

Midlands Partnership University NHS Foundation Trust

Wards for older people with mental health problems

Inspection report

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Ratings

Overall rating for this service	Good 
Are services safe?	Good 
Are services caring?	Good 
Are services well-led?	Good 

Our findings

Wards for older people with mental health problems

Good   

Our rating of this location stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well led and the governance processes ensured that ward procedures ran smoothly. The trust had shared learning from other areas which had been implemented across this service.

However:

- Generally, the rationale for restrictive interventions for individual patients was recorded well. However, we did not see this within all the patient care records we reviewed. Not all care plans included discussions with the patient around restrictive interventions in place to keep people safe.
- Staff had monitored and recorded fridge temperatures that were used to store medications. However, staff had not taken action when the fridge temperatures were outside of the recommended limit for a period of time and staff had not escalated or dealt with it. This could potentially effect the efficacy of the medication within the fridge.

Background to inspection

We carried out this unannounced focused inspection because we received information of concern about the safety and quality of the services.

We inspected the safe, caring and well-led key domains. We rated safe, caring and well-led as good.

We inspected the 4 older adult wards, Bromley and Baswich at St George's hospital in Stafford and Holly and Oak at the Redwoods Centre in Shrewsbury.

- Bromley ward has 14 beds and is mixed sex
- Baswich ward has 12 beds and is mixed sex
- Holly ward has 16 beds and is mixed sex
- Oak ward has 16 beds and is mixed sex

Our findings

What people who use the service say

Staff looked after them well, they were kind, supportive and helpful. Some patients said staff couldn't do enough for them. There were enough staff to aid them when required and keep them safe. There were lots of activities which they enjoyed. The wards were clean and generally felt calm.

How we carried out this inspection

During the inspection we:

- visited the 4 older adults mental health wards
- reviewed the quality of the environments
- observed how staff cared for patients
- spoke with 15 patients who were using the services
- spoke with 8 carers or family members
- spoke with 32 staff members
- reviewed 18 patient care and treatment records
- reviewed 16 medicine prescription records
- attended 4 multi-disciplinary meetings
- reviewed a range of policies, procedures and other documents relating to the running of the services

You can find 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>.

Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Managers completed quarterly environmental audits of the wards. All the wards had an outside area. Baswich and Bromley ward had a shared garden. Following a serious incident, the fence on Holly ward garden had been heightened and furniture was fixed so it could not be moved. However, the other ward gardens had not had the same modifications. Staff had assessed the garden areas and actions included ensuring patients were risk assessed before accessing the garden. Staff told us they escorted patients when they wanted to use the garden. We were unsure why the same modifications were not in place on the other wards, although we were reasonably assured appropriate assessments and measures were in place and no incidents had been reported.

Our findings

Staff could observe patients in all parts of the wards. Wards at the Redwoods centre had a large communal area with 2 bedroom corridors on each side. Staff placed themselves so they could observe all communal areas including the corridors. Wards at St George's did not have the same layout. However, staff placed themselves where they could observe patients. Staff placement in the communal areas ensured that the garden area was also observed.

Baswich ward at St George's hospital and Holly ward at the Redwoods centre had installed non-contact technology in patients' bedrooms, to assist with observations. This meant that patients could be observed by staff through video and sensor equipment from the nursing office when required. The system could also take vital signs such as pulse and breathing rate. The system ensured that patients could not be constantly observed, just when nursing staff required an observation. Staff told us that information was given to the patients and their carers on admission to gain their consent, or they could opt out and the video would be turned off.

New flooring was being installed on the day of our visit on Baswich ward. Patients only had use of one of day areas for a number of hours, whilst it was being installed. Staff had managed the situation appropriately.

The wards were mixed sex and were not compliant with mixed sex guidance. At the Redwoods centre, one of the two bedroom corridors was allocated to one sex. There were times when mixed sex guidance could not be followed. At the Redwoods centre, one of the two bedroom corridors was allocated to one sex. At times, patients were admitted to the opposite sex corridor. At the time of our inspection, 2 female patients were allocated bedrooms on the male corridor. It was evident that staff had considered the guidance and had put robust plans in place to maintain the safety and privacy of patients. Staff completed risk assessments and care plans and ensured that staff could observe the corridor at all times. At St George's hospital, staff placement ensured that any potential sexual risk or privacy and dignity breach was reduced. Some patients had mixed sex ward care plans. There had not been any sexual safety incidents reported.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe, by patient observations, risk assessments and care plans. Up to date ligature risk assessments were in place for all the wards. Rooms with ligature points, such as assisted bathrooms, were kept locked and could only be accessed with staff assistance.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff answered alarms and nurse call bells in a timely manner.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. Wards had a systematic approach to ensure all areas of the ward, including furniture and fixtures were kept clean and tidy.

Staff followed infection control policy, including handwashing. Hand hygiene and personal protective equipment (PPE) audits were completed every quarter, and all wards scored above 90% compliance. Staff also completed audits based on the national standards of cleanliness; all wards had scored 5 stars.

Clinic room and equipment

Our findings

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Results from the latest resuscitation audit showed all wards were 93% or above. Staff checked, maintained, and cleaned equipment. Maintenance and calibration records were in place for medical devices to ensure they worked correctly.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Some staff said there were times when they were short staffed but this did not affect patient care.

The service had low vacancy rates. Baswich ward had 1 vacancy for a healthcare assistant, and Bromley ward had 2 vacancies. Holly ward establishment for healthcare assistants has been increased from 10 to 14 recently, and these vacancies had been advertised.

Holly ward had 2 vacancies for qualified nurses, which had been advertised. Bromley ward had recruited 2 band 5 nurses who were due to start imminently.

The service used bank or agency nurses and support staff when needed. In October 2023, Baswich ward used bank or agency on 24 shifts, Bromley ward on 19, Oak ward on 80 and Holly ward on 42 shifts. Apart from Bromley ward, most shifts were for support staff. Managers requested staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. Levels of sickness in October 2023 ranged from 4% on Baswich and Holly wards, to 11% on Bromley ward due to 3 staff being on long term sick leave. Managers replaced them temporarily with bank staff who had previously worked on the ward.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants for each shift. Managers used the Safer Staffing Tool to ensure staffing requirements were correct. The ward manager could adjust staffing levels according to the needs of the patients.

Staff and patients told us they rarely cancelled escorted leave or activities, even when the service was short staffed. Activity coordinators, physiotherapy aid and occupational therapists supported ward based activities. We observed various activities on all the wards we visited. Patients had regular one-to-one sessions with their named nurse and the service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information such as incidents, current presentation including observation levels and risks to keep patients safe when handing over their care to others during shift changes.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. An on call system was in place.

Managers could call locums when they needed additional medical cover and made sure all locum staff had a full induction and understood the service before starting their shift.

Our findings

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All the wards were above 94% overall compliance for required training. The mandatory training programme was comprehensive and met the needs of patients and staff.

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

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed, and is rarely used on the older adults wards. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 18 functional analysis of care environments (FACE), older adults risk assessments and associated management plans. Apart from risk to self or other people, other risk factors included early warning signs, falls risks, skin integrity such as pressure ulcers and neglect of physical self. Assessments were thorough and included historical risks, and mental and physical health concerns. They were reviewed and updated during multi-disciplinary team meetings.

Staff assessed patient's mental capacity and recorded capacity to consent clearly each time a patient needed to make an important decision, or they made decisions in patients' best interests when capacity was lacking following a formalised meeting. This included use of the non-contact technology in patients' bedrooms.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We reviewed 18 patient care records. Staff knew about any risks to each patient and acted to prevent or reduce risks. This included any physical health risks. Individualised, person centred, holistic care plans were in place to manage and mitigate identified risks. Staff used The National Early Warning Score (NEWS2) to identify and manage patients whose physical health could be deteriorating. Physical health including food and fluids, pain management and toileting needs were monitored with the patient hourly and recorded.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff from the multidisciplinary team attended daily huddles, tasks meetings and handovers where risks were discussed and management plans were modified or put in place. We observed 2 multidisciplinary daily meetings. They were well attended, comprehensive and thorough. All patients were discussed. Items of discussion included presentation over the last 24 hours, physical health, Section 17 leave, communication with family, risks, discharge and mental capacity. All decisions were recorded onto the patient care record.

Staff reviewed patients who were on enhanced nursing observations at allocated times or intermittently, and all patient's welfare was checked at least hourly.

Staff followed procedures to minimise risks where they could not easily observe patients and completed individualised risk assessments and care plans. Staff at the Redwoods Centre placed themselves at the top of the ward so they could observe patients.

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

Our findings

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Any restrictive practices were discussed and reviewed in the multidisciplinary team meetings regularly and documented in the majority of patient's care plan. However, in 2 out of 18 patient care records we reviewed, staff had not fully recorded the rationale for the restrictive intervention or the discussion with the patient.

The trust had a restrictive items list. Restricted items were stored safely and staff would access them for patients when required. Staff completed a checklist to ensure that items were returned and appropriately stored once finished with.

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. Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff documented restrictive interventions and included post incident reviews.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation, although this was used minimally. Staff completed post rapid tranquilisation physical observations and completed non-contact observations when patients refused.

Safeguarding

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

Staff received training and kept up to date on how to recognise and report abuse, appropriate for their role. All clinical staff completed safeguarding adults and children training up to level 2. All wards were above 97% compliant. Qualified staff completed safeguarding adults' level 3 training. Baswich ward was the lowest compliance at 82%.

Staff could give clear 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 knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding was discussed, recorded and reviewed in morning meetings and with the multi-disciplinary team. Safeguarding concerns were recorded as incidents on the trust's incident reporting system.

Managers took part in serious case reviews and made changes based on the outcomes and liaised with the trust's safeguarding lead when necessary. Staff had access to a safeguarding advice line.

Staff followed clear procedures to keep children visiting the ward safe in separate areas.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

The Trust used an electronic patient care record so records were stored securely. They were kept up to date and were complete.

Our findings

Medicines management

The service used systems and processes to safely prescribe, administer, record and generally store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 16 patient prescription charts. Staff completed medicines records accurately and kept them up to date. Pharmacy staff completed audits and monitored any actions that required completion by ward staff.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Prescriptions were reviewed in multidisciplinary team meetings. Pharmacy staff were regularly available for advice. Medicine leaflets were readily available for patients and carers.

Staff generally stored and managed all medicines and prescribing documents safely. Medicines were kept safely in locked clinic rooms. The medicine fridge on Baswich ward was unlocked although this was immediately rectified by staff. However, staff on Holly ward had been recording the medicine fridge as above the recommended temperature for 9 consecutive days and they had not actioned or escalated this. We reported this to the ward manager on the day of our inspection to get this rectified immediately. This had not caused any harm to patients.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff learned from safety alerts and incidents to improve practice.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patients received regular blood tests and electro cardiograms (ECGs) as necessary.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The service reported 349 incidents between 1 August 2023 to 31 October 2023. Oak ward reported the most at 50%, followed by Baswich ward at 19%, Bromley ward at 16% and Holly ward at 15%. All wards reported assault, threats and verbal abuse as the highest type of incident. Oak ward had 53% of these type of incidents which were associated with one patient. Managers regularly discussed these incidents and care plans and risk management plans were in place to reduce and manage them.

Staff raised concerns and reported incidents and near misses in line with trust policy. We reviewed 12 incidents. They were consistently recorded within the patient care record and updated in risk assessments and care plans. This meant staff were aware of which incidents they needed to report. Incidents from the previous 24 hours were discussed and reviewed in morning meetings.

Managers shared learning about serious incidents with their staff and across the trust. Staff had access to the lessons learned bulletin with information and access to further resources.

Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong.

Our findings

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. Information was included in team meetings, and lessons learned bulletins. Themes and trends were analysed and shared with staff, and any identified risks or learning was highlighted.

There was evidence that changes had been made as a result of feedback. Staff spoke of various changes that had been made across the wards following incidents or complaints. Changes had been made in the garden on Holly ward, in line with recommendations made following a serious incident 2 years prior to our inspection. However, we did not see this replicated across the other 3 wards.

Staff met to discuss the feedback and look at improvements to patient care. Incidents and patient safety from the service were discussed at various meetings such as team meetings, ward huddles and clinical governance. Learning from other areas was shared, for example, CQC action plans from other services across the trust were incorporated into the older adult wards.

The non-contact technology and footage had been used to review incidents. Staff were alerted when patients were on the edge of the bed or had got up from their beds. Staff described how measures had been put in place following incident reviews to prevent future incidents such as falls. The trust had noted a 23% reduction in falls on Baswich ward and Holly ward since it had been implemented.

Managers debriefed and supported staff after any serious incident. Psychology staff offered reflective practice sessions when required.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Our observations of staff were that they were kind, patient and respectful. They treated people with compassion. Staff gave patients help, emotional support and advice when they needed it. Staff we spoke with were passionate about working with older adults and this was conveyed in their interactions with patients.

Staff supported patients to understand and manage their own care treatment or condition. Capacity was assessed and staff knew how to support patients and fully explain treatment plans. Some patients had Do Not Attempt cardiopulmonary resuscitation and Respect forms in place and patients had been able to make informed decisions.

Staff directed patients to other services and supported them to access those services if they needed help. Patients who had discharge plans were able to describe them and said they had been involved in them.

Our findings

Patients said staff treated them well and behaved kindly. Patients said staff were 'lovely', friendly and helpful. Staff were caring. Staff understood and respected the individual needs of each patient. They were knowledgeable about patients' care plans and individual risks. Members of the multidisciplinary team worked well together and discussed patients' needs daily. Staff we spoke with and our observations of staff and patient interactions showed that staff were respectful and understood patient's individual needs.

Staff supported patients to attend and participate in activities that would aid their recovery. Ward based activities included music, art, yoga aimed at the patient's ability and weekly visits by a therapy dog. Patients and carers said they enjoyed the activities and they were available every day. Patients on Bromley ward were visited by children from the local nursery to aid intergenerational socialisation.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Patients told us they knew how to raise a complaint if necessary.

Staff followed policy to keep patient information confidential. Patient information was recorded in the trust's electronic patient care record.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us they had been shown around the ward when they were admitted. When they were disorientated, staff helped them and guided them to where they wanted to go.

Staff involved patients and gave them access to their care planning and risk assessments. Care plans were person centred and patient views and wishes were documented. Patient's strengths and protective factors were often detailed. Staff offered patients a copy of their care plans. Accessible versions were available and the speech and language therapist supported patients when they needed extra support.

The trust were implementing a new care planning system called 'patient knows best'. The aim was to be more patient centred. Patients would be able to access their patient care records through an app and then input onto their own care plans and assessments. This had commenced whilst we were on inspection, so neither managers, staff or patients had been able to evaluate its effectiveness yet.

Staff involved patients in decisions about the service, when appropriate. The Trust was piloting a hospital avoidance service for dementia patients. This was part of the trust's dementia transformation. A team would visit patients at home instead of admitting them to hospital. Together with other interested parties and managers, ex patients and carers had been involved in discussions about what patients want and need and how the service could be more accessible when they needed it.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held regularly and patients could feedback issues, make suggestions or make complaints and give compliments.

Our findings

Staff requested feedback from patients. We reviewed information collated from questionnaires received between 1 September and 27 November 2023. Overall experience was positive, the lowest scoring ward was Bromley ward at 82%, the highest was Holly ward at 100%. We did not receive any feedback from Oak ward. Negative comments and suggestions were centred around food.

As part of a quality improvement initiative on Bromley ward, patients were able to prepare their own lunch with the aim to optimise and maintain independence skills.

Following patient feedback and as part of a quality improvement initiative on Bromley ward, bedrooms had been redecorated and brightened up.

Staff supported patients to make decisions on their care in multidisciplinary team meetings. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made sure patients could access advocacy services. Information was displayed on the wards and advocates would visit whenever required.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with 8 carers or family members. The majority were complimentary about staff and said staff kept them updated with their relative's progress. Generally, staff were approachable, respectful and kind. Staff provided carers with at least weekly contact. Carer engagement and involvement was clearly recorded in the patient care record.

Staff helped families to give feedback on the service. Responses from the carers survey between 1 September and 27 November 2023 for each ward showed they had a very good overall experience.

The trust collated feedback from carers from this service which formed part of the 5 year care group strategy 2023 to 2028. The trust have committed to regular engagement sessions to listen and learn for service users and carers.

One relative we spoke with was not happy with their relative's care on Bromley ward and had put in a formal complaint. Some of their concerns had been partially upheld. Other relatives we spoke with said they knew how to make a complaint but had not had reason to.

Staff gave carers information on how to find the carer's assessment. Carers were provided with welcome packs which included information about external carer's organisations and how to access carer's assessments and support.

Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good.

Our findings

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff we spoke to said ward managers were supportive, approachable, accessible, and visible. Matrons also contributed to the leadership on the ward and were visible on the wards. Staff told us that they felt supported by senior leaders within the trust and had seen them on various trust events. Staff said managers were open and transparent.

Ward managers were provided with relevant training, skills and support to perform their role.

Matrons attended a monthly leadership meeting and a daily huddle to share learning and to provide feedback.

Staff could attend 'Trust Talk' and ask questions of the senior leaders and listen to what is going on across the trust.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Ward managers for the service could attend engagement forums related to the 5 year care group strategy.

The trust values were embedded in supervision and the recruitment process was designed to ensure staff shared the same vision and values of the trust.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that managers treated them with respect, and supported and valued them. Morale was good and staff worked well together. Managers discussed morale and staff wellbeing in team meetings and staff knew how to raise concerns if they needed to. Staff knew how to contact the Freedom to Speak Up Guardians.

Oak ward had had a period of low morale and a permanent manager had not been in place for a period of time. However, improvements had been made and a new manager put in place. The team now felt more supported and morale had improved.

The trust held roadshow events to gain feedback from staff and share improvements that had been made across all the inpatient wards. Nurses had attended a trust nursing conference.

The trust were keen to understand issues staff had identified. For example, following the latest NHS staff survey, senior leaders invited staff to attend sessions to hear their concerns and receive feedback.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Matrons for the service met monthly to review and monitor quality across the wards and attended a daily huddle to share learning and to provide feedback.

Staff completed a range of audits that provided assurances and identified areas for improvement, including patient care records completion, quality of care plans, Mental Health Act and Respect forms.

Our findings

Managers reviewed the non-contact technology installed on Baswich and Holly wards in clinical forums and the trust had evaluated its impact which showed a reduction in incidences of falls on those wards in the 12 months following implementation.

There was a clear governance framework in place and a number of meetings were in place at all management levels and these fed into the board. Ward managers and matrons attended monthly clinical governance meetings. We saw minutes of these meetings which had a standard agenda and clear actions assigned to the relevant people.

Actions and areas for improvement from previous CQC inspections for the acute mental health wards had been shared with the older adult service, and changes had been made where necessary.

Staff attended regular staff meetings and discussed governance issues, which included incidents, learning lessons, results of audits, outcomes of complaints or compliments, and areas requiring improvement or good practice.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The wards had individual risk registers in place and these matched the concerns of the staff. Managers were able to add items onto the risk register as necessary and these risks were reviewed regularly at clinical governance meetings.

Managers collected a range of care delivery information, such as key performance indicators. The trust had access to a wide range of performance data such as training, supervision, and appraisals. Across the service, supervision compliance was above 97%, appraisals above 88% and mandatory training above 94%.

Information management

Staff engaged actively in local and national quality improvement activities.

Managers collected and reviewed ward performance data. This ensured that governance processes and procedures were effective and helped staff quickly identify areas of concern and areas of good practice.

Learning, continuous improvement and innovation

The trust promoted quality improvement through events, training, and sharing of ideas. A number of quality improvement projects were ongoing.

Bromley and Holly wards had achieved a trust gold award. These awards were given for a number of quality improvements made on the wards. Baswich ward had achieved a silver award and Oak ward had received a bronze award. In addition, Bromley ward had achieved an award for outstanding infection, prevention and control in May 2023.

A number of staff on all wards had completed quality improvement training and managers continued to mentor colleagues undertaking the training.

All 4 wards had huddle boards. These consisted of areas of quality improvement and staff met weekly to formally discuss progress, actions and achievements, which were recorded and noted for reference for all staff and managers.

The older adult wards at St George's hospital had received a prestigious platinum award for the Recondition the Nation work they completed in the 2022/2023 campaign.

Oak ward was highlighted for its improvements at a recent celebration event for the care group.

Our findings

Holly ward had been accredited under the Quality Network for Older Adults Mental Health Services.

Our findings

Areas for improvement

Action the service **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 service SHOULD take to improve:

- The service should ensure that the rationale for restrictive interventions is always fully recorded. (Regulation 17)
- The service should ensure that medicines are stored at the correct temperature to ensure they are safe to use (Regulation 12)

Our inspection team

Our inspection team consisted of 1 operations manager, 2 inspectors, 1 specialist advisor and 2 experts by experience. Experts by experience have either used services or have cared for someone who has used services.