Essex Partnership University NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1LY9	Basildon Mental Health Unit	Gloucester ward	SS16 5NL
R1LZ9	Rochford Hospital	Beech ward Maple ward	SS4 1RB
R1LX8	Brian Roycroft Ward	Brian Roycroft Ward	CM20 3NR
R1LX2	Thurrock Hospital	Meadowview ward	RM16 2PX
R1LX4	St Margaret's Community Hospital	Kitwood ward Roding ward	CM1 6TM
R1LX7	Broomfield Hospital Mental Health Wards	Ruby ward Topaz ward	CM1 7LF
R1LY4	Landemere Centre Mental Health Wards	Tower ward Bernard ward	CO15 1LH

Summary of findings

R1LY2	Colchester Hospital Mental Health Wards	Henneage ward	CO4 5JY

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

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

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

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

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

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

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

Summary of findings

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Overall summary

We found the following areas the provider needs to improve:

- Bernard and Tower wards were not safe. Corridors that were identified fire escape routes had items stored along them. This would impede progress of anyone trying to escape in the event of a fire and would hinder any emergency services attempting to gain access. The fire escape route went into a small garden area. The gate out of this area was secured with a key pad and staff did not know the number combination to unlock the gate.
- Managers had not identified all ligature points on Ruby and Henneage. They were not recorded on the ligature risk assessment. They were, however, in communal areas where patients should be supervised. On Tower, ward managers had highlighted all ligature risks but guidance for staff on management of these risks was not clear.
- We found a number of medicines management issues. Staff had not listed all medicines given covertly. We found out of date British National Formulary books on five wards. Staff did not follow the correct protocols for a patient on a combination of high dose medications. These included physical health monitoring and indicating the high dose on the patient's drug chart. Staff had not labelled medicines with the date of opening and we found out of date dressings. There was an oxygen cylinder with no expiry date. Staff had not cleaned two tablet crushers. Three patients went without one of their medications for a day, due to issues with the system for ordering the medication. Another patient had a dose of medication omitted as staff had written the drug chart incorrectly. Two patients did not have allergy information completed on all sections of the drug chart.
- Bernard and Tower wards did not have enough bathrooms to meet patients' needs. On Bernard, there was one working bathroom for 14 patients. Tower only had one combined bathroom and shower room for 14 patients.
- The service often ran below established qualified staffing levels. Between 1 April 2017 and 31 August 2017, there were four months of night shifts that had a qualified fill rate of 50% or less and a further 15 months that had qualified fill rates below 75%.

However, we found the following areas of good practice:

- The multidisciplinary staff teams completed thorough, holistic and detailed assessments prior to and on admission. They covered aspects of the patient's history and needs together with an assessment of risk. The plans were personalised and identified patients' needs and preferences. Staff updated these plans regularly. All patients had risk assessments completed before and during admission. Risk assessments were detailed, clear, used historical information to identify risks and staff updated them regularly.
- The service had implemented a new falls procedure following high numbers of falls incidents. The trust employed a falls lead who facilitated a monthly falls group to review falls incidents and share learning.
- Teams carried out twice daily 'safety huddles'. These 'huddles' consisted of all staff on duty meeting and assessing the safety of the wards and ensuring patients' needs were being met.
- The ward areas were clean, tidy and well maintained and furnishings were in good condition. The clinic rooms were clean, tidy and well equipped for carrying out physical examinations. Staff ensured equipment was serviced and carried out regular checks.
- Patients spoken with told us that staff were caring and kind. We observed positive interactions between patients and staff.
- Managers ensured regular supervisions took place for staff. Managers facilitated monthly team meetings where they discussed incidents and complaints, including learning from other services in the trust.

Summary of findings

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

Are services safe?

We found the following areas the provider needs to improve:

- Bernard and Tower wards were not safe. Corridors that were identified fire escape routes had items stored along them. This would impede progress of anyone trying to escape in the event of a fire and would hinder any emergency services attempting to gain access. The trust fire officer had completed a fire risk assessment in September 2012. Managers had not reviewed this since September 2016 and had not completed all identified actions. The fire escape route went into a small garden area. The gate out of this area was secured with a key pad and staff did not know the number combination to unlock the gate.
- Managers had not identified all ligature points on Ruby and Henneage. They were not recorded on the ligature risk assessment. Ruby ward had two televisions fixed to the wall and Henneage had light fixtures in the corridors, dining room and lounge that managers had not identified as ligature points. They were, however, in communal areas where patients should be supervised. On Tower ward, managers had identified all ligature risks but guidance for staff on management of these risks was not clear.
- We found a number of medicines management issues. Staff had not listed all medicines given covertly. We found out of date British National Formulary books on five wards. Staff did not follow the correct protocols for a patient on a combination of high dose medications. Staff had not labelled medicines with the date of opening and there were out of date dressings. There was an oxygen cylinder with no expiry date. Staff had not cleaned two tablet crushers. Three patients went without one of their medications for a day, due to issues with the system for ordering the medication. Another patient had a dose of medication omitted as staff had written the drug chart incorrectly. Two patients did not have allergy information completed on all sections of the drug chart.
- The service often ran below qualified staffing levels. The trust reported a qualified staffing fill rate of 91% from 1 April to 31 August. However across the twelve wards there were four months of night shifts that had a qualified fill rate of 50% or less and a further 15 months that had qualified fill rates below 75%. Ruby reported the lowest fill rates of 72%. Managers had reported 83 staffing issues incidents from 1 April 2017 to 31 August 2017. Topaz had reported the highest number at 60.

However, we found the following areas of good practice:

Summary of findings

- Teams carried out twice daily 'safety huddles'. These 'huddles' consisted of all staff on duty meeting and assessing the safety of the wards and ensuring patients' needs were being met.
- Staff completed patients' risk assessments before and during admission. Risk assessments were detailed, clear, used historical information to identify risks and staff updated them regularly.
- Patients and staff had access to appropriate alarms and nurse on call systems on all wards. Bedrooms were fitted with observation panels. Some bedrooms were fitted with accessible technology for patients at risk of falls.
- The service had implemented a new falls procedure following high numbers of falls incidents. The trust employed a falls lead who facilitated a monthly falls group to review falls incidents and share learning.
- The ward areas were clean, tidy and well maintained and furnishings were in good condition. The clinic rooms were clean, tidy and well equipped for carrying out physical examinations. Staff ensured equipment was serviced and carried out regular checks.

Are services effective?

We found the following areas of good practice:

- The multidisciplinary staff team completed thorough, holistic and detailed assessments prior to and on admission. They covered aspects of the patient's history and needs together with an assessment of risk. The plans were personalised and identified patients' needs and preferences. Staff updated these plans regularly.
- There was evidence of a full physical health check on or shortly after admission and there was evidence that staff monitored patients' physical health regularly. Staff would support patients to access healthcare support as needed. Staff completed a number of assessments to support patients' physical health.
- Staff held ward rounds and care programme approach meetings regularly with the patient, their families and relevant professionals. Staff used these reviews to monitor progress and update assessments. Staff reviewed do not attempt resuscitation statements regularly with families and patients.
- Medication charts had the correct consent to treatment forms T2 and T3 in place.

However, we found the following areas the provider needs to improve:

Summary of findings

- The trust used two secure electronic recording systems, one in the north and one in the south. Staff working in the north could not access the system in the south and vice versa. If the service transferred a patient between north and south areas staff could not access their records.
- Kitwood and Roding wards did not have a psychologist in post and were recruiting. Meadowview ward did not have a psychologist on site as there was only on ward on site. Staff told us they would request psychology when required.

Are services caring?

We found the following areas of good practice:

- Patients we spoke with told us that staff were caring and kind. We observed positive interactions between patients and staff.
- Carers we spoke with were positive about the care and support provided to their relative. Carers were encouraged to be involved in their relatives care.
- Patients had opportunities to express their views through weekly community meetings and one to one time with staff.
- Managers displayed 'you said, we did' boards on wards. Examples of action taken included the introduction of morning newspaper groups and a memory café.

Are services responsive to people's needs?

We found the following areas the provider needs to improve:

- Bernard and Tower wards did not have enough bathrooms to meet patients' needs. On Bernard ward, there was one working bathroom for 14 patients. Tower had one combined bathroom and shower room for 14 patients.

However, we found the following areas of good practice:

- The wards had a number of rooms for leisure and therapeutic activities. The clinic rooms had the facilities and equipment needed to undertake physical examinations.
- There were programmes of activities, both on and off the wards including at weekends. There were also rooms where patients could meet visitors including designated rooms off the wards, which patients used when children were visiting. The wards had secure garden areas which patients were able to access.
- Staff facilitated regular community meetings for patients so they could raise any concerns. Staff were aware of how to handle complaints appropriately and how to report them. Managers discussed feedback about complaints in team meetings. We checked meeting minutes, which confirmed this.

Summary of findings

Are services well-led?

We found the following areas of good practice:

- The trust measured service performance through quality dashboards and the patient safety thermometer. The patient safety thermometer measures harm to patients on a single day each month. Managers told us that the processes and systems implemented by the trust supported them in their roles.
- Managers ensured regular supervisions took place for staff. Managers facilitated monthly team meetings where they discussed incidents and complaints, including learning from other services in the trust.
- The ward managers were highly visible on the wards and offered clinical support and encouragement to staff.
- Staff knew of the whistleblowing policy and were happy to raise concerns with managers. Staff did not raise any instances of bullying or harassment with us during the inspection.

However, we found the following areas the provider needs to improve:

- Following the merger of the two trusts, some staff spoken with in the north told us that they did not feel involved with the changes.
- The trust was operating two electronic record systems and staff told us they only had access to one system, depending on whether they were located in the north or south. Staff could not access the records of patients who had transferred between the north and south.
- Eight of the twelve wards often operated under established staffing levels for qualified staff. We looked at fill rate records for the period 1 April 2017 to 31 August 2017, which confirmed this.
- Staff at the Bryan Roycroft unit, which the trust was closing temporarily, felt uncertain about their future. They told us that managers had not told them when the unit was closing and where they would be working following the closure.

Summary of findings

Information about the service

Essex Partnership University NHS Foundation Trust formed on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust and South Essex Partnership University NHS Foundation Trust.

Essex Partnership University Foundation Trust provides inpatient care to older patients in fourteen wards at ten locations. There are 293 beds in total. These wards provide assessment, care and treatment for older patients with organic and functional mental illnesses.

At Basildon Mental Health Unit, Gloucester ward is a mixed sex 25 bedded unit.

At Rochford Hospital, there are two wards, Beech and Maple, both 24 bedded mixed sex units.

Brian Roycroft Ward, Harlow, is a 16 bedded unit. The ward was in the process of closing temporarily for refurbishment. There were three patients on the ward during our visit.

At Thurrock Hospital, Meadowview ward is a mixed sex 24 bedded unit.

At St. Margaret's Community Hospital, Epping there are two mixed sex wards; Kitwood, 16 bedded and Roding, 14 bedded.

At Broomfield Hospital Mental Health Wards, Chelmsford there are two wards; Ruby and Topaz, both 17 bedded mixed sex units.

At the Landermere Centre, Clacton there are two wards. Bernard is a 15 bedded male unit and Tower is a 14 bedded female unit.

At Colchester Hospital Mental Health Wards, Henneage ward is a 17 bedded mixed sex unit.

Clifton Lodge, Westcliff-on-sea, is a 35 bedded mixed sex unit. This unit is in the process of registering as a social care provision and was not inspected.

Rawreth Court, Rayleigh is a 35 bedded mixed sex unit. This unit is in the process of registering as a social care provision and was not inspected.

The CQC carried out a comprehensive inspection of this core service in June 2015 as part of the comprehensive inspection of South Essex Partnership University NHS Foundation Trust and in August 2015 as part of the comprehensive inspection of North Essex Partnership University NHS Foundation Trust. We rated this core service as 'good' overall in South Essex and as 'requires improvement' in North Essex.

Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified in this service. These related to:-

Regulation 12 – safe care and treatment Regulation 15 – premises and equipment

In August 2015 CQC identified the following areas of improvement for this service:

- The trust must have effective systems in place for the safe prescribing and administration of medication.
- The trust must ensure that medical equipment is working effectively and stored appropriately.
- The trust should ensure that the outcomes and actions from ligature and environmental audits are completed.
- The trust should ensure that outcomes and learning outcomes of serious incidents and complaints are shared throughout to the trust.
- The trust should ensure that systems are in place for the effective recruitment and retention of staff.
- The trust should review the electronic records system and ensure that staff can access essential documents when they need to, in order for them to deliver effective care in a timely manner.
- The trust should collect data that includes racist abuse against patients and staff and develop ways of protecting people.

Following the inspection of North Essex Partnership University NHS Foundation Trust we found significant improvements were required and issued a Section 29A Warning Notice.

The CQC carried out an unannounced, focused inspection at Henneage, Kitwood and Roding wards in

Summary of findings

September 2016. This inspection focused on three domains, safe, caring and well-led. Ratings are not given for this type of inspection. CQC identified the following areas of improvement:

- The trust must improve their governance and assurance systems relating to the assessment and management of risk such as ligature risks, mixed sex accommodation and learning from incidents.
- The trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight.
- The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation.
- The trust should ensure learning from serious incidents is shared with teams to ensure future risks are mitigated.
- The trust must ensure that emergency equipment is fit for use.
- The trust must have effective systems in place for the safe administration and storage of medication.
- The trust must ensure there is sufficient staff on duty at all times to provide skilled care to meet patients' needs.
- The trust must ensure that all staff receive regular supervision, and training.
- The trust must proactively address any practices that could be considered restrictive, for example, access to toilets, access to the gardens, and access to snacks and beverages.
- The trust must ensure that wards ensure dignity and comfort for patients and that maintenance is completed in a timely manner.
- The trust must ensure that policies and procedures give clear information for staff reference when reporting incidents. That policies and procedures are updated to reflect current national guidance.
- The trust must ensure that wards have sufficient bathrooms for patients to bathe or shower in.
- The trust should ensure that care and treatment records, including risk assessments, are sufficiently detailed, personalised and kept up to date.
- The trust should formally review each restraint involving the prone position.
- The trust should ensure that their action plans clearly state how they are addressing issues raised from the NHS staff survey.

Following the unannounced inspection of Henneage, Roding and Kitwood wards the CQC issued a further section 29A warning notice relating to regulation 17 good governance, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and requirement notices.

We reviewed these as part of the inspection. We have identified the issues which remain later in this report, the trust had addressed some but not all of these actions from the June 2015 inspection, August 2015 inspection and the unannounced inspection in September 2016.

Our inspection team

Our inspection team was led by:

- Team Leader: Julie Meikle, head of hospital inspection (mental health) CQC.
- Lead inspector: Victoria Green, inspection manager (mental health) CQC.

The team that inspected wards for older people with mental health problems included four inspectors, one inspection manager, one specialist advisor who was a consultant psychiatrist and an expert by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting.

Why we carried out this inspection

This was an unannounced inspection. Our monitoring highlighted concerns and we decided to carry out a focused inspection to examine these. These included concerns about falls incidents and ward environments.

Summary of findings

How we carried out this inspection

We have reported in each of the five domains safe, effective, caring, responsive and well led. As this was a focused inspection we looked at specific key lines of enquiry in line with concerns raised with us. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report. We have not given ratings for this core service, as this trust has not yet had a comprehensive inspection.

This inspection focused on all aspects of the safe and caring key questions, assessment and best practice under the effective key question, complaints and facilities under the responsive key question and leadership and governance under the well-led key question.

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited 12 wards, looked at the quality of the service environment and observed how staff were caring for patients
- spoke with 28 patients who were using the service
- interviewed 11 ward managers and spoke with senior managers
- spoke with 45 other staff members; including doctors, nurses, psychologists, occupational therapists, activity workers and healthcare assistants
- attended and observed three multidisciplinary meetings and one staff handover meeting
- spoke with nine carers of patients using the service
- looked at 55 treatment records of patients
- attended and observed two activity groups
- looked at a range of policies, procedures and other documents related to the running of the service.

What people who use the provider's services say

- We spoke with 28 patients who shared positive comments about their experience of living on the wards.
- Patients were positive about staff, describing them as helpful, wonderful, kind and caring. Patients told us that they liked the wards and their care and treatment was good. Three patients told us that there were not enough staff.
- Most patients were positive about the food provided, describing it as good and decent portion sizes.
- One patient told us that staff do wonderful work and another told us they do a really good job.
- Patients told us that they felt safe on the wards.
- Patients told us that their relatives were encouraged to be involved in their care.
- We spoke with nine carers. All were positive about the care their relative received.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure the proper and safe management of fire risks and ensure fire escape routes are accessible.
- The trust must ensure that all ligature points are identified, mitigated against and known by staff.
- The trust must ensure the proper and safe management of medicines.
- The trust must ensure that wards have sufficient bathrooms for patients to bathe or shower in.
- The trust must ensure that there are sufficient numbers of suitably qualified and competent staff to meet patient need.

Action the provider SHOULD take to improve

- The trust should consider the use of one electronic record system.
- The trust should review psychology input across the wards.
- The trust should ensure both north and south parts of the trust are fully involved in changes as part of the merger.

Essex Partnership University NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Gloucester ward	Basildon Mental Health Unit
Beech ward Maple ward	Rochford Hospital
Brian Roycroft ward	Brian Roycroft ward
Meadowview ward	Thurrock Hospital
Kitwood ward Roding ward	St. Margaret's Community Hospital
Ruby ward Topaz ward	Broomfield Hospital Mental Health Wards
Tower ward Bernard ward	Landermere Centre Mental Health Wards
Henneage ward	Colchester Hospital Mental Health Wards

Mental Health Act responsibilities

We did not inspect all key lines of enquiry in relation to the Mental Health Act.

- We looked at 113 medication charts, and where required they had the correct consent to treatment forms T2 and T3 in place and attached. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and records that a

patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.

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

Our findings

Safe and clean environment

- Bernard and Tower wards were not safe. Corridors that were identified fire escape routes had items stored along them. This would impede progress of anyone trying to escape in the event of a fire and would hinder any emergency services attempting to gain access. The trust fire officer had completed a fire risk assessment in September 2012. Managers had not reviewed this since September 2016 and managers had not completed all identified actions. The fire escape route went into a small garden area. The gate out of this area was secured with a key pad and staff did not know the number combination to unlock the gate.
- The layout of the wards did not always allow for staff observation of patients. Gloucester and Kitwood had blind spots that did not have mirrors fitted. However, managers mitigated blind spots on other wards by the installation of mirrors and walk arounds by staff.
- Two of the units were single sex wards, one for males and one for females. The other twelve units were mixed sex wards.
- The wards were compliant with the guidance for mixed sex accommodation. On the mixed sex units, all of the wards had separate male and female bedroom areas and separate bathroom facilities. There were separate lounge areas for male and female patients on all wards but on Maple, staff used the single sex lounge as a meeting room.
- We found issues with the management of ligature risks. Across all wards, there were ligature points in areas including the communal gardens, bedrooms and bathrooms. Managers had completed ligature audits. We found ligature points on Ruby and Henneage wards that managers had not identified in the audits. Ruby had two televisions fixed to the wall and Henneage had light fixtures in the corridors, dining room and lounge that managers had not identified as ligature points. They were, however, in communal areas where patients should be supervised. On Tower, managers had identified all ligature risks but guidance for staff on management of these risks was not clear. On the other wards, staff managed and reduced risks by the use of individual risk assessments and awareness of risk areas. The wards were equipped with a number of anti-ligature fittings. Any high risk patients would be on 24-hour one to one observation. Managers told us there had been no incidents of patients ligating from a fixed anchor point. Patients said they felt safe on the wards. Ligature point is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves.
- Teams carried out twice daily 'safety huddles'. These 'huddles' consisted of all staff on duty meeting and assessing the safety of the wards and ensuring patients' needs were being met.
- The clinic rooms were clean, tidy and well equipped for carrying out physical examinations. Staff ensured equipment was serviced and carried out regular checks.
- There were no seclusion rooms on the wards.
- The ward areas were clean, tidy and well maintained and furnishings were in good condition.
- We looked at some of the patients' bedrooms, which were in good condition. The kitchens on all wards were well equipped and clean.
- Patients and staff had access to appropriate alarms and nurse on call systems on all wards. Bedrooms were fitted with observation panels. Some bedrooms were fitted with accessible technology for patients at risk of falls. Staff were alerted if patients tried to get out of bed.

Safe staffing

- We identified concerns about staffing levels. Whilst the trust had estimated the number of staff to provide safe staffing, managers had not ensured that they had the required staff on shift.
- Ward managers reported that Bernard had the highest number of vacancies at 76% whole time equivalent for qualified staff and 64% whole time equivalent for healthcare assistants. After Bernard, Topaz and Tower had the highest vacancy rates for qualified staff at 62% and 60% respectively.The trust reported that Bernard ward had the highest number of vacancies at 37% for all staff as of the end of October 2017. After Bernard, Bryan Roycroft and Topaz had the highest overall vacancy rates at 25% and 21% respectively.

Are services safe?

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

- The service reported a qualified staff fill rate of 91% from 1 April 2017 to 31 August 2017. Ruby reported the lowest fill rates of 72%. Roding, Gloucester, Maple and Meadowview reported fill rates of over 90% for all qualified shifts in the reporting period. Across the twelve wards there were four months of shifts that had a qualified fill rate of 50% or less and a further 15 months that had qualified fill rates below 75%. Managers had overfilled healthcare assistant shifts when they were understaffed by qualified staff. Staff fill rates compare the proportion of planned hours worked by staff to actual hours worked by staff (day and night). Mental health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing.
- Managers had reported 83 staffing issues incidents from 1 April 2017 to 31 August 2017. Topaz had reported the highest number at 60. Seven other wards had reported between one and six staffing issues incidents. Brian Roycroft, Kitwood, Roding and Meadowview had not reported any staffing issues incidents.
- The trust reported 10,814 shifts were filled with bank staff and 1,007 by agency staff from 1 May 2017 to 31 October 2017. Maple, Topaz and Bernard reported the highest use of agency staff at 276, 225 and 225 of the total filled. Topaz and Ruby had the highest number of shifts covered by bank staff at 1284 and 1194 respectively.
- The sickness rate across the service was 7%, which was above the trust target of 5%. Seven wards reported sickness rates above the trust target. Maple reported the highest at 16%, Beech at 12%, and Tower and Bernard at 8%.
- The service had a compliance rate of 76% for mandatory training at the time of the inspection. The majority (95%) of staff had completed safeguarding adults and children training. The compliance rates for specialist mandatory training were 76% for falls prevention and 75% for dementia awareness.

Assessing and managing risk to patients and staff

- The trust reported that Bernard had used seclusion or segregation once in July 2017 and three times in August 2017.
- There had been 255 incidents of restraint between 1 April 2017 and 31 August 2017. One hundred and four of these took place on Maple. There were no incidents of prone restraint. Out of 574 recorded incidents of challenging behaviour, staff had de-escalated patients without the need for restraint in 55%.
- We looked at 55 patient records on the trust's electronic care record system. Staff completed patients risk assessments before and during admission. Risk assessments were detailed, clear, used historical information to identify risks and staff updated them regularly. They contained information about the patient's needs and preferences. Staff reviewed risks in ward rounds and care programme approach meetings.
- Patients could leave and access the building when they needed to according to their agreed leave arrangements and care plan. Patients were individually risk assessed for access to outside areas.
- The multidisciplinary team decided patient observation levels on an individual basis following patient risk assessments. Levels of observation could be increased or decreased as required. Staff recorded observation levels in patients' care records.
- Staff reported they used de-escalation and distraction techniques to minimise the use of restraint. Staff reported that some of these restraints were for patients who required holding in order for staff to provide personal care. These interventions were care planned for patients who required them. Staff also told us that all physical contact, including a guiding hand was recorded as restraint.
- There was minimal use of rapid tranquillisation across the wards. When staff had used rapid tranquillisation, they had completed physical observations in line with guidance.
- The trust had trained 86% of staff in therapeutic and safe interventions. This training had replaced the prevention and management of aggression training. This was general training provided to all staff across the trust. There was no specific training in relation to therapeutic and safe interventions for older people. Staff were not aware there was a trust policy and procedure for the use of restrictive interventions on older people.
- Ninety five percent of staff had received training in safeguarding adults and children. Staff were able to identify what abuse was. Staff, both qualified and unqualified, were aware of how to make a referral to the local authority. Managers reported positive relations with the local authority safeguarding teams. Staff would

also seek support and guidance from the trust's safeguarding lead. Staff reported incidents and concerns through the trust's electronic recording system. The service had reported six safeguarding vulnerable adults incidents during the period 1 April 2017 to 31 August 2017.

- We found issues with medicines management on a number of wards.
- We found out of date British National Formulary books in the clinic rooms on five wards. One was dated 2007. Staff told us that they used the electronic British National Formulary and advised they would dispose of the books.
- On Henneage, there was one patient on a combination of high dose medications at 175% of the recommended limit set in the British National Formulary. There was no indication on the drug chart that this patient was on high doses of medication. There was no physical health monitoring attached to the drug chart.
- On Topaz, we found a bottle of morphine in use that staff had not labelled with the date of opening, and out of date dressings. On Maple, there was an oxygen cylinder with no expiry date. On Roding, we found two tablet crushers that staff had not cleaned. One had the remnants of crushed medication. Staff told us that there were currently no patients requiring crushed medication. We also found risperidone that had no date of opening and had expired in May 2017.
- On Tower, doctors had prescribed two patients as required oromorph for pain relief. There was one day when this medication had not been available. Staff told us that they managed the pain with paracetamol. Staff told us that one of the patients was in pain and became highly agitated. Another patient did not have eye drops administered as prescribed on one day and one of their medications was unavailable for one day.
- On Bernard, a patient had a dose of medication omitted as staff had written the drug chart incorrectly. Staff were not sure if this had been reported as an incident. Two patients did not have allergy information completed on all sections of the drug chart.
- Staff administered medication covertly to a number of patients. These patients had covert medication plans in place. We also saw that capacity assessments and best interest meetings, involving the family had taken place. The multidisciplinary team regularly reviewed the use of covert medication. However, on Kitwood staff had not listed all medicines given covertly. Staff did not record if they had offered patients medication overtly before giving covertly.
- Medicines were securely stored on the wards. Staff checked the temperatures of both the clinic room and the fridge used to store medicines daily. These were within the correct range. Systems were in place for the ordering and disposing of medications. We did not see any evidence of unrecorded omissions on medication charts. Pharmacists visited the wards at least once a week and staff reported they could access them outside of this when needed. The pharmacy team topped up medication stocks and completed medication reconciliation.
- Rooms were available outside the wards for when children visited.

Track record on safety

- Staff reported four serious incidents between 1 July 2017 and 31 October 2017. Three of the incidents were 'Slips, trips and falls or found on the floor'. The other was an unexpected death following a fall.
- The service had implemented a new falls procedure following high numbers of falls incidents. The trust employed a falls lead who facilitated a monthly falls group to review falls incidents and share learning.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on the trust's electronic recording system. Staff were able to describe what incidents to report and how to report them. Staff told us that they would report all incidents. We reviewed the incident database, which confirmed this.
- Staff discussed issues arising from incidents in team meetings and in supervisions. We confirmed this on checking team meeting minutes.
- The Duty of candour requires providers to be open and transparent with patients when something has gone wrong. The trust had a Duty of candour policy, which the service followed.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Staff assessed patients' needs and planned their care.
- We looked at 55 patient records. The multidisciplinary staff team completed thorough, holistic and detailed assessments prior to and on admission. They covered aspects of the patient's history and needs together with an assessment of risk. The plans were personalised and identified patients' needs and preferences. Staff updated these plans regularly.
- Staff evidenced in patients records that patients had a full physical health check on or shortly after admission and they monitored patients' physical health regularly. Staff would support patients to access healthcare support as needed. Staff completed a number of assessments to support patients physical health, including malnutrition universal screening tools, pressure area risk assessment charts and falls assessments.
- Staff held ward rounds and care programme approach meetings regularly with the patient, their families and relevant professionals. Staff used these reviews to monitor progress and update assessments.
- The trust used two secure electronic recording systems, one in the north and one in the south. Staff working in the north could not access the system in the south and vice versa. If the service transferred a patient between north and south areas staff could not access their records. However, staff knew where information was stored on the system they could access and showed us how it was organised.

Best practice in treatment and care

- Staff followed best practice in treatment and care. Staff followed National Institute for Health and Care Excellence guidelines for the treatment of older people. These included physical health care support, the dementia pathway, use of as required medication, offering a range of activities, falls management and protection of dignity. Managers emailed changes in National Institute for Health and Care Excellence guidance to their teams.
- Nine of the 12 wards offered 1:1 psychology input for all patients. Although Kitwood and Roding did not have a psychologist in post managers were trying to recruit to the post. Staff on these wards told us they could request psychological input from the trust psychology department. Meadowview did not have a psychologist on site but staff were able to request input from a psychologist from another site if a patient needed this input.
- All wards provided occupational therapy input to patients.
- Staff used a range of tools to measure patient outcomes. These included the model of human occupation screening tool, modified early warning signs (MEWS) and the Abbey pain tool to measure pain in patients with dementia who cannot verbalise.
- Staff carried out a range of audits. These included audits of; patient safety, medication, care plans, risk assessments, hand hygiene, protective clothing, infection control and Prescribing Observatory for Mental Health (POMH-UK) national audits of psychosis.
- Staff reviewed do not attempt resuscitation statements regularly with families and patients.

Skilled staff to deliver care

- The service employed skilled staff to deliver care. The teams consisted of ward managers, nurses, nursing assistants, consultant psychiatrists, junior doctors, psychologists, occupational therapists and activities co-ordinators. Gloucester, Maple and Beech employed discharge co-ordinators that supported patients to move on to suitable accommodation. Staff told us that they accessed speech and language therapy on request. Physiotherapists and dieticians carried out scheduled visits to the wards.
- Staff received regular management supervision every four to six weeks.

Adherence to the MHA and the MHA Code of Practice

- We looked at 113 medication charts, and where required they had the correct consent to treatment forms T2 and T3 in place and attached. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and records that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Patients were treated with kindness, dignity and respect. We spoke with 28 patients and nine carers. Carers we spoke with were positive about the care and support provided to their relative. Patients told us that staff were caring and kind but three patients told us that there was not enough staff.
- Carers were encouraged to be involved in their relatives care.
- We observed positive interactions between patients and staff. We saw examples of staff treating patients with kindness and patience.
- Carers' meetings took place monthly on Kitwood and Roding.

The involvement of people in the care they receive

- Patients were involved in the care they received. Care plans demonstrated that staff tried to involve patients as much as possible in their care plans. Carers were also encouraged to be involved in care plans.
- Patients had access to advocacy. The service promoted this through leaflets and posters on notice boards.
- We spoke with nine carers, they told us that staff were caring and respectful and the service provided good care and treatment.
- Patients had opportunities to express their views through weekly community meetings and one to one time with staff.
- Managers displayed 'you said, we did' boards on wards. Examples of action taken included the introduction of morning newspaper groups and a memory café.
- Staff encouraged carers to complete the friends and family test in order to receive feedback and make improvements to the service.

Are services responsive to people's needs?

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

Our findings

The facilities promote recovery, comfort, dignity and confidentiality

- Not all facilities promoted comfort and dignity. Bernard and Tower wards did not have enough bathrooms to meet patients' needs. On Bernard, there was one working bathroom for 14 patients. Staff used one shower room for storage and another shower room was not functional. Tower had one combined bathroom and shower room for 14 patients.
- The wards had a number of rooms for leisure and therapeutic activities. The clinic rooms had the facilities and equipment needed to undertake physical examinations. There were quiet areas where therapeutic groups could meet or where patients could spend 1:1 time with their named nurse. There were programmes of activities, both on and off the wards including at weekends. There were also rooms where patients could meet visitors including designated rooms off the wards, which patients used when children were visiting. The wards had secure garden areas which patients were able to access.
- The service provided patients on some wards with the key code to access bedroom areas. Some wards kept bedroom doors locked. Staff told us that they would open bedrooms on patient's request. Patients had access to drinks and snacks.
- Bedroom doors were fitted with privacy screens.
- Patients told us that the food was of good quality.

Listening to and learning from concerns and complaints

- Three of four patients asked said they knew how to make a complaint. One carer asked said they did not know how to make a complaint.
- Staff facilitated regular community meetings where patients could raise their concerns.
- Staff were aware of how to handle complaints appropriately and how to report them. Managers discussed feedback about complaints in team meetings. We checked meeting minutes, which confirmed this.

Are services well-led?

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

Our findings

Good governance

- Managers told us that the processes and systems implemented by the trust supported them in their roles. The trust was operating two electronic record systems and staff told us they only had access to one system, depending on whether they were located in the north or south.
- Managers measured service performance through quality dashboards and the patient safety thermometer. The patient safety thermometer measures harm to patients on a single day each month.
- Overall compliance with mandatory training was 86%. Managers told us that the trust had recently introduced new mandatory training courses, which were not yet accessible. However, the trust was including the courses in the compliance figures, which reduced the overall rating.
- Managers reported they had good administrative support and had sufficient authority to fulfil their roles.
- Managers provided regular supervision to staff. Managers kept detailed supervision records and followed up required actions.
- Managers addressed poor performance and absences with support from human resources. We saw evidence of this in staff supervision records.
- Managers did not ensure that shifts were covered by a sufficient number of staff of the right grades and experience.
- Managers and staff completed audits of care records, care programme approach reviews and medication. However, we found a number of issues with medicines management.
- Managers facilitated monthly team meetings where they discussed incidents and complaints, including learning from other services in the trust.
- Staff made safeguarding referrals appropriately to the local authority when necessary.
- Managers had the ability to submit items to the trust risk register.

Leadership, morale and staff engagement

- Following the merger of the two trusts, we asked staff about their experience of the changes. Feedback was generally positive but staff in the north reported that the merger was more of a takeover by the south.
- The ward managers were highly visible on the wards and offered clinical support and encouragement to staff.
- The sickness rate across the service was 6.6%, which was above the trust target of 4.5%.
- Staff knew of the whistleblowing policy and were happy to raise concerns with managers. Staff did not raise any instances of bullying or harassment with us during the inspection.
- Morale within all teams was generally high, although there was some impact on staff morale following the merger of the two trusts. Staff at the Brian Roycroft Ward, which the trust was closing temporarily, felt uncertain about their future. They told us that managers had not told them when the unit was closing or where they would be working following the closure.
- Staff worked well together within a multidisciplinary approach.
- There had been formal leadership development for managers.
- Managers and staff were able to describe their responsibilities under the Duty of candour.

This section is primarily information for the provider

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 • Bernard and Tower wards were not safe. Corridors that were identified fire escape routes had items stored along them. This would impede progress of anyone trying to escape in the event of a fire and would hinder any emergency services attempting to gain access. The fire escape route went into a small garden area. The gate out of this area was secured with a key pad and staff did not know the number combination to unlock the gate. • We found a number of medicines management issues. Staff had not listed all medicines given covertly as covert. We found out of date British National Formulary books on five wards. Staff did not follow the correct protocols for a patient on a combination of high dose medications. We found medicines staff had not labelled with the date of opening and out of date dressings. There was an oxygen cylinder with no expiry date. We found two tablet crushers that staff had not cleaned. Three patients went without one of their medications for a day. Another patient had a dose of medication omitted as staff had written the drug chart incorrectly. Two patients did not have allergy information completed on all sections of the drug chart. This was in breach of regulation 12

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

This section is primarily information for the provider

Requirement notices

- Bernard and Tower wards did not have enough bathrooms to meet patients' needs. On Bernard, there was one working bathroom for 14 patients. Tower had one combined bathroom and shower room for 14 patients.

This was in breach of regulation 15

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Teams often ran below established qualified staffing levels. Between 1 April 2017 and 31 August 2017 there were four months of night shifts that had a qualified fill rate of 50% or less and a further 15 months that had qualified fill rates below 75%. This was in breach of regulation 18