South Staffordshire and Shropshire Healthcare NHS Foundation Trust

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

Quality Report

St George's Hospital, Stafford
ST16 3AG
Tel:0300 7907000
Website:http://www.sssft.nhs.uk/

Date of inspection visit: 8 September 2017
Date of publication: 08/11/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRE13	St George's Hospital	Brocton Ward	ST16 3AG
RRE13	St George's Hospital	Chebsey Ward	ST16 3AG
RRE58	George Bryan Centre	West Wing	B78 3NG
RREX9	Redwoods Centre	Pine Ward	SY3 8DS
RREX9	Redwoods Centre	Laurel Ward	SY3 8DS
RREX9	Redwoods Centre	Birch Ward	SY3 8DS

This report describes our judgement of the quality of care provided within this core service by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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

Where applicable, we have reported on each core service provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Are services safe?	
Are services effective?	

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

In the last inspection in March 2016, we recommended that the trust should ensure that patients placed in the corridors of opposite gender were offered support, have risk assessments and care plans to manage the risks. Since that inspection we received information that caused us to re-inspect focussed on these key concerns.

• On this inspection, we found that the trust had not fully addressed these issues.Patients on Birch ward were placed in the opposite gender sleeping corridors without a robust risk assessment that follows a detailed management/care plan on how the risk of sexual safety was safely managed. There was no documented evidence to show that regular reviews were taking place.

• The trust did not ensure that the action plans put in place as a result of lessons learnt were followed up and monitored to ensure that changes in practice were fully embedded across the services.

• Staff in Laurel ward were not carrying out intermittent observations 5-15 minutes according to the trust policy.

However:

• The trust had changed two wards Pine and Laurel to single gender wards in response to concerns about sexual safety on the wards.

• Staffing levels were maintained to sufficient numbers to provide safe care.

Summary of findings

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

Are services safe?

- Patients placed in the opposite gender sleeping corridors on Birch ward had no detailed risk management/care plan that addressed how the risk of sexual safety was to be safely managed. The risk assessments were not robust enough. This was not in line with the Department of Health national guidelines on mixed gender accommodation.
- Staff in Laurel ward did not carry out intermittent observations in line with the trust's policy. There was no specific rota for staff maintaining observations in West Wing ward communal area.
- Action plans put in place as a result of lessons learnt from sexual safety and observations were not fully implemented and monitored to ensure that changes in practice were fully embedded across the services.

However:

- The trust had changed two wards, Pine and Laurel, to single gender wards and staffing levels were maintained to sufficient numbers.
- Staff received training on safeguarding, and knew how to identify and report safeguarding concerns. Staff knew how to identify and report incidents. Staff received debriefs after serious incidents. Staff received lessons learnt from incidents.

Are services effective?

- Staff completed comprehensive assessments of each patient's needs that included the patient's medical history, physical health and family and social circumstances.
- The multidisciplinary team meetings involved different professionals such as doctors, nurses, psychologists, occupational therapists and recovery support workers. They worked closely with the home treatment and community mental health teams.

However:

- Care plans to address risks around sexual safety on Birch ward lacked detail, and were not person-centred.
- There was no structured documentation of handovers to ensure that clinically relevant information was shared at shift changes and day to day.
- Patient information was not always shared in a timely manner by the admitting team before patients arrived on the wards.

Summary of findings

Information about the service

The service comprises six acute inpatient wards across three sites. The acute wards offer specialist assessment, care and treatment to adults who are experiencing mental health difficulties. The wards provide services for both patients admitted informally and those detained under the Mental Health Act 1983. The clinical management system across all six wards consists of a dedicated multidisciplinary team including a full-time consultant psychiatrist.

At the Redwoods Centre in Shrewsbury, there are three adult acute wards; Pine, female ward, Laurel, male ward and Birch, mixed gender ward; each providing 18 beds.

At St George's Hospital in Stafford, there are two adult acute wards; Chebsey and Brocton both mixed gender wards; Brocton providing 20 beds and Chebsey 19 beds.

West Wing is a mixed gender adult admission ward providing 20 beds and is situated at the George Bryan Centre in Tamworth.

Each acute ward had received a Mental Health Act reviewer visit between November 2015 and September 2017.

Our inspection team

Our inspection team was led by:

Team leader: Raphael Chichera

The team that inspected this core service comprised five CQC inspectors and one assistant inspector.

Why we carried out this inspection

We carried out this inspection as an unannounced focussed inspection following concerns raised by our Mental Health Act Reviewer on a visit to Laurel ward on 31 August 2017. The concerns raised were that the ward did not follow safe practice in meeting guidance on mixed sex accommodation by placing males in the female corridor without care plans or risk assessments in place.

We last inspected this core service in March 2016 and we rated it as **good** overall. We rated safe as requires improvement and good for effective, caring, responsive and well-led.

Following this inspection, we told the trust that it must take the following action to improve acute wards for adults of working age:

- The trust must ensure that their policy on rapid tranquillisation is up-to-date and reflects current prescribing guidance from NICE. The trust must ensure that clinical staff have a consistent approach to the use of rapid tranquillisation, understand its risks and record its usage.
- The trust must comply with the Mental Health Act Code of Practice requirements for documenting observations and decision making during any episodes of seclusion and long-term segregation.

We also told the trust that it should take the following actions to improve:

- The trust should take action to reduce the noise levels on the wards at St Georges' Hospital.
- The trust should review and ensure that comprehensive environmental risk assessments are carried out following any construction work on the wards.
- The trust should not place female patients in rooms on male corridors without offering support, risk assessments and seeking ongoing consent from the woman unless there is an urgent clinical need in line with national guidance.
- The trust should ensure that staff receive training in writing personalised care plans that reflect an individual patient's voice.

Summary of findings

- The trust should ensure that staff receive regular supervision in line with local policy and professional guidelines.

We issued the trust with two requirement notices that affected acute wards for adults of working age. These related to:

• Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

• Regulation 17 HSCA (RA) Regulations 2014 Good governance.

The trust submitted action plans showing how they would address these issues including monitoring of mixed gender accommodation to make it safer.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

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

During the inspection visit, the inspection team: visited all six of the wards at the three hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients.

• spoke with 20 patients who were using the service

• spoke with the managers or deputy managers of each the ward

• spoke with 24 other staff members including doctors, nurses, occupational therapists, support workers and recovery support workers.

• interviewed the matrons with responsibility for these services

• attended and observed two handover meetings.

• looked at 35 care records of patients

• looked at some of the policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all patients place in the opposite gender sleeping corridors must have a robust risk assessment that follows a detailed management/ care plan on how the risk of sexual safety is effectively managed. These must be regularly reviewed with a view to move patients to appropriate corridors as soon as possible.
- The trust must ensure that putting patients of the opposite gender into another corridor will only be done when there is an urgent clinical need and must seek on-going consent from the patient in line with national guidance.

Action the provider SHOULD take to improve

- The trust should ensure that there is a specific rota for staff maintaining observations in West Wing ward communal area.
- The trust should ensure that staff on Laurel ward are carrying out intermittent observations 5-15 minutes according to the trust policy.
- The trust should ensure that all action plans put in place as a result of lessons learnt are followed up and monitored to ensure that changes in practice is fully embedded.
- The trust should ensure that there is structured documentation of handovers to ensure that clinically relevant information is shared within the teams and between shifts.

Summary of findings

- The trust should ensure that patient information is shared by the admitting team in a timely manner before patients arrive on the wards.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Brocton ward	St George's Hospital
Chebsey ward	St George's Hospital
West Wing	George Bryan Centre
Pine ward	Redwoods Centre
Laurel ward	Redwoods Centre
Birch ward	Redwoods Centre

Are services safe?

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

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

Our findings

Safe and clean environment

- Brocton and Chebsey wards were mixed-gender wards. Both wards had separate corridors for males and females and a female-only lounge. Brocton ward had a third corridor allocated to Ministry of Defence (MoD) patients. This was a mixed-gender corridor. On admission, staff went through the policies and procedures of the wards including areas that patients should not access.
- Chebsey ward had 19 bedrooms across two corridors specific for male and female. Two of the bedrooms were located in the day area at the front of the female corridor and so were designated as for both male and female. Chebsey ward had a mix of bedrooms that had ensuite facilities or had a sink only, and each corridor had same gender bathrooms. We observed staff were allocated to observe the day area at all times and completed the observation records. Staff redirected male patients who tried to access the female corridor, and vice versa.
- Brocton ward had 20 bedrooms across three corridors specific for female, male and MoD. Staff office gave a clear view of the day area and the MoD corridor although the bedroom corridors were not directly visible when staff were in the office. However, the office was located at the entrance of the female corridor so staff saw patients who entered the corridor. All the female bedrooms on Brocton ward were ensuite. The MoD corridor had ensuite bedrooms. The male corridor had five bedrooms with ensuite facilities, and two bedrooms with sinks. These rooms were next door to a bathroom on the same corridor. Women who wanted a bath rather than a shower had access to the bathroom on the male corridor with staff supervision.
- Staff occasionally placed patients on wards of patients of the opposite gender when there were not enough beds on a same-gender corridor. We found that from 1 June 2017 to 31 August 2017 this had happened four times, all on Brocton. Staff completed a risk assessment and care plan that took into account issues of safety and gender-specific needs and preferences. The risk assessments and care plans were detailed and clearly stated how the risks were managed. The manager increased a patient'sobservation levels to manage risks, where required. Staff moved patients onto a same-gender corridor at the earliest opportunity. Staff discussed any current concerns at daily handover meetings.
- We spoke with six female patients across Brocton and Chebsey wards including patients placed in the MoD mixed-gender corridor because the female bedrooms were fully occupied. We asked them how they felt on the mixed-gender ward. All patients told us that they felt safe on the wards. Some patients had expressed fear at the thought of a mixed-gender ward before admission but had since found it to be well managed, which helped them feel safe. Patients on both wards reported how closely staff observed the patients and the environment. They said that there were always staff around.
- The West Wing ward had 20 beds with four bedroom corridors. Staff told us they do not have a designated corridor for female and male patients. They were always changing according to the number of male or female patients on the ward. All bedrooms had ensuite facilities and there was a separate lounge for females. There were female and male toilets in the communal area. They were not labelled male or female. Staff told us that patients prefer to use the toilets in their bedrooms. On the day of inspection, there were three males sleeping in the female corridor with seven females. All patients had an up to date risk assessment that had been reviewed. All female patients had a care plan that reflected the risks of males sleeping in the same corridor. However, none of the male care plans had been updated to address this risk of them sleeping in female areas. Staff reported that placement of males in female area was discussed with the patient and as a team. Only one patient out of seven stated that they had been moved without discussion. Staff regularly reviewed patients that were sleeping in the opposite gender corridor.
- Staff maintained observations in the bedroom area. However, there was no specific rota for this. Staff told us that all staff were aware that there was a need for a staff member to be in that area at all times. They could not

evidence how this was maintained, especially with the ward using bank and agency staff. This posed a risk of observations being missed in the bedroom area of the ward.

- On the day of our inspection, we found that the trust had changed Pine and Laurel wards to single-sex wards the previous day. Laurel was now a male only ward and Pine a female only ward. There was one male patient in the early stages of gender transition that remained on Pine ward. We looked at the risk assessment, care plan and rationale for this decision. We saw that the risk assessment and care plan were detailed and took all safeguards, privacy and dignity into account. The discussions held with the patient and the female patients on the ward were clearly documented and why it was appropriate at that time for this patient to remain on Pine ward. We were given reassurances that this was an exceptional case and would be regularly monitored.
- Birch ward had 18 bedrooms with separate corridors for men and women and a female-only lounge. All the bedrooms were ensuite and there were designated toilet and bathroom facilities for male and female patients. At the time of inspection there was one male patient placed in the female corridor. Staff told us that patients were often placed on the opposite gender corridor when their same-gender corridor was full.
- We looked at records for the last six patients that had been placed in opposite gender corridors. They all had risk assessments in place and reported as an incident. However, the quality of risk assessments in place were not detailed enough to show that risks of sexual safety had been specifically looked into before placing patients in the opposite gender corridor. We saw that two patients assessed as having a history of sexually inappropriate risks were placed in the female corridor without a clear rationale documented as to why this was appropriate.
- All six patients had a care plan in place for being placed on the female corridor. However, the care plans were not detailed enough to show how the risks of placing male patients in the female corridor were mitigated. They did not have details of what measures staff had put in place to manage the risk. They did not say what they had done to minimise the risk and what procedures staff needed to follow to ensure that the risk was minimised. There was no evidence recorded that a discussion had taken place with the patient. This was not in line with the Department of Health national guidance on mixed gender accommodation.
- There was no evidence documented to show that all patients placed in the opposite gender corridor were regularly reviewed. The ward said they discussed this in the morning meetings but they did not document it. There was no documentation for handovers, they said they just write on a piece of paper what to handover and then shred it after.
- All staff carried personal safety alarms on each shift. These were regularly tested to ensure they were working. This helped to ensure the safety of patients and staff. All wards had nurse call systems for patients to seek assistance when in need in their bedrooms and bathrooms.

Safe staffing

Establishment levels: qualified nurses whole time equivalent.

• Laurel ward 11.1, Pine ward 11.3, Birch ward 11.8, Brocton ward 12.4, Chebsey ward 9.8 and West Wing 9.2.

Establishment levels: nursing assistants whole time equivalent.

• Laurel ward 10.6, Pine ward 9, Birch ward 6.9, Brocton ward 9.3, Chebsey ward 12, and West Wing 11.8.

Number of vacancies at the time of inspection: qualified nurses whole time equivalent.

• Laurel ward 2.7, Pine ward 4.5, Birch ward 2.1, Brocton ward 0.6, Chebsey ward 3 and West Wing 5.2.

Number of vacancies at the time of inspection: nursing assistants whole time equivalent.

• Laurel ward 0.8, Pine ward 1, Birch 2, Brocton ward 0.7, Chebsey ward 2.4 and West Wing 0.6.

Number of shifts filled by bank or agency staff from June 2017 to August 2017.

• Laurel ward 122, Pine ward 166, Birch 171, Brocton ward 251, Chebsey ward 308 and West Wing 182.

Number of shifts not filled by bank or agency staff from June 2017 to August 2017.

Are services safe?

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

• Laurel ward 9, Pine ward 11, Birch ward 22, Brocton ward 4, Chebsey ward 8 and West Wing 15.

Staff sickness rate in the last 12-month period from September 2016 to August 2017.

• Laurel ward 4.4%, Pine ward 5.6%, Birch 12.2, Brocton ward 5.9%, Chebsey ward 4% and West Wing 7%.

Staff turnover rate in the last 12-month period from September 2016 to August 2017.

• Laurel ward 14.5%, Pine ward 11.8%, Birch ward 18.2, Brocton ward 13%, Chebsey ward 40% and West Wing 17.5%.

- The managers established their staffing levels in line with the national institute for health and care excellence (NICE) guideline SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals. They took into account the bed occupancy and the acuity of their patients to ensure that they met patients' nursing needs safely. They reviewed the staffing levels regularly through the trust's system of safe care arrangements.
- The wards had enough staff to meet the needs of patients. Both patients and staff told us there were enough staff on duty most of the time. We looked at the staff rotas for the two months prior to the inspection and found that the wards were rarely understaffed and staffing numbers mostly matched the number of nurses and nursing assistants on duty.
- All the acute wards used both bank and agency staff to help ensure sufficient staffing levels. Ward managers used bank staff in the first instance. Trust data for August 2017 showed that Chebsey ward used the highest and Laurel ward the lowest number of bank and agency staff. Staff and patients from Birch ward and West Wing told us staffing levels at times went below the required numbers. Patients told us that staff rarely cancelled leave or activities.
- Ward managers adjusted staffing levels to meet the increased clinical needs of patients. We saw that the managers on West Wing and Chebsey had adjusted staffing levels to take into account patients on one-to-one and two-to-one observations, which involved using extra bank and agency staff. Ward managers used the trust's live system of care to request any bank and agency staff when needed. They tried to use staff familiar with the wards wherever possible. They told us that at times, this was not possible.
- All wards had at least two qualified nurses on each shift. We observed that the qualified nurses spent time interacting with patients in the communal areas. Staff and patients confirmed that nurses were present in communal areas most of the time when the wards were not busy. Staff in Laurel ward told us that the ward can be very busy due to acuity of patients and this can take away time to spend with patients. Staff in Birch ward told us that it was settled most of the time, so there was plenty of time to spend interacting with patients. The wards had enough staff available so that patients could have regular one-to-one time with their named nurse.
- Patients told us they were getting time with their named nurses on a regular basis.
- All of the wards had enough staff to carry out physical interventions safely.
- Staff told us they had good access to medical input during normal working hours or out-of-hours in an emergency. The doctors were on site weekdays from 9am to 5pm. The trust had an out-of-hours doctor on call system that helped ensured a doctor could attend the ward quickly if needed.
- The trust provided mandatory and essential training to staff. This included training on health and safety, infection control, safeguarding adults and children, moving and handling, basic life support, information governance, the Mental Health Act, the Mental Capacity Act, fire safety, food safety, equality and diversity, and managing violence and aggression. The average rate for completed staff mandatory training was Laurel 87%, Pine 88%, Birch 85%, Brocton 93%, Chebsey 91% and West Wing 91%.

Assessing and managing risk to patients and staff

- We looked at 35 care records of patients and found that two records from Laurel ward did not have a risk assessment. Staff told us at times there could be delays to complete risk assessment for new admitted patients if the ward was busy or delays in getting information from the home treatment team. All other risk assessments contained detailed and consistent information about historical and present risks of patients. They were regularly reviewed and updated.
- The risk assessments in Birch ward were not followed by clear management plans on how staff should manage the sexual safety risks identified. Two of the records reviewed showed that patients with risks of sexual

nature were placed in the female corridor without clear risk management plans in place. We could not find any discussion or rationale documented as to why this had been considered appropriate.

- The wards had policies and procedures for the use of observations to manage risk to patients and staff. Staff from Laurel ward did not demonstrate good practice that followed the trust policy on observations. We saw that staff did not observe patients on intermittent observations 5-15 minutes according to the trust policy. Staff checked patients at set times every hour instead of checking patients at random times so that patients were not able to tell when staff would do the next check. Five staff we spoke with from Laurel ward were not aware of what the trust's policy said on this. Staff we spoke with from all other wards demonstrated a good understanding of the observations policy. We saw that staff maintained continuous observations of patients on one-to-one care and carried out intermittent observations randomly according to policy. Staff recorded the observations in line with the policy. Staff actively engaged with patients with activities and positive engagement. The wards had a robust and consistent induction process for undertaking patient observations.
- In the 12-month period from September 2016 to August 2017, Chebsey reported the highest episodes of restraint with 196, followed by Laurel with 150, Brocton 104, Pine 141, West Wing 67 and Birch 13. In the same period, 59 out of 671incidents of restraint were in prone position. Staff told us at times restraints started in the prone position for the shortest possible time. Therefore, no matter how short a time staff had held the patient in that position used, it was recorded as prone position for that period.
- Records showed that staff had received training in safeguarding. They knew how and when to make a safeguarding referral and were able to give us examples of how and when they had raised safeguarding concerns. We looked at the safeguarding referrals made in the period from 1 August 2016 to 10 September 2017 because of any allegations of sexualised behaviour. West Wing had the highest with 14, followed by Laurel and Brocton with four, Pine had three, Chebsey, two and Birch, one. Staff knew who the designated lead for safeguarding was and how to contact them for support and guidance.
- The trust had a policy for children visiting the wards. Staff discussed and risk assessed all visits from children taking into account any child protection issues. All locations had rooms away from the wards where relatives and children could visit patients safely.

Reporting incidents and learning from when things go wrong

- The trust used an electronic system for reporting incidents. Staff knew how to use this and gave examples of reportable incidents. Incidents sampled during our inspection showed that staff reported incidents appropriately.
- The trust had a duty of candour policy. Staff were aware of the duty of candour and gave us examples of openness and honesty with patients when there were mistakes made. Staff recorded any discussions with patients.
- The trust and ward managers shared lessons learnt from incidents with staff through a range of methods including handovers, emails, supervision, reflective practice sessions and postings on the intranet. Managers offered staff debriefs and support after serious incidents. However, we found that lessons learnt that had action plans in place were not always fully embedded in practice. There was no evidence in Birch and Laurel wards to show that senior managers had followed up these action plans to ensure that all staff had been following new practice from action plans. For example, staff from Birch ward did not follow lessons learnt from sexual safety action plan and staff from Laurel ward did not fully follow lessons learnt from the updated observation policy.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- We looked at 35 care records and saw that staff had completed a comprehensive assessment for all patients on admission. The assessments covered patients' relevant past history such as family, medical and social history, emotional and behavioural state and a physical examination.
- We looked specifically at care plans around sexual safety for patients that had been placed in the corridor of opposite gender. We found that care plans in Brocton, Chebsey and West Wing wards fully addressed the needs identified in the risk assessment on how to manage sexual safety on the wards. The care plans were up to date, regularly reviewed and person centred.
- We looked at six care records for the last patients that had been placed in opposite gender corridor in Birch ward. We found that all six patients had care plans for being placed on the female side. However, the care plans lacked detail to show how the risks of placing male patients in the female corridor were managed. They did not address any of the risks around sexual safety or contain details for staff and patients to follow to ensure that the risk is minimised. They were just statements that stated a patient had been placed in the female corridor. There was no evidence documented to show these care plans were regularly reviewed. Staff told us they discussed this in the morning meetings but they do not document it.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team meetings involved different professionals within the team and sometimes included other professionals from the home treatment and community teams. The teams involved doctors, nurses, psychologists, occupational therapists and recovery support workers. We observed discussions that addressed the identified needs of the patients such as risk, physical health, mental health, discharge planning and changes to care plans. The doctors offered patients choices about treatment and gave the information necessary to make informed decisions. Staff involved patients and family members to contribute their thoughts and feelings about the care and treatment provided.
- We observed two handovers across the core service one in Brocton ward and another in West Wing. Staff effectively communicated the needs of patients and treatment plans to each other. This included feedback from multidisciplinary team meetings, any changes in care plans, physical health, mental state, risks, observation levels or changes, MHA status and incidents. However, we observed that in Laurel and Birch wards there was no structured documentation about handovers. Staff told us that they had face-to-face handover, just wrote on a piece of paper information that needed to be shared and it was shredded soon after the handover. This meant there was no audit trail of clinically relevant information that had been shared within the teams.
- The wards had good working relationships with the home treatment and community teams. However, we saw that information was at times not shared in a timely manner when patients were admitted to the wards. We saw that patients could be admitted into the ward before ward staff had received all relevant information about the patient. Staff from the home treatment and community teams attended inpatient multidisciplinary team meetings to share information about patients. They shared information about patients likely to move between the services and discussed patients due for discharge. This helped ensure that staff understood patients' needs and offered relevant support.

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 How the regulation was not being met: Patients placed in the opposite gender corridor of mixed gender ward did not have robust risk assessments and management/care plans that clearly outlined how the risks were to be safely managed and regularly reviewed in line with the Department of Health guidance on mixed gender wards. This was a breach of regulation12(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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