Partnerships in Care Limited

Priory Hospital Norwich

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as requires improvement because:

- Staff did not always document the presentation of risk and nor did they create contingency plans when patients went on leave from the ward. Records did not always demonstrate that staff reviewed the outcome of leave. This meant that potential risks for patients might not be thoroughly considered and mitigated.
- The service did not always manage medicines safely. Whilst the provider had successfully identified some medicine errors it was not yet clear if the learning from this had been embedded to prevent the same happening in the future.
- Access to a clinical psychologist was limited to one day a week which reduced the ability to provide therapeutic interventions in line with best practice.
- The service did not maintain consistent COVID-19 cleaning records of high touch areas.
- The service did not provide masks with a clear area over staff mouths to facilitate communication for patients with hearing impairment.
- The service had not ensured that all the ligature risks were recorded on the environmental ligature risk assessment despite recently being updated which meant that staff might not be aware of these risks and how they should be managed.

However:

- Staff managed safety incidents well and had improved reporting of incidents and sharing of lessons learnt. Staff engaged in clinical audits to evaluate the quality of care they provided.
- Staff minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
- Patients were supported to live healthier lives and were offered a variety of activities seven days a week.
- The service was well led and the leadership of the hospital had improved since the last inspection. The governance processes had been strengthened although there was scope for further improvement based on the areas identified at this inspection.
- Staff at the hospital felt respected, valued and supported by the management team and we observed a positive culture during our visit. Staff described the managers as open and as having promoted a culture of openness and learning.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to Priory Hospital Norwich

The Priory Hospital Norwich is an independent hospital and is part of the Priory Group (Partnerships in Care). The hospital is an inpatient acute mental health unit for adults of working age. The hospital has the capacity to care for up to a total of 44 patients. There are two adult wards open: Woodlands Ward (10 females) and Redwood Ward (12 males).

The adult service was last inspected on 30 September and 1 October 2019 following an escalation of concerns. This inspection resulted in urgent enforcement action that restricted patient admissions to the service and placed several conditions on the providers registration to ensure the safety of patients. The provider made the decision to close for a period of 6 months and the acute adults ward closed for 8 months until the service re-opened in June 2020. The restriction on admissions has now been removed. Since the hospital has re-opened the managers have made significant improvements to develop a positive culture in the hospital by promoting person centred care, learning and transparency.

The hospital is registered to carry out the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act

What people who use the service say

We spoke with nine patients. Most patients spoke highly of staff and told us they felt safe on the ward and that staff were supportive and caring. However, one patient told us the attitude of one or two staff was uncaring and insensitive in the way they spoke to patients.

Five out of nine patients told us they were given a tour of the ward upon admission and eight patients told us they could access a wide range of activities seven days a week that included badminton, mindfulness, nature walks and arts and crafts.

Seven patients told us they felt confident to raise a complaint and one patient told us they had made a complaint, and this had been resolved quickly.

Patients told us they engaged in twice weekly medicine reviews, in collaboration with their psychiatrist, and all nine patients told us they were given information regarding their medicine and its side effects. However, one patient felt the review meetings were not private enough due to the number of staff present.

Feedback from carers was overall positive. Three out of four carers told us they felt their relatives were safe and were very happy with the care their relatives received. One carer said the staff were exceptional and everyone they had spoken to had given them time to ask questions and the care was excellent and staff superb. However, one carer told us they had not been fully involved in their relative's care and had not been given information on how to provide feedback about the service.

Summary of this inspection

How we carried out this inspection

We carried out an unannounced visit to Priory Hospital Norwich on 8 & 9 June 2021 and carried out further remote interviews with patients and carers on 14 June 2021. We focused on all five key lines of enquiry within the safe, effective, caring, responsive and well-led domains. During the inspection we:

- spoke with the clinical director and the hospital director
- spoke with nine patients and four carers
- spoke with one consultant psychiatrist
- spoke with two ward managers
- spoke with seven staff (nurses, health care assistants and occupational therapy assistants)
- spoke with an independent advocate
- spoke with a mental health act administrator
- reviewed twelve care plans
- reviewed two clinic rooms on both wards
- attended the daily flash meeting
- attended the monthly care notes review meeting
- reviewed five risk assessments
- reviewed eight prescription charts
- and reviewed a range of policies and procedures, data and documentation relating to the delivery of the service.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a Provider 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 MUST take to improve:

- The service must ensure the proper and safe management of medicines (Regulation 12 (g)).
- The service must ensure that care plans are regularly reviewed and updated and where there are identified safeguarding or clinical risks these are embedded within a safety plan to enable staff to respond appropriately to patient needs (Regulation 12 (a & b)).
- The service must ensure that Section 17 leave records have a contingency plan and that the outcome of leave is clearly documented in the patients care notes (Regulation12 (a)).
- The service must provide therapeutic psychological interventions to patients (Regulation 18(1).
- The service must ensure infection prevention and control measures are always adhered to (Regulation 12 (h)).

Action the service SHOULD take to improve:

- The service should consider ways to improve the WIFI accessibility for patients on both wards.
- The service should ensure staff accurately record restraint techniques used in their datix reporting.
- The service should ensure that the risk assessments of the ward environment are safe and accurately reflect potential risks.

Summary of this inspection

- The service should ensure the data recording systems are integrated to improve efficiency and avoid the risk of information being missed.
- The service should consistently use the risk screening tool for admissions to avoid patients being admitted incorrectly.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

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

Requires Improvement

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Good

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

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

Safety of the ward layout

Staff had recently updated the ligature risk assessments for both wards and had identified ligature anchor points, and environmental risks, and mitigated the risks to keep patients safe. However, we saw two potential risks on Redwood Ward that had not been included. This was raised with managers at the time of inspection and rectified immediately. Managers advised that the room where the items were identified was locked and access was supervised by staff.

The wards for men and women were separate and there was no mixed sex accommodation.

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

Maintenance, cleanliness and infection control

All wards were well equipped, well maintained, well-furnished and fit for purpose. Staff made sure the general cleaning records were up-to-date and the premises were clean. However, additional cleaning records for high touch areas in response to COVID-19 were not always up to date. We found on Redwood Ward that the cleaning schedule for COVID-19 had missing dates and on two occasions staff had only recorded they had cleaned the hot spot areas twice. The policy advises that cleaning should be completed as a minimum four times daily.

The provider supplied staff with appropriate Personal Protective Equipment (PPE) to ensure staff and patient safety. Manager's undertook regular audits to ensure staff adhered to wearing PPE appropriately. However, staff on Redwood ward were required to pull down their disposable masks to communicate with a patient with profound hearing loss, although this was at a 2-metre distance this placed staff and patient at risk of COVID-19 infection. The provider had not

taken steps to source clear masks which would have reduced the risk to patients and staff, and we raised this with the provider whilst on inspection who took action to rectify this. However, there was evidence of signage throughout the hospital reminding staff to comply with social distancing within meeting rooms and hand sanitisers were placed throughout.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment. However, during the previous six months the clinic room temperature had not been recorded on eight occasions on Woodlands Ward and four occasions on Redwood Ward. The sharp bins on Woodland Ward had no date of when assembled. The fridge temperature on Redwood Ward had not been recorded on four occasions in the last six months.

Safe staffing

Nursing staff

The service had vacancies for seven registered nurses and relied heavily on bank and agency staff to cover shifts, particularly during periods of unexpected sickness or absence. Managers mitigated this by covering shifts themselves or calling in familiar and regular agency and bank staff when needed to ensure the ward was safe. The service had a pro-active recruitment drive underway including recruitment of a night co-ordinator.

There was a robust system in place to check new staff met all the necessary safe staffing requirements. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This included staff experiencing a morning as a “patient” to assist them in gaining insight into the patients’ perspective of the ward environment.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The service had enough staff on each shift to carry out any physical interventions safely and patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Staff shared key information to keep patients safe when handing over their care to others. Managers held daily flash meetings to discuss any incidents, admission and discharges, staffing & maintenance.

Medical staff

The service had enough daytime and night time medical cover and a doctor available on site to go to the ward quickly in an emergency. The service had one full-time and one part-time consultant psychiatrist. In addition, the part-time consultant offered some remote support to ensure consistency for patients. Managers could call locums when they needed additional medical cover.

Managers made sure all medical staff completed the basic mandatory training and received full induction and understood the service before starting their shift.

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

Requires Improvement

Mandatory training

The mandatory training programme was comprehensive. Managers monitored mandatory training and alerted staff when they needed to update their training. Agency staff accessed the same training as permanent staff members at the hospital.

Most staff had completed and kept up to date with their mandatory training and overall compliance was 87% for all training. However, only 45.9% of staff had completed their Basic Life Support training as delivery of this had been affected by the COVID-19 pandemic. Managers told us that 51.3% of staff were booked to undertake the training and 100 % of staff were booked to update their Immediate Life Support training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission and, in most instances, reviewed this regularly, including after any incident. We saw evidence that incidents were reviewed, and immediate learning was acted upon and shared with the teams.

Management of patient risk

We looked at twelve patient care plans. Most care plans captured clinical risk, however we found one patient did not have a safety plan in place despite a change in their physical health needs.

We looked at five Section 17 leave records and found staff did not always document the outcome of leave and of the five records we reviewed two of them did not have a contingency plan. All five records did not document the presentation of risk whilst on leave and one record did not document the time the patient returned.

Managers were aware that patients needed to be offered COVID-19 vaccinations should they want them and had raised the issue with the local commissioning team. However, we found in one patient record where staff had documented on admission that the patient had received their first COVID-19 vaccination, but we could not find any follow-up actions taken by staff evidencing they had discussed with the patient plans for the second vaccination which was overdue.

Staff followed procedures to minimise risks where they could not easily observe patients and mirrors were in place to mitigate against areas where they could not easily observe patients.

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

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme. Managers held monthly meetings to review restrictive practice audits, identify lessons learnt and examples of good practice which were then shared with staff. However, we reviewed sixteen incidents between January to April 2021 and found that whilst staff documented techniques used when restraining patients, the circumstances in which the restraint was applied were not always fully described in the Datix log. This would assist with placing the incident in context and help identify opportunities for ongoing learning.

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 debriefed following an incident and patients were also offered debriefs.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. 85% of all staff had undertaken e-learning for safeguarding and 71% had attended face to face training. Opportunities for training had been disrupted due to COVID-19.

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. Several staff we spoke to knew who the Safeguarding Lead for the hospital was and were confident to seek advice when necessary. Managers had good oversight of safeguarding incidents and maintained close liaison with the local authority safeguarding team. However, of the thirteen safeguarding incidents reviewed on the safeguarding log only nine documented that the care and risk assessment had been updated accordingly.

Managers took part in serious case reviews with staff and made changes based on the outcomes.

Staff access to essential information

Patient notes were comprehensive, and all staff could access them, and records were stored securely. However, during our inspection some staff were not always clear on where specific information was stored and were required to review several locations to ensure they had all the relevant information

Medicines management

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Managers had identified numerous prescribing errors via their internal processes and an action plan had been implemented. Following the inspection, managers provided additional evidence demonstrating a reduction in medicine prescription errors.

Staff reviewed and provided specific advice to patients and most carers about their medicines. We spoke with nine patients and they all told us they were they were given information about their medicine. Furthermore, two patients said they felt listened to and worked collaboratively with the doctors.

Staff stored most medicines and prescribing documents in line with the provider's policy. However, out of the ten medicines checked we found two items with no date recorded of when they were opened.

Staff did not always follow current national practice to check patients had the correct medicines. Several staff had wrongly administered medicine to a patient over a period of days before the error was realised. Managers were investigating this error at the time of the inspection and had taken steps to prevent further errors occurring, using a range of tools including supervision, reflective practice, training and direct observation of administration of medicines by nurses.

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

Requires Improvement

Staff reviewed the effects of each patient's medicine on their physical health according to NICE (National Institute of Clinical Excellence) guidance including monitoring of blood tests and regular checking of their vital observations.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. There were clear systems in place and incidents were regularly reviewed by managers who cascaded lessons learnt to staff via team and clinical governance meetings, emails and monthly posters identifying key themes.

Staff raised concerns and reported incidents and near misses in line with provider policy. Managers pro-actively promoted a no-blame culture of openness and transparency. Staff welcomed this and told us they were confident they could raise concerns. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff and patients after any serious incident and investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service and staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, we learnt that a patient's bedroom door was unable to be opened due to difficulty with the lock. Following this incident daily checks to all doors was included in the daily environmental audit completed by staff.

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

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

We looked at twelve patient care records. Staff had completed a comprehensive mental health assessment for eleven of these patients either on admission or soon after.

Staff assessed patient's physical health soon after admission and regularly reviewed this during their time on the ward. Staff regularly reviewed and updated care plans when patients' needs changed in most cases. Out of the twelve patient care records reviewed two were not comprehensive and the care plan for one patient with profound hearing loss did not reflect their communication needs

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

Requires Improvement

We looked at twelve patient care plans, ten care plans were personalised, holistic and recovery orientated. However, two care plans did not include the patient views. Managers have recently commenced care planning audits and discussion and supervision with staff to drive up the quality of care plans.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service.

Staff identified patients' physical health needs but did not always record them in their care plans. We found one patient had not had their care plan updated following a significant ill health event and there was no safety plan detailing how the risks would be managed. We raised this with the provider, and it was rectified immediately by managers during the inspection.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes, for example life skills sessions. Patients who did not have ground leave were provided with vapes to encourage a reduction in smoking and there was a dedicated support line which patients could access to stop smoking.

The service had a clinical psychologist at the hospital once a week to support staff and this was under review by the managers who recognised that this clinical intervention was not currently available to patients.

The team provided a holistic approach to care by using a multi-disciplinary approach with patients being at the centre of their care. The occupational therapy team used the MOHOST (Model of Human Occupation Screening Tool) when working with patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers held monthly meetings to review restrictive practices and lessons learnt from incident audits. Areas of further learning and areas of good practice were fed back to staff in a variety of formats. For example, through daily team briefings, 1-1 supervision, emails and monthly posters visible in staff meeting rooms. The managers were also in the process of re-introducing the "Safeward" model into the wards which has the aim of minimising the number of conflictual situations between staff and patients.

Managers used results from audits to make improvements, for example they increased the presence of occupational therapy assistants during the weekly ward reviews on each ward as they had seen an increase in patient incidents when care reviews were being conducted.

Skilled staff to deliver care

The service had a range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work and managers supported staff through regular, constructive appraisals of their work.

Managers supported permanent, non-medical staff to develop through yearly, constructive appraisals of their work and support with career progression if appropriate.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

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

Requires Improvement

Managers made sure staff attended regular team meetings or gave information to those that could not attend.

Managers identified any staff training needs and gave staff the time and opportunity to develop their skills and knowledge, including ensuring staff received any specialist training for their role.

At the time of inspection, managers were exploring the possibility of recruiting a peer volunteer to work with patients in the service.

Multi-disciplinary and interagency teamwork

Staff held regular multidisciplinary meetings to discuss patients and improve their care and made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. At the time of inspection, 74 % of staff were trained in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and knew who their Mental Health Act administrator was and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and were advised of their rights on a weekly basis. Following the lifting of COVID-19 restrictions the independent advocate had recommenced twice weekly visits to the wards.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and for most patients it was recorded clearly in the patient's notes each time. However, out of the twelve patient care records we reviewed, one did not document that the patient had been read their rights since their initial admission into hospital twenty days previously.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely however, there was no sign at the main entrance to Redwood Ward notifying them of this. This was highlighted to the ward manager who took immediate action to rectify this during the inspection. The service had notice boards on both wards advising patients of their rights.

Managers and staff made sure the service applied the Mental Health Act correctly by completing regular audits undertaken by the Mental Health Act administrator and findings were discussed at the monthly Clinical Governance meetings.

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

Requires Improvement

Good practice in applying the Mental Capacity Act

At the time of inspection 74 % of staff had received training in the Mental Capacity Act and most staff interviewed had a good understanding of at least the five principles.

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

Good

Our rating of caring improved. We rated it as good.

We spoke with nine patients. Eight patients told us that staff were discreet, respectful, and responsive when caring for patients. During the inspection we saw evidence of positive interactions between staff and patients on both wards. However, one patient fed back they had witnessed one or two staff shouting at patients and had a disrespectful attitude towards patients which was fed back to managers to investigate further.

Staff gave patients help, emotional support and advice when they needed it and supported patients to understand and manage their own care, treatment or condition. Eight patients told us that staff were helpful, supportive and caring. One patient told us that one staff member was particularly understanding and helped her write her feelings down which later prompted her to verbally express how she felt.

Staff directed most patients to other services and supported them to access those services if they needed help. However, one patient with specific communication needs was not supported to engage with their pre-existing support network during their time of admission.

Staff followed policy to keep patient information confidential.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission and patients told us they received a welcome pack when they first arrived.

Staff involved patients and gave them access to their care plans and risk assessments. The care planning audits that management undertook demonstrated a steady increase in patient input into their care plans during the period of February 2021 to May 2021 and this was under continual review.

Staff made sure patients understood their care and treatment. However, we found one patient whose communication needs had not been appropriately addressed. This was raised with the management team during inspection who took immediate action to address this.

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

Requires Improvement

Staff involved patients in decisions about the service, when appropriate and could give feedback on the service and their treatment and staff supported them to do this. Each ward held twice daily community meetings for patients to raise any concerns and provide feedback. However, whilst patients' comments were documented it was not always clear whether actions had been taken. Following feedback, managers took immediate action to amend the daily log to capture actions taken.

Patients' access to WIFI was intermittent due to the location of the hospital. One patient told us they were frustrated due to lack of internet access and believed the nearest library was 30 minutes away. However, the provider informed us there was a library less than two miles away. The provider told us patients could access the library by using hospital transport and were aware of the WIFI issue and were looking at ways to resolve this.

Staff made sure patients could access advocacy services and the independent advocate had recently recommenced twice weekly visits to patients on both wards. Whilst visiting restrictions were in place due to COVID-19 staff supported the advocate to make weekly contact with patients via the telephone.

Involvement of families and carers

We spoke to four carers. Three carers told us that staff supported, informed and involved them appropriately. One carer told us they did not feel fully involved in their relative's care and had not been kept up to date about their progress.

Staff helped families to give feedback on the service and were provided with a Carers information booklet when their relative was admitted. One carer told us they had not been informed on how to provide feedback but felt confident to raise any issues with the staff.

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

Good

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

Access and discharge

Bed management

The service had introduced a risk screening tool to support decision making when accepting patient referrals. However, the screening tool was not consistently used, therefore there was a risk of patients being admitted incorrectly and there was no central location for staff to review all documentation for patients newly admitted.

The service had accommodated out of area placements and had developed positive working relationships with several clinical commissioning groups across the country.

Managers and staff worked to make sure they did not discharge patients before they were ready and when patients went on leave there was always a bed available when they returned.

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

Requires Improvement

Patients were moved to alternative provision only when there were clear clinical reasons, or it was in the best interest of the patient.

Discharge and transfers of care

Managers monitored the number of delayed discharges and were in regular contact with commissioners to ensure patients were not delayed unnecessarily.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Managers were in the process of introducing crisis cards for patients at the point of discharge from hospital.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom which they could personalise, and patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private. Whilst visiting restrictions remained in place due to COVID-19, managers had recently re-introduced planned visits from friends and relatives who could access the open space within the hospital.

Patients could make phone calls in private by using either their personal mobile or the patient phone on each ward.

The service had an outside space that patients could access easily. Patients could make their own hot drinks and snacks and were not dependent on staff and the service offered a variety of good quality food. There was plenty of fresh fruit and snacks available for patients to access whenever they wished.

Meeting the needs of all people who use the service

The service did not always support and make adjustments for disabled people and those with communication needs or other specific needs. We saw one patient's communication requirements where not fully met.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients and patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

Most patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas.

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

Requires Improvement

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes and shared feedback from complaints with staff and learning was used to improve the service.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

The service encouraged patients to complete a satisfaction survey when they were discharged. It also used compliments to learn, celebrate success and improve the quality of care.

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

Good

Our rating of well-led improved. We rated it as good:

Leadership

The director of clinical services and registered manager joined the hospital in June 2020 and had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed and were visible and approachable for patients and staff.

Vision and strategy

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

Staff felt respected, supported and valued and were provided with opportunities for development and career progression.

Staff told us they could raise any concerns without fear and all staff we spoke with were aware of whistleblowing procedures.

Culture

The Managers undertook weekly quality ward round reviews on both wards and staff told us that managers promoted a positive working environment that provided them with consistency and promoted a no blame culture which encouraged openness and transparency.

Staff who had previously worked at the hospital, prior to a change in management, told us the new managers had made effective changes to the service resulting in the culture for patients and staff being much improved.

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

Requires Improvement

Governance

Our findings from the other key questions demonstrated that governance processes had significantly improved since the last inspection. This supported managers to maintain oversight of performance and risk and they had put measures in place to improve patient safety. However, whilst good clinical governance practices had been developed, further improvements were required to ensure managers had total oversight and that all systems were robust and effective. For example, managers did not identify through governance systems and audits that staff were not always documenting the presentation of risk, nor did they create contingency plans when patients went on leave and whilst an action plan had been implemented to reduce medicine administration errors its effectiveness was not yet known.

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.

Information Management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. However, information was stored in more than one location which meant there was a risk of staff not being aware of all patient information. Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing