Birmingham Heartlands Hospital

Quality Report

Bordesley Green East
Birmingham
B9 5SS
Tel: 0121 424 2000
Website: www.uhb.nhs.uk

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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, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

Birmingham Heartlands Hospital was acquired by University Hospitals Birmingham NHS Foundation Trust on 1 April 2018.

The medical care service at the trust provides care and treatment for ten specialities across four sites; Queen Elizabeth Hospital Birmingham, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. The trust had 1,579 inpatient medical beds across the four sites, with 462 of these beds based at Birmingham Heartlands Hospital.

We carried out an unannounced focused inspection of ward 29 (elderly care) at Birmingham Heartlands Hospital on 23 July 2019, in response to concerning information we had received in relation to the care of patients in this ward.

We did not inspect any other core service or wards at this hospital or any other locations provided by University Hospitals Birmingham NHS Trust. During this inspection we inspected using our focused inspection methodology. We did not cover all key questions or key lines of enquiry and we did not rate this service at this inspection. We inspected elements of safe, caring and well-led.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During this inspection we;

- Spoke with seven patients who were using the service and eight relatives.
- Spoke with 12 members of staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers.
- Reviewed 10 complete medical and nursing care records relating to physical health.
- Reviewed five additional patient records relating to observations and sepsis screening pathways.

Our key findings were as follows;

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had robust systems in place to ensure the safety of patients. this included risk assessments and monitoring of clinical outcomes.
- Staff kept appropriate records of patients' care and treatment.
- The service prescribed, gave, recorded and stored medicines well.
- Staff cared for patients with compassion.
- Staff provided emotional support for patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the service promoted a positive culture that supported and valued staff.
- The service was committed to improving services by learning from when things went well and when they went wrong.

Heidi Smoult
Deputy Chief Inspector of Hospitals (Midlands Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)		We carried out an unannounced focused inspection of ward 29 (elderly care) at Birmingham Heartlands Hospital on 23 July 2019, in response to concerning information we had received in relation to care of patients in this ward. We did not inspect any other core service or wards at this hospital or any other locations provided by University Hospitals Birmingham NHS Trust. We did not cover all key questions or key lines of enquiry and we did not rate this service at this inspection. We inspected elements of safe, caring and well-led.

Summary of findings

Contents

Birmingham Heartlands Hospital

Services we looked at
Medical care (including older people's care)

Summary of this inspection

Background to Birmingham Heartlands Hospital

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Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We previously inspected Medicine at Heartlands Hospital in October 2018 it was rated as requires improvement at that time.

Our inspection team

The team that inspected the ward was led by a CQC inspection manager, two CQC inspectors, and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Birmingham Heartlands Hospital

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During the inspection we visited ward 29 a medical ward as a result of concerning information we had received in relation to the care of patients on this ward.

The ward had 28 beds including four cubicles.

We spoke with 12 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with seven patients and eight relatives. During our inspection, we reviewed 15 sets of patient records.

Medical care (including older people's care)

Safe	
Caring	
Well-led	

Are medical care (including older people's care) safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received mandatory training and kept up-to-date with it. We were provided with June 2019 data which identified 97% of nursing staff on Ward 29 were compliant with mandatory training against a trust target of 90 %.

Mandatory training was comprehensive and met the needs of patients and staff. The training included; resuscitation awareness, inclusion & diversity level 1, manual handling theory, health, safety & welfare, fire safety, infection prevention & control level 1, safeguarding children and adults' level 1, information governance and Prevent.

Clinical staff were in the process of completing training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Ward 29 had so far trained 50% (14) of staff in the care of patients living with dementia. This was in line with the trusts planned trajectory.

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

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.

Concerning information received by CQC before this inspection suggested staff on ward 29 did not always protect patients from abuse, neglect, harassment and breaches of their dignity and respect. We did not find evidence to support this during our inspection.

We found, safety and safeguarding systems, processes and practices had been developed, implemented and communicated to staff.

In January 2019, the fourth edition of the intercollegiate document, 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' was published by the Royal College of Nursing. This document stated that all medical and nursing staff should have, as a minimum, level two child protection training.

Nursing staff on ward 29 received training specific for their role on how to recognise and report abuse. We were provided with training data for June 2019. Safeguarding level 2 children and adults training was recorded at 100%. Safeguarding mental capacity act and depravation of liberty safeguard (DOLS) training was also at 100%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The trust had introduced the 'See Me: Learning disabilities Care Bundle', so that wherever staff were working, they could develop the skills to care for people with learning disabilities and their carers. The staff had access to a range of resources. This included encouraging staff to "Talk and Listen to Me", "Enable Me to Eat and Drink" and "Help Me to be Safe and Mobile". A care bundle is a set of three to five evidence based practices or interventions supported by research, that when used together cause significant improvement in patient outcomes.

All staff on ward 29 had been allocated a training session specific to the care of patients living with dementia. We saw these sessions on the staff rota. Fourteen staff had already attended and two staff were planned to be ward champions. They had attended a four day event to equip them to support other team members.

We spoke with six members of staff who all demonstrated an awareness of what constituted a safeguarding alert or

concern and how to refer to the trust safeguarding team and the local authority. Records we reviewed identified safeguarding concerns were escalated and managed in line with trust policy

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. From October 2018 to 24 July 2019 there were 16 incidents raised with a safeguarding flag on the reporting system. Of these 11 met the safeguarding threshold. The two most common themes were concerns regarding abuse by family members/neighbours and allegations against staff members. However, of the four relating to staff two were the concerns raised by CQC prior to the inspection. All incidents were investigated as per the trust policy and included police involvement and suspension of staff where necessary.

All staff we spoke to were aware of their responsibilities within safeguarding. They knew who the safeguarding lead was for children and adults. There were also posters displayed in staff areas with the contact details of the safeguarding lead.. Staff told us they would approach the safeguarding leads should they need advice or need to refer a safeguarding concern to the local authority.

Safeguarding policies and procedures were available to all staff through the provider's intranet.

Consent to care and treatment we witnessed during this inspection was always sought in line with legislation and guidance. Documentation in medical and nursing notes identified where patients' capacity had been considered before seeking consent. We reviewed two sets of notes identified to us as patients deprived of their liberty. All documentation was completed, and legal authority was sought and documented. Registered mental health nurses were identified to support these patients with ongoing mental health needs.

Policies and procedures were in place for extra observation or supervision, restraint and, if needed, rapid tranquilisation. There were enhanced observations/ enhanced care guidelines on ward 29. We were informed a lead nurse for quality was leading on a piece of work that aligned the enhanced observation/ care procedure across the organisation. The plan was to have a procedure in place which sat under the safeguarding umbrella. An enhanced care task and finish group was already planned, to explore with the divisions what the procedure should look like and how this could be supported in practice.

We were provided with evidence of a new adult restraint policy which was presented to the trust policy review group on Friday 26 July 2019. A procedure had also been drafted and a training needs analysis had been undertaken to identify the areas that required the most training in relation to restraint, and how that training should look. It was expected that this training would start in September 2019.

All staff on ward 29 were subject to enhanced disclosure and barring service checks prior to employment with the trust.

Assessing and responding to patient risk.

Concerning information received by CQC before this inspection suggested staff on ward 29 did not always act upon risks to patients or appropriately update patient care records.

We found staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

A National Early Warning System (NEWS) was used for patients to assist staff in the early recognition of a deteriorating patient. NEWS was a guide used by medical services to quickly determine the degree of illness of a patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating. We saw NEWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way.

During our inspection we reviewed 10 patient observation charts. Nursing staff adhered to trust guidelines for the completion and escalation of patients who had a raised NEWS score. All charts reviewed had full observations recorded which included blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output. Pain scores were recorded on all charts we reviewed. The NEWS chart had been completed correctly at each time of recording the patient's observations. If patients required

fluid balance charts, all of these were up to date and accurately calculated. Patients scoring four or above on their NEWS were required to have further set of observations recorded within a set timescale for example from four hourly to one hourly. Of the 10 charts reviewed, all patients had observations performed in line with the trust 'escalation of NEWS monitoring in adult patients' with the exception of one patient who was not for escalation. Ward matrix information provided by the trust showed ward 29 escalated patients when they had a NEWS score of four or above.

Staff had received sepsis awareness training when the sepsis proforma was originally rolled out in 2018, staff told us they were currently receiving updates on this training. We were able to see this on the staff roster system. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevented prolonged treatment and had been shown to be associated with significant mortality reductions when applied within the first hour. Staff knowledge of sepsis and the sepsis pathway was consistent on ward 29. Senior nursing staff told us they were confident all nursing staff were aware of the requirement for escalating heightened NEWS scores.

We reviewed five sets of notes and observations specifically for patients with possible sepsis. We saw all five patients had a sepsis proforma completed and where necessary the sepsis six bundle had been fully implemented within the required timeframe. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality (death) of patients with sepsis. It consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis for example administering oxygen and intravenous (IV) antibiotics . Ward matrix information included one element which all wards were assessed against were 'septic patients being assessed and discussed within 30 minutes', of the notes we reviewed all five met this target.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools.

Staff took the time to identify and respond to the changing risks of patients. For example, the adult inpatient care risk assessment booklet included a tissue viability assessment and pathway. Patients assessed as at risk had a pressure-relieving mattress ordered on the day of admission. This ensured that patients at risk of possible skin damage were identified early and risks could potentially be reduced. The admission booklet also contained a falls risk assessment that included, for example, patient history, footwear and eyesight assessments. This ensured all factors that could contribute to a patient's risk of falls were reviewed.

We reviewed 10 sets of nursing notes which contained the risk assessments document. Within this document, there were risk assessments for falls, manual handling, skin integrity, malnutrition, continence, mental health, pain and bed rails. All risk assessments had been completed within 24 hours of admission and most had evidence of on-going assessment of the patient, with the exception of four where additional on-going assessment was not completed. However, we reviewed actual patient care for these four patients and all care was up to date and timely.

At our 2018 inspection, falls risk had been an area of on-going risk identified in a number of ward areas as well as ward 29. Patients deemed at risk of falls were mainly managed by allocating them a bed which was highly visible to staff members (near the nurse's station). A member of staff was allocated to remain in the location where the vulnerable patient(s) were admitted, or the patient was placed on a special bed which went all the way down to the floor. Allocation of a member of staff to each bay for monitoring had significantly reduced falls on ward 29 in the three months preceding our inspection. There were nine reported in May seven in June and two in July. All falls were documented in medical and nursing notes using a post falls check sticker. We saw these in medical notes fully completed with post falls care plans in place and all observations also completed.

Venous thromboembolism (VTE) assessments were completed on admission to the hospital in the emergency department and were also assessed on admission to ward 29 in line with National Institute for Health and Care Excellence (NICE) guidelines. We looked at 10 sets of records and found them all to have completed VTE assessments. A venous thromboembolism is a blood clot that starts in a vein.

The hospital used nationally recognised risk assessments, such as the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify patients, who

are malnourished, at risk of malnutrition or obese. We observed that patients identified at risk had a care plan in place and were monitored more frequently by staff to reduce the risk of harm. On review of the 10 records all had received MUST, falls and pressure ulcer assessments.

We saw all patients had their skin integrity assessed within six hours of admission as suggested by the NICE Quality Statement and Quality QS89 Statement 1. Patient's pressure areas were also assessed on admission to the ward. Pressure ulcers affect an area of skin and underlying tissue and are categorised according to severity from one to four. For example, category one identifies the discolouration of skin, with category four being full thickness skin loss with underlying damage to muscle, bone or tendons. All pressure ulcers reported by the service as a serious incident were category two, which denotes partial thickness skin loss with a superficial ulcer without bruising.

Patient notes confirmed that referrals were made to a tissue viability nurse for assessment and advice when necessary.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). We saw posters in all departments about how to contact the liaison psychiatry team

Any patient admitted for self-harm or overdose had an automatic referral to the Rapid Assessment Interface and Discharge (RAID) team. Staff we spoke with told us that if they were concerned about a patient's mental health or wellbeing then any staff member could contact the RAID team for advice. All staff told us the RAID team responded quickly and ward staff spoke highly of them.

Staff shared key information to keep patients safe when handing over their care to others.

We reviewed 10 sets of medical care records. Where patients were admitted as an emergency, they had been seen and assessed by a consultant within 12 hours of admission and assessed by a member of the medical team within 30 minutes. This was in line with national guidance.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Ward 29 leaders used nationally recognised tools for setting and reviewing the establishment for staffing. The ward displayed the planned and actual staffing information for the day and we found this to be true representations of staffing during the shift.

The ward manager was responsible for forwarding staffing vacancies on a shift basis to the divisional lead. If there were staffing shortages on the shift, the divisional lead was responsible for escalating and managing this. We witnessed this during our inspection.

Staffing on ward 29 was reviewed in order to keep patients safe. Due to a lack of registered nurses applying for posts the ward had increased its establishment of healthcare assistants to monitor and provide care for highly dependent patients and patients at risk of falls. There were eight registered nurse vacancies during this focused inspection. However, the ward manager and matron were regularly attending engagement and recruitment days to encourage staff to join the team. The staff vacancies did not appear to impact on the patient care being provided, although staff were busy, patients were receiving care and treatment in a timely, safe and dignified manner.

Hospital bank staff were also used to fill any vacant posts on shifts. We spoke with three staff on ward 29 that were working on the bank and liked to work on ward 29 as they felt part of the team. This regular use of the same bank staff ensured consistency of staff members who knew the ward and also ensured the ward got the right skills they required to enhance the staffing for the shift.

Without exception all patients and relatives we spoke with were "extremely" happy with the care, but all identified the ward was "short staffed".

Arrangements for handovers and shift changes ensured that patients were protected from avoidable harm. On

ward 29 we observed a multidisciplinary meeting (MDT) where all overnight admissions were reviewed first by a consultant, before the remainder of patients. A comprehensive medical review of each patient took place and included appropriate escalation of those patients who were at risk of clinically deteriorating, sepsis and a review of diagnostic tests

Ward 29 also had a twice daily handover review during the day shift. The afternoon handover was a short meeting of the nursing team to discuss new information and each patient's care. The evening handover was conducted at the entrance to each bay or room in order that the staff could witness how the patient looked at handover. This would ensure that any deterioration would be apparent. Confidential information was not disclosed at this point.

We reviewed the medical records of patients who had complex needs and found evidence of MDT working and coordinated care. For example, we saw where different healthcare professionals and external agencies, such as the local authority, had been involved in planning and implementing an appropriate care pathway.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

The trust had implemented an electronic prescribing and medicines administration (ePMA) system across all inpatient clinical areas. This system was used to support and improve medicine safety. We saw that the routes of administration of medicines given to a patient were recorded on the electronic medicine charts. Nursing staff told us that since they had moved to the electronic system, it was a much clearer process to administer medications. This was due to not having numerous medication charts to look through, the dose, time and route were clearly marked, and the system would not allow the nurse to see the medications that were not yet to be given, reducing the risk of medication errors.

We reviewed electronic medication charts for five patients and found them to be complete, up to date, and reviewed on a regular basis. The electronic prescribing system directed prescribers with correct prescribing of all medicines.

Patient's weight and any allergies were also recorded. Records showed patients were getting their medicines when they needed them. We observed nurses administering medicines, checking doses and names. Nurses wore red aprons to indicate they were carrying out medicine rounds and should not be disturbed.

Staff followed current national practice to check patients had the correct medicines.

Staff knew about the five rights of medicines administration. One of the recommendations to reduce medicine errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time. (Institute for Healthcare Improvement 2007). We witnessed patients being assisted with medication where necessary.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Ward 29 was visited by a pharmacy technician daily and usually a pharmacist. If there were concerns outside of the usual visit time, staff could be bleeped. We saw evidence documented in medical notes of a pharmacist reviewing patients' medication and ensuring any changes were explained to patients and relatives to ensure patient safety.

Medicines were stored safely behind locked doors or in restricted areas, which were only accessible to authorised staff. Separate cupboards for the storage of controlled medicines were clearly marked to ensure safety. All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.

Controlled medicines are medicines controlled under the Misuse of Drugs regulations 2001. These legal controls govern how controlled medicines should be stored, produced, supplied and prescribed. Quarterly audits of controlled medicines took place at the trust and information for each ward was communicated to the ward leaders. We reviewed controlled medicines records on ward 29, medicines were stored appropriately, and records were accurately completed.

Medical care (including older people's care)

Disposal arrangements were in place for out of date medicines, or medicines, which were no longer required. Medicines were disposed of in grey medicine disposal bins or returned to pharmacy.

Intravenous fluids were stored in a locked store rooms on ward 29. This reduced the risk that intravenous fluids could be tampered with or accessed by unauthorised people.

Medicines requiring refrigerated storage were stored at the correct temperatures to ensure they were fit for use. Fridge temperatures were recorded, including current lowest, highest and actual. Staff we spoke with on the ward were aware of action to take should the temperature exceed recommended levels.

We found oxygen cylinders were stored securely near the arrest trolley, in a well ventilated area. This was in line with the Health and Safety Executive (HSE) guidance.

The service had systems to ensure staff knew about medicine safety alerts and incidents, so patients received their medicines safely.

Staff knew how to report a medicine incident following trust policy. Any known allergies or sensitivities to medicines were recorded on the electronic medicine charts. This information is important to prevent the potential of a medicine being given in error and causing harm.

Medicine errors, including those resulting in harm, were reported as part of the incident reporting process. Medicines incidents were reported on a monthly basis to the medicine safety group. There had been nine reported medicine errors on ward 29 from January 2019 to July 2019.

The top two incidents were omitted medicine and wrong drug/dose prescribed.

Staff were able to discuss incidents where errors had occurred and described the actions taken to help prevent a similar error.

Are medical care (including older people's care) caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Concerning information received by CQC before this inspection suggested patients on ward 29 were not treated in a respectful and considerate way and were not treated with dignity, kindness and compassion. In addition, concerns were raised about ward staff demonstrating disrespectful, discriminatory and abusive behaviours towards patients.

During this inspection we found, all staff on ward 29 treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed good care and staff interacting with patients and relatives. Staff introduced themselves to patients when changing shifts. We saw that staff engaged and interacted with patients and relatives in a kind and respectful manner and saw that patients and people close to them had given positive feedback shown on ward notice boards and cards displayed on the ward. We witnessed one nurse encouraging her patients to move even if they were in bed by encouraging an instructional dance. This was very well received by patients and visitors. One said, “it made my day”.

Staff were observed by us to be discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way .

To gain a better understanding of patient experience we spoke with some patients and their relatives who told us staff were caring and compassionate towards them.

Patients said staff treated them well and with kindness. Relatives told us “my mum is much safer here”, they always pull the curtains round, I feel they respect her privacy”, “staff are good -some are committed to excellence on this ward”. One particular relative felt that ward 29 summed up all that was good in the NHS,” if you want to see if the NHS works come to this place I can’t fault it”.

Medical and nursing staff we spoke with demonstrated an understanding of patient care needs.

Medical care (including older people's care)

We observed doctors on the wards sitting down to talk with patients so that they were on an equal level. Patients said this made them more at ease and did not feel doctors were "looking down on them."

Staff followed policy to keep patients care and treatment confidential.

The Patient-Led Assessments of the Care Environment (PLACE) results from 2018 showed the inpatient wards achieved 73% for their privacy and dignity assessment which was below the England average of 84%. The trust provided us with an update on the changes and improvements that had been made as a result of these figures.

We observed staff using curtains around bed spaces to respect privacy and dignity of patients and using a separate room to discuss any concerns or worries.

We saw patients were provided with 'lounge suits' when they did not have access to their own clothes in order that they didn't have to sit in night clothes all day. This was part of an initiative within the trust called 'Eat, Drink, Dress, Move'. Patients are encouraged to eat well, keep hydrated, get dressed in day clothing and footwear, get up and about and be as independent, self-caring and as active as possible.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. All staff displayed compassion and understanding when discussing patients who had a cognitive impairment. They were respectful and empathic in their attitudes and actions.

Staff demonstrated to us they understood and respected the personal, cultural, social and religious needs of their patients and how they may relate to care needs. Patients we spoke with were grateful to staff in supporting them with prayer times and meal choices.

The hospital had a multi-faith and inter-denominational chaplaincy department who were available to provide emotional and spiritual support to patients who required this. Members of the Christian and Muslim faiths were available through an on-call system 24 hours a day, however additional faith leaders could be accessed if required (Jewish, Sikh, Hindu and Buddhist religions).

Patients' spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care across the services and ensured that the delivery of spiritual, pastoral and religious care was adequate and appropriate. The chaplaincy liaised with communities to ensure they accommodated patients of other faiths where required.

Emotional Support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff told us they actively encouraged relatives to visit at all times of the day as there was opening visiting, especially when they knew patients required additional emotional support. We observed one member of staff who was discussing treatment options with a patient offer to call in a patient's family to be with them whilst they discussed this important information. One patient told us they felt "much more supported on ward 29 than they had on another ward they had been on".

We observed staff supporting patients who became distressed in an open environment and helped them maintain their privacy and dignity. We witnessed staff using curtains and closing doors to ensure patients were supported when they were distressed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were given information about relevant counselling services and peer support groups where applicable.

Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "staff are really helpful, and I can ask them anything." Patients also said that staff were approachable and provided moral support when required.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

During our inspection we spoke with seven patients and eight relatives about whether they felt involved and understood about their care. They mostly told us they felt very involved with their care and treatment choices and had a good understanding of their condition and the treatment plan devised for them by their medical team.

Patients told us that staff communicated with them in a way, which they could understand, explaining their care, treatment and condition. Staff communicated with patients in a way that was appropriate. We observed staff asking patients what they would like to be called and introduced themselves and their role. We observed staff involving patients and their relatives during assessments and when taking observations on the ward. If the patient's relative had any questions, staff were able to discuss these at the time.

We saw medical staff taking the time to involve patients during their care and encouraging them to ask questions should they have any. We saw evidence in patient's notes of staff having conversations with patients' family members and keeping them involved in patient care. Patients we spoke with mostly told us doctors and nurses informed them of their care and treatment and plans regarding transfer and discharge. We saw therapists supporting and involving patients with their therapy.

We observed staff involving the patient and their family/ carers in discharge planning to ensure the patient was discharged in a safe and dignified manner. This included arranging times with the carer, so they would be available to meet them at their discharge destination, and bringing in appropriate clothing for the patient to be discharged home in.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

We saw all staff taking time to clarify patients' understanding of their care and treatment. In one observation, we saw a member of the medical staff discussing the patient's diagnosis with them in a kind and respectful way, but also in a way which was not rushed and gave the patient the opportunity to ask questions. In another observation, we saw staff members discussing with a patient and their relatives about the progress they had made in their recovery from an illness. Again, this was done in a way which was appropriate to the patient's level of understanding (although at the same time, not patronising) and gave both the patient and their relatives the opportunity to clarify anything they had not understood and ask further questions about anything.

We also observed medical and nursing staff arranging times with patients and their relatives for an ideal opportunity to discuss the treatment and care plan in place for the patient and the plan going forward, this ensured they would be able to have a meaningful discussion which would involve all those involved in the patient's holistic plan pf care. This was also supported by comments made by the patients we spoke with. If patients had not understood fully what was going on with their care and treatment, most patients and their relatives were confident to ask staff questions.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. We saw thank you cards, and gifts received by the staff in response to the kindness they had shown.

Are medical care (including older people's care) well-led?

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Ward 29 was part of the acute medicine directorate and was led by a clinical service unit lead, senior operations manager, matron and a governance and audit lead. The day to day management of the ward was led by the ward manager and the matron.

Medical care (including older people's care)

Concerning information received by CQC before this inspection suggested ward 29 leaders did not have integrity and were often displaying and allowing staff to display behaviours not aligned to the trust's values and behaviours.

We found, ward leaders had the necessary skills and knowledge required to lead the service effectively. They understood the challenges to quality and sustainability such as financial pressures and bed capacity.

The ward manager and matron were committed to nurturing and developing the team on ward 29. They were involved in ensuring that, on a day to day basis, there was a safe and effective approach to clinical staffing and patient flow. All staff were encouraged to develop and learn new skills including specialised training in caring for patients living with dementia and learning disabilities.

We met with the ward manager, matron and registered nurses during the inspection and found they were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward's performance against the trust priorities and the areas for improvement.

We saw the matron was visible on the ward and staff were happy that access to the matron had improved since the matron's office had been co-located to the ward area. The ward manager said they were supported by the matron and medical divisional leads. Staff knew how to contact the medical and nursing lead for their area. Staff told us that ward manager and matron were approachable and supportive and offered advice and training. However, staff also told us that there had been some instability on the ward earlier in the year due to "senior staff changes but that things were settling down now".

Prior to our inspection the trust's senior leadership team had been highly responsive when contacted about the concerns that had been raised with CQC in relation to ward 29. For example, the ward had been included in the trust's quality improvement programme '8 wards in 8 months', staff focus groups had been held with the executive chief nurse and freedom to speak up guardian, ward visits had been undertaken by the trust governors and safeguarding team and 'safety huddles' had been introduced.

Staff meetings were held regularly to ensure staff were kept up-to-date with information about their department and the service. There were various methods of communication across the teams, including meetings, newsletters, notice boards and e-mail. Areas covered included; patient safety, staffing and staff vacancies and ward performance.

Staff on ward 29 had established a secure, restricted-access social media communication group to enable them to stay up to date with changes and new policies. This meant staff could stay up to date even if they could not attend staff meetings.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The staff on Ward 29 reported a good culture. Staff felt supported by their colleagues and matron. They told us they were proud to work within the trust and on ward 29. Staff said their line manager looked after them well. We also observed positive and supportive interactions between the matron and the ward manager. The matron described having an open-door policy where any member of staff could see them privately. This was confirmed by staff we spoke with who felt they could address any concerns with the matron and manager.

Nurses told us the managers were particularly supportive of new ideas for improvement. Healthcare support workers and nurses felt listened to and most said they were confident to raise issues and concerns. New initiatives had been welcomed on ward 29 including changes being developed as a result of an improvement programme called "8 wards in 8 months", described as' a journey of transformation and rejuvenation of the speciality of older peoples nursing'. This initiative was led by the staff in order to engage and encourage them to develop their services with the support of the trust. Initiatives included a 'reminiscence trolley'. The trolley had books, old toys, old tins, sweet boxes, smells – oils & old soaps. The staff used the trolley with patients and learn stories about their early lives. The introduction of the 'lounge suits' was also part of the initiative.

In order to encourage staff to feel valued for their hard work the wards had also introduced '#you'vebeenmugged'. (A

mug full of chocolate and sweet treats as a thank you). Staff we spoke with told us this was having a very positive impact on staff morale. The winner was shared on the area social media page and staff congratulated and supported each other. Ward 29 staff also nominated their team member of the month, with the ward manager providing a prize for the winner.

The ward team were encouraged to engage in supportive therapy with the use of emotional touchpoints. ('A touchpoint is any moment where a user interacts in some way with the service' NHS Institute Innovation and Improvement, 2009). These can be used for patient experiences but in this instance were used to help staff understand their own feelings and concerns in relation to their work. Emotional touchpoints 'are the moments where the person recalls being touched emotionally (feelings) or cognitively (deep and lasting memories) touchpoints and emotion words (both positive and negative) can be used to help staff to talk about their experiences of giving care. Staff were seen weekly if they wanted to participate. Staff we spoke with that had used the service felt it helped them understand their own feelings and emotions in relation to the stresses of working on a busy ward.

The trust had an appointed 'Freedom to Speak Up Guardian'. All staff, both medical and nursing, were aware of the trust 'Freedom to Speak Up / Raising Concerns' (Whistleblowing) policy. Staff on ward 29 said they would feel confident about raising concerns and speaking with their manager if they had a problem or concern.

All the staff we spoke with talked about an open and transparent culture within the hospital. Quotes from staff included, "everyone is friendly" "we work well as a team and support each other." Staff also confirmed they enjoyed caring for their patients and we observed good interaction during the inspection.

Service leaders spoke highly of staff on the wards and how hard they had worked and adapted to the daily pressures.

We observed co-operative, supportive and appreciative relationships amongst staff on ward 29. The teams worked collaboratively and shared responsibility for patient care and safety. One staff member told us the "staffing pressures were difficult, but we all work as a team, so it never really feels that bad".

The trust had processes in place to ensure equality and diversity was promoted within and beyond the organisation. During our inspection, no staff members voiced concerns over the way in which they were treated from an equality and diversity perspective.

Outstanding practice and areas for improvement

Outstanding practice

- The service had developed the use of emotional touch points for staff to support wellbeing.
- The development of “8 wards in 8 months” a staff centred approach to enabling change.