Kent and Medway NHS and Social Care Partnership Trust

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

Inspection report

Trust Headquarters, Priority House
Hermitage Lane
Maidstone
ME16 9PH
Tel: 01622725000
www.kmpt.nhs.uk

Date of inspection visit: 10 & 11 May 2023
Date of publication: N/A (DRAFT)

Ratings

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

Our findings

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

Requires Improvement 

We carried out an unannounced focused inspection of the acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT), because we received information that gave us concerns about the safety of the service.

The trust provides assessment and treatment for adults of working age with mental health issues in nine acute wards and one PICU, based in three hospital sites across the trust. Littlebrook Hospital, based in Dartford, has four wards; Amberwood is a 17 bedded male-only acute ward, Pinewood is a 16 bedded female-only acute ward, Cherrywood is a 17 bedded female-only acute ward, Willow Suite is a 12 bedded male-only PICU. Priority House, based in Maidstone, has three wards; Boughton is an 18 bedded male-only acute ward, Chartwell is an 18 bedded male-only acute ward, Upnor is an 18 bedded female-only acute ward. St Martin's Hospital, based in Canterbury, has three wards; Bluebell is an 18 bedded male-only acute ward, Fern is an 18 bedded female-only acute ward, Foxglove is a 16 bedded female-only acute ward.

During this inspection we visited all three acute wards and the PICU at Littlebrook Hospital, Boughton and Upnor wards at Priority House, and Fern and Foxglove wards at St Martin's Hospital.

We inspected the key lines of enquiry relating to safe and well-led. Following this inspection, the ratings for safe and well-led went down. We rated safe as 'inadequate' and well-led as 'requires improvement'. This meant that the overall rating for the service also went down to 'requires improvement'. Previously, the service was rated 'good' overall and for the key questions of effective, responsive and well-led, and 'requires improvement' for the key question of safe.

Following this inspection, we served the trust with a Warning Notice, because we found that significant improvement was needed to ensure that all staff followed local and national recommendations to complete and record post dose vital sign monitoring, following the administration of rapid tranquilisation to patients. We were concerned that staff were not always aware of any potential impact these medications had to patients' health, meaning that patients were exposed to the risk of harm. The Warning Notice required the provider to make improvements to meet the legal requirements set out in the Health and Social Care Act by 22 June 2023.

Our key findings were:

- In all three hospitals we found that physical health checks following the administration of oral and intramuscular 'as required' medicines for rapid tranquilisation were not always happening and/or recorded.
- At St Martin's and Littlebrook Hospitals we found that some patients' care plans did not include guidance which informed staff how to support patients to manage their medical conditions.
- At St Martin's Hospital we found that medical staff did not always complete the relevant core assessment.
- At Priority House we found that 'as required' medication was frequently used, however, we did not always find records to explain why the administration of these medications was necessary. In some cases the records did not justify the use of these medicines.

Our findings

- At Littlebrook Hospital and Priority House we found that individual risk assessments and care plans were not always being reviewed and updated following incidents.
- At Littlebrook Hospital and Priority House we found inconsistencies in how staff implemented actions from environmental risk assessments and audited ligature risks.
- Many staff were unable to access the online incident reporting system that the trust had recently introduced.
- At St Martin's Hospital we found that patients had limited access to showers on the wards.
- At St Martin's Hospital we found gaps in the staffing rotas on Fern ward with many unfilled shifts on the rota.
- In all three hospitals we found issues with restrictive practices. There were inconsistencies in how staff recorded and reviewed blanket restrictions.
- Governance arrangements were not always robust.

However,

- In all three hospitals, most patients told us that they felt safe, the wards were clean and staff treated them with kindness and respect.
- We received positive feedback from family members of patients at Littlebrook Hospital.
- We noted some positive interactions and caring support from staff at Fern ward, St Martin's Hospital, and Boughton ward, Priority House. We also found that staff at Cherrywood Ward, Littlebrook Hospital, understood patients' needs well.

How we carried out the inspection

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

- visited eight wards at three hospital sites and looked at the quality of the ward environment
- spoke with 35 members of staff, including senior managers, ward managers, doctors, members of the multidisciplinary team, nurses and health care assistants
- spoke with 28 patients who were using the service
- spoke with 4 family members
- looked at 35 care and treatment records of patients
- reviewed the medicines administration records and associated care records for 41 patients
- looked at a range of policies, procedures and other documents relating 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

What people who use the service say

Our findings

The patients we spoke with told us that they felt safe in all three hospitals, and that the wards were clean. Most of the patients told us that overall, there were enough staff on the wards, and felt that staff were trained to support them well. They also told us that they regularly saw doctors and had their medications promptly when needed. However, some patients at St Martin's Hospital felt that staff spent a lot of time in the office.

Most of the patients told us that staff were polite, kind and respectful.

Most of the patients told us that they had not been restrained while on the wards. However, some raised concerns about the restrictive practices in place. For example, a patient at Boughton ward, Priority House, told us that the garden was hardly ever open.

We received positive feedback from family members of patients at Littlebrook Hospital.

Is the service safe?

Inadequate 

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

Safe and clean care environments

All wards were clean, well equipped, and fit for purpose. However, they were not always well maintained.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas, knew about any potential ligature anchor points and mitigated the risks to keep patients safe. However, we found inconsistencies in how staff implemented actions from these risk assessments and audited ligature risks. For example, at Littlebrook Hospital and Priority House we found that some audits and checklists were not always completed, despite them being identified as control measures on the environmental risk assessments. In some wards we found action plans in place, however they did not always include information about whether actions had been completed. We were not assured that managers had good oversight of this. A manager at Littlebrook Hospital told us that they were solely relying on staff to inform them whether any repairs had actually been completed. This meant that we were not assured that any potential environmental risks were always appropriately identified and managed. Following the inspection, the trust submitted additional information to provide assurance that staff appropriately completed and updated environmental risk assessments. The information submitted included a progress paper produced following the inspection, with updates on the work that had been underway since the risk assessments were completed in November 2022, and any further action that had been agreed.

Staff could observe patients in all parts of the wards. We saw that any blind spots were mitigated by mirrors. There were completed records confirming that patient observations were happening as prescribed.

Our findings

The wards complied with guidance and there was no mixed-sex accommodation. Patients had the ability to lock and unlock their own bedrooms, and had lockers available in separate locked rooms, where they could store valuable or personal belongings.

Staff had easy access to alarms and patients had easy access to nurse call systems.

During the inspection we were not assured that all managers had good knowledge and understanding of the fire safety procedures for their wards. For example, managers were not always able to explain whether any fire drills were taking place, or where to locate fire evacuation procedures. However, following the inspection, the trust submitted information around fire safety, which included comprehensive fire evacuation strategies for each ward.

Maintenance, cleanliness and infection control

Ward areas were clean, well-furnished and fit for purpose. However, the service had not fully addressed the maintenance issues we identified at St Martin's Hospital following our inspection in November 2021. During this inspection, we found that patients still had poor access to showers. On Fern ward there were four showers, however, only two could be used for 18 patients. On Foxglove ward two bathrooms were flooding. The trust told us that all four showers on Fern ward had been refurbished as part of a recent ward refurbishment, however, there were still occasional issues with flooding which were being explored as and when these arose. We were also informed that the trust was undertaking additional works to minimise the impact of this, and that the estates team had been liaising with the wards and clinical risk teams to find appropriate solutions.

Some managers told us that sometimes they had to wait for a long time for maintenance works to be completed and found this frustrating.

Staff made sure cleaning records were up-to-date and the premises were clean. All premises we visited were clean and tidy. We saw that housekeeping staff were employed on all the wards. Each ward had a board with up to date information around cleaning audits and schedules.

Staff followed the trust's infection control policy, including handwashing.

Seclusion room

We observed the seclusion rooms at Priority House and Littlebrook Hospital. The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

Clinic room and equipment

Staff had access to emergency equipment. However, they were not always checked regularly. The medical equipment on Willow Suite, Littlebrook Hospital (blood pressure machine, vital signs monitor, weighing scales, electrocardiogram (ECG) machine, defibrillator, and suction machine), were overdue for servicing. For example, the ECG machine was due for a service on 11 October 2022, however, this had not happened. This was highlighted during the inspection and staff replaced the defibrillator immediately. Staff told us that they would take steps to ensure that all the medical equipment was suitable for use.

Our findings

Medicines and oxygen cylinders were stored safely and securely. Access to medicines storage areas was appropriately restricted. These areas were clean and equipped with handwashing facilities. Staff had access to appropriate medicines disposal facilities.

Safe staffing

Most of the wards had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Most of the wards had enough nursing and support staff to keep patients safe. Overall, the service had 103.97 whole time equivalent (WTE) registered nurse posts and 127.65 WTE healthcare assistant posts. There were 27.65 WTE registered nurse vacancies, and 28.57 WTE healthcare assistant vacancies. Ward managers told us about their recruitment plans and explained that they could adjust staffing levels according to the needs of the patients. Managers limited their use of bank and agency staff, when possible, and requested staff familiar with the service. However, at St Martin's Hospital we found gaps in the staffing of Fern ward. When acuity on the ward was high, it was difficult for managers to access additional staff to cover. We also found that staff were often moved from Fern ward to assist in other wards.

The trust informed us that the unfilled shifts included all additional shifts requested over the roster establishment to cover things like patient observations. They also explained that the unfilled shifts reflected the establishment gaps on the rota and would not include other staff available to the wards, such as allied health professionals, physical health nurses and trainee posts.

During our inspection patients told us that they rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We saw completed local induction forms and competencies, such as observation and engagement of patients.

The service had low turnover rates over the previous six months. There was an average turnover rate of 9.1% across the acute wards and psychiatric intensive care unit. The trust informed us that the service had been launching various initiatives to improve staff retention. For example, the service was planning to offer Trainee Nursing Associate and Registered Nurse Degree Apprenticeship opportunities.

Levels of sickness were low over the previous six months. Overall, the average level of sickness across for the service was 3.4%. Managers supported staff who needed time off for ill health.

The service had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough medical cover and a doctor available to go to the ward quickly in an emergency. However, we found that on Fern ward, St Martin's Hospital, there was a gap in covering for a consultant who was away for four weeks. A manager at Priority House told us that sometimes it was difficult to ensure consultant cover.

Our findings

Managers could call locum consultants when they needed additional medical cover. Overall, there were two locum agency consultants and the service was trying to recruit for these posts. There were two whole time equivalent speciality doctor post vacancies, however, the service was planning for these roles to be carried out by higher specialist trainees.

The trust informed us that where there were long term medical vacancies, these posts had been converted to advanced clinical practitioner, or physician associate roles, to support the senior medical practitioners on the wards.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff had completed and kept up to date with their mandatory training. All areas of mandatory training had a 90% target for compliance. For five out of the eight wards we visited, the compliance percentage ranged between 83.2 to 89.3%, however, this was either because the service had recently introduced new training, or the audience for some training courses had been amended.

In addition, the trust had introduced some bespoke supplementary training/learning, such as Preventing Patient Abuse, Sexual Safety Awareness and Safer Wards Culture, delivered by the trust's safeguarding team in response to concerns about ward culture and sexual safety. Managers across the service attended this training/learning to raise their awareness and support them to then hold relevant conversations with staff.

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

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well and follow best practice in anticipating, de-escalating and managing challenging behaviour. We were not assured that the provider had in place, or staff participated in a restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. However, at Littlebrook Hospital and Priority House we reviewed 25 patient records and found that individual risk assessments and care plans were not always being reviewed and updated following incidents. This meant that patient risk was not always assessed and managed appropriately. For example, a patient at Littlebrook Hospital was identified as demonstrating anti-social behaviour and being at risk from others, and the patient was involved in an altercation with another patient. However, the relevant care plan and risk assessment had not been updated to reflect these risks.

At St Martin's Hospital we reviewed 10 patient records and in four of them we found that whilst medical staff were clerking patients in, they did not always complete the core assessment. We found relevant notes, however, the medical sections of the core assessment were not always completed. We were not assured that any risks related to patients' physical health were always fully considered, or assessed during admission.

Management of patient risk

Our findings

Staff did not always know about the risks to each patient, or act to prevent or reduce risks. For example, at St Martin's and Littlebrook Hospitals we found that three care plans did not include guidance to inform staff how to support patients to manage their diabetes. Following the inspection the trust sent us assurances that relevant guidance had been added to a patient's care plan at Littlebrook.

We also found that positive behaviour support plans were not always completed for those who needed them. In some cases these were written as part of the main care plan, rather than on the appropriate section on the electronic system, which had specific sections for identifying triggers and effective interventions. For example, a patient at Littlebrook Hospital had been identified as being verbally hostile to others and had made threats of violence. However, there was not a behaviour support plan in place, or any other relevant support plan.

Staff followed procedures to minimise risks where they could not easily observe patients across the wards, such as intermittent observations and enhanced observations when required. We also saw that staff underwent a competency assessment in observations.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

In all three hospitals we found issues with restrictive practices. We found that blanket restrictions were used, such as access to drinking water, gardens and certain rooms on wards. For example, at Littlebrook Hospital and Priority House there were designated areas where patients could have access to hot and cold drinks, however, in most of the wards we found that there were no cups available to them and patients had to ask for cups.

There were inconsistencies in how staff recorded blanket restrictions. For example, we found that at Littlebrook Hospital staff did not always keep a record of the restrictions in place, whilst staff at Priority House kept relevant logs. Staff were unclear about whether the trust had an active reducing restrictive practice programme.

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. Most of the patients we spoke with told us that they had not been restrained. We observed some positive interactions between staff and a patient who was distressed on Boughton Ward, Priority House. However, on Fern ward, St Martin's Hospital, patients were more frequently restrained when acuity was high and some staff felt that this was because some patients were not always appropriately placed. For example, we saw that the number of patient restraints on Fern ward, St Martin's Hospital, had significantly reduced in May 2023 following some patients moving to psychiatric intensive care units.

Staff mostly kept records and followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long term segregation, or placed in seclusion.

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.

Our findings

Staff received training on how to recognise and report abuse, appropriate for their role, and kept up to date with their safeguarding training. All required safeguarding training completion levels met the trust's compliance target of 90%, except the Safeguarding Adults Level Three training, for which the compliance rate was 45%. However, the trust explained that for some training courses, including the Safeguarding Adults Level Three training, this was either because the service had recently introduced new training, or the audience had been amended.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers told us that they felt confident that all staff knew how to recognise and report abuse. We saw evidence that safeguarding referrals had been raised when necessary.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain clinical records, whether paper-based or electronic.

All staff could access patient notes easily. All notes were recorded on an electronic recording system.

Records were stored securely. The electronic system was password protected and used an identity card for access. Staff stored any paper records in a locked room when not being used.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service did not always use systems and processes to safely record and store medicines. Staff did not always use the least restrictive option to ensure that people's behaviour was not controlled by excessive or inappropriate use of medicines. However, staff regularly reviewed the effects of medications on each patient's mental and physical health, although this was not consistently recorded.

Staff followed systems and processes to prescribe and administer medicines safely. Staff used an electronic prescribing and medicines administration (EPMA) system. Doctors and pharmacists recorded clinical advice where relevant on prescription entries. Associated patient progress notes were also kept electronically.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Clinical pharmacists visited the wards regularly to ensure medicines use was optimised by providing expert advice to staff and patients. They contributed to multidisciplinary ward rounds where possible, and conducted medicines audits. Staff could access clinical pharmacy advice when needed, including out of hours via an on-call pharmacist. Pharmacy staff conducted drop-in clinics for patients and their carers, and proactively approached patients who would benefit from their input.

Our findings

Staff did not always complete medicines records accurately and keep them up to date. Staff used the EPMA system to record administration. When patients refused their medicines, this was also recorded. We did not see any missed doses on the medicines records that we reviewed as part of this inspection. The Mental Health Act 1983 (MHA) consent to treatment documents were available in areas where medicines were administered. However, on Cherrywood ward, Littlebrook Hospital, we saw three MHA consent to treatment forms that did not accurately reflect the medicines being administered. On Pinewood ward, Littlebrook Hospital, we saw one MHA consent to treatment form that did not accurately reflect the medicines being administered. Staff confirmed there was no Section 62 of the MHA forms completed. We highlighted this concern to staff during this inspection.

Medicines were dispensed by an external pharmacy contractor and delivered to the wards. If medicines were required out of hours, staff could access an emergency drugs cupboard with the authorisation of senior staff. If required, staff could also access medicines using appropriate prescriptions dispensed in the community. Medicines related documents were stored in clinical areas which were only accessible by relevant staff, or stored electronically in password protected systems.

Staff monitored the temperatures of medicines storage areas daily. However, staff did not always act if temperature readings were outside of the desired range. On Willow Suite, Littlebrook Hospital, when the maximum fridge temperature was too high, there was no evidence that this was highlighted to managers to take steps to safeguard medicines. We found that in April 2023, for example, the fridge temperature was too high four times. When there was an issue with the fridge on Cherrywood ward, Littlebrook Hospital, we found that staff took appropriate action to safeguard the medicines supplies.

Staff did not always conduct quality control checks to ensure that blood glucose testing kits were suitable for use. On Upnor ward, Priority House, the blood glucose testing kit had not been quality control checked since February 2023 and prior to that, the kit had not been checked regularly for accuracy. When the readings were outside of the desired range, staff did not always escalate this to managers. However, as quality control samples were sent to an external company monthly, there was assurance that the blood glucose machine was suitable for use.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Pharmacy staff completed medicines reconciliation (the process of ensuring that this list of medicines a person is taking is accurate) in a timely manner.

Staff learned from safety alerts and incidents to improve practice. The pharmacy department published newsletters to share information to improve practice.

We reviewed the medicines administration records and associated care records for 41 patients. Staff did not always use the least restrictive option to ensure that people's behaviour was not controlled by excessive or inappropriate use of medicines. The EPMA system prompted staff to review medicines prescribed to manage behaviour that staff find challenging, seven days after they had been started. Clinical pharmacists also prompted doctors to review the need for 'as required' medicines if they were not being used. However, when medicines for rapid tranquilisation were administered, staff did not always follow the trust guidelines relating to the documentation of post dose vital signs monitoring, or recording the administration of lorazepam by intramuscular injection as an incident. On Upnor ward, Priority House, we found that 'as required' medication, such as lorazepam and promethazine, were frequently used, however, we did not always find records to explain why the administration of these medications was necessary. We also saw examples where reviews had not happened for long periods. We could not be assured medicines to control people's behaviour were always being used appropriately.

Our findings

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence (NICE) guidance. Staff made attempts to monitor each patient's physical health daily. They made use of the National Early Warning Scores (NEWS2) tool to improve detection of and response to clinical deterioration. Staff took appropriate action to safeguard patients' safety and monitor the effects of their medicines on them in accordance with NICE guidance. For example, staff had a system in place to ensure that patients on lithium received regular blood tests. A specific form was used to record physical health checks of patients having high dose antipsychotic therapy.

Staff were also able to seek advice from specialist physical health nurses.

We saw evidence that staff offered patients' electrocardiogram readings on admission.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff did not always know what incidents to report and how to report them. For example, staff did not always record the administration of medication by intramuscular injection as an incident.

The trust had recently introduced a new online system for staff to report incidents, however, some staff told us that they did not have access to the system yet, and they had no training on how to use it. The trust confirmed that training sessions had been offered to staff since March 2023, however, not as many staff attended as expected. Most ward managers and matrons had attended the training, for them to then cascade to relevant staff, but this was an ongoing process. Some staff told us that the change of the online incident reporting systems had not been managed well.

Managers debriefed and supported staff after any serious incident. Most of the staff we spoke with said that there were debriefs following incidents.

Managers investigated incidents and told us that learning was discussed with staff during team meetings and individual supervisions. However, some staff at Littlebrook Hospital told us that learning from incidents was not always distributed to all staff. We reviewed a sample of sixteen recent team meetings minutes from all the wards we visited, and saw that learning from incidents was not consistently discussed during meetings. However, learning from incidents had been discussed during nine team meetings.

Managers told us that changes had been made as a result of learning from incidents. For example, following an incident where a patient used a ligature, staff reviewed how patient observations were conducted, and introduced additional environmental checks.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Our findings

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, were visible in the service, and approachable for patients and staff. Most of the staff we spoke with felt supported by their line managers. Some staff felt confident in local management despite morale being low in some cases, because of high patient acuity, or gaps in staffing.

Staff told us that they received regular supervisions and appraisals and felt that there was good team working. Most staff were aware of the freedom to speak up guardian, and were confident they could raise concerns without fear of retribution.

Some managers told us that they felt supported despite the recent management changes that affected the entire service, and a senior manager described being accessible to staff through an open leadership style. However, some senior managers told us that they were still waiting on induction training for the new roles and direction from the executive team. These were new roles so managers felt that receiving training and direction was essential.

Vision and strategy

Staff knew and understood the trust's vision and values and worked within them. There was a commitment from all staff to do a good job.

Some managers told us about how they were working alongside the values of the trust and emphasised certain areas, such as being transparent.

Some senior managers discussed their vision and strategy for their areas of responsibility. For example, a senior manager told us that they were aiming to provide quality care in a timely manner, and wanted to be pivotal in working to challenge issues around delayed transfers of care.

Culture

Staff felt respected, supported and valued. Some staff described the culture as friendly, positive and caring, and told us that the trust provided opportunities for development and career progression.

Despite some challenges, most of the staff we spoke with were positive and felt proud working for the trust and within their teams. A senior manager told us that the trust was very positive and welcoming, and there was an open and supportive culture.

Some managers discussed the work they wanted to do to further improve culture. For example, a senior manager told us that they wanted to contribute to a culture of staff feeling able to speak up about issues of bullying and harassment they sometimes experienced from families and patients, to improve staff retention and for staff to have greater job satisfaction.

Governance

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

Our findings

Governance processes and management oversight needed to be strengthened on areas such as, medicines management, assessment and management of risks, completion of audits, and incident reporting. For example, managers at Littlebrook Hospital told us they were completing audits to ensure that patient care plans were promptly reviewed and updated. However, our findings indicated that this was not always happening. Following the inspection, the trust submitted copies of care plans audits.

Some staff told us that some meetings and audits were not happening regularly, because of the management changes that had recently taken place across the service. For example, staff at Cherrywood ward, Littlebrook Hospital, reported during a team meeting that was held in May 2023, that they had not had a governance meeting for a while on the ward, and could not recall one being held in the last few months. No staff team meetings had taken place at Boughton ward, Priority House, since November 2022.

The impact these changes had on governance processes was also acknowledged by senior managers. One told us that they were still awaiting direction from the trust regarding governance structures.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect. For example, staff told us that they used to have incident thematic reports embedded within relevant meetings on Boughton ward, Priority House, but this had stopped because of the management restructure.

There were various clinical governance, quality and safety meetings held at service level. We saw meeting minutes from the clinical effectiveness and outcomes group, the quality and performance meetings, and the patient safety meetings. However, there were gaps due to the recent management restructure. For example, there were no patient safety meetings held in March and April 2023.

Managers were completing bi-monthly clinical quality checks at ward level. These checks were looking at compliance for various areas, such as, patient records, safeguarding, medication management, risk assessments, and therapeutic observations. However, we were not assured that these were completed regularly. We only saw an example of these checks for Littlebrook Hospital, and a report which included data from all the acute wards, completed in May 2023 following the inspection.

Medicine management audits were conducted by pharmacy and a report was shared bi-monthly. The trust informed us that a report was extracted by the performance team looking at National Early Warning Scores (NEWS2), and this was shared daily with matrons and ward managers for them to review and take action on as required. We reviewed the Medicines Management Report completed in February and March 2023, and saw that our inspection findings about monitoring of patients' physical health not being appropriately recorded following administration of rapid tranquilisation to patients, had already been highlighted as an issue for Willow Suite, Littlebrook Hospital, and Fern ward, St Martin's Hospital. However, as this had not been addressed at the time of the inspection, there are concerns about the effectiveness of this audit in prompting improvement.

Staff handover meetings were detailed and covered a range of information related to patients' care.

The trust had ward specific risk registers, which covered high risk areas and described mitigations to manage the risks.

Our findings

Managers told us that they would generate action plans to manage any risks, issues and performance. For example, a manager described the actions they had taken to address concerns about a staff member who did not appropriately complete patient observations. Also, a senior manager described how they would hold regular meetings with all stakeholders to work through an improvement plan that had been put in place to address some issues raised by staff.

There was a service improvement plan in place. This was developed following our last inspection in 2021 and it was monitored quarterly. The last update was in April 2023. This was then reported into the trust's Quality Committee to monitor progress.

Information management

Staff collected and analysed data about outcomes and performance. They had access to sufficient equipment and information technology to do their work. The secure record keeping system was easily available to staff to update patient care records and to review when needed. However, many staff told us that they were unable to access the new online platform to report incidents. A senior manager told us that they could not yet access the risk registers for their area of responsibility because of the recent switch of the online platforms. However, they were confident that ward managers could access them.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. At Priority House we observed a manager explaining to a patient how staff had liaised with a Local Authority about a particular issue.

Learning, continuous improvement and innovation

Some managers told us that because of the recent management restructure they had limited time in their role and were not aware of any engagement in any local or national quality improvement activities, while others referred to quality improvement projects that had happened in the past and had either stopped or were waiting to restart. However, the service was considering innovative ways to support staff to further develop. For example, to attract more medical interest, the service was considering setting up academic posts and working closely with local medical schools.

Staff were responding to patient needs to improve services. For example, a sensory room had been created at Littlebrook Hospital in response to feedback from patients. Staff had also secured some gym equipment and told us that they had introduced animal assisted therapy.

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 patients' physical health needs are appropriately assessed during admission, and care plans must always include guidance to inform staff how to support patients to manage medical conditions - Regulation 12(1)(2)(a).
- The trust must ensure that medicines to control people's behaviour are always used appropriately. When 'as required' medication is used the trust must ensure that there are records to explain why these medications were prescribed and administered - Regulation 12(1)(2)(g).
- The trust must ensure that action is taken to safeguard medicines supplies when temperature readings are outside of the desired range – Regulation 12(1)(2)(g).
- The trust must ensure that all emergency equipment are checked regularly – Regulation 12(1)(2)(e).
- The trust must ensure that all incidents and near misses are appropriately reported and recorded, and staff review and update risk assessments and care plans following incidents to include actions taken to mitigate risks - Regulation 12(1)(2)(a)(b).
- The trust must ensure that any maintenance issues are rectified in a timely way - Regulation 15(1)(2)
- The trust must ensure that staff always record and regularly review any restrictive interventions in place, and have the opportunity to engage in restrictive interventions reduction programmes – Regulation 13(4)(b).
- The trust must ensure that the service has robust governance processes in place that allow staff to review practice and risk areas for assurance, and to improve quality – Regulation 17(1)(2).

Action the trust Should take to improve:

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

- The trust should ensure that staff consistently complete, are aware, and follow up on actions relevant to health and safety audits and checklists.
- The trust should ensure that there are always enough, suitably qualified and competent staff on duty at all times.
- The trust should ensure that patients always have access to drink.

Our inspection team

The team that inspected the service comprised of four inspectors, a pharmacist specialist, a medicines inspector, a specialist advisor and two experts by experience.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

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

This section is primarily information for the provider

Enforcement actions

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