# North West Boroughs Healthcare NHS Foundation Trust

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

Hollins Park House, Hollins Park Hospital
Hollins Lane, Winwick
Warrington
Cheshire
WA2 8WA
Tel: 01925664000
www.nwbh.nhs.uk

Date of inspection visit: 22 July 2020
Date of publication: 17/09/2020

## Ratings

| Overall rating for this service | Good |
|---|---|
| Are services safe? | **Requires improvement** |
| Are services effective? | |
| Are services caring? | |
| Are services responsive? | |
| Are services well-led? | |

# Summary of findings

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

**Good** 

### Summary of this service

We did not rate the hospital at this inspection as it was a focused inspection of the safe key question for one ward. The previous inspection rating of good from October 2018 still applies.

- The service did not provide safe care and environmental risks were not mitigated through existing control measures. Staff assessed patient risk, however did not carry out patient observations in line with trust policy to keep them safe. A ward ligature risk assessment was completed and reviewed; however, this did not identify all the ligature risks in the environment.
- On the tour of the ward we found that when en-suite doors were closed there was a gap between the door and door frame which was a potential ligature point. These doors were of a solid construction and potentially weight bearing, and this risk was not identified individually on the environmental ligature point risk assessment.
- Staff did not record the times and intervals of observations in accordance with the trust's observation, safety and engagement policy. The policy specifies:
- at section 2.5 'they avoid predictability when undertaking intermittent observations; for example, ritualistic practices i.e.'15 min checks' are not likely to reduce risk of harm to self.
- at section 6.16 'all records specifically utilised in services in support of this policy must be fully completed with timed observations being captured accurately and contemporaneously'.
- These sections confirm observations should be irregular but within the prescribed window. This is to avoid patients being able to predict when they will next be observed and therefore reduce the opportunity for a patient to harm themselves or others during this timeframe.

However

- The ward environment was clean. The ward had enough nurses and doctors. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by an assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- 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 and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- 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.

# Summary of findings

- The service had experienced a high bed occupancy and had experienced admissions to the ward by people from outside Halton, though had managed beds so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this. At the time of the inspection the ward had suspended admissions following a serious incident on the ward.
- Weaver ward had experienced changes to the leadership team with a new temporary ward manager and at the time of inspection there were no deputy ward managers in place. The ward manager had introduced an action plan to address shortfalls in the monitoring of patient observations prior to the inspection.

We carried out this urgent focused inspection of Weaver ward at the Brooker Centre, Runcorn, due to concerns about the safety of patients on this ward. This was following a serious incident and complaints from patients and their families.

Prior to the inspection we requested the following information:

- staffing levels, including the expected, actual and fill rate numbers for staff on shift, a breakdown of agency/ bank and permanent staff, details of how many shifts that agency/bank staff covered on these two weeks and details of how many agency/bank staff completed a ward induction and when they completed it.
- information on bed occupancy for the weeks commencing 07 and 13 July 2020.
- the numbers of patients on varying levels of observations for the weeks commencing 07 and 13 July 2020.
- information on risk assessment/security checks of the ward environment.
- incident numbers and type of incident from 01 July onwards.
- details of complaints made by patients 01 July onwards.

During the inspection we:

- looked at the quality of the environment and observed how staff were caring for patients.
- spoke with two people who were using the service.
- spoke with the ward manager and operations manager.
- spoke with six other staff members including the clinical lead, registered nurse, health care assistant, psychologist, ward administrator and ward pharmacist.
- looked at seven care and treatment records and five prescription charts.
- carried out a specific check of the medication management, checked the clinic and treatment rooms.
- looked at a range of policies, procedures and other documents relating to the care and treatment of patients.
- requested additional individual patient records to review off site.

## Is the service safe?

**Requires improvement** 

Our rating of safe went down. We rated it as requires improvement because:

We did not rate the hospital at this inspection as it was a focused inspection of the safe key question for one ward. The previous inspection rating of good from October 2018 still applies.

# Summary of findings

- The service did not provide safe care and environmental risks were not mitigated through existing control measures. Staff assessed patient risk, however, did not carry out patient observations in line with trust policy to keep them safe. A ward ligature risk assessment was completed and reviewed; however, this did not identify all the ligature risks in the environment.
- On the tour of the ward we found that when en-suite doors were closed there was a gap between the door and door frame which was a potential ligature point. These doors were of a solid construction and potentially weight bearing, and this risk was not identified individually on the environmental ligature point risk assessment.
- Staff did not record the times and intervals of observations in accordance with the trust's observation, safety and engagement policy. The policy specifies:
- at section 2.5 'they avoid predictability when undertaking intermittent observations; for example, ritualistic practices i.e.'15 min checks' are not likely to reduce risk of harm to self.
- at section 6.16 'all records specifically utilised in services in support of this policy must be fully completed with timed observations being captured accurately and contemporaneously'.
- These sections confirm observations should be irregular but within the prescribed window. This is to avoid patients being able to predict when they will next be observed and therefore reduce the opportunity for a patient to harm themselves or others during this timeframe.

However

- They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Weaver ward was clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff were able to use restraint and seclusion, but only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- 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 had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

# Detailed findings from this inspection

## Is the service safe?

**Safe and clean care environments**

**Weaver ward was clean well equipped, well furnished, well maintained and fit for purpose.**

**Safety of the ward layout**

Staff on Weaver ward could observe patients in all parts of the ward. Parabolic mirrors were used to observe difficult to see areas, for example an arterial corridor leading to bedrooms and a seclusion room.

Weaver ward is a 17 bed female admission ward with no mixed sex accommodation.

The ligature risk assessment for Weaver ward identified that bedroom and en-suite bathroom doors were potential ligature risks. The risk was to be mitigated by staff observation of patients though viewing panels in bedroom doors. En-suite bathroom doors could be locked to prevent them being used as a ligature point if agreed through a multidisciplinary team decision. These doors were of a solid construction and potentially weight bearing However, during a tour of the environment we noted that when the door was closed there was a gap between the door and the frame. This potential ligature point was not separately identified on the risk assessment. This meant staff may see the locking of the en-suite door as sufficient mitigation to prevent a ligature, when locking the en-suite door created another ligature point.

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

**Maintenance, cleanliness and infection control**

Weaver ward areas were clean, well maintained, well furnished and fit for purpose.

Staff on Weaver ward made sure cleaning records were up-to-date and the premises were clean. Patients and staff told us the ward environment was clean and there was additional cleaning throughout the COVID-19 pandemic.

Staff on Weaver ward followed infection control policy, including handwashing. Before entering the ward, we had to wear face masks and use hand gel. In the entrance foyer there was personal protective equipment (PPE) available. This included single use items such as gloves, aprons and face masks. Reusable visors and goggles were also available and could be disinfected on the ward. We observed staff wearing face masks and washing their hands regularly.

The seclusion room on Weaver ward allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic rooms on Weaver ward were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff on Weaver ward checked, maintained, and cleaned equipment.

**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**

Weaver ward had enough nursing and support staff to keep patients safe. Prior to the inspection, the trust provided us with information on staffing levels at Weaver ward. The expected staffing numbers for an early and late shift was two registered nurses and three health care assistants. The night shift expected figures were one registered nurse and three health care assistants. On the 22 July 2020, the staffing figures were two registered nurses and four health care assistants on the morning and afternoon shift and one registered nurse and four health care assistants on the night shift.

# Detailed findings from this inspection

The ward manager on Weaver ward was on maternity leave and cover was provided by another ward manager on a fixed term contract, who had been in post approximately eight weeks at the time of inspection. Two deputy ward managers had recently been relocated to other clinical areas. The ward manager was supported by a band 7 clinical lead nurse and an experienced nurse redeployed from a community mental health team during COVID-19. Information provided by the trust prior to the inspection and our review of staff rosters during the inspection confirmed a fill rate of between100% and 150% dependent upon the needs of the ward. The ward staff were also supported by:

- psychologist working 0800 -1800 Tuesday to Friday.
- activity co- coordinator 0900 -17700 over 7 days
- occupational therapist 0900-17-00 Monday to Friday.

The trust had given the ward manager permission to recruit four registered nurses on temporary contracts to cover any additional needs due to the high occupancy levels and demands the ward had experienced, though these posts had not been recruited to at the time of the inspection. In the weeks prior to the inspection the ward bed occupancy rate was 93%. Vacancy rates on the ward had reduced, with the recruitment of three student nurses who would be registered with the Nursing and Midwifery Council in September and December 2020 and would then begin a period of preceptorship. These staff were working on the ward as health care assistants. A ward housekeeper had also been recruited and was waiting to complete the employment process. Staff told us the ward at times was covered with staff from other wards and this could disrupt the skill mix and balance of experienced staff on the ward.

The service had low rates of bank and agency nurses. For the weeks commencing 07 and 13 July 2020 there were 20 shifts covered by bank staff, this equated to 12 individuals. Managers limited their use of bank and agency staff and requested staff familiar with the service. During this period four of these staff had either previously been or were substantive members of staff. During this period only one member of agency staff was used for one shift.

Managers supported staff who needed time off for ill health. Staff told us about the positive support they had from the ward management and service leadership team during recent difficult challenges to the ward. Staff spoke positively about the support from the psychologist and ward manager in supporting their wellbeing and return to work following sickness.

The ward manager could adjust staffing levels according to the needs of the patients and review the skill mix of staff.

Patients on Weaver ward had a regular one to one session with their named nurse. One patient told us they had three named nurse sessions a week as part of the self-harm pathway. This included planning for leave, using the coping strategies they had learnt and using a safety plan to contact support if they needed it, for example contacting the ward to speak to a staff member to reduce their anxiety.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The two patients we interviewed said they were able to have leave, and this had included contact with their families. In patient records we reviewed there was evidence that patients had visited their home and spent time off the ward with their families and other significant people.

The service had enough staff on each shift to carry out any physical interventions safely. Staff we spoke with expressed concern that because of the COVID-19 pandemic they had not been able to refresh their physical intervention training and new staff had not been able to have face to face training. We had not received any concerns about the management of physical intervention on Weaver ward at the time of the inspection.

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

**Medical staff**

# Detailed findings from this inspection

The service had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency.

**Mandatory training**

The trust provided us with information on induction training for staff on Weaver ward. This information included ward induction training for agency staff. The ward manager and staff we spoke with told us they had completed both induction and mandatory training. The ward manager confirmed she had a ten day induction, which included management training on the trust management systems. The ward induction checklist for agency staff did not include incident reporting or the self-harm pathway. Information provided by the trust confirmed training for staff took place on the following dates in June 2020 on the self-harm pathway. Training included the ward and deputy manager, registered nurses, healthcare assistants, student nurses and psychology:

- 2 June - self- harm pathway
- 16 June - safety planning
- 19 June - chain analysis
- 23 June - substance misuse pathway and chain analysis
- 30 June - substance misuse pathway and chain analysis

A total of 31 staff including the ward and deputy managers, registered nurses, assistant practitioners, healthcare assistants and psychologist had completed training on the self-harm pathway.

**Assessing and managing risk to patients and staff**

**Staff followed best practice in anticipating, de-escalating and managing challenging behaviour**. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

**Assessment of patient risk**

Staff on Weaver ward did not consistently complete the whole of the trust observation, risk assessment and management plan. The observation form has risk assessment and management plan on the title sheet, which includes a diagnosis and rationale for observation levels. This section should include a rational for the observation and the patient's capacity to understand and participate in observation and reduce the need for it. In three of the seven records we reviewed, we found no information recorded in the rational for observation or patient's capacity to understand and participate with staff to reduce the need for observation.

Staff on Weaver ward completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We saw evidence in patient's records that medical staff referred patients to physiotherapists and occupational therapists for assessment of their mobility and other medical needs. GP's were contacted to inform them of patient risk and progress. Assessment of risk also included monitoring of nutrition, hydration and sleep.

Staff used a recognised risk assessment tool. Staff used the risk and management plan in conjunction with the self-harm pathway to assess and manage patient risk. The self-harm pathway was introduced to Weaver ward in July 2019 to support patients to reduce the incidents of self-harm. The pathway was based on National Institute for Health and Care Excellence (NICE) guidance short and long term management of self-harm (NICE 2004/2011 and NICE 2013 quality standards for self-harm). The pathways were designed to help patients understand how and in what context they self-injure, their own triggers and the function that the self-injury serves. The pathway involved the patient developing a safety plan to be updated throughout their admission during named nurse sessions and was to be used at times of emotional crisis. Patients were encouraged to develop skills in distraction, self-soothing, grounding and problem

solving. We reviewed the records of 2 patients who chose to utilise the pathway. We saw patients completed a self-harm chain identifying triggers and contributing factors such as their emotional. physical or psychological state. This included the coping skills the patient used to reduce their distress and the outcome. We saw the support plans which helped patients understand their triggers, explore different resources and identify skills they could benefit from using to help them stay safe.

Safety plans on Weaver ward were person centred and written using patient's own words. Safety plans identified patient's goals, triggers and signals they noticed when becoming distressed. Plans included the skills, support and who a patient could seek help from to stay safe. Weaver ward had introduced an information leaflet for patients on the self-harm pathway. One of the concerns we received, leading to the focused inspection raised by a relative was they did not have information on the self-harm pathway. The relative told us the pathway was not explained to them by staff so they could sufficiently understand it, nor were they provided with information about it. The trust should ensure that they do all they can to help families fully understand the self-harm pathway.

Risk assessment on the self-harm pathway included considering the least restrictive practice to help patients take responsibility for their own safety. The pathway was discussed in daily ward safety huddles and staff had reflective practice sessions. We reviewed reflective practice sessions for June and July 2020. These included discussion and reflection on individual patients care led by the psychologist to help staff identify and manage risk and encourage patients to use the skills and resources they were developing to keep safe. Sessions included staff requests for training on managing specific risks within the pathway. For example, how to respond to a ligature incident. Reflective practice sessions supported staff to discuss incident management, use the training and guidance available and seek peer support from other mental health professionals.

**Management of patient risk**

Staff on Weaver ward did not follow the trust policy to minimise risks where they could not easily observe patients. Staff carried out observations at predictable intervals which put patients at risk. Staff did not record the wellbeing of the patient or staff interaction with the patient during observations and records did not always clearly show which staff member had carried out the observation. Staff did not always record observations at the prescribed frequency, particularly during night-time. Staff completed a risk assessment to determine the level of observation a patient required. The trust policy identified three levels of observation:

- General observation level one – this is the minimum level of observation for all in inpatient areas. Staff should know the location of all patients in their area, but patients need not be kept in sight. Patients subject to general observations will normally have been assessed as being a low-risk to themselves or others.
- Intermittent observation level two – the patient's location and safety must be visibly checked at specified intervals. These intervals may range between ten and thirty minutes. This is for patients who pose a potential, but not immediate risk. The specified frequency of observation should be recorded in the care plan. Observing patients at predictable times can provide them with the opportunity to plan or engage in harmful activities. This should be considered when determining the frequency of observation required. Level 2 observations include zonal observation. This is an approach a ward or clinical area may use to enhance observation of a group or patient within a specific ward or environment, for example a ward caring for patient's living with dementia. A staff member may be assigned to observe and engage with patients using specified zones within the ward area.
- Within eyesight level three – this means a nominated staff member will be allocated to each patient being managed on this level of observation and the patient must be kept within continuous eyesight. This level of observation is for patients who could, at any time, try to harm themselves or others, or is perceived as being vulnerable.

# Detailed findings from this inspection

The decision to introduce or increase the frequency of observations may in the first instance be taken by a registered nursing staff or mental health practitioner, when possible in conjunction with medical staff, and in response to an assessed risk. Wherever possible, decisions about the level of supportive observation required by a patient should be jointly made by the multidisciplinary team. Decision making in respect of the authority to change practice should be described within the patient's care plan, so that responsibilities for managing risk are well understood.

In the two weeks prior to inspection there were four patients on enhanced level 2 observations. At the time of inspection, and following a serious incident on the ward, all patients were on enhanced level 2 observations and one patient was on continuous one to one level 3 observations. Prior to the inspection we asked the trust to provide us with the levels of patient observations for the weeks commencing 07 and 13 July 2020. The trust information we received was there were no patients on one to one observation between 7 July and 13 July. During the period 7 July to 13 July there were 4 patients on enhanced level 2 observations of between every 10 to 30 minutes. At the time of our inspection all patients were always observed on enhanced level 2 observations of between every 10 to 30 minute intervals and 1 patient on a one to one level 3 observation by staff.

In the seven patient records we reviewed we saw patients were assessed for risk by medical and or nursing staff on admission and a level of observation was agreed to monitor risks identified to patient safety. From the initial assessment a level of observation was prescribed and the time intervals for observing patients agreed by the multidisciplinary team. These levels were reviewed throughout the day by nursing and medical staff and any changes agreed with the medical staff and recorded in patients' care records. In one of the seven patients records we reviewed we found that observation levels had not been agreed by the multidisciplinary team. Staff would record their observations on an observation record.

The trust's observation, safety and engagement policy stated that observations should be irregular but within the prescribed window:

- Section 2.5 'They avoid predictability when undertaking intermittent observations; for example, ritualistic practices i.e.'15 min checks' are not likely to reduce risk of harm to self
- Section 6.16 'All records specifically utilised in services in support of this policy must be fully completed with timed observations being captured accurately and contemporaneously

This was to avoid patients being able to predict when they will next be observed and therefore reduce the opportunity for a patient to harm themselves or others during this timeframe. The trust had been issued with a Regulation 28 report to prevent future death in October 2019. This was in relation to the death of a patient on another ward at a different location, where the coroner raised concerns about the quality of observations, in particular that they were carried out at precise intervals that could be predicted by patients and that managers were not checking observations were being carried out in accordance with trust policy. The trust response indicated that training would be provided to all staff at that hospital on the correct procedure for completing therapeutic observations. The learning from this Regulation 28 does not appear to have been shared across the trust. On Weaver ward, in all seven records reviewed, nursing staff and health care assistants were carrying out observations of patients at precise intervals. If a patient was on level two quarterly observations, we found staff on both day and night shifts were recording they had carried out an observation at fifteen minute intervals. For example, 10:00, 10:15, 10:45 and 11:00 or 01:00, 01:15, 01:30 and 02:00. We also saw the same examples for patients who were prescribed level two 10 minute or half-hourly observations.

Staff on Weaver ward did not record observations in line with trust's observation, safety and engagement policy. In the seven patient's records we reviewed we found limited detail on observations charts about a patient's wellbeing and focused on the location of the patient and what they were doing. The charts lacked information on any patient interaction with staff, which would allow staff to assess risk or gauge a patient's view of personal risk. Observations records did not specify who was reviewing the observations, the grade of the staff completing the record and if this was checked by a registered nurse for completion and accuracy. For example, where patients were prescribed level two

observations every 15 minutes, staff on day and night shifts were recording one signature for a period of one hour and not four signatures, to clarify four separate observations. The trust's observation, safety and engagement policy specified the ward or deputy manager and registered nurses are responsible for ensuring observation records are complete and accurate. The ward and operations managers clarified there was no medical decision that while patients were sleeping, they would only be observed hourly when the observation record indicated every fifteen minutes.

The ward manager on Weaver ward had completed an audit of observation records from 13 July onwards and had noted the same issues around adherence to the trust policy and completion of observation records. As a result, the ward manager had added this concern to the ward action plan that they were in the process of developing. The manager had sent emails to all staff about the completion of observation records. This detailed dates for meetings with staff from 22 July until the end of August to discuss non-adherence to the trust policy. The manager also confirmed all staff would be given a copy of the observation policy and this would be recorded in clinical/managerial supervision for all grades of staff. They planned to monitor this through staff performance against the trust policy. The operations manager told us there was a wider issue relating to compliance in observation recording since a new version of the observation policy had been introduced and the trust was arranging additional training for staff, but we were not given details of training dates at the time of inspection.

Staff on Weaver ward followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients told us staff did not routinely search them but would ask them to show then the contents of handbags when returning from off ward activities, in case they brought restricted items onto the ward. This information was provided for patients in the ward information pack, which explained patient's rights and safety checks that took place for patients who were informal or detained under the Mental Health Act.

**Use of restrictive interventions**

Levels of restrictive interventions on Weaver ward were reducing. Patients and staff told us that during the COVID-19 pandemic, visits to the ward had been restricted due to government guidance. Over recent weeks patients said they were able to have unescorted leave outside the hospital. In addition, the ward manager had reintroduced a relaxation area near to the staff office, where patients could watch television or read. This ward manager told us this facility had previously been suspended due to patients congregating near the staff office and this being noisy and causing disruption. The ward manager had moved the staff office to another area and reintroduced the seating area.

Staff on Weaver ward participated in the provider's restrictive interventions reduction programme, which met best practice standards. Prior to the inspection the requested records sent to us by the trust recorded areas of the ward that were locked routinely. For example, access to the laundry, bathroom, shower room and art room. During out tour of the ward the manager explained access to these rooms was restricted at times due to risk as they had identified ligature points and other risks in the review of the ward ligature risk assessment March 2020. Patients told us they could access these areas on request and dependent upon their levels of observation and need, without staff supervision. Patients and staff told us that access to the art room on the ward was being reviewed by the ward manager. They told us the occupational therapist and a healthcare assistant were removing all items that presented a risk to patients from the room, so it could be used throughout the day without staff supervision. Where risk was identified, and restrictive practices had been used these incidents could be taken to the trust's least restrictive practice group. We saw a recent report of an incident taken to this group. This was presented to the group and discussed so advice and guidance on how to support patients with the least restrictive approach and learn lessons to develop practice.

Staff on Weaver ward 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 told us they used different verbal techniques to support patients reduce their distress based on patient's protective factors and individual support plans.

Staff on Weaver ward understood the Mental Capacity Act definition of restraint and worked within it.

# Detailed findings from this inspection

Staff on Weaver ward followed NICE guidance when using rapid tranquilisation. We reviewed the records of a patient when rapid tranquilisation had been used. The reason for the use of rapid tranquilisation was recorded and all physical observation records were completed.

**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 on Weaver ward received training on how to recognise and report abuse, appropriate for their role.

Staff on Weaver ward kept up-to-date with their safeguarding training.

Staff on Weaver ward could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, the ward manager and staff interviewed told us about patients who had been referred to the safeguarding adults team following increased serious incidents. This was to provide additional assurance to the staff team that safety incidents were being responded to regarding these patients.

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

Staff on Weaver ward followed clear procedures to keep children visiting the ward safe. Patients told us that visits with children were outside of the ward. For example, a patient has me their children in the hospital coffee shop.

Staff on Weaver ward knew how to make a safeguarding referral and who to inform if they had concerns.

**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 on Weaver ward were comprehensive, and all staff could access them easily.

Although the service used a combination of electronic and paper records, staff on Weaver ward made sure they were up-to-date and complete. However, this did not apply to observation records as previously mentioned.

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

Records on Weaver ward were stored securely.

**Medicines management**

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

Staff on Weaver ward followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed five prescription charts with the ward pharmacist and found these were regularly reviewed my medical staff and for example, the use of antipsychotic medicines were reviewed jointly between the medical staff and pharmacist.

Staff on Weaver ward reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff on Weaver ward stored and managed medicines and prescribing documents in line with the provider's policy.

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

# Detailed findings from this inspection

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

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The ward had a dedicated pharmacist, who reviewed patient's medicines and attended the ward multidisciplinary meetings to offer advice and support to medical and nursing staff. For example, we saw evidence in patient's records where the pharmacist had given advice on the prescribing of an antipsychotic medicine when a patient had a long term condition, which this medicine could impact upon.

Staff on Weaver ward reviewed the effects of each patient's medication on their physical health according to NICE guidance.

**Track record on safety**

**Reporting incidents and learning from when things go wrong**

Prior to the inspection there had been a serious incident on Weaver ward. In October 2019 the trust was issued with a Coroner Regulation 28 report in relation a prevention of a future death. This was in relation to the death of a patient on another ward at a different location, where the coroner raised concerns about the quality of:

- observation levels on the date of the incident were not correct.
- quality of observations.
- lack of risk assessment of suicide and self-harm

The Coroner Regulation 28 report highlighted observations were carried out at precise intervals that could be predicted by patients and that managers were not checking observations were being carried out in accordance with trust policy. The trust response indicated that training would be provided to all staff at that hospital on the correct procedure for completing therapeutic observations. In answer to the Coroner Regulation 28 letter trust outlined their actions in response to the serious incident. This included review of the trust observation policy, additional training and development for staff and the introduction of an electronic observation recording system. Identified improvements were enhanced monitoring governance systems and process to ensure improvements were embedded. However, the learning and improvement identified as a result of the Coroner regulation 28 report received on 28 October 2018 were not shared trust wide.

Staff on Weaver ward recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff on Weaver ward knew what incidents to report and how to report them. Prior to the inspection we requested the trust provide us with the number and type of incident on Weaver ward from 01 July onwards. In total there was 73 incidents reported as follows:

- Accident- 1
- Admission / Appointments / Referral- 1
- Death- 1
- Environment / Facilities- 1
- Medication Incident- 3
- Patient Care- 8
- Self-Harm- 53

# Detailed findings from this inspection

- Violence & Aggression- 5

Staff on Weaver ward raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they reported anything untoward as an incident through the trust reporting system. Staff told us it was mandatory for patients to be debriefed following an incident and patients were informed about incident management, through individual named nurse sessions, community meetings or 'you said we did' feedback.

Staff on Weaver ward understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers on Weaver ward debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff on Weaver ward met to discuss the feedback and look at improvements to patient care. The ward participated in the trust daily safety huddles to discuss the management of patients care, discuss incidents and risk assessment and risk management of patients.

## Areas for improvement

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 12: Safe care and treatment

12(2)(a)(b)

Care and treatment must be provided in a safe way for patients. The trust must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. The trust must ensure that staff adhere to the trust policy when agreeing and reviewing patient observation levels and in the carrying out of observations. The trust must ensure that all ligature risks in the environment are identified, recorded and mitigated against to ensure the safety of patients.

12(2)(b)

The trust must do all that is reasonably practicable to mitigate risk and must adopt control measures to make sure the risk is as low as is reasonably possible.

On the tour of the ward we found when en-suite doors were closed there was a gap between the door and door frame which was a potential anchor point. These doors were of a solid construction and potentially weigh bearing, and this risk not identified individually on the environmental ligature point risk assessment.

17(1)(2)(a)

Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The trust must ensure that learning and improvement identified as a result of serious incidents is shared across the whole trust and improvement made in response to this learning. This must include immediate actions to ensure learning from the Coroner Regulation 28 issued on October 19, 2019 is shared across all inpatient wards.

17(1)(2)(b)(c)

Systems or processes must be established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Systems or processes must be established and operated effectively to maintain securely an accurate,

complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The trust must ensure that systems and processes are implemented to effectively audit observation records to ensure observation records are completed in line with trust policy.

The trust should ensure that they do all they can to help families fully understand the self-harm pathway.

# Our inspection team

The team that inspected the service comprised two CQC inspectors.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 17 HSCA (RA) Regulations 2014 Good governance |