Derbyshire Healthcare NHS Foundation 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 | Inspected but not rated |
|---|---|
| Are services safe? | **Inspected but not rated** |
| Are services effective? | **Inspected but not rated** |
| Are services caring? | **Inspected but not rated** |
| Are services responsive to people's needs? | **Inspected but not rated** |
| Are services well-led? | **Inspected but not rated** |

# Our findings

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

**Inspected but not rated**

This inspection was a focussed, unannounced inspection of acute wards for adults of working age provided by Derbyshire Healthcare Foundation NHS Trust. The inspection was focussed to specific areas of the 5 key questions and specifically on Ward 35 at the Radbourne unit.

At our last inspection we rated the acute wards for adults of working age and psychiatric intensive care units as requires improvement.

We carried out this unannounced focused inspection because we had concerns about the quality of services following a routine visit by a Mental Health Act reviewer and to look at those parts of the service that did not meet legal requirements following our last inspection in 2019.

As this was a focussed inspection for Ward 35 at the Radbourne unit, we have not rated the service and the previous rating of requires improvement remains in place. Ward 35 is a 20 bedded female acute and admission ward.

We previously inspected the trust's acute wards for adults of working age and psychiatric intensive care units (PICUs) at the Radbourne Unit in November 2019. The November 2019 inspection was a routine inspection. The main areas of improvement identified during the inspection in November 2019 were around blanket restrictions, staff training and governance processes.

The concerns raised by the Mental Health Act reviewer were around patients not knowing their rights under the Act, incidents not being reported and followed up appropriately, patients not being able to store personal possessions securely, patient risks not being assessed and care planning not being in place for patients.

The purpose of this inspection was to look into these concerns and to see if the trust had met the requirements of the previous inspection on Ward 35.

Due to the seriousness of the concerns following our site visit, in September 2023 we used our powers under Section 31 of the Health and Social Care Act, to request assurances from the trust to ensure the ward was safe, patients received the right care and treatment and appropriate measures were in place to monitor these changes. The trust responded immediately and put appropriate measures in place with a detailed action plan.

We raised a number of immediate concerns with the trust and they took immediate actions to make improvements on the ward including immediate improvement with the ward environment, restrictive practices, informing patients of their rights and improving and updating care plans and risk assessments.

We found:

- The trust still had dormitories but had a dormitory eradication programme was in place for all the trust's sites and it is planned this work will be completed for Ward 35 in March 2026.

# Our findings

- Managers did not ensure patients and staff received appropriate support after being involved in or witnessing serious incidents.
- Staff did not always have a thorough handover that included incidents and support required by patients after incidents.
- The clinic room was not cleaned regularly, and medication audits were not robust and did not assess, monitor and improve medication management. Staff were not aware of the illicit drug policy and the correct recording processes around this.
- The ward ligature risk assessment was not robust and did not give clear guidance on mitigating measures in place for all ligature anchor points.
- Staff sickness levels were high and increasing on the ward and appropriate systems and support was not in place to reduce this.
- The ward had a high usage of bank and agency workers that were not trained in the trusts restrictive intervention programme and therefore were unable to support the ward if restrictive interventions were required.
- Staff were not supported through regular managerial supervisions.
- The service did not operate effective systems and processes to ensure that managers monitor assessed and improved quality of services.

However:

- Staff mandatory training compliance rates had improved since our last inspection.

**How we carried out the inspection**

During our inspection on 19 and 20 September 2023, we visited Ward 35, an acute ward for adults of working age at The Radbourne Unit.

During the inspection we:

- observed how staff cared for patients.
- spoke with 5 patients who were using the services.
- spoke with 10 staff including a ward manager, nurses, nursing assistants, clinical leads and an advanced clinical practitioner.
- looked at the quality of the ward environment.
- reviewed 4 patient records.
- reviewed 9 incident records.
- reviewed a range of policies, procedures and other documents relating to the running of the services.

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.

**What people who use the service say**

# Our findings

During the inspection we spoke with 5 patients and 2 family members. All 5 patients and both family members we spoke to told us staff were generally kind, but they were always rushed, and the ward felt understaffed. In addition, they also told us they were not aware they could have access to their care plans and had not been involved in their developing these.

One patient told us the occupational therapists were really good and there were activities available every day.

Two informal patients told us they both had only been informed of their rights 2 days ago. One patient detained under the Mental Health Act told us staff had tried to explain their rights to them, but this was not done clearly so they did not really understand their rights.

Three out of the 5 patients we spoke to told us they had belongings that had been stolen and 1 felt as nothing was labelled, they ended up using other people's items.

## Is the service safe?

**Inspected but not rated**

Our rating of safe stayed the same. The previous rating of requires improvement remained.

### Safe and clean care environments

**The ward area was not safe, clean, well-furnished or fit for purpose.**

#### Safety of the ward layout

Staff did not complete and regularly update thorough risk assessments of the ward area and remove or reduce risks identified. When observing areas of the ward we found a heater that was on and left unattended. The heater did not have a cover and had been damaged. We raised this with the trust immediately after the inspection and they had the heater inspected and the heating element had been disconnected. After the inspection the whole unit was disconnected from the mains electrical system.

Staff could observe patients in all parts of the ward. The ward had Closed Circuit Television in place to mitigate possible blind spots and certain areas of the ward including the courtyard was always supervised by staff when in use.

The ward complied with guidance and there was no mixed sex accommodation. The ward was a female only ward.

There were potential ligature anchor points in the service. We found potential ligature anchor points including a blind in the recreational room and a light fitting in the dining area, which are both areas patients can access without staff supervision. Staff did not know about any potential ligature anchor points and mitigations to keep patients safe. Staff did not have access to a ward specific ligature risk assessment on the ward. Three of the 5 ward staff we spoke to did not know where the ward specific ligature risk assessment was, and the ward manager and 2 other ward staff stated the policy was online. We raised this with the trust after the inspection and the trust updated their ligature risk assessment and made it available to all staff on the ward. The updated risk assessment detailed all areas of the ward. However, it did not give clear guidance or specific actions staff should take to mitigate each risk identified.

# Our findings

Staff had easy access to alarms and carried personal alarms. However, patients did not always have easy access to nurse call systems. The ward had 2 dormitory areas which consisted of 2 nurse call points on either side of the room. In an emergency patients would need to go to one side of the dormitory out of there bed space to access the call system. This meant all patients could not call for assistance quickly in an emergency.

### Maintenance, cleanliness and infection control

Ward areas were not clean, well maintained, well-furnished or fit for purpose. Areas of the ward were dirty including dirty communal sinks, piles of clothes, stained curtains, and overflowing bins in the dormitory area. It was not clear who the clothes belonged to and if they were clean or soiled clothes. This posed as an infection control risk to the other patients within that dormitory. We raised this with the trust immediately after the inspection. The trust completed a ward cleanliness audit and implemented a checklist to ensure on each shift that the ward environment is tidy. The ward had not had an environmental audit since 2021, however, the trust had planned to complete an environmental audit on the ward between October and November 2023.

The ward had a small outdoor courtyard space furnished with one bench for 20 patients. This outdoor space was mainly used as a smoking area and did not consist of a bin. The floor was covered in used cigarettes and empty cigarette packets. There was no separate space for non-smokers and due to the small area, patients were at risk of passively smoking. We raised this with the trust immediately after the inspection and the trust put signage to clarify the accessibility of fresh air breaks on display, held a meeting with patients to discuss and clarify smoking/non-smoking areas and how to access these.

There was one accessible bathroom on the ward. However, this space was used as storage for wheelchairs and walking aids such as frames. We raised this with the trust immediately and they removed all items from the bathroom to make it accessible.

Staff made sure cleaning records were up-to-date. One patient and one family member we spoke to were concerned about the cleanliness on the ward. The cleaning records for the bathroom areas and ward areas had been completed. However, none of the staff could not confirm when the curtains in the dormitory areas had last been changed. The stained curtains and piles of clothes posed as an infection control risk to patients. We raised this with the trust immediately and they conducted a review and identified 12 curtains that required attention, these were fully cleaned, and no bed space was left without curtains whilst they completed this process. They also immediately reviewed and completed a ward cleanliness audit and implemented a checklist to ensure on each shift that the ward environment is tidy.

### Seclusion room

The ward had access to 2 seclusion rooms. These were shared between all 5 wards at the Radbourne Unit. The seclusion rooms could not be viewed at the time of the inspections as they were both in use. Staff were required to walk through communal areas including the reception area to access the seclusion room. Staff told us this would be difficult at times, particularly as the patients would usually be agitated during the transfer to this area. The ward had an increasing number of seclusion episodes over the last 6 months from 1 in April to 8 in September with a total of 24 seclusions in the last 6 months.

### Clinic room and equipment

The clinic room was not fully equipped. The clinic room did not have a tape measure or BMI chart in place. When staff were asked about a tape measure, they told us this was in the reception area as it was used to measure staff uniforms. This meant nursing staff did not have access to all equipment when required.

# Our findings

The clinic room had accessible resuscitation equipment and emergency drugs but staff did not check these regularly. We found gaps in daily checks on emergency resuscitation equipment. Between 13 August and 26 August, the daily checks had not been completed for 5 days. This increased the risk of emergency equipment not being available or working correctly when required.

Staff did not always check, maintain, and clean equipment. We found the clinic room had ran out of medium and large sized gloves and there were dusty boxes of masks within the emergency equipment Personal Protective Equipment bag. This bag also consisted of opened masks, and it was not clear when they expired as they were out of their boxes.

We found the clinic room was cluttered and not organised with medication including supplements not labelled. The clinic room cleaning records were not completed regularly in the last 6 months. There was only 1 cleaning record per month between April and September 2023 and there were no cleaning records for May 2023.

We raised concerns about the clinic room with the trust immediately and they restocked the clinic room, ensuring there was the appropriate type of gloves. They removed opened masks and checked medication stocks ensuring they were all labelled appropriately.

## Safe staffing

**The ward did not have enough nursing staff, who knew the patients and received basic training to keep people safe from avoidable harm.**

### Nursing staff

The ward did not always have enough nursing and support staff to keep patients safe. We reviewed incidents on the ward and found an incident where a patient who required 3 staff trained in the trust's physical intervention programme during all hospital visits, had to be supported by 1 trained and 2 untrained staff due to lack of staffing during a hospital visit. We found another incident where a family member was not informed of an incident their relative was involved in due to lack of staffing. We raised concerns about sufficient appropriately trained staff being available on the wards and the trust responded with processes in place where the ward manager can request additional staffing if required.

During an incident review we found multidisciplinary team members including occupational therapists supported the ward and had been included in the staffing numbers to reach safe staffing levels. There were 3 incidents in June 2023 where the occupational therapists were brought into ward safe staffing numbers to complete patient observations due to a lack of nursing staff available on the ward. This meant patients were unable to have therapy sessions required within their treatment plans due to the occupational therapists completing other tasks such as patient observations.

The ward had high and increasing rates of bank and agency nursing staff. In June 54% of staff on shift were bank or agency and in September 66% of staff on shift were bank or agency staff to cover staff sickness.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke to one bank member of staff who told us they were shown around the ward and were given an overview of the risks on the ward before they started their shift. However, this staff member could not access patient records and did not know what the ligature risks on the ward were.

Levels of sickness were high and increasing. Levels of sickness were at 4.4% in April and rose to 20% in September 2023. One staff member told us staff no longer think twice about ringing in sick as they don't want to be at work and did not feel supported by managers.

# Our findings

The ward manager could adjust staffing levels according to the needs of the patients. The ward manager told us they could adjust staffing levels to meet the needs of the patients on a daily basis. However, they have not achieved safe staffing levels and asked multidisciplinary staff including occupational therapists to assist ward staff.

All patients knew who their named nurse was but not all patients had regular one to one sessions with their named nurse. The ward had on display each patient name along with who their named nurse was in the communal area. Within 1 of the 4 patient care records we viewed, the patients named nurse was on long term sick and they had not received a regular one to one session.

The ward had enough staff on each shift to carry out any physical interventions safely. All staff we spoke to stated there was always enough staff on the ward to carry out physical interventions safely and when staff pulled their personal alarms additional staff from other wards would be present to support the ward very quickly.

Staff did not always share key information to keep patients safe when handing over their care to others. We reviewed handover records and found the ward had a combination of electronic and paper handover records. The records in place did not consistently handover serious incidents, including incidents of patient ligating, absconding and incidents of head banging. This increased the risk of patients not receiving the support they require after incidents.

### Medical staff

The ward had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. All staff told us there was always a doctor available at the unit for medical emergencies.

### Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Staff training compliance rate was at 82% overall. This was an area of improvement identified within the last inspection which the trust had now met.

The mandatory training programme was comprehensive and met the needs of patients and staff. However, we found not all staff with the appropriate training were administering rapid tranquilisation. We found records showing a nurse without up-to-date immediate life support training administered rapid tranquilisation. Although this was completed with a fully trained staff member, it would be best practice to ensure both nurses had this training in place.

## Assessing and managing risk to patients and staff

**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. However, staff did not assess and manage risks to patients and themselves well.**

### Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, but did not always review this regularly, including after any incident. We reviewed 9 patient incidents. Staff had not updated 5 risk assessments following these incidents. We reviewed 4 patients care records and found risk assessments failed to give a narrative on how patient risk should be managed and mitigated. When incidents were entered into risk assessments a copy of the incident form entry was included rather than an update on how the risk is managed or specific guidance to staff around patient support. Staff had failed to complete an incident form or update the patient risk assessment after the patient had swallowed 10-15 tablets. We raised this as an immediate safety risk to the trust. The trust completed an audit of all patient risk assessments and updated risk assessments in collaboration with patients to ensure all patients had the appropriate level of risk screening and safety planning in place.

# Our findings

### Management of patient risk

Staff did not know about any risks to each patient and did not have the information to act to prevent or reduce risks. We found risk assessments did not provide a person-centred narrative around how to support a patient around potential risk. However, when we raised this with the trust, they completed an audit of all patient risk assessments and updated risk assessments in collaboration with patients to ensure all patients had the appropriate level of risk screening and safety planning in place.

We found staff did not always complete post incident physical health checks. During an incident review we found an incident where a patient had been involved in an episode of head banging and staff failed to complete post incident neurological observations. This increased the risk of the staff not recognising if the patient's physical health deteriorated.

### Use of restrictive interventions

Levels of restrictive interventions were high on the ward. There were blanket restrictions in place on the ward including restrictions to fresh air. Patients were only able to have fresh air breaks at set times and although staff told us they could request this when they wanted, there were no signs in the patient areas informing them of this.

There were a number of restricted of prohibited items on the ward. But the list for this was kept within the staff area or locked patient locker area. This was an area of improvement raised at the previous inspection that the trust had still not met.

We raised these concerns around restrictive practice with the trust and they immediately displayed information to ensure patients were aware of restricted items. They put signage to clarify the accessibility of fresh air breaks within patient areas.

Staff participated in the trust's restrictive interventions reduction programme, which met best practice standards. All permanent ward staff were trained in the trust's restrictive interventions reduction programme. However, agency and bank staff were not trained in this meaning they could not assist staff on the ward with restraint if required to maintain the safety of patients.

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. We saw staff utilising the ward de-escalation room to avoid using restraint and the seclusion room. However, the ward had an increasing number of seclusion episodes over the last 6 months from 1 in April to 8 in September with a total of 24 seclusions in the last 6 months.

Staff did not always follow the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Patient records showed staff did not always complete appropriate physical health observations after administering rapid tranquilisation. We reviewed the trusts rapid tranquilisation policy, and this guided staff to complete physical health checks after administering this medication. People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of rapid tranquillisation. We reviewed three rapid tranquilisation records and within 2 of these staff had failed to record physical health checks. The trust had an audit process in place, but this did not always identify all areas of improvement required. We raised our concerns with the trust immediately and they implemented an audit process to monitor rapid tranquilisation processes and ensure they are all completed.

When patients were placed in seclusion, staff did not always keep clear records and follow best practice guidelines. We reviewed 2 seclusion records, and we were not assured that seclusion reviews had taken place as outlined in the Mental

# Our findings

Health Act Code of Practice. We could not ascertain 2 nurses had completed the reviews. On both records within the multidisciplinary team reviews, it was not clear who was present and there was no record if the patient was offered food or fluid during seclusions. There were no patient specific seclusion care plans in place. This was not in line with the trusts seclusion policy which stated nursing reviews should take place by 2 registered nurses, a seclusion care plan should be in place and MDT reviews should be completed. We raised our concerns with the trust immediately and they shared the trusts seclusion policy and guidance with ward staff within handover with the opportunity for ward staff to discuss with the clinical lead and ask questions.

After the inspection the trust stated that audits will now be completed going forward to ensure that seclusion reviews are completed as required and patient rights protected and they reviewed their seclusion pathway to ensure they can accurately review processes and compliance.

### Medicines management

**The ward did not always 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 physical health.**

Staff did not always follow systems and processes to prescribe and administer medicines safely. We found staff administered intravenous medication to a patient without the legal authority in place.

We found medication fridge temperatures were not regularly taken. During August 2023 staff had had not recorded the temperature for 10 days. This increased the risk of patients consuming spoiled medication or appropriate emergency equipment not being available when required. During an incident review we found this had been reported as an incident every month between February 2023 and September 2023.

Staff did not have the required knowledge of the process for the disposal of illicit drugs. Although there was a policy in place, staff were not aware where they would record the storage of illicit drugs whilst waiting for the same to be collected by the police or the pharmacist. Two staff told us they would log this within the controlled drugs book, 1 stated they would log an incident form and 1 stated they would log this within patient records.

Medication was not always labelled and stored with drawers within the clinic room. We could not determine if these were stock medications or individual patients medication. We raised our concerns to the trust about this and managers checked medication stocks and labelled all medication appropriately.

We found medication audits did not identify recording errors. We found a record where a patient had been administered rapid tranquilisation and staff had completed all physical observation records after this. However, the staff member had not completed the medication administration records and this error had not been identified by the medication audit.

Staff did not review the effects of each patient's medicines on their physical health according to the National Institute for Health and Care Excellence guidance. Within 2 of the 3 rapid tranquilisation records we reviewed staff failed to record physical health checks.

We raised concerns about physical health checks with the trust immediately and they completed physical health observations for all patients currently on the ward and put an audit process in place to monitor rapid tranquilisation processes and ensure they are all completed.

### Track record on safety

**The service did not have a good track record on safety.**

# Our findings

The ward did not have a good track record in safety. They had a total of 679 incidents on the ward in the last 6 months with 4 major incidents and 63 moderate incidents. The average number of incidents per month was 101 with the highest number of incidents in August 2023, when the ward had 127 incidents.

### Reporting incidents and learning from when things go wrong

**The ward did not always manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately.**

Staff did not always know what incidents to report and how to report them. Nursing assistants and bank staff did not have access to the trusts incident reporting system. If these staff witnessed an incident, they would have to report them to a nurse, who would report the incident on their behalf.

When reviewing patient records, we found an incident where a patient overdosed on medication and this had not been reported on the trusts incident reporting system.

Staff understood the duty of candour. However, due to staffing levels staff could not always inform family members of incidents.

Managers did not always debrief and support staff after any serious incident. We reviewed 124 incident records involving restraint between February 2023 and September 2024 and found on 47 incident managers had failed to debrief staff and patients. Four of the 5 ward staff we spoke to told us they did not always get a de-brief after being involved in or witnessing a serious incident on the ward.

There was evidence that changes had not been made as a result lessons learnt after incidents. During an incident review we found medication fridge temperatures on the ward were not taken regularly between February 2023 and September 2023. There were incident logs for medication fridge temperatures not being recorded every month on the trusts incident recording system between February 2023 and September 2023. However, the trust failed to put appropriate lessons learnt and measures in place and monitor these to prevent these incidents from reoccurring.

## Is the service effective?

**Inspected but not rated**

Our rating of effective stayed the same. The previous rating of good remained.

### Assessment of needs and planning of care

**Staff did not always assess the physical and mental health of all patients on admission. They did not develop individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans did not reflect patients' assessed needs, and were not personalised, holistic and recovery oriented.**

Staff did not always complete a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 4 patient care records and found one of these patients did not have a care plan in place.

Patients did not always have their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed 4 patient care records and found that staff had failed to complete regular physical health

checks for all of them. Two of these patients were identified as having physical health needs upon admission. This was not in line with the trusts policy which stated upon admission, a doctor and nurse must jointly complete a comprehensive assessment of the patient's physical health. Staff had failed to ensure that the daily National Early Warning Score (NEWS2) score had been completed. Clinical leads told us this was standard practice and all patients should have daily NEWS2 completed.

We raised concerns about physical health checks with the trust immediately and they completed physical health observations for all patients currently on the ward and put an audit process in place.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. Within the 4 care records we reviewed we found that none gave a full overview of the patients physical and mental health needs, 3 were missing physical health care plans even though 2 patients had physical health conditions identified at admission and 1 did not have a care plan in place at all.

Staff did not regularly review and update care plans when patients' needs changed. Care records we reviewed were not reviewed regularly. Staff did not update care plans after incidents.

Care plans were not always personalised, holistic and recovery orientated. Although 2 of the care plans, we reviewed had specific goals and future plans in place, 1 of the care records we reviewed did not have any goals in place and 1 did not have a discharge plan in place.

When we raised concerns about care planning to the trust they immediately reviewed all patient care plans ensuring all patients had a physical health care plan in place and all patients were given the opportunity to be involved in this.

### Skilled staff to deliver care

**Managers did not support staff with regular supervision.**

Managers did not support all staff through regular, constructive managerial supervision of their work. Supervision compliance rates were at 55% and 31% of staff had not received a managerial supervision in over 3 months.

Managers did not make sure staff attended regular team meetings. The ward planned to have monthly team meetings but only had 2 within the last 3 months and one of these was specifically to discuss staff rotas. The meetings did not give staff the opportunity to raise issues or points to discuss any other business.

### Multidisciplinary and interagency teamwork

**Staff from different disciplines worked together as a team to benefit patients. However, staff did not have an effective handover process in place.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All patients received a weekly ward round which was attended by a multidisciplinary team including a doctor, nurse and occupational therapist.

Staff did not always make sure they shared clear information about patients and any changes in their care, including during handover meetings. We reviewed handover records and found the ward had a combination of electronic and paper handover records. The records in place did not consistently handover serious incidents, including incidents of patient ligating, absconding and incidents of head banging. This increased the risk of patients not receiving the support they require after incidents.

# Our findings

### Adherence to the Mental Health Act and the Mental Health Act Code of Practice

**Staff did not understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharge these well. Managers did not make sure that staff could explain patients' rights to them.**

Staff did not always receive or keep up-to-date with training on the Mental Health Act. We found 50% of nurses were not up-to-date with training on the Mental Health Act. Three of the 5 ward staff we spoke to did not know the basic principles of the Mental Health Act and could not explain the rights of an informal patient and 2 of the 5 staff told us they had only recently received some training following a visit from the CQC Mental Health Act reviewer.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff told us they had access to all the trusts policies online.

Patients did not have easy access to information about independent mental health advocacy. We found notice boards were empty on the ward and there was no information on how patients could access an advocate. We spoke to an advocacy service that supported the ward they told us they had received no referrals from the ward and had to attend the ward to inform patients of their service. When they attended the ward they had always been welcomed by staff. We raised this with the ward and they immediately updated the patient notice board with information on how patients can access an advocate.

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, repeated them as necessary and recorded it clearly in the patient's notes each time. We reviewed 4 patient care records and found within 3 records staff had only informed informal patients of their legal rights after the Mental Health Act Reviewer raised this an issue during their visit on 5 September 2023. We found 1 record where a patient was administered intravenous medication without a valid consent to treatment order in place.

Informal patients knew that they could leave the ward freely but the ward did not display posters to tell them this. We spoke to 5 patients on the ward and the 2 informal patients told us they both had only been informed of these 2 days ago. One formal patient told us staff had tried to explain their right to them, but this was not done clearly so she did not really understand her rights. The ward had a sign informing informal patients of their rights, but this was outside the ward doors so patients inside could not read the sign.

Managers and staff did not make sure the service applied the Mental Health Act correctly by completing accurate audits. Although the trust had an audit process in place it did not always identify when patient had not been informed of their rights.

We raised concerns with the trust around the adherence of the Mental Health Act and lack of staff understanding around the basic principles immediately after the inspection. The trust assured us their Mental Health Act team undertook immediate face to face training with all staff at handover and shared information around the Mental Health Act with them. They also ensured all patients had been informed of their rights.

## Is the service caring?

**Inspected but not rated**

Our rating of caring stayed the same. The previous rating of good remained.

# Our findings

## Kindness, privacy, dignity, respect, compassion and support

**Staff treated patients with kindness. But they did not always support patients to understand and manage their care, treatment or condition.**

Staff did not always give patients help, emotional support and advice when they needed it. One patient told us there was a lack of support for patients who witnessed incidents. We reviewed 124 incident records involving restraint between February 2023 and September 2024 and found on 47 incidents, managers had failed to debrief staff and patients.

Staff supported patients to understand and manage their own care treatment or condition. All patients attended ward rounds but no patients had access to their care plan. Following the inspection the trust told us all patients had been given the opportunity to be involved in their care planning and get a copy of this.

Staff did not direct patients to other services or support them to access those services if they needed help. The notice boards within the patient areas were empty and did not give information on advocacy services, or how patients could raise a complaint. The ward manager updated this once it had been raised with them.

Staff did not always maintain patients privacy and dignity. A bedroom on the ward had a clear glass panel in the door, anyone walking past this bedroom could see directly into the patient's bed space.

Patients said staff treated them well and behaved kindly. All 5 patients and both carers we spoke to told us staff were generally kind but they were always rushed and the ward felt understaffed. One patient told the occupational therapists were really good and there were activities available every day.

## Involvement in care

**Staff did not involve patients in care planning and risk assessment. They did not ensure that patients had easy access to independent advocates.**

### Involvement of patients

Staff did not involve patients or give them access to their care plans and risk assessments. We spoke to 5 patients. They all told us they were not aware they could have access to their care plans and had not been involved in their developing these.

Staff did not always make sure patients understood their care and treatment. We spoke to 5 patients on the ward the 2 informal patients told us they both had only been informed of these 2 days ago. One formal patient told us staff had tried to explain their right to them but this was not done clearly so she did not really understand her rights. We raised concerns with the trust around the adherence of the Mental Health Act and lack of staff understanding around the basic principles immediately after the inspection. The trust assured us all patients had been informed of their rights.

Staff did not involve patients in decisions about the service, when appropriate. The ward stated they had community meetings in place; however, 2 patients told us these didn't happen very often and 2 patients had never attended a patient community meeting. The ward staff told us they are supposed to have patient community meetings every week but when we asked for meeting notes they had only had 7 meetings in the last 3 months.

Patients could not give feedback on the service and their treatment and staff did not support them to do this. All patients told us they could attend ward rounds. However, 2 patients told us they find these intimidating and daunting.

# Our findings

The ward did not have the complaints policy in display within the patient ward area. We raised this with the ward and they immediately put a copy on display.

Staff made sure patients could access advocacy services. The advocacy service attended the ward area regularly and was able to attend ward rounds with patients.

### Involvement of families and carers

**Staff did not inform and involve families and carers appropriately.**

Staff did not always support, inform and involved families or carers. We spoke to 2 family members, and both told us getting invited to ward rounds was inconsistent and 1 told us they had never seen a care plan or been involved it's development.

When reviewing incident records, we found a family member had not been informed of an incident involving their loved one due to lack of staffing.

One family member was concerned their loved one's items had been stolen from their locker.

## Is the service responsive?

**Inspected but not rated**

Our rating of responsive stayed the same. The previous rating of good remained.

### Access and discharge

**The trust had systems in place to manage the bed occupancy. However, the ward did operate, at times as over 85% capacity. If patients needed to return the unit staff could not always guarantee a patient could return to the same ward.**

### Bed management

Managers did not make sure bed occupancy did not go above 85%. When patients went on leave there was not always a bed available if they returned. At the time of the inspection the ward occupancy was over 100%. The ward as a 20 bedded ward had 21 patients assigned to it. Eighteen patients were on the ward and 2 patients were on section 17 leave and 1 patient was at the acute hospital. Should all 3 patients have needed to return to the ward there would not have been sufficient beds. When managers were questioned about this, they told us the bed management team only filled a patient's bed if they were on section 17 leave with a view to discharge and if all patients were to return, the bed management team would aim to find them a bed on the unit. The trust had a bed management policy in place but there was no guidance in place around the use of patient beds when they are section 17 leave.

The service did not have access to a psychiatric intensive care service. Therefore, all patients who required this would be placed out-of-area. The trust has a plan in place to bring psychiatric intensive care services into the area as part of their refurbishment plans.

# Our findings

Managers and staff did not always work to make sure they did not discharge patients before they were ready. We reviewed 1 patient record where a patient stated they were still suicidal and did not want to be discharged. However, the multidisciplinary team decided that as the ward could not offer them more support and they would benefit from community services, and it was agreed the patient would be discharged with a 2 day follow up.

### Facilities that promote comfort, dignity and privacy

**The design, layout, and furnishings of the ward did not support patients' treatment, privacy and dignity. Each patient did not have their own bedroom with an en-suite bathroom and patients could not keep their personal belongings safe.**

Each patient did not have their own bedroom. The ward had 7 single bedrooms and 13 dormitory bed spaces and there were 6 toilets, 2 showers and 2 bathrooms between 20 patients. Each patient did have their own bedspace that had been personalised. The trust has a dormitory eradication programme in place for all their sites and it is planned this work will be completed for Ward 35 in March 2026.

All patients did not have a secure place to store personal possessions. There was no lockable space within patients bed space. All patients were assigned a small locker for valuable items in a locked room, which they could access with the supervision of a staff member. However, we found 7 of these lockers had the keys left in them, 2 lockers did not have a door and 2 had the locks broken. Three out of the 5 patients we spoke to told us they had belongings that had been stolen and 1 felt as nothing was labelled so they ended up using other people's items. As there was not sufficient space in the storage room there were items stored in bags and suitcases piled up on the side of the room next to the lockable lockers. When we raised this with the trust they immediately made lockers available for the ward and reorganised storage space for the ward.

The ward had quiet areas and a room where patients could meet with visitors in private. The ward had a dining room, recreational room and access to a family room on the unit for young visitors.

Patients could make phone calls in private. Patients had access to their mobile phones or the ward phone to make phone calls and could use the quiet lounge area or recreational room to make phone calls.

The service had an outside space, but patients could not access this easily. The outdoor space was kept locked and mostly used as a smoking area. The nursing office had a sign on display stating when patients could have "fresh air" breaks and that patients could request additional time outside should they wish. However, this sign was not on display within a patient area so patients would not know when the fresh air breaks are or that they could request this at any time. Once we had raised this with the trust they immediately put appropriate signage in place and allocated smoking and non-smoking areas for patients.

Patients could make their own hot drinks and snacks and were not dependent on staff. The ward had a small kitchen area where patients could make themselves a hot drink or have a fruit snack.

### Meeting the needs of all people who use the service

**The ward could meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.**

The service could support and make adjustments for disabled people. The ward did not have access the accessible bathroom, until we raised that this space was being used for storage. The trust then removed these items to make this bathroom accessible.

# Our findings

Staff did not make sure patients could access information on treatment, local service, their rights and how to complain. The patient information boards were empty when we first went onto the ward and did not include any information on local services or how to make a complaint. When we raised this with staff they updated the information board with the trusts complaint policy and advocacy information.

The ward did not have information leaflets available in different languages. However, ward staff told us they were able to order these if required.

Patients had access to spiritual, religious and cultural support. Patients on the ward had access to a pastural service, but this was not advertised on the patient information board.

### Listening to and learning from concerns and complaints

**Although patients and family members told us they knew how to raise a complaint, the ward did not have a complaints policy on display within the patient communal area.**

Patients, relatives and carers knew how to complain or raise concerns. All patients and carers we spoke to told us they knew how to raise a complaint. The ward had received 2 complaints in the last 3 months.

However, the ward did not display information about how to raise a concern in patient areas. The ward had several empty notice boards throughout the ward area. There was no information around how to raise a complaint or access an advocate in the communal area. When this was raised with the ward manager a copy of the complaints policy and advocacy information was put on display.

## Is the service well-led?

**Inspected but not rated**

Our rating of well-led stayed the same. The previous rating of requires improvement remained.

### Leadership

**The ward leaders did not have the skills and knowledge to perform their role. They did not have a good understanding of the ward they managed and even though they were visible in the service they were not approachable for staff.** The ward manager was not aware that staff had not updated the patient care records, did not know why there was no ligature risk assessment available on the ward and was not aware why the ward notice boards were empty. Two staff we spoke to told us they didn't feel supported on the ward and 3 staff told us they did not feel respected.

### Culture

**Not all staff felt respected, supported and valued. They could raise any concerns without fear but didn't always see any outcomes.** Two of the ward staff we spoke to told us there was a new nursing team on the ward that was starting to come together. However, 3 of the ward staff told us they didn't feel respected by management and even though 1 had raised concerns with the freedom to speak up guardian there was no outcome from this.

Four of the 5 ward staff we spoke to told us the manager often shouted at colleagues in the nursing office and even though they had escalated this with the freedom to speak up guardian there had not been any changes.

# Our findings

### Governance

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

Our findings from other key questions showed audit processes in place were not always effective.

Effective audit processes were not in place to identify and mitigate risk in the environment including ward cleanliness and robust ligature risk assessment.

Medication audits did not identify recording errors. The trust failed to put processes in place even though medication audits had consistently found medication fridge temperatures had not been recorded consistently.

Audit processes in place had not identified where staff had failed to put in place and update patient care plans and risk assessments and complete appropriate physical health checks for patients. Audit processes had not identified staff were not partaking in a thorough and detailed handover and information around incidents, post incident care and debriefs were not being completed.

### Management of risk, issues and performance

**Teams did not have access to the information they needed to provide safe and effective care and used that information to good effect.** Our findings in the other key questions highlighted staff did not have the appropriate information to provide safe care for patients with a physical health condition, staff did not always effectively handover serious incidents on the ward and did not update patient records after serious incidents.

Managers had a lack of oversight and impact of poor care planning, poor risk assessing, staff knowledge and application of policies and the Mental Health Act rights, poor seclusion reviews, lack of post incident de briefs, all staff not being trained in the trusts restrictive intervention programme and not giving all staff access to completing incident forms.

# 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 patient dignity is maintained during the transformation of the dormitory area into single patient rooms (Regulation 10).
- The trust must ensure staff and patients receive a de brief after serious incidents (Regulation 12).
- The trust must ensure the clinic room is cleaned regularly (Regulation 12).
- The trust must ensure staff give a thorough handover including incidents and support required by patients (Regulation 12).
- The trust must ensure the ligature risk assessment is robust and gives clear guidance on mitigating measures in place for all ligature anchor points (Regulation 17).
- The trust must ensure medication audits are robust and assess, monitor and improve medication management (Regulation 17).
- The trust must ensure staff are aware of the illicit drug policy and the correct recording processes around this (Regulation 17).
- The service must operate effective systems and processes to ensure that managers monitor assess and improve quality of services (Regulation 17).
- The trust must ensure systems and processes are in place to reduce staff sickness (Regulation 17).
- The trust must ensure bank and agency staff are suitably trained to support the ward staff (regulation 18).
- Managers must ensure staff receive regular managerial supervisions (Regulation 18).

**Action the trust Should take to improve:**

- The trust should ensure emergency resuscitation equipment checks are completed.
- The trust should ensure patient information boards are kept up to date with patient information.
- The trust should ensure systems and processes are in place to improve staff and team culture on the ward.
- The trust should ensure they meet the safe staffing levels without the use of multidisciplinary team members.
- The trust should ensure that all patients can call for assistance in an emergency.
- The trust should ensure all patients receive one to one time with a nurse when their named nurse is not available.
- The trust should ensure family members are informed of incidents if the patient has asked for them to be involved with their care.
- The trust should ensure ward environments have a regular environmental audit.

# Our findings

- The trust should ensure the bed management policy in place gives clear guidance around bed capacity and the use of patient beds when they are on section 17 leave.
- The trust should ensure informal patients can read a sign or poster informing them of their rights inside the ward area.
- The trust should ensure family members and carers are involved in their loved one's care and treatment, with permission.
- The trust should ensure constructive, open team meetings are held where staff can bring items they would like to discuss.
- The trust should aim to reduce the levels of bank and agency staff supporting the ward.

# Our inspection team

The team that inspected the service comprised a CQC lead inspector, a specialist advisor nurse and an expert by experience. The inspection team was overseen by Greg Rielly, Deputy Director of Operations.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect |