

Requires Improvement

Worcestershire Health and Care NHS Trust

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

Quality Report

Isaac Maddox House
Shrub Hill Road
Worcester
Worcestershire
WR4 9RW

Tel: 01905 733658

Website: www.worcestershire.nhs.uk

Date of inspection visit: 19 - 23 January 2015

Date of publication: 18/06/2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Robertson Centre	R1AY2	Harvington	DY11 6RJ
Hillcrest	R1APQ	Hillcrest	B98 7WG
Newtown Hospital	R1AX7	Holt, Hadley PICU	WR5 1JG

This report describes our judgement of the quality of care provided within this core service by Worcestershire Health and Care NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Worcestershire Health and Care NHS Trust and these are brought together to inform our overall judgement of Worcestershire Health and Care NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

Requires Improvement



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

Requires Improvement



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

Requires Improvement



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

Requires Improvement



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

Requires Improvement



Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement



Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Background to the service	8
Our inspection team	8
Why we carried out this inspection	8
How we carried out this inspection	8
What people who use the provider's services say	9
Good practice	9
Areas for improvement	9

Detailed findings from this inspection

Locations inspected	11
Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Findings by our five questions	13
Action we have told the provider to take	28

Summary of findings

Overall summary

We gave an overall rating for acute wards for adults of working age and the psychiatric intensive care unit (PICU) of **requires improvement** because:

- Assessments had been completed to identify ligature risks on the wards but action had not been taken to reduce all of these in some cases.
- Individual care plans for managing the ligature risks did not identify the individual behaviours of the patient that would alert staff to an increased risk of the patient self-harming.
- There were blind spots on all wards that meant that staff could not ensure patients' safety.
- In Harvington ward learning from some incidents had not reduced the risks to patient safety.
- The current care plan and risk assessment formats did not show staff how to support patients. This had been identified and a new format was to be used.
- The number of systems used to record patient's information meant that some information was not shared and this posed a risk to patient safety.
- Staff did not demonstrate a good understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA). Patient's capacity to consent to their treatment had not been assessed in some cases.
- Staffing levels on Harvington ward did not ensure patients safety.
- A blanket restriction had been applied on Harvington ward. This meant that none of the patients could use the canteen area off the ward to eat their meals because of the risk of some patients absconding.
- The environment on Harvington ward did not promote patients recovery and ensure they were comfortable during their stay.
- There were no clear lines of responsibility across the service to ensure that improvements were made and risks to patients' safety were reduced.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

By safe, we mean that people are protected from abuse and avoidable harm

We rated safe as **requires improvement** because:

- The layout of all the wards meant that staff could not observe patients in all parts of the ward.
- Ligature risks had been identified in previous audits, but there was no clear action to address all the identified risks.
- Individual care plans did not show staff how to mitigate these risks.
- There were insufficient staff in Harvington ward to safely meet patients' needs.
- Action had not been taken to reduce risks to patients following incidents in Harvington which showed that learning from incidents did not always result in changes being made.

The wards were clean. Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was accessible. Staff used de-escalation techniques effectively. Restraint was used only as a last resort. Seclusion rooms were not provided. Staff had been trained in safeguarding and knew how to make a safeguarding alert. Appropriate arrangements were in place for the management of medicines.

Requires Improvement



Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as **requires improvement** because:

- The trust had recognised that the current care plan and risk assessments format was not detailed so that staff would know how to support each patient. A new system was being introduced to address this.
- The number of systems used to record patient's information meant that information was not communicated effectively across teams.
- Staff did not show that they had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). Their assessments of patient's mental capacity lacked detail.
- Staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.

Requires Improvement



Summary of findings

Most patients physical health needs were monitored. Most staff received training and supervision to ensure they had the skills to deliver care and treatment. Staff received an annual appraisal. Multi-disciplinary teams and inter agency working were generally effective in supporting patients.

Are services caring?

We rated caring as **requires improvement** because:

- We observed that some patients were not treated with dignity and respect. Staff in Harvington were not able to respond to all patients in a timely manner.
- Some patients were not involved in their care plans.
- The privacy of patients had not been respected in Holt ward.

Patients told us that staff were caring, respectful and polite. However, they were not always able to respond to them as they were busy doing paperwork tasks. Patients were orientated to the ward on their admission. Patients had access to advocacy services. Patient's families and carers were involved in their care where this was appropriate.

Requires Improvement



Are services responsive to people's needs?

We rated responsive as **requires improvement** because:

- A blanket restriction had been applied on Harvington ward. This meant that none of the patients could use the canteen area off the ward to eat their meals because of the risk of some patients absconding.
- The environment in Harvington was not comfortable and did not promote patients' recovery.
- Hillcrest and Harvington wards were cold and the heating could not be controlled by staff or patients.
- **Mealtimes in Harvington were not a pleasant experience. All patients were restricted to eating in the ward as there were insufficient staff to support patients to access the canteen off the ward.**

The bed management process was robust so that patients did not often have to move between wards during their admission. Patients could access therapeutic activities, although this could improve in the evenings and weekends in Harvington. Staff were aware of the diverse needs of patients and provided a range of support. Staff knew how to support patients who wanted to make a complaint.

Requires Improvement



Summary of findings

Are services well-led?

We rated well-led as **requires improvement** because:

- There were not clear lines of responsibility across the service to ensure that improvements were made and risks to patients' safety were reduced.
- Harvington ward systems did not ensure that there were sufficient staff to safely support patients and meet their individual needs.

Staff were aware of the visions and values of the trust. They felt well supported by senior managers. Ward managers embedded learning from audits to improve care practices.

Requires Improvement



Summary of findings

Background to the service

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Worcestershire Health and Care Trust are based on three hospital sites at Redditch, Worcester and Kidderminster.

Kidderminster - The Robertson Centre: Harvington acute ward has 18 beds for men and women.

Redditch - Hillcrest ward has 18 beds for men and women.

Worcester - Newtown Hospital Holt acute ward that has 18 beds. Hadley PICU ward that has 9 beds. Both wards are for men and women.

We have not inspected the services provided by Worcestershire Health and Care Trust at the Robertson Centre, Hillcrest and Newtown Hospital previously.

Our inspection team

Our Inspection team was led by:

Chair: Dr Ros Tolcher, Chief Executive Harrogate and District NHS Foundation Trust.

Team Leader: Pauline Carpenter, Head of Hospital Inspection, Care Quality Commission.

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of eight people: two experts by experience, one inspector, two nurses, one Mental Health Act Reviewer, an occupational therapist and a consultant psychiatrist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- Visited all four wards at the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- Spoke with 27 patients and two of their relatives
- Spoke with the managers or acting managers for each of the wards
- Spoke with 38 other staff members: including doctors, nurses, occupational therapist, psychologist and social workers
- Attended and observed two handover meetings and three multi-disciplinary meetings

We also:

- Collected feedback from 33 patients using comment cards.
- Looked at 26 treatment records of patients.
- Carried out a specific check of the medication management on Harvington ward.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Looked at 17 patient's medicine charts.

Summary of findings

We did an unannounced inspection to Harvington ward on 28 January 2015 to:

- observe the mealtime,
- look at staffing levels and
- review the management of ligature risks.
- Carried out a specific check of the medication management on Harvington ward.

- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Looked at 17 patient's medicine charts.

We did an unannounced inspection to Harvington ward on 28 January 2015 to:

- observe the mealtime,
- look at staffing levels and
- review the management of ligature risks.

What people who use the provider's services say

We spoke with patients and their relatives. Most patients were positive about their experience of care. They told us that staff were caring, kind, friendly, listened to them and treated them with dignity and respect.

Some patients told us that staff spent too much time doing paperwork which meant they did not have time to spend with patients and respond to them when needed.

Patients told us that restraint was not used often. However, when they had to be restrained for their own safety all the staff did their best to reassure them. They were given an opportunity to talk about how they felt after the incident in line with best practise.

Most patients told us they felt safe and staff ensured their safety when there was an incident on the ward.

Some patients told us the wards and their bedrooms were cold.

In Harvington ward patients told us that staff were not always present on the ward and that they often did not have their one to one time with staff.

Good practice

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **MUST** take to improve the acute wards for adults of working age

- All staff working in the acute wards must be clear about the steps they need to take to reduce the risks of ligature points to patients.
- Action must be taken to reduce the blind spots in the wards so that staff can observe patients in all parts of the ward.
- There must be sufficient staff in Harvington ward to safely meet patients' needs.
- There must be learning from all incidents in Harvington to reduce risks to patients.

- There must be systems in place to ensure that patients' capacity to consent is assessed and their human rights are respected in all cases.
- The heating systems on all wards must be sufficient to ensure patients comfort, safety and wellbeing.

Action the provider **SHOULD** take to improve

- There should be one patient record system used across the trust to ensure that information is not lost when the patient moves across teams.
- Care plans and risk assessments should be detailed so that all staff know how to safely support each patient. Patients' involvement should be recorded.
- Staff should know how to use the Mental Health Act and the accompanying Code of Practice correctly.

Summary of findings

- All staff should have an understanding of the Mental Capacity Act (MCA) and how this applies to patients.
- All staff should receive the training and supervision they require to be able to meet patient's needs.
- Windows in wards should ensure that patient's privacy is respected at all times.
- The environment in Harvington ward should be improved to support patients' treatment and promote their recovery.
- The mealtime experience should be improved in Harvington.
- There should be clear lines of responsibility across the service to ensure that improvements are made and risks to patients' safety are reduced.

Worcestershire Health and Care NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Harvington ward	Robertson Centre
Hillcrest ward	Hillcrest
Holt ward	Newtown Hospital
Hadley PICU	Newtown Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The documentation in respect of the Mental Health Act varied. Patients had not been given a copy of their section 17 leave. Most of the section 17 leave forms detailed the time of the leave and whether this was escorted or unescorted. Patients section 17 leave had been monitored well in Hillcrest and Hadley but this was variable in Harvington.

Staff routinely explained to patients their rights under the Mental Health Act. These were repeated to patients to ensure they understood them. Information was provided to patients about their rights in leaflets which were produced in other languages where needed.

Patients were referred to the Independent Mental Health Advocate (IMHA) service where appropriate.

In Harvington one patients section had been renewed on the day of expiry. This is not seen as good practice.

Detailed findings

Records did not show discussions with the Second Opinion Appointed Doctor (SOAD). There were no records to show that patients had been informed of the outcome of the SOAD visit.

The outcomes of managers' hearings panel reports were not available in patient files on the acute wards. The reports from the Approved Mental Health Professional (AMHP) were not available in some files.

Mental Capacity Act and Deprivation of Liberty Safeguards

Some staff told us they had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, many staff we spoke with lacked an understanding of this legislation.

We saw that staff in Hillcrest ward had an understanding of assessing patients' mental capacity and their individual

role in this. However, in the other wards nurses thought this was the role of the doctor. Doctors had recorded that the patient lacked mental capacity but it was not clear how this decision had been reached.

Staff had a limited understanding that capacity was linked to specific decisions. Records showed that where it was assessed that the patient lacked mental capacity this was for all decisions the patient would make.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated safe as **requires improvement** because:

- The layout of all the wards meant that staff could not observe patients in all parts of the ward.
- Ligature risks had been identified in audits but it was not clear in Harvington ward when these risks would be reduced. Individual care plans did not show staff how to mitigate these risks.
- There were insufficient staff in Harvington ward to safely meet patients' needs.
- Action had not been taken to reduce risks to patients following incidents in Harvington which showed that learning from incidents did not always result in changes being made.

The wards were clean. Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was accessible. Staff used de-escalation techniques effectively. Restraint was used only as a last resort. Seclusion rooms were not provided. Staff had been trained in safeguarding and knew how to make a safeguarding alert. Appropriate arrangements were in place for the management of medicines.

Our findings

Harvington, Hillcrest and Holt wards

Safe and clean ward environment

- The layout of the wards did not allow staff to observe all parts of the ward. Mirrors had been installed in Hillcrest to reduce these risks.
- Staff had completed assessments of ligature risks on all wards in January 2014 and again in January 2015. Some of the risks identified in Harvington ward in January 2014 remained in January 2015 but action had not been taken to reduce these. In January 2014 the suspended ceilings in Harvington ward were identified as a high risk, particularly in dormitories where there was less observation. The action stated was to replace them. This was identified again in January 2015 as no action had been taken.

- The trust had taken action to address some of the ligature risks identified, such as changing windows and replacing wardrobes. It was not clear when plans to reduce other identified ligature risks would be implemented. Managers told us that it was a long process to get funding agreed and ratified.
- In Hillcrest ward where a fire extinguisher had been removed from a wall leaving two holes that had been identified as a risk on a ligature audit. Staff were unable to tell us when this would be done.
- There had been an incident in Harvington ward where a patient had tried to self-harm with a ligature. However, care plans did not detail how staff were to support each patient at risk so that the risks would be reduced. Staff described how to reduce the risks but it was not clear that this information was passed to all staff who worked on the ward.
- Staff carried a ligature cutter when on the ward in their 'emergency bag' and in all but Harvington ward there was also a ligature cutter in the clinic room. In Harvington ward staff were unable to locate this.
- Male and female sleeping areas were separate on all three wards. In Hillcrest the accessible shower room was in the male bedroom corridor and the accessible bathroom was in the female bedroom corridor. Staff ensured that there were no females in the corridors before a male used the bathroom and vice versa. There was also a female only lounge near to the male corridor. Staff could see into this lounge from the office which reduced the risks to females using this lounge.
- In Harvington the accessible toilet was in the male corridor. Staff supporting a female patient to use this toilet but then left her there. The patients care plan did not show how the risks of using this toilet were reduced.
- Staff regularly checked the emergency resuscitation equipment to make sure it was fit for purpose and could be used effectively in an emergency. It was kept in a place where it was accessible.
- There were no seclusion rooms on any of the wards. Staff used de-escalation techniques to reduce the need for seclusion.
- All ward areas were clean. Hillcrest and Holt wards were well maintained and furnished. In Harvington the female sanitary bins were full and patients told us they were often overflowing.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- In Harvington one toilet in the female area was closed and had not been fit to use for two weeks. The covers on the sofas in the lounge were ripped which could be an infection risk.
- Ward managers sent daily safety reports to the senior management team and had a weekly conference call. This highlighted staffing issues and issues with outstanding repairs. In Hillcrest an environment check was done every night to identify risks to safety.

Safe staffing

- The number of nurses identified in the staffing levels set by the trust matched the number on all shifts on all wards.
- When one patient needed closer observation because of their safety risk the staffing levels were not increased. Managers told us they were able to obtain additional staff when more than one patients needs had changed and more staff were required to ensure their safety.
- Generally where bank and agency nurses were used, these staff were familiar with the ward.
- A qualified nurse was not present in communal areas of the ward at all times in Harvington ward.
- There were insufficient staff on Harvington ward to safely meet the needs of patients. On each shift during the day there were two qualified nurses and two nursing assistants. At night there was one qualified nurse and one nursing assistant. Patients told us that staff were not available so they could have the escorted leave that had been agreed by their doctor or regular one to one time with a nurse.
- One patient in Harvington needed assistance from two staff with their personal care. Staff told us that if a patient was prescribed a controlled drug then two nurses were required to sign and give these. This would take both nurses away from the ward as the clinic room was situated in a bedroom corridor.
- During our unannounced visit to Harvington we observed times when no staff were present in the communal areas as all staff were in the office preparing for handover.
- Staff in Harvington ward told us that they often did not get their break as this would leave the ward unsafe.
- During the night shift in Harvington cleaning needed to be done by staff. Staff said that this reduced the time they had to ensure patients' safety.
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Assessing and managing risks to patients and staff

- Staff undertook a risk assessment of every patient on admission and updated these regularly. However, these did not provide staff with the information needed to ensure that patients' risks were reduced to ensure their safety.
- The risk assessment tool used under estimated significant risks because it did not look in detail at patient's risks so did not aid risk management. It was used inconsistently across each of the wards. Some patient records had a number of copies filed in different places and it was not clear which was current.
- Where increased risks had been identified there was not always a clear, regularly reviewed management plan in place so that staff knew how these risks could be reduced.
- In Harvington two care plans for patients at risk of self-harm were not clear as to how staff would support each patient.
- There were good policies and procedures for the use of observation and searching patients.
- On all wards de-escalation was used and staff gave us examples of how communicating with the patient helped to ensure that the number of restraints used had reduced.
- All staff and patients said that restraint was only used as a last resort. Staff told us that the amount of face down restraints had reduced and if used the patient would be moved as soon as possible.
- Seclusion rooms were not provided and staff used de-escalation to manage patients who became aggressive.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and did this when appropriate.
- The pharmacist inspector visited Harvington. Appropriate arrangements were in place for the management of medicines. The use of rapid tranquillisation followed NICE guidance.
- The fridge that contained medicines was unlocked in the Harvington clinic room on one day of our inspection. The clinic room was locked but this could be a risk to patient safety when using the clinic room.
- Children were not allowed to visit the wards but a separate family room was provided for their visits to ensure their safety.

Track record on safety

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- In the last year there had been six serious untoward incidents involving working age adults. There was one on Hillcrest, three on Harvington and two on Holt.
- One of the serious untoward incidents had related to an incident that had occurred while a patient from Harvington was on leave. Despite this there continued to be four different record systems used between inpatient and community teams. This made it a risk for patients who could still be at risk of not being cared for by community teams while on leave. Staff told us that the daily 'rapid review' meeting between ward and community teams reduced these risks. However, when we spoke to staff we found that information was not shared with all staff following this meeting and was recorded on different systems.

Reporting incidents and learning from when things go wrong

- Staff knew what and how to report incidents.
- All incidents that should be reported were reported.
- Staff received feedback from investigation of incidents and met to discuss this.
- There was evidence in Holt and Hillcrest that change had been made as a result of feedback. In Hillcrest the safety of the environment and communication between doctors and ward staff had improved and tasks were allocated on each shift.
- In Harvington staff had not identified the risks to a patient who had self-harmed. The patient's care plan and risk assessment was not detailed to show staff how to identify risks in the future. This did not show that sufficient action had been taken to learn from the incident.

Hadley PICU

Safe and clean ward environment

- The ward layout did not allow staff to observe all parts of the ward. Staff were not able to see patients in one of the lounges as lockers, which were no longer used, blocked the view.
- Ligature risks had been identified. Managers were aware but told us it was a long process to get funding agreed and ratified.
- The ward complied with guidance on same sex accommodation.

- There was no seclusion room. Staff told us that they used de-escalation techniques to reduce the need for seclusion.
- The ward was clean, had good furnishings and was well maintained.
- Staff checked the environment every two hours to make sure the ward was safe and there were no items around that could harm patients.
- All staff had alarms issued. Staff told us there was a very quick response if the alarm needed to be used.

Safe staffing

- The number of nurses identified matched the number on most shifts.
- A qualified nurse was present in ward communal areas at all times.
- Generally where bank and agency nurses were used, these staff were familiar with the ward.
- The ward manager was able to adjust staffing levels daily to take account of the needs of patients.
- Staff worked 12 hour shifts. We discussed this with the ward manager and saw that they ensured that staff had breaks in between shifts and when rotating from night to day shifts.
- There were enough staff to carry out physical interventions. Bank and agency staff had to be trained in the management of actual and potential aggression (MAPA).
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Assessing and managing risks to patients and staff

- Staff undertook a risk assessment of every patient on admission, updated this regularly and after every incident. However, these did not all provide staff with the information needed to ensure that patient's risks were reduced and ensured their safety.
- The risk assessment tool used, which consisted of a number of tick boxes, under estimated significant risks because it did not look in detail at patient's risks so did not aid risk management. It was used inconsistently across each of the wards. Some patient records had a number of copies filed in different places and it was not clear which was current.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- We looked at 26 patient records and found that where increased risks had been identified there was not always a clear, regularly reviewed management plan in place so that staff knew how these risks could be reduced.
- The different record systems used within the trust meant that there was a risk of errors when a patient moved from ward to ward or from community teams. There was a risk that important information might not be passed on between teams.
- There were good policies and procedures for use of observation and searching patients.
- Restraint was only used after de-escalation had failed and using the correct techniques. Staff recognised when they were not able to manage a patient safely. They informed senior management of this and were supported with extra resources, such as additional staff to ensure patients and staff were safe.
- Use of rapid tranquillisation followed NICE guidance.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and did this when appropriate.
- Some medicines prescribed to patients were above the recommended safe doses.
- Children were not allowed to visit the wards but a separate room was provided for their visits to ensure their safety.

Track record on safety

- In the last year there had been one serious untoward incident involving working age adults.

Reporting incidents and learning from when things go wrong

- All staff knew what to report and how to report. All incidents that should be reported are reported.
- Staff received feedback from investigation of incidents.

There was evidence of change having been made as a result of feedback.

Are services effective?

Requires Improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We rated effective as **requires improvement** because:

- The trust had recognised that the current care plan and risk assessments format was not detailed so that staff would know how to support each patient. A new system was being introduced to address this.
- The number of systems used to record patient's information meant that information was not communicated effectively across teams.
- Staff did not show that they had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). Their assessments of patient's mental capacity lacked detail.
- Staff did not always use the Mental Health Act and the accompanying Code of Practice correctly.

Most patients physical health needs were monitored. Most staff received training and supervision to ensure they had the skills to deliver care and treatment. Staff received an annual appraisal. Multi-disciplinary teams and inter agency working were generally effective in supporting patients.

between teams and was not available to staff when they needed it. In Hillcrest staff had mitigated the risks of this and ensured that the information about each patient was available to those who needed it.

- In Harvington there was a whiteboard in the office which was used to record patient information. However, this had not been updated so it was possible to see how many patients were on the ward, what their risks were and who was detained under the Mental Health Act (MHA).
- Most records showed that patients' physical health was monitored. However, some patient's records did not show that their physical health needs were reviewed after their admission even where risks had been identified.

Best practice in treatment and care

- In Harvington staff told us how they had used National Institute for Clinical Excellence (NICE) guidance to support female patients of child bearing age who were prescribed Depakote. They had worked with patients to ensure they had the information they needed and their medication followed NICE guidelines.
- Psychology was limited as there was only one clinical psychologist across the acute wards and PICU. However, another psychologist was to be recruited to work three days a week.
- An art therapist visited each ward one day a week. Patients told us that they benefitted from this and felt more relaxed after these sessions.
- Patients had access to physical healthcare; including access to specialists when needed. In Holt ward 'well men' and 'well women' clinics were held weekly.
- Staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These enabled the clinicians to build up a picture over time of their patients' responses to interventions.

Skilled staff to deliver care

- The staff working on the acute wards came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology and social work. Other staff from the trust provided support to the wards, such as the pharmacy team and physiotherapists.

Our findings

Harvington, Hillcrest and Holt wards

Assessment of needs and planning of care

- Patients' needs were assessed following their admission to the ward. However, the format of care plans and risk assessments used did not show staff how to support the patient to meet their individual needs. This had been recognised and a working party had been set up to review and improve this. Staff told us that the 'recovery star' model was being introduced and we saw this in Hillcrest. This was to ensure that care plans and risk assessments were more focussed on the patient.
- In Harvington, it was not clear from reading patient's care plans and risk assessments how staff would support the patient to meet their individual needs.
- Different records systems were used across the wards and in community teams. This meant that information about a patient could be lost when they moved

Are services effective?

Requires Improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Most staff received appropriate training, supervision and professional development. Staff received training in safeguarding, life support techniques and the use of physical interventions. Records showed that most staff were up to date with statutory and mandatory training.
- Qualified and unqualified nursing staff received training in Dialectical Behaviour Therapy (DBT) and Cognitive Behavioural Therapy (CBT) so they could support patients who would benefit from this. They shared their learning across the staff team. However, some staff in Harvington told us they could not use these skills as there were not enough staff. They said that the ward was staffed only to be safe and not to be able to use their skills with patients and offer effective treatment.
- Most staff received clinical and managerial supervision every month, where they reflected on their practice and incidents that had occurred on the ward. However, staff in Harvington told us that their formal supervisions were often cancelled as they were short of staff. They said that they were supported by all staff on an informal basis.
- All staff had received an annual appraisal and said the format of this had changed so it was more useful and supportive to their role.
- Preceptorship training was offered to newly qualified nurses. This helped ensure that they had the skills needed and were well supported.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary team (MDT) meetings. However, the use of different records systems meant that all the team did not have access to all the records for a patient. For example, junior doctors wrote in paper records and the nurses then had to update the care programme approach (CPA) documents and the care plans from these written notes. We saw that CPA documents did not correspond with the patient's risk assessment and the MDT had not reviewed these.
- We observed that there were effective handovers between the MDT between shifts in Holt and Hillcrest. In Hillcrest staff had effective working relationships with teams outside of the organisation, for example, the local general hospital.
- Staff in Harvington had received an award from the trust for challenging the current paperwork systems and were working together to change these.
- In Harvington there were daily 'rapid review' meetings with the MDT including community mental health

teams. This had improved communication however, not all the information was recorded in the same place and not all information was handed over to staff on the late shift.

- In Holt the MDT liaised with the local substance misuse provider where needed to ensure effective treatment for patients.

Adherence to the MHA and MHA Code of Practice

- Training in the use of the Mental Health Act (MHA) and Code of Practice was not mandatory so not all nursing staff had done this.
- Records showed that consent to treatment requirements were adhered to and attached to medication charts. In Harvington there was a good system in place where the pharmacist checked this and prompted the patient's responsible clinician (RC) when needed. However, one record showed that the RC had not corrected this.
- Most patients had their rights under the MHA explained to them on admission and routinely thereafter. However, some patients had not had their rights explained to them again but their records had stated that staff were unsure if the patient had understood initially.
- Audits were completed to ensure the MHA was being applied correctly but this was not always regularly and there was some evidence that learning had not taken place from these.
- Patients had access to the IMHA service and staff were clear on how to support patients to access this. In Hillcrest one patient's nearest relative had not been advised of their rights or the patient's right to an IMHA.

Good practice in applying the MCA

- Training in the MCA and DOLS was not mandatory. Staff with the exception of Hillcrest did not show they had a good understanding of the MCA. Nursing staff thought that the MCA was the responsibility of the doctors.
- For patients who might have impaired capacity, capacity to consent was not assessed and recorded appropriately. The doctor had written that the patient lacked capacity but they had not recorded how they had assessed this.
- Staff had a limited understanding that capacity was linked to specific decisions. Records showed that where it was assessed that the patient lacked mental capacity this was for all decisions the patient would make.

Are services effective?

Requires Improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Hadley PICU

Assessment of needs and planning of care

- Patients' needs were assessed following their admission to the ward. However, the format of care plans and risk assessments used did not show staff how to support the patient to meet their individual needs. This had been recognised and a working party had been set up to review and improve this.
- Different records systems were used across the wards and in community teams. This meant that information about a patient could be lost when they moved between teams and was not available to staff when they needed it.
- Records showed that patients' physical health was monitored.

Best practice in treatment and care

- The psychiatrist referred patients to the clinical psychologist for psychological interventions in preference to using medicines when this was appropriate. Psychology was limited as there was only one clinical psychologist across the acute wards and PICU. However, another psychologist was to be recruited to work three days a week.
- Some medicines prescribed to patients were above the recommended safe doses stated in the British National Formulary (BNF)
- Patients had access to physical healthcare; including access to specialists when needed.

Skilled staff to deliver care

- The staff working on the PICU came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology and social work. Other staff from the trust provided support to the wards, such as the pharmacy team, dieticians and physiotherapists.
- Staff received appropriate training, supervision and professional development. Staff received training in safeguarding, life support techniques and the use of physical interventions. Records showed that staff were up to date with statutory and mandatory training. Staff had also received training in suicide prevention and risk management.

- Dialectical Behaviour Therapy (DBT) was offered to patients where appropriate. Nursing staff had received training in this so they were not reliant on the psychology service to provide this.
- Staff received clinical and managerial supervision every month, where they reflected on their practice and incidents that had occurred on the ward.
- All staff had received an annual appraisal and said the format of this had changed so it was more useful and supportive to their role.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary team (MDT) meetings. However, the use of different records systems meant that all the team did not have access to all the records for a patient. For example, junior doctors wrote in paper records and the nurses then had to update the care programme approach (CPA) documents and the care plans from these written notes. We saw that CPA documents did not correspond with the patient's risk assessment and the MDT had not reviewed these.
- We observed that there were effective handovers between the MDT between shifts. Staff had effective working relationships with teams outside of the PICU and outside of the organisation.

Adherence to the MHA and MHA Code of Practice

- Training in the use of the Mental Health Act (MHA) and Code of Practice was not mandatory so not all nursing staff had done this.
- Patients had their rights under the MHA explained to them on admission and routinely thereafter.
- Audits were completed to ensure the MHA was being applied correctly but this had not identified that one patients Section 17 leave had expired.
- Patients had access to the IMHA service and staff were clear on how to support patients to access this.
- A Second Opinion Appointed Doctor (SOAD) had visited patients when requested. However, there were no records as to their discussions with the statutory consultees about the patient. There were no records that the patient was told about the outcome of the SOAD visit.

Good practice in applying the MCA

Are services effective?

Requires Improvement



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Training in the MCA and DOLS was not mandatory. Staff did not show they had a good understanding of the MCA. Nursing staff thought that the MCA was the responsibility of the doctors.
- For patients who might have impaired capacity, capacity to consent was not assessed and recorded appropriately. The doctor had written that the patient lacked capacity but they had not recorded how they had assessed this.
- Staff had a limited understanding that capacity was linked to specific decisions. Records showed that where it was assessed that the patient lacked mental capacity this was for all decisions the patient would make.

Are services caring?

Requires Improvement 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We rated caring as **requires improvement** because:

- We observed that some patients were not treated with dignity and respect. Staff in Harvington were not able to respond to all patients in a timely manner.
- Some patients were not involved in their care plans.
- The privacy of patients had not been respected in Holt ward.
- Mealtimes in Harvington were not a pleasant experience.

Patients told us that staff were caring and treated them with respect. Patients were orientated to the ward on their admission. Patients had access to advocacy services. Patient's families and carers were involved in their care where this was appropriate.

Our findings

Harvington, Hillcrest and Holt wards

Kindness, dignity, respect and support

- Most patients told us that staff were caring, respectful and listened to them. Some patients in Harvington told us that staff were always too busy to spend time with them and there were often no staff present in the ward area.
- In Holt and Hillcrest we observed that staff interacted with patients in a positive and respectful way. Patients were treated with care and staff respected their dignity.
- In Harvington ward we observed that staff stood at the side of the ward particularly during mealtimes and did not engage with the patients.
- In Harvington we observed the mealtimes on each of the three times we visited. There were not enough dining chairs and tables available so several patients ate their food using trays on their laps. Patients told us that they got used to eating sat on the sofas as there were not enough chairs and tables.
- One patient in Harvington ward asked us if we could support them to use the toilet. The patient needed two staff to support them. Only one staff member was available so they asked the patient if they could wait.

The patient said they could not wait so staff had to ask another staff to assist with this. Staff did not talk with the patient when supporting them or apologise for the delay.

- We observed one patient in Harvington become upset during a music session. Staff spoke with them in a respectful way and supported them with dignity.
- Male patients in Holt ward told us and we saw that privacy windows were not provided in the bedroom areas so they were overlooked by neighbouring wards and properties. We raised this with staff who had not previously identified this as an issue.

The involvement of people in the care they receive

- The admission process informed and orientated the patient to the ward.
- Records did not record the involvement of the patient in their care plan and there was no evidence that this was shared with the patient.
- We observed that patients were involved in their ward round and were treated by all staff with dignity and respect. Patients said they felt involved in their care.
- Patients had access to advocacy services. The advocate attended patient's review meetings where this was appropriate.
- Patient's families and carers were involved where this was appropriate.
- Patients gave feedback on the service they received in community meetings. Action was taken that showed that staff listened to patients and improved the service where possible.
- Peer support workers were employed in Harvington and Hillcrest. We saw that this made a positive difference to patients who felt their views were listened to and understood.

Hadley PICU

Kindness, dignity, respect and support

- We observed that patients were comfortable to approach staff who met their individual requests. Staff offered support to patients in a sensitive and caring way.
- We observed that it was generally the occupational therapists who engaged patients in activities and not the nursing staff. This meant that patients were not engaged in as many activities as they could have been.

The involvement of people in the care they receive

Are services caring?

Requires Improvement 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- The admission process informed and orientated the patient to the ward.
- Patients gave feedback on the service they received in community meetings. Action was taken that showed that staff listened to patients and improved the service where possible.
- Patients had access to advocacy services. The advocate attended patient's review meetings where this was appropriate.
- Patient's families and carers were involved where this was appropriate. Staff respected patient's wishes when they did not want their family involved in their care.
- Patients were able to get involved in decisions about their service and some had been involved in recruiting staff.

Are services responsive to people's needs?

Requires Improvement 

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We rated responsive as **requires improvement** because:

- A blanket restriction had been applied on Harvington ward. This meant that none of the patients could use the canteen area off the ward to eat their meals because of the risk of some patients absconding.
- The environment in Harvington was not comfortable and did not promote patients' recovery.
- Hillcrest and Harvington wards were cold and the heating could not be controlled by staff or patients.
- Mealtimes in Harvington were not a pleasant experience. All patients in Harvington were restricted to eating in the ward as there were insufficient staff to support patients to access the canteen off the ward.

The bed management process was robust so that patients did not often have to move between wards during their admission. Patients could access therapeutic activities, although this could improve in the evenings and weekends in Harvington. Staff were aware of the diverse needs of patients and provided a range of support. Staff knew how to support patients who wanted to make a complaint.

Our findings

Harvington, Hillcrest and Holt wards

Access, discharge and bed management

- There was a robust bed management process. Staff from the wards and community teams had regular contact with the bed manager. This helped to reduce the risks of patients being placed out of area and being moved between wards without justification on clinical grounds.
- Patients were informed that when they went on leave their bed could not be kept open due to pressure on beds. However, there was evidence that patients were not discharged until they were ready to leave.
- There was good discharge planning. There was liaison with community teams to ensure that the patient was supported in the way they needed following discharge.

The ward optimises recovery, comfort and dignity

- Harvington ward was not comfortable to sit in. The ward needed to be redecorated and the chairs needed replacing as the covers were torn.
- There were a range of rooms provided in each ward. These were used to good effect in Holt and Hillcrest wards. However, in Harvington ward the activity room was often used for meetings and a smaller room which used to be a relaxation room was no longer used. Staff said there were plans to refurbish this into a kitchen but they did not know the timescale for this.
- Patients were able to make a phone call in private on Holt and Hillcrest wards. In Harvington ward the payphone had been broken for a few months. This meant that patients had to use their own mobile phone or the phone in the nursing office. The pay phone was repaired when we visited Harvington unannounced.
- In all wards there were some shared dormitories and some single bedrooms. In Harvington ward there was one dormitory which five women shared. Patients had to go out of the dormitory to use the toilet. One of these toilets could not be used and staff told us this had been closed for over two weeks. Patients had to ask staff to access their bedrooms. These requests were not always responded to in a timely manner in Harvington as there were insufficient staff.
- In Hillcrest and Harvington wards patients told us that their bedrooms and the ward was cold. We observed this and staff told us that they were unable to control the heating but that extra blankets were always available for patients.
- Patients had access to outside space in all wards.
- In Holt and Hillcrest patients told us that the food was okay and they had a choice. We observed the mealtimes and saw that these were social occasions where staff and patients sat together.
- In Harvington we observed the mealtimes on each of the three times we visited. Staff told us that patients used to be escorted to the canteen area in the community teams office area for meals. However, this had stopped as some patients had absconded and there were not enough staff to support this. This meant that all patients were restricted.

Are services responsive to people's needs?

Requires Improvement 

By responsive, we mean that services are organised so that they meet people's needs.

- Patients were able to make hot drinks and snacks until midnight and from 6am. During this time patients told us that night staff would make them a hot drink if they needed one and it was not detrimental to their sleep pattern.
- In each ward patients had their own locker where they could store their possessions.
- Occupational therapists were allocated to each ward. We saw that activities were provided on each ward and patients on Holt and Hillcrest told us they enjoyed these and they helped to aid their treatment.
- In Harvington patients told us they did activities during the week, although access to the activity room was sometimes limited, as meetings were held there. However, in the evenings and at weekends there were fewer activities as staff did not have the time to support these. Occupational therapists were not employed at these times. Patients told us they were often bored in the evenings and at weekends.
- Some patients with S17 leave on Harvington had less time off the ward as was agreed because there was not sufficient staff to support them. One patient had four hours escorted leave from the ward each day but often had less than an hour each day.

Meeting the needs of all people who use the service

- Accessible bath, toilet and shower facilities were provided on all wards. However, in Harvington we saw that the accessible toilet was used by a female patient but was in the corridor that led to the male bedrooms.
- There was easy access to interpreters.
- A choice of food was provided to meet patients' religious and ethnic requirements. Some patients told us that the choice of vegetarian diets was often limited.
- Patients had access to spiritual support.
- One patient in Harvington had a specific therapy before their admission. Staff worked with the patient's family to ensure the patient continued to access this therapy during their time on the ward.
- In Hillcrest we saw that staff had received training to improve their knowledge of diabetes, stoma care and tissue viability to meet individual needs of patients.

Listening to and learning from concerns and complaints

- Some patients told us they knew how to make a complaint and would feel confident to do so.

- In Hillcrest we saw that staff had learnt from a complaint made. Relatives were informed of the outcome of the investigation and what had been improved as a result.
- Staff received feedback on the outcome of investigations of complaints and acted on the findings.

Hadley PICU

Access, discharge and bed management

- The PICU service within the trust was for men and women. Four of the beds were for patients from the trust's catchment area and five beds were for out of county to generate income.
- The ward manager was clear that only three women could be admitted to the PICU at any time due to the constraints of the environment. They told us that this had not restricted a patient being admitted when required.
- Staff ensured that care coordinators from other areas visited their patient so that the patient was not stuck there when they no longer needed the service.
- Other wards within the trust now supported patients during their transfer to the PICU and this improved the experience for the patient.
- The process of each patient being transferred from the PICU to acute wards and then to community mental health teams was monitored. This helped to ensure that patients discharge was not delayed for other than clinical reasons.

The ward optimises recovery, comfort and dignity

- The PICU had enough rooms to support a range of treatment and therapeutic activities.
- Patients had free access to their bedroom, activity rooms and quiet rooms during the day.
- Patients could make a phone call in private. Patients told us that the pay phone was broken but was repaired the next day.
- Smoking was restricted to every two hours to promote patients' health. Staff told us that it was previously every three hours but after discussion with patients it was now two. Staff said if a cigarette would help a patient when they were upset they could have one rather than let their distress escalate. This showed that they responded to patient's individual needs.
- Patients could bring in their own possessions to help them feel comfortable. Some items were restricted if this impacted on the safety of the patient.

Are services responsive to people's needs?

Requires Improvement 

By responsive, we mean that services are organised so that they meet people's needs.

- Patients had access to activities; including at weekends.

Meeting the needs of all people who use the service

- The PICU was located on the ground floor and was accessible to patients who used wheelchairs.
- Patients' individual needs were met, including cultural, language and religious needs.
- There was easy access to interpreters where needed.
- A choice of meals to meet dietary and patients' religious and cultural needs was available.

Listening to and learning from concerns and complaints

- Some patients told us they knew how to make a complaint and would feel confident to do so.
- Staff told us that they acted on informal complaints made to ensure improvements were quickly made.
- Staff received feedback on the outcome of investigations of complaints and acted on the findings.

Are services well-led?

Requires Improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We rated well-led as **requires improvement** because:

- There were not clear lines of responsibility across the service to ensure that improvements were made and risks to patients' safety were reduced.
- Harvington ward systems did not ensure that there were sufficient staff to safely support patients and meet their individual needs.

Staff were aware of the visions and values of the trust. They felt well supported by senior managers. Ward managers embedded learning from audits to improve care practices.

Our findings

Harvington, Hillcrest and Holt wards

Vision and values

- The trust's vision and strategies were evident and on display in wards.
- Staff told us they were empowered to make decisions at ward level and were able to feed these back at the trust management level.
- Staff knew who the most senior managers in the organisation were and these managers had visited each ward. Staff told us they felt listened to by senior managers in the trust.

Good governance

- At the time of the inspection it was not clear who the clinical lead for acute inpatient services was. Each ward had a different arrangement for consultants and junior doctors. This meant that a single doctor did not take overall responsibility for the acute inpatient services.
- Nursing staff were expected to ensure that Care Programme Approach (CPA) care plans were up to date and the Mental Health Act (MHA) was used correctly. This was not overseen by the clinical lead.
- Staff on all wards were aware of the risks associated with using different records systems. However, it was not clear who was responsible for managing and mitigating these risks.

- The National Schizophrenia Fellowship had completed an audit of the acute inpatient service. It was not clear what the action plan from this audit was and who was responsible for ensuring it was implemented.
- Ward systems were effective in ensuring that staff had received mandatory training, were supervised, incidents were reported and staff learnt from these, complaints and feedback from patients and safeguarding procedures were followed.
- **Incidents were reported and staff learnt from these, complaints and feedback from patients and safeguarding procedures were followed.**
- In Harvington we found that shifts were not always covered by a sufficient number of staff and staff did not maximise their time on direct care activities.
- We found across the wards that procedures relating to the MHA were not always followed correctly. There was limited understanding of the Mental Capacity Act (MCA) procedures.

Leadership, morale and staff engagement

- In Harvington ward it was not clear how many patients were on the ward, how many were on leave and who was detained under the MHA. We found that there were no clear lines of responsibility. All staff felt responsible and we found this meant that some tasks were not done and it was not clear who was responsible for not doing them. For example, where repairs were needed, staff told us this had been reported to the maintenance team but were not clear when these were reported or when repairs were to be completed. This meant that some repairs were not done.
- Hillcrest and Holt were well led. There were clear lines of responsibility, staff were well supported and morale was good.

Commitment to quality improvement and innovation

- All acute wards had been accredited by the Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services (AIMS). In Hillcrest we saw that changes were made as a result of going through this process. This included staffing levels, increased psychology input, the pharmacist now visited the ward and the change to using 'Recovery Star' model for care planning and CPA.

Hadley PICU

Are services well-led?

Requires Improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Vision and values

- The trust's vision and strategies were evident and on display in the ward.
- The ward manager said they were empowered to make decisions at ward level and were able to feed these back at the trust management level.
- Staff knew who the most senior managers in the organisation were and these managers had visited the ward. Staff told us they felt listened to by senior managers in the trust

Good governance

- It was not clear who the clinical lead for acute inpatient services was. Nursing staff were expected to ensure that Care Programme Approach (CPA) care plans were up to date and the Mental Health Act (MHA) was used correctly. There were not systems in place to support this.
- Ward systems were effective in ensuring that staff had received mandatory training, were supervised, shifts were always covered by a sufficient number of staff and staff maximised their time on direct care activities, incidents were reported and staff learnt from these, complaints and feedback from patients and safeguarding procedures were followed.

- The procedures relating to the MHA were not always followed correctly. There was limited understanding of the Mental Capacity Act (MCA) procedures.

Leadership, morale and staff engagement

- Staff knew how to use the whistle blowing process and felt able to raise concerns without fear of victimisation.
- The recently appointed ward manager was positive and conveyed this to other staff. Staff morale was good.
- There were opportunities supported by the trust for leadership development.
- Staff worked as a team and supported each other.

Commitment to quality improvement and innovation

- The ward manager had not previously managed a PICU. To improve their knowledge they planned to visit other PICU's to learn best practice from them and share ideas.
- Monthly audits were completed on the ward which looked at standards of care, privacy and dignity and infection control. These were done by matrons who did not work directly in the PICU so gave an independent view. The ward manager had embedded the results of this to improve practice in the PICU and showed us action plans of how further improvements were to be made.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing

The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure the safety of patients at Harvington ward.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities)
Regulations 2010 Care and welfare of people who use services

The trust must ensure that patients are protected against the risk of receiving unsafe care by effective planning of care.

The trust must ensure patients welfare and safety by providing a warm environment.

The trust must ensure that staff in Harvington wards supports patients to meet their individual needs.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2010 Consent to care and treatment

The trust must ensure that arrangements are in place for obtaining the consent of patients to their care and treatment.