Hertfordshire Partnership University 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	Good
Are services safe?	**Requires Improvement**
Are services caring?	**Good**

Our findings

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

Good

We carried out this unannounced focused inspection because we received information giving us concerns about patient safety and quality of the service on Oak Unit.

This was a focused inspection, looking only at Oak Unit, the psychiatric intensive care unit.

Our rating of this service stayed the same and was rated as good. Our rating of safe went down from good to requires improvement. That is because we found breaches of regulations and issued Requirement Notices telling the service provider what it must improve.

In these circumstances the rating linked to the area of the breach is normally limited to requires improvement.

(See the Areas for improvement section for more information.)

- See our website for more information about our Ratings principles

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC, including information given to us from patients and the public. For this inspection, we looked at the safe and caring domain.

Hertfordshire Partnership University NHS Foundation Trust provides acute wards for adults of working age and psychiatric intensive care across six wards, over three sites. Oak Unit is a 12 bedded, male only, psychiatric intensive care unit (PICU), which is housed in a purpose-built premises at Kingsley Green, Radlett. The unit provides care and treatment for patients who are experiencing an intense period of mental distress and are very unwell. There were 11 patients admitted to the unit when we carried out this inspection, one of whom was on leave away from the ward. All patients on Oak Unit were detained under The Mental Health Act 1983.

The Acute wards for adults of working age and psychiatric intensive care units service was last inspected in March 2019, when it was rated good.

During this inspection we found:

- The ward used regular bank and agency staff to cover vacancies, which meant there were enough staff deployed on the unit.
- Staff carried out regular safety audits of the environment.
- The ward layout was deemed to be safe and risks were well managed.
- Staff understood how to protect patients from abuse.
- Staff were generally discreet, respectful, and responsive when caring for patients. We observed a number of positive interactions between staff and patients.

Our findings

- Patient care records showed that staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.
- Staff were supporting one patient to develop and display some artwork on the ward.
- Patients had easy access to an independent advocate, who visited regularly.

However:

- Staff were regularly required to carry out continuous patient observations for longer than the recommended time of two hours, some without being allocated a break.
- Not all staff had easy access to clinical information, and it was not easy for them to maintain high quality clinical records.
- Staff turnover, vacancy rates and sickness levels were high.
- The temperature on the ward was uncomfortably hot and could not easily be adjusted by staff. However, there were plans in place to mitigate this.

How we carried out the inspection

This inspection was unannounced, meaning the provider did not have advanced notice of the inspection.

The inspection team visited Oak Unit on 18 and 19 October 2022. We further visited on 31 October 2022.

During the inspection we:

- visited the ward and observed how staff cared for patients
- toured the clinical environments, including the clinic room and reviewed emergency equipment
- reviewed three patient care records
- spoke with seven patients
- spoke with two carers
- spoke with the independent advocate
- carried out a variety of observations on the ward including serving of lunch, ward based activities and a group cookery session
- reviewed how staff managed patient safety incidents by examining CCTV footage and incident paperwork
- observed one staff handover
- interviewed five staff including nurses, nursing assistants and a ward manager
- reviewed patient observation records, staffing rotas and patient observation allocation sheets and minutes of recent patient “mutual help” meetings
- reviewed data supplied by the trust, documents, policies and procedures relevant to the running of the service.

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

Our findings

What people who use the service say

We spoke with seven patients and two family carers, and we reviewed one written compliment. Patients gave us mixed views about how they experienced the care and treatment they received.

All but one patient told us there were enough staff on the ward. Three patients told us they felt safe and supported by staff. However, three patients told us they did not always feel safe on the ward because some patients were threatening and had been physically aggressive, assaulting them or others. One said they felt unsafe by the practice of physical restraint, because they found the experience abusive and degrading, but noted that "98% of staff are respectful". However, another patient told us they had experienced physical restraint and "staff were always gentle". Two patients told us they had raised their concerns with staff about not feeling safe but had not received suitable assurances. One said staff had not responded helpfully and the other told us that they had not any feedback since they raised the issue. However, another patient told us "everything I've raised has been dealt with".

Two patients told us that while there were always enough staff on the ward, a lot of them were carrying out safe and supportive observation duties, so when patients asked them for something, they were not able to help with their query or request. However, if staff were available, they could speak to them about their feelings. One patient told us that staff were "great, amazing and incredible". The minutes we reviewed from a sample of the patient "mutual help" meetings, showed numerous positive "thank you" comments from patients to staff.

One patient told us they became agitated when the lounge was noisy and overcrowded. Another said the ward was so noisy, they couldn't hear their telephone conversations. Patients on Oak Ward have access to a quiet lounge and their bedrooms. If the ward environment is over stimulating, patients can be supported to access these areas.

One patient told us if they bought vaping machines from the trust, that they costed almost double the price that they could buy them for in the community. They felt this was unfair. Another told us if the machine on the ward where they bought vapes was empty and this caused "tensions to rise". Another they also told us the times set for patients to be able to go outside and use their vaping machine coincided with a staff handover meeting, which meant there were not always enough staff to support them to use their vapes at the time they were scheduled to use them. They said this was frustrating and it made them angry.

One patient told us that staff were not always consistent in their responses, indicating some were more boundaried in their approach than others. They also told us that some overseas staff were unwilling to talk to patients about their sexuality and often spoke to each other in a language the patients didn't understand. Another patient told us that some situations with other patients "escalate unnecessarily," because "staff don't listen to patients and resolve things quickly".

Some patients told us there were lots of activities for them to participate in, such as art and craft, playing music, chess games with the occupational therapist, a smoothie making group, cooking sessions, a walking group and using the gym. However, others told us there were not enough activities, and they were bored. All the patients told us they could go outside for fresh air, but some noted there was no shelter for them to use while vaping, so they could be cold and wet. A separate outside area, the courtyard, which had a shelter was being refurbished and not accessible to patients. Patients had monthly Mutual Help Meetings, where they could discuss issues with staff. At these meetings, they were able to request additional activities, such as board games, access to specific PlayStation games or devices to access social media. These would then be taken forward for a multidisciplinary team meeting for a review to the appropriateness of the requests and actioned if deemed appropriate.

Our findings

Family carers told us they were often kept waiting for between 30 minutes and an hour before their relative was brought to see them for their arranged visits. They felt this was too long to be kept waiting. They told us they were not as not fully involved in their relative's care as they would have liked to have been and were not given opportunities to provide feedback about the service or given information about how to make a complaint if they were unhappy with the service. One family carer told us that their relative felt there were not enough staff on the ward and the ward round meeting that they were invited to attend was set at a fixed time on the same day every week, which was inflexible.

Is the service safe?

Requires Improvement

Safe and clean care environments

All wards were safe, generally clean, well equipped, well furnished, well maintained and fit for purpose. However, patient toilets were stained and the environment was in need of redecoration.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We reviewed a sample of routine audits of the environment that staff had carried out. These included water hygiene checks and environmental risk assessments. There was a clear list of items that were not permitted on the ward, for example things a person could use to cause harm to themselves or others.

Staff could observe patients in all parts of the ward, but this was not always easy due to the layout. The bedroom corridor led off the communal ward area and had a closed-circuit television (CCTV) camera to aid observation in one area. There were also suitable mirrors positioned to aid observation of the harder to observe areas of the bedroom corridor.

Managers carried out random audits of the CCTV footage which they used to review incidents and the use of restraint.

The ward complied with guidance and there was no mixed sex accommodation. Oak Unit was a single sex, male only ward.

There were no potential ligature anchor points in the service which hadn't been mitigated. Areas where patients had unsupervised access, such as bedrooms and bathrooms contained fixtures and fittings that were designed to minimise ligature risks.

Staff had easy access to alarms. Observations we carried out on the ward and our review of CCTV footage showed that staff responded promptly and effectively when alarms were raised.

Maintenance, cleanliness and infection control

Ward areas were generally clean and well maintained, well-furnished and fit for purpose. While the ward area was generally clean, some patient toilets were stained and there was surface dust in areas that were easy to clean, such as communal wash hand basins. Furnishings were mostly in good condition, with some evidence of recent damage by a patient to one chair. The ward environment was not particularly therapeutic, it was bare and looked "tired", and needed cosmetic upgrading. However, the trust was in the process of refurbishing the ward area which was due for completion in November 2022. We saw evidence of patient involvement during our second visit. We saw the ward had recently held workshops with patients to get their views about redecorating the ward, which included choosing of paint colours.

Our findings

We reviewed maintenance logs and saw that staff had routinely reported any issues that required attention and we saw that the response time from the maintenance service was generally good, although some issues such as faulty doors mechanisms and air conditioning repairs had required repeat reporting before being resolved effectively. However, maintenance staff would ensure the environment was safe if they could not complete a repair on the first visit and would return promptly to complete the repairs. The air conditioning was due for upgrade and was due for completion by 30 November 2022.

The ward was uncomfortably hot when we visited, and staff told us they were unable to adjust the temperature effectively. The ward was either too hot or too cold. The trust had plans in place to improve the temperature control on the ward and this work was due to be carried out in November 2022.

Staff made sure cleaning records were up to date. We saw cleaning records which showed that routine cleaning of the ward area was carried out. Staff carried out cleaning audits, which were undertaken monthly, for August, September and October 2022. These audits demonstrated a cleaning compliance of 96% for September, 98% for August and 94% for October 2022. Cleaning audit action plans clearly identified the remedial action required which included the cleaning of areas which were still dusty.

Staff followed infection control policy, including handwashing. Trust audits showed staff demonstrated compliance rates of between 90-100% with hand washing, when checks were carried out during 2022. Trust infection prevention and control audits for quarter one and two in 2022 showed full compliance was 93% and 77%. Personal protective equipment audits showed 87% compliance each month between April and July 2022. However, when we carried out this inspection, we observed two staff wearing fluid resistant face masks incorrectly.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. Staff could observe patients from outside the seclusion room, which was on the patient bedroom corridor. The space was well ventilated.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We reviewed these checks for the month leading up to this inspection and found all were completed effectively.

Staff checked, maintained, and cleaned equipment. Staff carried out appropriate checks to ensure the equipment was fit for purpose and was cleaned effectively.

Safe staffing

The service had enough nursing and medical staff, who received basic training to keep people safe from avoidable harm, but many were temporary and not all of them knew the patients well. Not all staff were provided with a break when they should have received one.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The required number of staff fluctuated to reflect the changing needs of patients. We reviewed staffing rotas covering the period 1 – 7 October 2022 and found that each shift had between 8 and 17 members of staff. When we visited the ward on 31 October, there were 15 staff on shift, two of which were supernumerary.

Our findings

The service had high vacancy rates. The trust told us that full time equivalent vacancy rates for Oak Unit was 39% at the time of this inspection. Staff told us that since January 2022, four nurses had left, three for career development reasons and one because working on the ward was stressful.

The service had high rates of bank and agency registered nurses. The night shift on 31 October had five nurses, three of which were agency nurses. During the night shift on 31 October 2022, the ward had five registered nurses, two substantive and three agency staff, all of whom knew the ward and service users. The service had high rates of bank and agency health care support workers. There were 12 health care support workers on shift, 10 were permanent trust bank staff and two were agency staff. We saw that out of the 10 bank staff, one staff member was a substantive Oak ward staff member working a bank shift. Six other staff were familiar with the ward, which showed that seven of the 12 health care support workers were familiar with Oak ward and the patients.

Managers were not able to limit their use of bank and agency staff due to the high vacancy levels. They could request staff who were familiar with the service but could not guarantee this. However, where possible, managers used “block contract” agency staff, to provide consistency and stability for patients and other staff on the ward.

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. The trust had a standard induction policy and procedure. Ward staff were responsible for ensuring temporary staff completed a ward based induction.

The service had high but reducing turnover rates. The trust had introduced a number of initiatives to improve staff support and to reduce turnover rates. We reviewed trust data and found that in the 12 months leading up to this inspection, there was a cumulative high of 58% staff turnover in December 2021, falling to 41% in September 2022.

Managers supported staff who needed time off for ill health. Staff told us that managers worked with them to reduce the negative impact of stress and implemented supportive measures such as changing their shift patterns if necessary.

Levels of sickness were increasing. For the period September 2021 to September 2022, the average monthly sickness rate was 8.4%. In the three months leading up to this inspection, sickness levels had reached between 10.3 and 14.4%

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The trust used a recognised safe staffing planning tool.

The ward manager could adjust staffing levels according to the needs of the patients. This could be adjusted to take account of changing patient need. Ward managers could request additional staff in response to changing patient need and we saw staffing was increased to reflect this.

The service had enough staff on each shift to carry out any physical interventions safely. Additionally, if required, staff based elsewhere on the hospital site could respond in an emergency.

Staff shared key information to keep patients safe when handing over their care to others. Staff completed effective handovers at the start and end of each shift. However, we found once instance when staff were not aware of how to support a patient to use a prescribed sleep apnoea machine, but the patient was able to use the equipment unaided.

Our findings

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. We reviewed the training records which showed compliance with statutory, essential and local training. The compliance rate for all these types of mandatory training was 80%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training included basic and intermediate life support, fire safety, equality and diversity, human rights and the Mental Capacity Act.

Managers monitored mandatory training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and mostly followed best practice in anticipating, de-escalating and managing challenging behaviour. However, we saw some missed opportunities to engage effectively with patients. 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 completed risk assessments for each patient on admission arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patient care records showed that staff routinely updated risk assessments and care plans to reflect changes in a patient's presentation and following any incidents. The ward also held a Psychiatric Intensive Care Unit (PICU) safety meeting held every week, which was attended by the trust's "subject matter expert" from the practice development and patient safety team.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We spoke with four bank and agency staff who all demonstrated that they knew the ward and the patients well, having worked on Oak Unit regularly. Each could provide a good patient summary, including the patients' safe and supportive observation levels and their risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Following individual risk assessment, patients who are acutely unwell or present a high level of risk might need staff allocated just for them, to monitor and support them for extended periods of time, to keep them and everyone else safe. We reviewed a sample of these safe and supportive patient observation rotas, for the night shifts of 1-17 October 2022. We reviewed 16 safe and supportive observation rotas. The 16 safe and supportive observation rotas we reviewed, showed that on each shift, some staff were required to carry out continuous patient observations for long periods, in excess of the recommended maximum of two hours, and without the recommended regular breaks. National Institute for Health and Care Excellence guidance recommends that staff do not carry out continuous observations for more than two hours, and if they do, they should have regular breaks. We saw five shifts where staff were required to perform these duties for three, four or five hours continuously. The staff allocated to provide safe and supportive observations for patients who were receiving care and treatment away from Oak Unit, at the local general hospital, carried out continuous patient observations for their whole shift, without any breaks.

We reviewed 16 safe and supportive patient observation rotas. On one shift (7 October), a patient did not receive their prescribed safe and supportive observations for three hours. Another patient had a gap of one hour on the same night. We reviewed the observation records for both patients and found they had each been signed by staff, indicating that the observations had taken place.

Our findings

However, on the night of 31 October when we visited the ward, we observed all patients were receiving their prescribed safe and supportive observations. We also observed staff were not required to perform these duties for more than the recommended two hours at a time, and saw them routinely being replaced by colleagues after undertaking one hour of continuous observation.

Staff followed procedures to minimise risks where they could not easily observe patients. The CCTV camera supported this because it covered the patient bedroom corridor and garden, and we saw examples of staff using this effectively.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. They kept records to show when room searches had been carried out.

Use of restrictive interventions

Levels of restrictive interventions were low, although there had been an uncharacteristic rise during October 2022, linked to an increase in the acuity of the patients on the ward at that time. There were no incidents of prone restraint being used on the ward for the year leading up to this inspection.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. This included participating in relevant restrictive practice training. The trust confirmed that in order to work on the ward, all agency staff were required to have up to date training in either the trust recognised restrictive intervention training, or an equivalent. Of the 62 bank staff booked to work shifts between 16 -22 October 2022, all except six were up to date with their Respect training. The week after our inspection visit, the trust confirmed that those six staff were booked to complete their training.

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 good examples of staff using appropriate de-escalation techniques with patients. However, we also saw examples of staff, who were unfamiliar with the ward and the patients, missing opportunities to engage and de-escalate an aggressive patient when it would have been appropriate to do so. The ward environment was often noisy when we carried out this inspection, due to the high acuity of the patients on the wards, and we observed this was difficult for some patients. However, there was a quiet lounge and patients could access their bedroom during the day should they need to find a quiet place.

There had been 29 episodes of seclusion between October 2021 and October 2022 and generally, patients spent only short periods of time being secluded.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Training compliance rates for safeguarding adults was 89% for level one and 75% for level two. There was only one member of staff non compliant with their level two training and the trust confirmed that they were booked to complete it. All staff who were required to complete level three safeguarding adults training had completed it. Completion rates for safeguarding children level one training was 89%.

Staff followed clear procedures to keep children visiting the ward safe. A suitable visitor room for children was located off the ward area, so patients with children could maintain contact with them safely.

Our findings

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Most safeguarding incidents related to incidents when patients had assaulted each other. Our review of the ward's incident data showed that staff linked safeguarding to incident reporting.

Staff access to essential information

Not all staff had easy access to clinical information and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive but not all staff could access them easily. Staff told inspectors they could wait many months before having access to the electronic patient record system. They described waiting between three and eight months before being able to access the patient record system. While staff waited, they had to ask other staff to record patient information for them. This caused delays and frustration for staff.

Records were stored securely. Staff observed good information governance protocols, for example not sharing passwords for the electronic patient record system, instead providing other staff with the relevant information to add into the patient care record if they could not access it themselves.

Medicines management

Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Patient care records showed that staff reviewed each patient's medicines regularly, for example in doctors' reviews and multidisciplinary meetings.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Records showed staff carried out suitable checks to ensure patients' medicines were clearly recorded, liaising with GPs and other relevant professionals as necessary.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Regular patient care reviews took place and staff worked alongside prescribers and pharmacists, in line with best practice.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents.

Staff knew what incidents to report and how to report them. They routinely reported incidents using an electronic reporting system. There were 318 recorded incidents for the period October 2021-2, 146 of which were patient incidents of violence and aggression. Of these, 24 were categorised as low or no harm and 3 were categorised as moderate harm, which we report on elsewhere in the report. Incidents recorded at a 'moderate harm' level or above are taken to the trust's moderate harm review panel.

Staff raised concerns and reported incidents and near misses in line with trust policy. The trust collected and monitored this information, providing scrutiny and oversight.

Our findings

Staff reported serious incidents clearly and in line with trust policy. There had been two serious incidents in the year leading up to this inspection. One of these had resulted in harm to staff, who sustained multiple injuries during an unprovoked attack by a patient. Managers had investigated the incidents and identified learning, actions and good practice.

The service had no never events on the ward.

Managers debriefed and supported staff after any serious incident. Records showed these took place after incidents and managers considered involving patients and staff where appropriate.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations when appropriate. When patients remained acutely unwell or had refused for their families to be involved in their care, managers considered this and included a rationale for not having involved them in the incident review.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers considered the emotional impact of involving staff in incident reviews, particularly if they had been injured by patients and were away from work when the investigation took place.

There was evidence that changes had been made as a result of feedback. In response to an incident review, the door to the 136 suite was to be replaced, to include a serving hatch for staff to provide food for a patient to consider if they may wish to eat it, even if they had initially declined a meal.

Is the service caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff generally treated patients with compassion and kindness. Most understood the individual needs of patients. However, some patients and carers told us that not all staff were responsive or kind.

Staff were generally discreet, respectful, and responsive when caring for patients. We observed large numbers of staff present in the dining area when patients were eating. The dining area was very crowded. There was space for staff to move back and still maintain eyesight on patients who were on observations, without crowding around patients whilst they ate their food. We also saw patients pacing without any staff direction or support. We saw patients approach staff and be told “I’m on obs”, but they were not given any guidance on where they could go and find the support they needed. This led to some patients expressing frustration. However, we also observed staff being responsive to distressed patients and supporting patients with individualised activities such as playing instruments and singing in the lounge and planning art therapy. We observed staff gently but firmly ask patients to stop inappropriate conversations and maintain personal space/boundaries.

Staff mostly gave patients help, emotional support and advice when they needed it. We observed missed opportunities where staff could have intervened proactively with distressed or bored patients. Some patients told us staff did not listen to them and did not intervene quickly enough to prevent incidents of aggression developing between patients. They told us this made them feel unsafe. However, patients could give feedback on the service and their treatment and staff supported them to do this. We saw patients were encouraged to give feedback about the service in “mutual help” meetings.

Our findings

We were told that some staff did not introduce themselves to new patients and they observed the patients, without engaging or talking to them. We observed some staff were talking amongst themselves, not talking to patients and not responding when patients approached them. However, we also saw ward staff proactively intervening and redirecting patients when necessary. The drama therapist provided telephone support to a patient who was receiving care and treatment for their physical health at another hospital and staff had supported a patient to fulfil their ambition and hold an art exhibition of their own work.

Staff directed patients to other services and supported them to access those services if they needed help. The ward doctor and drama therapist continued to support a patient during their end of life care, even though they had been moved to another hospital. We saw examples of staff supporting patients to travel long journeys so they could maintain contact with their families or be discharged back to their home community.

Patients said staff did not always treat them well and behave kindly. One patient told us this made them angry. One family carer told us that their relative had said "not all staff are nice" and another told us that when they visited the ward, some nursing assistants were "rude and abrupt" but the "nurses are nice". However, we observed examples of staff being kind and patient with patients who, because they were very unwell, were verbalising racially unpleasant comments. We saw that staff responded well in these very difficult situations.

Staff who worked regularly on the ward understood and respected the individual needs of each patient. They spoke respectfully and knowledgably about the patients they cared for.

Staff followed policy to keep patient information confidential. However, we found one example of a patient record which was still active on the electronic patient record system, some time after the patient had been discharged from the ward. The record had been updated, in error, with information pertaining to a different patient. We advised staff about the error and they assured us they would deal with it promptly.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff gave patients opportunities to be involved in their care planning via ward rounds. Not all patients wanted a copy of their care plan and staff recorded if that was the case. Some patients told us they had been fully involved in their care and were very happy with their care plan. However, not all patients we spoke with felt involved in their care and treatment.

Patient care records showed that staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. We saw that an interpreter had been requested for one patient, for their admission, ward meetings and three additional times each week while they were to be a patient on the ward.

Staff involved patients in decisions about the service, when appropriate. One patient told us they had been consulted about how to redecorate the ward. We saw the ward had recently held workshops with patients to get their views about redecorating the ward, which included choosing of paint colours.

Our findings

Patients could give feedback on the service and their treatment and staff supported them to do this. We saw patients were encouraged to give feedback about the service in weekly “mutual help” meetings. However, the minutes of these minutes did not show evidence of any resulting actions, so it was not possible to know if the feedback was used effectively. We did see several comments of patents thanking staff for their help and assistance.

Staff made sure patients could access advocacy services. The trust had a contract with a local independent advocacy service and the advocate visited the ward regularly. The advocate told us that patients were also supported to telephone them if they wanted support or advice. Staff displayed information about the advocacy service on the ward, so patient could know about it.

Involvement of families and carers

Staff generally informed and involved families and carers appropriately.

The families and carers we spoke with told us that staff did not always keep them informed and involved in their relative’s care. They did not always receive updates when they felt they should have. However, we saw evidence of families and carers being supported to attend the ward to visit and attend care review when the patients had consented for staff to do so. Evidence provided by the trust showed that families and carers were regularly invited to attend wards rounds and the trust had on one occasion, arranged transport for a family member to attend a care review.

Carers told us they had not been given any information on how to receive a carer’s assessment. There was a form to prompt staff in ward rounds around the need for a carer’s assessment. The Trust had recognised that there was further development, with regards to communicating with carers about carers assessments.

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:

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

- The trust must ensure that staff receive regular breaks, in line with trust policy and national guidance, when they undertake continuous enhanced observations. (Regulation 12(1))
- The trust must ensure that staff have easy access to clinical information. (Regulation 17 (1)(2))
- The trust must ensure that staff respond effectively to patients, and manage escalating risk effectively, so that patients are safe and feel safe on the ward. (Regulation 12 (1) (2))

Action the trust Should take to improve:

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

- The trust should continue to ensure that, where appropriate, families and carers are suitably involved in their relatives' care and treatment.
- The trust should ensure that that patients feel listened to, heard and are treated with kindness.
- The trust should ensure that planned family visits to the ward are not unduly delayed and that any unpreventable delays are effectively communicated to those concerned in a timely manner.
- The trust should ensure that the temperature on the ward can be easily regulated, so patients and staff can be comfortable.

Our inspection team

The team that inspected the service comprised a lead inspector who was based remotely, one other inspector, an inspection manager, an assistant inspector and two experts by experience. The inspection team was overseen by a Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance