Avon and Wiltshire Mental Health Partnership NHS Trust

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

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Inadequate**
Are services well-led?	**Requires Improvement**

Our findings

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

Requires Improvement 

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services. We last inspected the service in February 2020 and rated it requires improvement overall.

We inspected the acute wards for adults of working age and psychiatric intensive care units, focusing on key lines of enquiry to review whether the service was safe and well-led. Avon and Wiltshire Mental Health Partnership NHS Trust provides 9 acute wards and 3 psychiatric intensive care units (PICU) for adults of working age. The wards are based across seven locations throughout Avon and Wiltshire.

• Callington Road in Bristol has 3 acute wards; Lime unit with 22 beds, which is male only, Silverbirch ward with 19 beds, which is female only and Cherry Ward with 18 beds, which is mixed sex. There are also 2 PICUs; Hazel with 12 beds, which is male only and Elizabeth Casson House with 8 beds, which is female only.

• Fountain Way, in Salisbury, has an acute ward; Beechlydene with 21 beds, which is mixed sex and a PICU; Ashdown, which is male only.

• Green Lane Hospital, in Devizes has a 20 bed acute ward; Poppy, which is mixed sex.

• Sandalwood Court, in Swindon, has a 15 bed acute ward; Applewood, which is mixed sex.

• Hillview Lodge, in Bath, has a 15 bed acute ward; Sycamore, which is mixed sex

• Southmead Hospital, in Bristol, has a 20 bed acute ward; Oakwood, which is mixed sex.

• Long Fox unit, in Weston-Super-Mare has a 18 bed acute ward; Juniper, which is mixed sex.

We visited eight of the 12 wards across four dates. We did not visit Ashdown, Poppy, Lime or Silver Birch wards but viewed a range of data, policies and documents relating to the running of these wards.

Following the inspection we issued a Warning Notice under Section 29A of the Health and Social Care Act 2008 due to our concerns that patients on the acute inpatient wards were not receiving safe care and treatment under regulations 12 and 17 of the Health and Social Care Act 2008 (regulated activities).The trust responded to the warning notice with an action plan and timeframes to address the issues and improve the safety of care.

Our rating of services stayed the same. We rated them as requires improvement because:

- The trust had not ensured that requirement notices served following our last inspection of acute inpatient services had been met and improvements maintained across the wards. Learning from recent significant incidents' initial reviews and root cause analysis had not been implemented across all wards.

Our findings

- Staff did not update risk assessments as necessary for all patients and risk management plans were not consistently developed in response to identified risks and safety incidents. Staff did not always report or respond to patient safety incidents. Staff did not consistently take action to respond to identified abuse.
- The ward environments were not maintained and monitored in a way to mitigate risks. Not all wards appeared clean and some were poorly furnished and in need of repair. The trust had not ensured that mixed sex wards were designed, utilised and monitored to mitigate associated risks and prevent sexual safety incidents. There were risks within the ward environments that had been identified on the risk registers up to 4 years ago. These risks had not been regularly reviewed and there was insufficient details and updates to evidence progress and plans to resolve these.
- We were concerned that prescribers did not safely prescribe and review pro re nata (as and when needed) medicines. Staff did not ensure clinic and physical health rooms were maintained and cleaned to ensure out of date medicines and dirty equipment were not used.
- There were high vacancy rates across the service, and these were above 30% on 6 wards. Staff felt they could not provide the level of care they wanted to due to these vacancies. When agency staff were used it was not always possible to allocate staff who were familiar with the ward. Agency staff did not have access to electronic care records to input observations and incidents, and support robust handover of information.
- We previously served a requirement notice for the trust to improve compliance with physical emergency response training. The training compliance on 6 of the wards was below 75% and as low as 45% on 1 ward.
- Staff did not consistently follow processes related to leave for patients detained under the Mental Health Act.
- Staff did not always feel respected, supported and valued in their roles. Staff from Juniper, Oakwood, and Beechlydene wards told us they had limited engagement with leaders from across the wider trust and felt their challenges and concerns were not fully recognised and understood by directors.
- Our findings from other key questions demonstrated that governance processes did not always operate effectively at team level to ensure that performance and risk were well managed. The identification, management, and review of risk, issues and performance was not always sufficiently implemented to provide assurance of a safe and quality service.

However:

- On Elizabeth Casson House, Hazel and Sycamore wards, although the risk management was variable, we saw evidence of some high standard risk assessment and care planning that had led to robust and individualised risk management for patients with complex needs.
- The overall compliance with mandatory training across the wards was good.
- The trust had completed environmental works to improve Elizabeth Casson House. Staff were positive about the refurbishment and the impact this had, and felt it was a safer and more therapeutic environment.
- All staff knew about the freedom to speak up guardian. Staff provided examples of concerns they had raised with the freedom to speak up guardian and how these were resolved. Teams generally worked well together and when there were difficulties managers dealt with them appropriately.

Is the service safe?

Inadequate 

Our findings

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

The ward environments were not maintained and monitored in a way to mitigate risks. Not all wards appeared clean and some were poorly furnished and in need of repairs. The trust did not take timely action to mitigate or remove identified environmental risks.

Safety of the ward layout.

There were ligature anchor points and environmental risks identified on all inpatient wards. The trust adapted the Dorset Ligature Audit approach, which was completed by a health and safety lead and ward managers. Staff used the ligature audit to identify fixed ligature points in all areas of the ward. Staff had documented on the ligature audits, and told us, that the risks identified were mitigated through use of engagement and observations, and individualised risk assessment and management. However, we found that staff were completing environmental intermittent observations, but these were usually every 15 minutes or longer. There were often communal areas of the ward that contained ligature risks that were unsupervised for long periods of time. We also found that on the acute wards, individual patient risk management plans were mostly generic, did not refer to environmental risks, and were not updated according to identified risks.

We noted that where 'residual risk' for ligature risks remained at a medium or high level, despite mitigations, there were fields within the audit form to identify actions to be taken and target dates for these. With the exception of Poppy and Sycamore ward, we found that actions and target dates had not been identified, and where target dates were identified, these appeared not to have been actioned as items remained 'open'. On Poppy ward, target dates and actions had been identified for September 2023, despite some residual risks identified as 'high, immediate action must be taken by ward staff to maintain safety'.

There had been 475 incidents involving a ligature across the acute inpatient wards in the 12 months before the inspection. 22 of these had involved the use of a fixed ligature point, and 453 had involved the use of a non-fixed ligature. 153 of these had taken place on Beechlydene ward and 78 on Applewood. On Beechlydene ward all incidents had involved the use of a non-fixed ligature and 59% of incidents involved the same patient. On Applewood ward, 74% of the incidents involved the same four patients. The 22 incidents involving a fixed ligature had occurred across Applewood, Poppy, Juniper, Silver Birch, Oakwood, and Cherry wards. There had been two patient deaths on the acute wards in 2022, both had involved the use of a ligature. One of these had involved the use of a fixed ligature point.

The management of identified environmental risks was variable throughout the acute wards. Due to identified environmental risks on some wards, not all communal areas were accessible on these wards. Applewood ward locked off rooms where risks had been identified, including the male lounge, and shower rooms. Applewood and Beechlydene only allowed garden access when supervised. On Applewood, the garden was continuously supervised by staff and therefore accessible. Oakwood, Cherry and Juniper ward used hourly or intermittent environmental observations, to monitor risk. However, these areas and rooms with identified high 'residual risk' level ligature risks were routinely left unobserved between these periods. On some wards staff and managers told us that staffing requirements had led to an inability to supervise and make garden and lounge spaces constantly available to patients.

We reviewed risk registers for the wards and found that most environmental risks and concerns had been added to these. These included fixed ligature points, ward layouts, roof access, fences that were scalable and had led to increased incidents of patients absent without leave, and unsafe seclusion environments which led to some patients being unable

Our findings

to access ensuite facilities while in seclusion. There were limited updates to confirm timeframes and action to be taken by the trust within risk register items. Staff also told us there were often long delays when escalating requests for environmental changes and repairs, and that they were not provided timeframes or dates by the trust. Risk registers were updated by ward managers and matrons.

There was a current risk on Poppy ward due to fire doors not being compliant with fire regulation standards. This was identified in 2021 by the health and safety teams. There was no further detail on the risk register to describe actions to mitigate the associated risks or an action plan to remedy this.

On Ashdown ward a risk had been identified due to some 'anti-barricade' door functions being prevented from working due to a metal plate over these. The last progress entry for this risk was recorded in January 2022, when an update had been requested from the estates team.

Staff on Beechlydene ward had raised concerns about the safety of the nursing station and its location. This was added to the ward risk register in 2018 but had not yet been addressed. There was limited detail within updates to the risk register entry and a timeframe for resolution was not apparent. Staff had escalated concerns in 2022 through a report submitted to the health and safety team, due to an increase in incidents on this area of the ward. Staff highlighted 12 safety incidents within the previous 12 months that related to concerns with this area. These incidents included violence, aggression, criminal damage, and sexually inappropriate behaviours.

The trust and ward staff had not ensured that mixed sex wards were laid out, utilised, and monitored to mitigate associated risks and prevent sexual safety incidents.

Cherry, Oakwood and Applewood wards were using allocated female areas for meetings, activities and communal areas. On Cherry ward the female lounge was based off the main communal area and routinely used as a shared area. Males were using a game console in this lounge at the time of our visit. The female lounge on Oakwood ward was located within the female corridor and was used for group activities due to limited space in other areas of the ward. The multidisciplinary meeting room on Applewood ward was located at the end of the female corridor. Staff told us males were generally escorted to this area, but we observed male patients wandering into the corridor alone.

Staff did not sufficiently monitor and observe single sex spaces. Male and female corridors were unlocked and accessible to any patient or staff. We observed males entering female ward areas during our inspection on Cherry, Beechlydene, and Applewood. On Oakwood ward we noted that staff congregated in ward offices and there were limited staff available and observing communal areas and single sex spaces. We also noted within care records that sexual safety incidents had occurred on Oakwood ward and only brought to staff attention by other patients, due to staff not observing the communal areas of the ward. Staff on Beechlydene ward told us that due to the design of the ward, low staffing numbers, and location of the nursing station, it could be difficult to manage the gender mix of the ward and ensure males and females did not enter each other's corridors and single sex spaces.

In the last 12 months there had been 111 incidents involving 'sexual abuse' or 'sexually inappropriate behaviour' across the 9 acute inpatient wards, 2 of these were categorised as serious incidents.

We also noted blind spots in the ward environments on Elizabeth Casson House, Oakwood, Juniper and Cherry wards, without mirrors or CCTV to mitigate the associated risks.

Maintenance, cleanliness and infection control

Our findings

On most wards staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing.

Oakwood ward was poorly maintained and there was damage throughout the ward, including stains and damages to walls. There was limited space for patients and 2 rooms that had been identified for groups were cluttered with storage, risk items, and in poor condition.

Although Juniper ward was mostly clean, we found that some areas of the ward were not, including the de-escalation area and clinic room, and there were stains and damage to furniture. Staff responded quickly to these observations and carried out the cleaning while we were still on site. There was an unsupervised activity room on the ward that contained risk items, and had broken furniture that was not fixed to the walls or floor. The ward did not have en suite bedrooms and this had been escalated as a risk by matrons in 2021, due to difficulties managing infection, prevention and control during coronavirus outbreaks on the ward, due to shared bathrooms. Staff told us that enhanced infection prevention and control procedures and cleaning schedules were used to reduce the risk.

On Juniper, Oakwood, and Beechlydene wards, some window mesh coverings were mouldy and dirty. Staff were unsure which team had responsibility to clean and maintain these.

Elizabeth Casson House had undergone a significant refurbishment which had improved the safety of the environment, which was now a more therapeutic space. This included the addition of activities and visiting rooms, larger communal areas and open space in the corridors. The redevelopment also included a new seclusion suite and enhanced care area. The trust had also been provided funding from a mental health charity to develop a quiet room for relaxation which included projectors, specialist lighting and beanbag seating.

Seclusion room

The seclusion rooms on Oakwood, Lime and Ashdown wards were highlighted on environmental risk registers as not meeting specifications in line with the Mental Health Act code of practice. The door on Juniper ward was also identified by the ward team and matron, as not being robust enough but this had not yet been added to the risk register. The extra care area on Cherry ward was noted on the risk register as not being fit for purpose, due to limited space for de-escalation of a patient. Lime ward and Cherry ward concerns were added to risk registers in 2019 and 2021. Concerns included doors that were not robust enough or with incorrect lock mechanisms, no access to outside light or ventilation, and no en-suite facilities due to associated environmental risks.

Oakwood ward seclusion door and en-suite was added to the risk register in December 2022. However, the door had been in situ for at least 18 months. Juniper ward had a high window with a blind function. However, this was broken and closed. Staff were unable to confirm the last time they had been able to use the blind to enable natural light. A trust wide review of seclusion was completed in October 2019 and highlighted some of the above concerns. A recommendation from that review was that ‘all suites should be reviewed again to ensure that all outstanding works and health and safety issues are resolved or mitigated to provide a safe environment’. Ward staff were unclear of time scales for these works to take place, and what mitigations should have been in place while waiting for outstanding works. There had been recent visits to Oakwood and Juniper ward to review the doors and costing for replacement but no confirmation of when the works would take place.

Clinic room and equipment

Three of the clinic rooms we visited were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, on Sycamore, Applewood and Oakwood wards there were out of date emergency items. On Sycamore ward, the emergency personal protective equipment grab bag stored with the emergency bag was

out of date. On Applewood and Oakwood wards there were out of date oxygen cylinders stored in the clinic rooms. There were enough in date oxygen cylinders available but it was not immediately obvious to people entering the clinic that some were out of date. Staff were unsure how and when these would be removed. The emergency fluids in the emergency bag on Oakwood ward had expired at the end of the previous month. Staff had recorded that the bag had been checked and not noted the expiry.

Staff did not always check, maintain, and clean equipment. There were no records or stickers to document cleaning of all equipment on Juniper, Oakwood, and Applewood wards. On Juniper and Oakwood wards there were over full and full (sealed) sharps bins in cupboards and on worktops. Staff were not aware of the process to have these removed or whether this had been requested. There were further out of date items within the clinic room on Sycamore ward, although these items were not in use.

Safe staffing

There were high levels of nursing staff vacancies across all the wards. Vacancies on the acute wards had increased over the previous 12 months. There were agency staff working on most shifts for all wards, and these staff were not always familiar with the wards.

Nursing staff

All wards had nursing and healthcare worker vacancies. Six wards had vacancies over 30% with the highest on Ashdown PICU (43.6%), Beechlydene (40.6%) and Poppy (38.3%). The vacancies on all acute wards had increased over the previous 12 months.

Ward managers on Silver Birch, Poppy, Applewood and Ashdown wards had added staffing vacancies to ward risk registers. The trust was actively trying to recruit more staff in all areas. Managers attempted to cover vacancies and absences with agency and bank staff familiar with the service. However, staff told us that they experienced increased pressures and stress due to high use of agency staff that were not always regular. Staff told us that agency staff were unable to access and input into the electronic care records, were less familiar with ward procedures, and less familiar with patients and risk management plans.

Staff on Applewood, Beechlydene, Juniper, and Oakwood wards told us that they felt there was not always enough staff on the wards to provide the level of care they wanted to. They gave examples of areas of the ward being locked off due to inability to supervise these, a lack of activities being provided and not enough staff to manage patient safety incidents. Leaders of the wards had recently completed a mental health safer staffing tool to identify safer staffing numbers for their ward. The results had been sent to the trust board and managers were awaiting approval of these.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

A nurse consultant had recently been recruited to Oakwood ward, following changes in consultants and periods of locum consultant cover. The feedback from ward staff and patients was that this had been a positive change for the ward.

Managers could call locums when they needed additional medical cover.

Our findings

Mandatory training

The overall compliance with mandatory training across the wards was good. However, the compliance with physical emergency response training (PERT) was below 75% on 6 wards (Lime, Silver Birch, Juniper, Applewood, Beechlydene, Ashdown). This ranged from 45% compliance on Juniper ward and 73% on Lime ward.

Changes to reducing restrictive intervention, and the introduction of infection prevention and control level 2 had led to lower compliance with these modules. There was an action plan in place to achieve full compliance with these courses in 2023.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

On the acute wards, staff did not update risk assessments as necessary for all patients and risk management plans were not consistently developed in response to identified risks and safety incidents.

Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not always complete risk assessments for patients on admission, or update these in response to new risks and following safety incidents. This included risks such as increased suicidal ideation, violence and aggression, safeguarding concerns, patients absent without leave, and sexual safety incidents or disinhibition.

Management of patient risk

We found that risk management plans were not always developed in response to identified risks. Staff did not always develop individualised risk management plans and goals and interventions were often generic.

Staff did not respond adequately and develop effective management plans in response to identified sexual safety risks and following incidents. On Oakwood and Beechlydene ward, patients had been identified as at risk of sexual disinhibition but staff had not developed management plans to reduce associated risks. Male patients had also been admitted to Oakwood ward, which was mixed sex, despite identified risks towards females. Staff had not reviewed the patient's risk management plan in response to this and the management plan in place did not have any specific interventions identified to mitigate these risks.

We saw evidence in care record progress notes on Elizabeth Casson House, Beechlydene and Hazel wards of staff identifying individual risks and potential management interventions; such as male staff being a trigger for violence, no lone working with females, and changing medicine brands. However, these observations had not been acted on or followed up by being inputted into an accessible area of the care records, such as in a care plan.

On Oakwood ward we found that a patient had become absent without leave (AWOL) on 3 occasions in the previous week. Staff had suspended the patient's leave following each incident but did not always document how long this would be suspended or update the section 17 leave forms. We saw evidence that staff had signed the patient out on leave following one incident and while their leave was still suspended. Following each suspension, staff had not updated the patient's risk assessment or risk management plan and the doctor or multidisciplinary team had not reviewed the section 17 leave when it was reinstated. During the incidents the patient had engaged in risk behaviours and on one

occasion the police were contacted. Staff had not updated the patient's risk assessment or risk management plan in response to this. At the time of the inspection the patient's leave was documented as suspended but there was a valid section 17 leave form within the ward leave folder. We asked staff how others would know that leave was suspended and were informed that when leave is suspended for 24 to 48 hours they did not update the leave form but would discuss this during handover meetings. We were concerned that this practice had, and would, lead to leave being utilised while suspended or reinstated without review by a responsible clinician.

We noted in a further patient's care record that their engagement and observation frequency had been increased due to suicidal ideation. However, there was limited information regarding, by who and how this decision had been made. The patient's risk management plans had not been reviewed in relation to increased risks. The risk management plan was created 4 months prior and had not been reviewed in the last month or following an increase in risk.

On Beechlydene and Oakwood wards we noted incidents of potential financial abuse between patients. Although staff had recognised the potential abuse they did not develop robust risk management plans in reponse to this.

On Applewood, Juniper, and Beechlydene wards we found that some patients did not have a risk assessment or risk management plan developed on admission. Risk assessments had been completed in the community prior to admission, and had identified risks including high suicidal ideation risk, and violence. On Applewood and Juniper ward two patients did not have risk management plans developed after a month of being on the ward.

We observed handovers between staff on Oakwood and Beechlydene wards. We noted on Oakwood ward that staff did not handover that one patient's section 17 leave was currently suspended. On Beechlydene we noted that health care workers were not involved in discussions during handover and were sat in a different area. Healthcare workers on the ward also raised this as a concern. On Applewood ward we were informed that staff had not received a thorough handover regarding patients' risks as agency staff were unable to access the electronic care records. Following the handover staff were involved in a safety incident and told us they had been unaware of the patient's risk due to the poor handover.

The frequency that staff undertook engagement and observations of patients was determined by the staff's view of their individual level of risk. We found that patients who were on enhanced observations (in line of sight at all times), or being 'intermittently' checked did not always have a related management plan to support staff in carrying out this role and understanding the patients specific risks. We also found that there was a focus on the location of patients rather than their wellbeing. Staff did not ensure that engagement and observations were used as an opportunity to engage and assess patients as a form of risk management. Managers told us that staff received training in engagement and observations during their induction on the ward. However, staff told us that they did not receive any formal training on this.

Staff on the mixed sex acute wards told us that they managed sexual safety risks through having staff observing communal areas and access to male and female corridors. However, on Oakwood, Cherry, Beechlydene, and Applewood wards we observed patients being unobserved for periods long enough to enable them to walk into single sex spaces. On Juniper and Oakwood wards we observed staff spending long periods in the nursing office having conversations, and patients having to wait at the nursing office door to have their needs met. A patient on Oakwood ward had informed staff that they did not feel safe around some other patients in communal areas. The patient was involved in a physical altercation with 2 patients and it was later found that they had acted to protect themselves as staff had not been available to support them. On Elizabeth Casson House we observed a patient becoming distressed in a communal area. Staff were not within the communal area and did not respond to the patient until an inspector brought this to their attention.

Our findings

On Elizabeth Casson House and Hazel and Sycamore wards the risk management was variable and we also saw some evidence of regular reviews and risk assessments, and robust, individualised risk management plans.

The trust had responded to initial feedback on risk management from the inspection teams and requested a review and update for all patients. We visited Juniper ward following this feedback and found that risk assessments and management plans had been reviewed as requested. However, we found that risk management plans were individualised but lacked targeted and measurable interventions to manage risk.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff had received training to support them in reducing or preventing the use of restraint in prone (face down) position. The use of prone holds during restraint had reduced. However, prone holds during restraint had been used on all wards during the previous 12 months. The use of prone restraint was significantly higher on Hazel ward, where it had been used during 50 of 145 restraint incidents.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was nursed in long-term segregation.

Safeguarding

Staff did not always take sufficient action to protect patients from abuse. Staff had training on how to recognise and report abuse but did not consistently apply this.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and mostly worked well with other agencies to protect them. We saw evidence within care records of staff taking appropriate action and contacted the trust safeguarding team for advice where needed. However, on Oakwood ward we saw two cases where staff had contacted the trust safeguarding team for advice following safeguarding incidents on the ward but not communicated or documented the advice within care records. We also found that in 2 cases, staff had not developed care plans in response to potential patient to patient financial abuse.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Not all staff had easy access to clinical information.

Our findings

Patient notes were not always comprehensive and actions and management of risk incidents were not always detailed. Some agency staff were unable to access electronic records. Staff told us that this led to them having to input agency staff's daily notes, and a lack of detailed handover from agency staff.

With the exception of Beechlydene ward, records were stored securely. Staff on Beechlydene ward told us that the nursing station counter could be climbed on and looked over to view confidential patient information and records.

Medicines management

Staff that prescribed and administered medication did not consistently use systems and processes to safely prescribe, administer, record and store medicines. Staff did not regularly review the effects of medications on each patient's mental and physical health.

We reviewed medicine records on Hazel, Beechlydene, Applewood and Oakwood wards. On Hazel, Applewood, and Oakwood ward, doctors prescribed pro re nata (PRN, as required) medication routinely on admission. We found that some of these medications had not been administered to patients since admission, and had not been reviewed. Staff told us that the medication was not cancelled, so that it could be used if the patient's needs changed or a doctor was not available to prescribe. We were concerned that these medications were prescribed when not required.

On Oakwood and Hazel ward we also found that patients were prescribed a range of PRN medications on admission to treat 'agitation', despite no previous need for more than one medication to be administered.

We also found that prescribers had written more than one route of administration in the same box for some PRN medications on Hazel and Beechlydene wards. This included intramuscular or oral administration. Staff told us that this practice was aligned with policy. We raised concerns that the practice of prescribing multiple routes for administration can lead to a risk of over or under dosing due to some medicines having different pharmokinetic profiles (the activity of drugs in the body over a period of time) that are not safely interchangeable.

Staff provided advice to patients and carers about their medicines when requested and prior to any changes,

Although staff reviewed each patients regular medicines regularly, we found that PRN medicine was not reviewed regularly on all four wards.

Staff mostly completed medicines records accurately and kept them up-to-date. Staff generally stored and managed all medicines and prescribing documents safely. However, on Juniper ward the medicines disposal bin was overfull and had not been sealed and taken out of use.

Pharmacists followed national practice to check patients had the correct medicines when they were admitted or they moved between services. However, we noted that pharmacists completed the medicines reconciliation form differently across wards. We found that pharmacists used ticks and crosses simultaneously on forms and nursing staff were not always able to interpret these.

Doctors reviewed patients regular medications during multidisciplinary meetings.

Our findings

Track record on safety

The trust had not ensured safety concerns raised during the last inspection of acute inpatient services had been resolved and improvements maintained across the trust.

Following our last inspection of the service, we served a requirement notice to the trust that improvements must be made under regulation 12 of the Health and Social Care Act (2008) for safe care and treatment. Although the trust had met some of the requirement notices, the improvements had not been implemented or sustained across all wards. The trust had not made the necessary improvements to the safety of ward environments, the assessment and management of patient risks, and the level of PERT training rates.

Reporting incidents and learning from when things go wrong

Learning from recent significant incidents' initial reviews and root cause analysis had not been implemented across all wards.

The learning and actions identified within recent root cause analysis' and initial 72 hour incident reviews for significant incidents had not been implemented across all wards. This included for serious sexual safety incidents and use of ligatures. Environmental risks and learning identified in relation to the monitoring of mixed wards had not been implemented on all wards. In the previous 12 months further learning and actions had also been identified regarding the level of engagement during observations, PERT training levels and individualised risk management plans.

Staff generally knew what incidents to report and how to report them. However, on Oakwood ward we found that incidents of patients becoming absent without leave had not been reported as incidents on the trust's incident system.

Staff engaged in serious incident investigation processes and round table meetings. However, staff told us that these often took place a few months after the incident and therefore learning was not identified quickly.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles but there had been and continued to be gaps in the leadership team on some wards.

Leaders had a good understanding of the services they managed and the current challenges they faced. Ward managers and matrons took action to respond to challenges for their wards but did not always feel that timely or effective action was taken when concerns were escalated to more senior managers or other divisions within the trust.

There was no ward manager in post on Juniper ward but a new manager was due to start the following week. There had been three recent changes to the ward mangers on Juniper ward and staff told us the ward needed more stability with the management team. The matron and a ward manager from elsewhere in the trust had been providing cover during the manager vacancy and staff told us they felt supported during this time. However, the matron was due to move to a different area within the trust and staff felt this may destabilise leadership again.

Our findings

Leaders were mostly visible in the service and approachable for patients and staff. Staff told us that they could approach leaders on the ward and more senior leaders, such as locality matrons, clinical leads and operations directors. At Callington Road hospital, ward staff had limited engagement with leaders above matron level but felt that concerns and issues could be escalated within the locality. Staff from Juniper, Oakwood, and Beechlydene wards told us they had limited engagement with leaders from across the wider trust and felt their challenges and concerns were not fully recognised and understood by directors.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff told us they identified with the trust's vision and values. The trust values were passion, respect, integrity, diversity and excellence. Staff told us that they were able to apply these within the work of their team and identified team objectives to align with these values. However, they did not feel that they had opportunities to feed into the design and development of the trust strategy.

Culture

Staff did not always feel respected, supported and valued.

Staff said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

The culture amongst clinical staff on the wards was generally positive and centred on the needs and experience of people who use services. However, staff on Juniper, Beechlydene and Oakwood wards did not always feel respected and supported by more senior managers and staff from other divisions within the trust. These concerns were varied across wards but included; permanent staff being rude and unsupportive to agency staff, bed managers and duty managers overruling ward staff clinical decisions to refuse admissions, and a lack of understanding or response to the challenges and stress faced by ward staff. Staff on Oakwood and Juniper wards told us that they didn't always feel proud or safe working in their roles due to the disrepair of environments, and a lack of a local restraint trained response team.

Although staff experienced some stress in their roles, most staff felt that the ward teams were happy and worked well together. Staff felt able to to raise concerns without fear of retribution and knew how to use the freedom to speak up process. All staff knew about the freedom to speak up guardian. Staff provided examples of concerns they had raised with the freedom to speak up guardian and how these were resolved. Teams generally worked well together and when there were difficulties managers dealt with them appropriately.

Following the trust completing works to improve the environment and safety on Elizabeth Casson House, staff reported a more positive culture and an improvement in the stability of the staff team. Staff felt more safe and proud to work on the unit.

Managers we spoke with recognised the importance and value in developing their own staff by offering training and progression. Staff provided examples of training courses and opportunities they had taken to develop and progress in their career.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level to ensure that performance and risk were managed well.

Our findings

Although managers attended a range of meetings to monitor the performance and quality of the wards, this had not ensured that issues we found on the ward had been identified and acted on.

Ward staff told us they completed audits of clinical records and this included a review of the quality. However, we found that the risk assessment and management of patients was poorly documented and safety incidents were not always reported.

There were systems and checks in place to maintain the safety and cleanliness of ward clinics and physical health equipment. However, we found that these systems and checks were not always followed and leaders within the ward had not identified or acted to resolve this.

The mandatory training rates for physical emergency response training (PERT) was raised as a requirement notice during our last inspection, and identified as a learning area following serious incidents in the previous 12 months. The compliance rates for this training remained low across 6 of the wards.

Management of risk, issues and performance

The identification, management and review of risk, issues and performance was not always sufficiently implemented to provide assurance of a safe and quality service.

Ward managers and matrons had acess to, and maintained ward level risk registers. Items on these risk registers could be escalated to a locality risk register by matrons. We found that risk registers did not always reflect all concerns raised by staff and managers.

We found that items included on risk registers had either no update or limited updates to evidence a plan, timescale or sufficient mitigations for these risks. Some risk entries were inputted onto risk registers over 24 months ago and had been escalated by matrons but a response to these escalations was not apparent. These items included unsafe environments that had led to increased safety incidents, and seclusion rooms that did not meet code of practice standards. Further environmental risks such as fire doors not meeting regulation (Poppy), and impeded anti-barricade doors (Ashdown) did not have progress updates or an action plan for resolution within the last 12 months.

Ward staff told us that there were financial pressures within the trust that compromised quality of care. This included a recent request to ward managers to reduce the cost of agency staff. Staff told us that they had been requested to use ‘cheaper’ agencies and that these agencies were less reliable, with planned agency staff not arriving for their shifts. Ward managers were working with matrons to monitor and resolve these concerns. Staff and leaders on all wards told us that repairs and improvements to the ward environments were delayed or difficult to arrange due to a lack of funds. On Oakwood ward we were told that the trust had not agreed any repairs or improvements to the ward due to a planned move to Callington Road site. However, this ward transfer was not expected to take place until 2024. Managers and staff on Beechlydene ward also told us that financial constraints impacted on the timeliness of improvements to the ward environment. There was an item on the wards community meeting display board that identified ‘funding’ restrictions as the reason ward environmental improvements had not been made. Patients had requested improvements to the ward environment during a previous community meeting.

Ward managers had a limited understanding of the ligature environmental audit process and these audits were not always completed in line with trust guidance. Leaders told us that the trust had adapted the Dorset NHS trust ligature assessment approach. However, managers were unable to differentiate between the previous tool used and new tool, other than the introduction of involvement from the estates and health and safety teams. Leaders told us that they were

unsure whether identified risks should be left open or closed on the document. We found that risks identified as high and medium 'residual risk' and requiring actions were often open with no target dates, or target dates had been missed with no updates. The trust policy stated that open risks should be reviewed by ward managers at a minimum of monthly but this was not apparent within records.

Staff also raised concerns that they stated had been escalated to managers that were not reflected within ward risk registers. This included 'same sex accommodation breaches' and lack of local response teams.

On Oakwood, Juniper, Cherry and Beechlydene wards, staff told us that female patients were sometimes admitted to male beds (and vice versa), that were therefore located on the male corridors. Staff mitigated associated risks by having a staff member supervising the corridor at all times, and told us that this was reported as an incident on the trusts incident system. Ward staff told us that this was considered a 'same sex accommodation breach' by the trust and was used as a last resort in response to a lack of beds for admission. During the inspection there was a male patient using a female bedroom on Oakwood and Juniper wards. Despite staff on all wards telling us that the number of these cases had been increasing and identifying associated risks, this was not included on ward risk registers. We asked the trust to provide data on the number of same sex accommodation breach incidents in the last 12 months but the data provided was incomplete. The trust were unable to provide data that included all wards, and incidents that we had noted during the inspection.

Staff on Juniper and Oakwood ward had raised concerns that they were unable to call for support from suitably trained staff during incidents of violence and aggression. The ward team could request staff from other nearby teams (such as intensive or older adults wards) to attend the ward but they did not have training in restraint and therefore could not support the team during these incidents. These concerns and any escalation by matrons was not reflected within risk registers.

Information management

Staff collected analysed data about outcomes and performance.

There were systems in place for leaders to access data about the outcomes and performance for the ward. Ward managers could access key performance indicators and quality assurance reports in advance of quality assuance meetings. Ward managers told us that they completed a report and work plan in response to areas where the ward was not meeting targets. The quality assurance data was used to identify an 'early warning score' for outcomes and performance for each ward. The system was accessible, easy to access and provided valid, timely relevant information.

The electronic system supported staff to report incidents and manage their own performance. However, agency staff told us that they could not access clinical records to review or update these and were unable to access the incidents system.

The service made notifications to external bodies as required.

Engagement

Staff had access to the trust's intranet system which provided them with up to date information on items such as policy updates.

Patients and carers could access information about the service through the trust website.

Patients told us that they were able to provide feedback either directly to staff or through ward community meetings.

Our findings

Learning, continuous improvement and innovation

Ward staff and leaders from the psychiatric intensive care units were part of the National Asscіation of Psychiatric Intensive Care units (NAPICU) and attended conferences where possible.

There was a trust sexual safety improvement project underway but this was in its infancy and staff had a limited understanding of the project and their role in it. Some staff and managers were unaware of the serious sexual safety incidents that had occurred elsewhere in the trust and the initial learning from these.

Elizabeth Casson House and Silver Birch ward were part of a project in partnership with the local acute trust. This was in it's initial stages and was part of a breast cancer screening project.

Applewood ward leadership team had implemented a learning board which identified learning needs and opportunities. The team organised bespoke training on these subjects during handover meetings.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that staff complete risk assessments for all patients and that these are regularly reviewed and updated.
- The trust must ensure that staff develop plans to manage identified individual patients risks and that these are reviewed and updates in response to changing needs and newly identified risks.
- The trust must ensure that staff follow processes for section 17 leave in line with the Mental Health Act.
- The trust must ensure that ward teams do all that is reasonably practicable to monitor and remove or mitigate environmental risks on all wards.
- The trust must ensure that the mixed sex ward environments are designed, utilised, and monitored to mitigate associated risks and prevent sexual safety incidents.
- The trust must ensure that staff follow policies and procedures to ensure the proper and safe management of medicines and maintenance of clinic room equipment.
- The trust must ensure that staff prescribe, administer and review the use of pre re nata (PRN) medicines in line with national guidelines to ensure this is used safely and effectively.
- The trust must ensure that staff receive necessary training to keep patients safe, and respond to identified risks. This must include compliance with physical emergency response mandatory training (PERT), and training in engagement and observation policy and process.
- The trust must ensure processes are in place to ensure risk and performance is monitored and action taken to improve the quality and safety of care. This must include the review of risk registers, and environmental audit tools, and timely action is taken where the quality or safety of care is compromised.
- The trust must ensure that processes are in place to respond to and communicate the findings of reviews and reports about the quality and safety of the service. This must include the implementation of learning and action plans following investigation of safety incidents.

Action the trust Should take to improve:

- The trust should ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on all wards. The trust should also ensure those staff have access to information systems, including care records and incident reporting.
- The trust should ensure that staff take action and document their response to safeguarding advice received from the trust leads.

Our inspection team

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

We carried out a focused inspection of the service. To fully understand the experience of people who use services, we asked the following two questions:

• Is it safe?

• Is it well-led?

Before the unannounced inspection visit, we reviewed information that we held about the location. During the inspection visit the inspection team:

- visited 8 wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 6 patients who were using the service
- spoke with 30 staff including, matrons, managers, senior practitioners, registered nurses, healthcare workers, allied health professionals, doctors and consultant psychiatrists.
- reviewed 41 care records for patients
- reviewed 37 patient medication charts
- carried out a specific check of medication management and clinic rooms on all the wards.
- Attended leadership and handover meetings, and looked at a range of policies, procedures and other documents relating to the running of the services.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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