

Good practice in applying the Mental Capacity Act (MCA)

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

We saw staff in handover discussing the need for a capacity assessment for one patient due to an important decision that needed to be made as there were doubts whether the patient had capacity to make the decision. One patient on Stanage ward had been encouraged to draw up an advance

Are services effective?

Requires Improvement

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statement and subsequently his wishes on future treatment was being respected. This showed that staff ensured they respected patients' capacitated decisions and that staff understood the legal framework to follow to when patients may lack capacity.

Staff reported that they received MCA training when the MCA was first implemented but there had been limited further or refresher training.

We were told that staff on Burbage ward had recently made an application for a Deprivation of Safeguard (DoLS) for one patient. On checking our records following the inspection, it does not appear that we were notified of the application and the outcome as a notifiable incident.

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:-

Overall the trust was providing a caring service for patients across the acute wards and the PICU. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients was generally positive about their experiences of the care and treatment provided by the staff on the acute wards and the PICU.

Staff were knowledgeable about patients' needs and showed commitment to provide patient led care. Patients had access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act. Patients felt that they were involved in their care. However some patients told us that they were not always able to participate fully in ward rounds due to the new ways that the multi-disciplinary team meetings operated. The service had good practice examples of providing comprehensive information to patients through touch screen computers.

Our findings

The Longley Centre – Rowan and Maple wards

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and understanding manner. The patients we spoke with were complimentary about staff attitude and engagement.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care.

The involvement of patients in the care they receive

The care plan documents across the trust were found in the electronic patient notes (EPN) system and from reviewing this it was sometimes difficult to see how the involvement of the individual was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in the EPN.

Community meetings were held regularly on the ward. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible. For example following several comments from patients about the quality of the food, a new provider had been agreed and new menus were being introduced.

Patients had regular access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act known as Independent Mental Health Advocates (IMHAs). Staff informed patients about the availability of the IMHAs and enabled them to understand what assistance the IMHA could provide with one exception noted. Patients we spoke with were aware of the IMHA service and complementary of the support received from the IMHA.

The Longley Centre – Intensive Treatment Service (PICU)

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. We talked with four of the six detained patients on the PICU. The feedback received from patients was positive about their experiences of the care and treatment provided by the staff on the PICU. The patients we spoke with were complimentary about staff attitude and engagement. We received a small number of negative comments about the restrictions placed on people and items that weren't allowed on the PICU.

Staff we spoke with felt that patients received good care on the wards. They told us they felt patients were given hope with regard to moving on and recovering.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care. We observed a multi-disciplinary handover meeting; patients' needs were discussed and considered with dignity and respect.

Good

Are services caring?

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

The environment of the PICU afforded dignity and respect to patients through the provision of individual bedrooms, some of which were en-suite.

The involvement of patients in the care they receive

The care plan documents across the trust were found in the electronic patient notes (EPN) system and from reviewing this it was sometimes difficult to see how the involvement of the individual was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in the EPN.

Community meetings were held regularly on the ward. We looked at the minutes from some of these meetings. The meetings were attended by patients using the service and staff on the ward. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible.

Staff were knowledgeable about patients' needs and showed commitment to provide patient led care. Patients felt that they were involved in their care. However some patients told us that they were not always able to participate fully in ward rounds due to the new ways that the multi-disciplinary team meetings operated. These involved patients arranging separate meetings with their consultant to raise issues and MDT meetings were business meetings without patients being seen.

Patients had regular access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act known as Independent Mental Health Advocates (IMHAs). Staff informed patients about the availability of the IMHAs and enabled them to understand what assistance the IMHA could provide with one exception noted. Patients we spoke with were aware of the IMHA service and complementary of the responsiveness and support received from the IMHA.

Michael Carlisle Centre – Stanage and Burbage wards

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and understanding manner. The patients we spoke with were complimentary about staff attitude and engagement.

Staff we spoke with felt that patients received good care on the wards. They told us they felt patients were given hope with regard to moving on and recovering.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care. We observed a clinical meeting; patients within these meetings were treated with dignity and respect, patient views were responded to and good interaction between the team and patient was observed.

There was access to fresh air via a small enclosed courtyard.

The involvement of patients in the care they receive

The care plan documents across the trust were found in the electronic patient notes (EPN) system and from reviewing this it was sometimes difficult to see how the involvement of the individual was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in the EPN.

Community meetings were held regularly on the ward. We looked at the minutes from some of these meetings. The meetings were attended by patients using the service and staff on the ward. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible.

Patients had regular access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act known as Independent Mental Health Advocates (IMHAs). Staff informed patients about the availability of the IMHAs and enabled them to understand what assistance the IMHA could provide with one exception noted. Patients we spoke with were aware of the IMHA service and complementary of the support received from the IMHA.

Good

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 good because:-

Patients were able to access beds in their local acute psychiatric service within reasonable timescales. Whilst there were some pressure on beds this did not significantly adversely affect patient care. The service was responsive to patients' needs. Restrictions were usually kept to a minimum. Patients' individualised needs were met.

Patients told us they felt involved in their care and treatment. The trust provided interpretation services to ensure that where there was a barrier for patients to communicate effectively, these were overcome using different approaches. The acute wards had a well equipped multi-faith room to enable patients with religious beliefs.

Patients felt they would know how to make a complaint. Staff tried to and resolved concerns with patients before they became a formal complaint.

Our findings

The Longley Centre – Rowan and Maple wards

Access, discharge and bed management

Admissions into the acute beds at the Longley Centre were gate kept by the crisis staff within the community teams or out of hours team, or by Approved Mental Health Professionals (AMHPs) following a Mental Health Act assessment. This ensured that there was proper consideration whether people require being as in-patients.

Discharge discussions took place at daily MDT meetings with expected discharge dates set and reviewed regularly. There was good working links with the home treatment staff within the community mental health teams to facilitate discharge from the wards. Weekly meetings occurred with representatives from the community mental health teams CMHT to consider discharge planning.

Patients were reported to be appropriately placed with no significant issues with delays on discharge. The wards were operating within safe bed numbers at the time of our visit.

We heard that at times AMHPs had difficulty admitting patients to the acute wards and on occasions people had to be treated out of area but this was not occurring on a regular basis.

The ward environment optimises recovery, comfort and dignity

The ward environment was clean and comfortable. There were two wards which could afford single gender wards. However each ward was mixed gender based on geographical localities from which patients lived prior to admission. Sleeping accommodation was in single rooms and single sex bays, with toilet and washing facilities en-suite or very close by; these facilities were clearly designated either male or female. Toilet and bathing facilities were grouped to achieve as much gender separation as possible. There was a day lounge for use by women only as well as spaces where men and women could socialise and take part in therapeutic activities together. Every effort was made to ensure the availability of staff who were the same sex as the users they are caring for. On rare occasions female patients were cared for on male corridors due to the numbers of patients of each gender.

The wards had communal areas and other quiet rooms which could be utilised as private interview rooms. There was a family visiting area off the wards but this area but there was some effort to make the space appropriate for children and family visiting.

The wards had access to an activities room There was a good range of information across the entire ward for patients on notice boards and via a range of leaflets on a range of matters.

Patients commented favourably on the quality and portions of the food. Patients were given choice of food including vegetarian options. Patients could make hot drinks and snacks with any risks managed on an individual basis.

Ward policies and procedures minimise restrictions

Restrictions were kept to a minimum within the context of providing care to patients that presented risks. The doors to the wards were kept locked but staff managed access into and off the ward. Informal patients were aware that

Good

Are services responsive to people's needs?

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

they may leave the ward at any time. Information about exiting the ward was available in the ward welcome pack but there was no information displayed near the front door to Maple ward.

Patients have access to their own mobile phones. Individual patients were risk assessed around any items of personal belongings that may need to be considered for confiscation; the need for searching patients was made on an individual basis.

Meeting the needs of all patients who use the service

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. There was a designated multi-faith prayer area off the ward. There were two multi-faith rooms one geared towards patients of Christian faith and one geared towards patients of Muslim faith with significant attention to detail such as bathing facilities available for ablutions and details of the direction to prayer towards Mecca. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. We were told that translation and interpretation service were available.

A choice of meals was available with effort made to ensure a varied range of cultural needs were met representing the needs of individuals and the multi-cultural nature of the communities the trust serves.

There were good links with groups from Black and Minority Ethnic Groups such as voluntary and faith organisations for people from Pakistani backgrounds and the Sheffield African Caribbean Mental Health Association.

Listening to and learning from concerns and complaints

Patients who used the service knew how to raise complaints and concerns. Information on how to make a complaint was displayed in most areas. Information on mental health advocacy services were also displayed. Informal complaints were often reported as being raised and resolved at community meetings or through the trust's fast track system. The ward held details of the fast track complaints that showed how these complaints had been looked at and resolved at local level. Patients reported confidence in the fast track complaints system to resolve their concerns quickly and locally. Formal complaints were discussed in various meetings including service and locality clinical governance meetings.

The Longley Centre – Intensive Treatment Service (PICU)

Access, discharge and bed management

Admissions into PICU beds at the Longley Centre were via assessment by the multi-disciplinary team for patients requiring transfer from the acute wards across Sheffield. Access into the PICU could also be secured following a Mental Health Act assessment for people in the community. This ensured that there was proper consideration whether patients require being cared for under conditions of psychiatric intensive care.

Patients were reported to be appropriately placed with no significant issues with delays on discharge. The acute wards did not raise concern about access to PICU beds.

The ward environment optimises recovery, comfort and dignity

The ward environment was clean and comfortable. Patients dignity was maintained as each patient had their own individual bedroom; three of which offered full en suite bedrooms with showers with single gender bathing facilities on the ward. The wards had communal areas and other quiet rooms which could be utilised as private interview rooms. The ward was mixed gender with a female only lounge. There was a family visiting area off the wards but there was some effort to make the space appropriate for children and family visiting.

The wards had access to an activities room. There was a good range of information across the entire ward for patients on notice boards and via a range of leaflets on a range of matters.

Patients did not have an opportunity to make a phone call in private through a designated patient phone on the wards. Patients utilised the ward office phone which was used outside of the office to maintain confidentiality. The ward was looking into obtaining a cordless phone.

Patients commented favourably on the quality and portions of the food. Patients were given choice of food including vegetarian options. Patients could make hot drinks and snacks with any risks managed on an individual basis.

Good

Are services responsive to people's needs?

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

Ward policies and procedures minimise restrictions

Restrictions were kept to a minimum within the context of providing care in a more secure environment. There was a clear list of items which were not allowed on the low secure ward which were kept in the security cupboard with access to these items under supervision. There was an appropriate balance between managing risks within low secure care and an appropriate level of positive risk taking. This was achieved through ensuring proper regard to relational security such as ensuring good knowledge of individual patients and appropriate staffing levels. There were no zonal restrictions within the wards so patients could access all areas of the ward including their bedrooms during the day.

Access to fresh air was limited. There was access to the outside smoking area which was a 'cage like' construction. We were told this was opened at regular intervals between 0630hrs and 2330hrs and was supervised at all times due to the ligature risk. Patients stated that they found the ward restrictions on access to fresh air and outside space frustrating. The trust is undergoing a process of expansion and the PICU is planned to move to a more appropriate environment with a garden area would be provided with improved access to an outside space by the end of 2015.

Meeting the needs of all patients who use the service

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. The trust had developed a booklet to raise staff awareness of the different religious groups, common customs and festival days. There was a designated multi-faith prayer area off the ward. There were two multi faith rooms one geared towards patients of Christian faith. Also, one geared towards patients of Muslim faith with significant attention to detail such as bathing facilities available for ablutions and details of the direction to prayer towards Mecca. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. We were told that translation and interpretation service were available.

A choice of meals was available with effort made to ensure a varied range of cultural needs were met representing the needs of individuals and the multi-cultural nature of the communities the trust serves.

Listening to and learning from concerns and complaints

Patients who used the service knew how to raise complaints and concerns. Information on how to make a complaint was displayed in most areas. Information on mental health advocacy services was also displayed. Informal complaints were often reported as being raised and resolved at community meetings. Formal complaints were discussed in various meetings including service and locality clinical governance meetings.

Michael Carlisle Centre – Stanage and Burbage wards

Access, discharge and bed management

Admissions into the acute beds at the Michael Carlisle Centre were gate kept by the crisis staff within the community teams or out of hours team, or by Approved Mental Health Professionals (AMHPs) following a Mental Health Act assessment. This ensured that there was proper consideration whether people require being as in-patients.

Discharge discussion take place at daily MDT meetings with expected discharge dates set and reviewed regularly. There was good working links with the home treatment staff within the community mental health teams to facilitate discharge from the wards. Weekly meetings occur with representatives from the CMHT to consider discharge planning.

Patients were reported to be appropriately placed with no significant issues with delays on discharge. The wards were operating within safe bed numbers at the time of our visit. We heard that at times AMHPs had difficulty admitting patients to the acute wards and on occasions patients had to be treated out of area but this was not occurring on a regular basis.

The ward environment optimises recovery, comfort and dignity

The ward environment was clean and comfortable. The wards were mixed gender based on geographical areas from which patients lived prior to admission. Sleeping accommodation was in single rooms and single sex bays, with toilet and washing facilities en-suite or very close by; these facilities were clearly designated either male or female. Toilet and bathing facilities were grouped to achieve as much gender separation as possible. There was a day lounge for use by women only as well as spaces

Good

Are services responsive to people's needs?

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

where men and women can socialise and take part in therapeutic activities together. Every effort was made to ensure the availability of staff who were the same sex as the users they are caring for.

The wards had communal areas and other quiet rooms which could be utilised as private interview rooms. There was a family visiting area off the wards but this area but there was some effort to make the space appropriate for children and family visiting.

The wards had access to activities rooms There was a good range of information across the entire ward for patients on notice boards and via a range of leaflets on a range of matters.

Patients commented favourably on the quality and portions of the food. Patients were given choice of food including vegetarian options. Patients could make hot drinks and snacks with any risks managed on an individual basis.

Ward policies and procedures minimise restrictions

Restrictions were kept to a minimum within the context of providing care to patients that presented risks. The doors to the wards were kept locked but staff managed access on and off the ward. Informal patients were aware that they may leave the ward at any time and there were notices by the door to inform patients. Information about exiting the ward was also available in the ward welcome pack.

Patients have access to their own mobile phones. Individual patients are risk assessed around any items of personal belongings that may need to be considered for confiscation; the need for searching patients is made on an individual basis.

Meeting the needs of all patients who use the service

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. The trust had developed a booklet to raise staff awareness of the different religious groups, common customs and festival days. There was a designated multi-faith prayer area off the ward. There were two multi faith rooms one geared towards patients of Christian faith. Also one geared towards patients of Muslim faith with significant attention to detail such as bathing facilities available for ablutions and details of the direction to prayer towards Mecca. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. We were told that translation and interpretation service were available.

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The ward held details of the fast track complaints that showed how these complaints had been looked at and resolved at local level. Patients reported confidence in the fast track complaints system to resolve their concerns quickly and locally. Formal complaints were discussed in various meetings including service and locality clinical governance meetings.

Are services well-led?

Good

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 good because:

We found that the service was well led with effective management of the service through a commitment to provide high quality care and continuous improvement in line with the trust's stated values and strategy. Staff we spoke with were aware of their roles and responsibilities and staff had knowledge of the trust's values and objectives.

Staff reported that they felt well supported by their managers. Staff felt that the executive and senior management of the trust were accessible.

Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings. Generally audits identified and addressed issues to ensure continuous improvement. Where we found issues which had not been picked up or addressed by the trust's own systems, we were assured that managers were already developing plans to address these in better ways to properly identify, address or manage the risks to patients.

Our findings

The Longley Centre – Rowan and Maple wards

Vision and values

The trust had a strategy with the overall aim of improving health; improving lives. The trust had a number of high level values which included respect and dignity, a commitment to quality of care, working together, improving lives, compassion and everyone counts

Staff on the acute wards showed professional commitment to these values as evidenced throughout our interviews with many staff. Patients commented favourably that they received high quality care which showed staff were working within the stated values of the trust.

Good governance

The wards were overseen by committed and experienced managers who oversaw the quality and clinical governance agenda. Wards had their own objectives which highlighted locally determined governance improvements.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance

systems were effective in identifying and managing risks to patients using the service.

Where we found issues which had not been picked up or addressed by the trust's own systems, we were assured that managers were already developing plans to address these in better ways to properly identify, address or manage the risks to patients. For example staff on Maple ward were monitoring the competing demands of the ward and managing the health based place of safety.

Leadership, morale and staff engagement

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their

dedication to providing quality patient care.

Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Regular team

meetings were held with minutes recorded.

Commitment to quality improvement and innovation

We saw that there were a number of audits which were carried out which were able to measure standards in terms of development and improvement within the service. This meant that the performance of the service was monitored in order to drive improvement.

The service continued to listen and engage with patients on an ongoing basis to ensure that patients received good quality care that met patients' needs.

The Longley Centre – Intensive Treatment Service (PICU)

Vision and values

Are services well-led?

Good

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.

The trust had a strategy with the overall aim of improving health; improving lives. The trust had a number of high level values which included respect and dignity, a commitment to quality of care, working together, improving lives, compassion and everyone counts

Staff on the PICU showed professional commitment to these values as evidenced throughout our interviews with many staff. Patients commented favourably that they received high quality care which showed staff were working within the stated values of the trust.

Good governance

The wards were overseen by a committed manager who oversaw the quality and clinical governance agenda. Nursing staff on the wards had lead responsibilities for carrying out checks on various elements of clinical practice such as medicines management, Mental Health Act adherence, records checks, environmental and security checks. Identified issues from these had been shared through team meetings or other forums.

Where we found issues which had not been picked up or addressed by the trust's own systems, we were assured that managers were already developing plans to address these in better ways to properly identify, address or manage the risks to patients. For example the practices of seclusion on the PICU was a priority for the trust to improve and the shortfalls in the environment of the PICU would ultimately be addressed by the new environment of the PICU.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance

systems were better identifying and managing risks to patients using the service.

Leadership, morale and staff engagement

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their

dedication to providing quality patient care.

Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Regular team

meetings were held with minutes recorded.

Commitment to quality improvement and innovation

The service continued to listen and engage with patients on an ongoing basis to ensure that patients received good quality care that met patients' needs. The trust board has approved a significant investment to build a new Intensive Treatment Service ward to improve the environment and work was underway at the time of our inspection. Patients had been consulted as part of the design and delivery of the new build and detailed plans were displayed within the PICU service. This would provide a much improved environment for providing care to patients requiring PICU care including improved space, including better gender separation and outdoor space.

Michael Carlisle Centre – Stanage and Burbage wards

Vision and values

The trust had a strategy with the overall aim of improving health; improving lives. The trust had a number of high level values which included respect and dignity, a commitment to quality of care, working together, improving lives, compassion and everyone counts

Staff on the acute wards showed professional commitment to these values as evidenced throughout our interviews with many staff. Patients commented favourably that they received high quality care which showed staff were working within the stated values of the trust.

Staff reported that there was regular presence on the ward from managers with more limited input from senior executive managers.

Good governance

The wards were overseen by committed and experienced managers who oversaw the quality and clinical governance agenda. Wards had their own objectives which highlighted locally determined governance improvements, for example on Stanage ward the ward had committed to improving supervision for staff, recovery goals and physical health checks with patients as well being involved in the

Are services well-led?

Good

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productive ward initiative. Progress on these objectives was monitored on an on-going basis. We saw that managers were also managing performance or capability issues to ensure patients received high quality care.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance

systems were more effective in identifying and managing risks to patients using the service.

Where we found issues which had not been picked up or addressed by the trust's own systems, we were assured that managers were already developing plans to address these in better ways to properly identify, address or manage the risks to patients. For example staff on Stanage ward were auditing the records in relation to MHA records and had identified many improved areas of practice but a small number of continuing shortfalls with improved action to prevent reoccurrence.

Leadership, morale and staff engagement

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their

dedication to providing quality patient care.

Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Regular team

meetings were held with minutes recorded.

Commitment to quality improvement and innovation

We saw that there were a number of audits which were carried out which were able to measure standards in terms of development and improvement within the service. These audits included safeguarding, cleanliness, MHA adherence, medication and health and safety. The wards monitored their performance against the measures we check using the safe, effective, caring, responsive and well-led domains. This meant that the performance of the service was monitored in order to drive improvement.

The service continued to listen and engage with patients on an on-going basis to ensure that patients received good quality care that met patients' needs.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk associated with the unsafe management of medicines. This was in breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At the Michael Carlisle and the Longley Centre • There were not always records of the patient being observed following the use of rapid tranquilisation. • Recording of fridge and room temperature where medication is stored was not always being completed and recorded. We found that the registered person had not protected people against the risk associated with unsafe premises. This was in breach of regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: There were environmental issues within the seclusion rooms and identified ligature risks across the Longley Centre and Michael Carlisle locations.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against the risk associated with the lack of proper information within written records. This was in breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requirement notices

How the regulation was not being met:

At the Michael Carlisle and the Longley Centre in the

following areas relating to the Mental Health Act:

• The recording of episodes of seclusion did not always include the rationale for seclusion.

• The recording of episodes of seclusion did not always include the time the doctor attended seclusion or the cogent reasons if there was a delay in attendance.

• The recording of rights to detained patients did not include action taken to revisit the patient or record further action when a patient had refused the explanation.

• The recording of rights to detained patients did not include recoding that patient's had been given information about access to the Independent Mental Health Advocacy service.

• Not all of the legal authorisations (T2 and T3 forms) were available with the medicine charts.