Leicestershire Partnership NHS Trust

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

Inspection report

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Ratings

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

Our findings

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

Requires Improvement 

We carried out this unannounced focused inspection because at our last inspection in 2021, we had concerns about the quality of services and issued enforcement action. At this inspection we assessed what work the Trust had undertaken, as a result of the enforcement action we issued. The Trust was required to make significant improvements in some key areas.

We did not inspect all key questions in all domains because this inspection was undertaken specifically to assess progress the Trust had made to meet legal requirements after the last inspection. We are monitoring the progress of improvements to other key lines of enquiry in other services following the inspection in 2021 and will re-inspect them as appropriate.

The action we told the Trust to take following the last inspection were:

- to improve ways in which patients could call for help in an emergency
- to take action to eradicate shared sleeping arrangements (dormitories).
- to improve ways in which patients' privacy and dignity were protected.

We inspected some but not all key question in the domains of safe, effective, caring, responsive and well led in one service. The key questions inspected were in relation to the areas of concern in the enforcement action we took following the last inspection.

At this inspection, we visited the following service:

- acute wards for adults of working age and psychiatric intensive care units.

We re-rated the 'Safe' and 'Responsive' key question only at this inspection. The 'Safe' key question rating improved from inadequate to requires improvement. The 'Responsive' key question rating improved from requires improvement to good. Other key questions not inspected at this inspection will be addressed at future inspections.

Effective, Caring and Well-led were not re-rated.

The overall rating of requires improvement for acute wards for adults of working age and psychiatric intensive care units remains the same.

The Trust overall rating of requires improvement remains the same.

The Trust have met all actions required in the enforcement action issued at the last inspection.

We found:

Our findings

- On Watermead and Thornton wards, all patients now had a way to summon help in an emergency. Across all wards at the Bradgate Mental Health Unit (BMHU), all patients had now been risk assessed for a wrist worn personal alarm, which could be used to summon help in an emergency. A paper-based risk assessment form was now in place for every patient which showed staff had considered the need for a wrist worn alarm. The form included the patient's involvement in the decision. Where patients had declined an alarm, staff documented this decision. Patients who wore wrist alarms, knew how they worked.
- Fixed alarms in toilets and bathrooms were now insitu.
- The Trust had completed major environmental works to eliminate shared sleeping arrangements (dormitories), in the timeframe outlined in their action plan. One ward remained with shared sleeping accommodation (dormitories) at the time of our inspection. However, this ward (Aston) was relocating to a newly refurbished, single occupancy bedroom ward so that refurbishment could start. This meant, all wards at the Bradgate Mental Health Unit (BMHU) would be single occupancy.
- Patients had sufficient space to store personal belongings. Every bedroom had a floor to ceiling wardrobe and a chest of drawers. Every patient had access to lockable storage and additional storage space in separate room on the ward.
- Staff were aware of the importance to protect patients' privacy and dignity. Every bedroom door now had a permanent sign which reminded staff to knock before entering.

However:

- Staff did not routinely upload paper-based risk assessments for patient wrist alarms into the patient's electronic care record as per Trust policy.
- Staff had not consistently completed care plans in the electronic patient record for those patients who wore wrist alarms.
- Staff did not test the wrist worn alarms or fixed room alarms regularly on all wards and record the outcome as per Trust policy.

How we carried out the inspection

We carried out this inspection to follow up on enforcement action we issued at the last inspection in 2021. These concerns were in relation to some of the key questions of Safe, Effective, Caring, Responsive and Well led. Therefore, our report does not include all the information usually found in a comprehensive report. We have only re-rated the 'Safe' and 'Responsive' key questions for one service.

The rating of 'Safe' improved from inadequate to requires improvement. The rating of 'Responsive' improved from requires improvement to good. All other key questions were not re-rated.

The overall rating of requires improvement for this service remains the same.

The Trust overall rating of requires improvement remains the same.

During our inspection, our inspection team carried out the following activities across wards:

- interviewed 11 staff including charge nurses, healthcare assistants and two senior managers
- spoke with 14 patients

Our findings

- visited six wards of seven wards and reviewed the environment and bedroom spaces
- reviewed governance systems and processes in place to deliver safe care and treatment
- reviewed minutes of team meetings, MDT meetings and board papers and reviewed a range of policies, procedures and other documents relating to the running of the service
- reviewed 35 care records, including risk assessments and care plans.

What people who use the service say

One patient told us how well balanced the system was to assess if patients needed a wrist band alarm. They told us the process was not discriminatory or had a hierarchy that singled out patients who needed an alarm. They told us they felt having an alarm was accepted by all. And made them feel safe. Another patient told us they had been risk assessed twice for a wrist band and had declined but understood the purpose of the wrist alarms. One patient on Aston ward said their visitor had not been given an alarm to wear. One patient told us they had agreed to have an alarm but could decide when they wore it; it depended on how they felt each day.

Some patients reported agency staff still did not knock on their bedroom doors.

Is the service safe?

Requires Improvement 

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

Safe and clean care environments

Safety of the ward layout

All patients had easy access to nurse call systems, which is a significant improvement since our last inspection. However, not all wards tested the patients' call system (wrist alarms) and fixed room alarms regularly and recorded the outcome for auditing purposes.

All wards now risk assessed every patient on admission to a ward and offered where needed, a wrist worn alarm. This was a system used for patients to be able to call for help in an emergency by pressing a button on a wrist band. Patients told us they were assessed upon admission to Beaumont ward (the admission ward for the Bradgate Mental Health Unit) and again when they arrived on their next ward.

We saw evidence that staff offered patients the choice to accept a wrist alarm or not, and staff used a paper-based risk assessment process to determine if a patient required an alarm.

Patients who wore wrist alarms knew how to use them.

Senior managers told us Ashby ward had plans to trial two new technology initiatives in the future. One was to scope out a proposal for a wi-fi enabled bedroom alarm system that did not require 'hard wiring' within the walls. This meant patients could press a button for assistance in their bedroom, and the signal transmitted by wi-fi would raise an alarm to staff. A second trial was to pilot wi-fi technology, installed in bedrooms, that could monitor patient vital signs and raise an alarm to staff if it detected a change in a patients' vital signs (e.g. heart rate), and trigger a camera to operate for a few seconds to allow staff to check on patients welfare.

Our findings

Fixed alarms were also in place in communal bathrooms and toilets. Fixed alarms were tested on a regular basis and results of tests recorded by staff. However, on Thornton ward, the fixed alarms weekly tests were not completed.

Alarms were available to visitors who needed to enter ward areas. These alarms were a press button alarm on a lanyard which looked the same as a smart card. Staff ensured that visitors were made aware of the system and how to use it, if one was needed. However due to the COVID-19 pandemic visitors were not allowed onto wards, unless there were valid reasons. Some wards had visitor rooms which meant visitors did not have to access ward areas and so the risk of needing an alarm was greatly reduced. At the time of our inspection, Thornton ward did not have visitor alarms but planned to have lanyard alarms once visiting restrictions were lifted.

All staff told us how they would respond if the call system was activated. The charge nurses on both Thornton and Beaumont wards told us they attended when the alarm was activated. They would quickly check the alarm panel to see where the patient was and attend to support staff with the patient. The process described was in place across all wards.

The wrist alarms worn by patients were required to be checked daily and recorded for auditing purposes as per Trust policy. However, not all wards had developed this as routine practice. Not all wards tested wrist alarms daily, and in most cases, we found gaps in recordings. On Watermead, Aston and Thornton, we found gaps in daily testing records. On Heather ward there were no testing completed for three patients using wrist alarms. On Beaumont ward the daily monitoring sheet for the two patients who had the alarms were not kept up to date. Both alarms had only been checked once within a 22-day period of receiving the alarms.

We saw the Trust guidance dated February 2022 for the allocation and monitoring of patients and visitors' alarms for wards at the Bradgate Mental Health Unit. This included how the call system for patients and visitors worked, and the allocation of patient safety alarms to patients and risk assessment process. Some staff told us they knew about the guidance on emails, from paper risk assessment forms or from handover meetings.

Assessing and managing risk to patients and staff

Staff assessed, evaluated and managed risks to patients regarding call alarms effectively, which was an improvement since our last inspection. However, staff did not always upload the paper-based risk assessment into patients' electronic care records.

Assessment of patient risk

Staff on all wards now carried out a risk assessment of every patient on admission for the need of a wrist worn alarm. When a patient moved from the admission ward to another ward, this process was repeated.

The risk assessment was a two-sided paper form which asked questions to determine if the patient presented with a risk that could require them to summon assistance in an emergency. It also identified if a patient wanted to have an alarm, did not meet the criteria for one or declined an alarm. Dependent on the answers given to the risk assessment, an alarm would be offered to a patient. Examples of reasons a patient was deemed appropriate to have an alarm or to ask for an alarm included, but not limited to, a risk of falls or vulnerability due to low mood.

A paper risk assessment was in place for every patient, on every ward, whether they required an alarm for an identified risk, because of personal choice to have one or if they had declined an alarm.

Our findings

All but one ward had developed an effective system to reflect, at a glance, which patients had a wrist worn alarm. All wards stored the paper-based risk assessments in a folder in the nursing office. Some wards stored their documentation with the daily handover information. Every ward had a white information board which showed the daily status of patients. Some wards used a coloured magnet on this board to indicate which patients had an alarm. Some wards had a dedicated column which had 'wrist worn alarm' written next to the patients' name.

However, we found on Heather ward, staff had not effectively embedded their 'at a glance' system to accurately reflect which patients had wrist alarms. The daily patient status board did not accurately reflect the paper-based risk assessments that showed which patients required an alarm. Three patients were wearing wrist alarms, five patients' names were written on the white board, and two on paper records. We raised this with senior managers at the time of the inspection.

Following the inspection, senior managers completed a review of which patients required alarms and gave us feedback. They carried out an immediate review of all patients and identified two patients that had transferred to the ward and staff had completed their risk assessment on the day of the inspection. All other patient's risk assessments had been completed. The team identified one place to store the assessments as part of staff handover book and a copy to be scanned onto the patient's electronic record. The white board in the nurse's office was updated with the allocation of alarm and named nurse for all 18 patients. The patients with alarms were checked to ensure there were no concerns with the alarms and they understood the purpose of the alarms.

The Trusts' policy for use of patient alarms, said a copy of the paper risk assessment should be scanned and uploaded into the electronic record for every patient. All patients had a paper risk assessment but not all paper copies had been scanned into the electronic patient record. At the time of our inspection 19 patients had been assessed to require or had requested a wrist worn alarm. We reviewed 13 electronic records and found staff had reflected the need or use of a wrist worn alarm in two electronic risk assessments. This was on Aston ward.

On Thornton ward, one patient had a wrist worn alarm. However, staff told us the patient had taken the alarm off the weekend prior to the inspection and disposed of it. Staff had not recorded this on the electronic records.

Is the service effective?

Requires Improvement 

We did not re-rate effective at this inspection. The previous rating remains.

Assessment of needs and planning of care

Staff assessed all patients on admission for call alarms using a paper-based risk assessment. However, care plans for most patients did not reflect the allocation of a wrist worn alarm where needed.

The Trusts' policy for use of patient alarms, said a copy of the paper risk assessment should be scanned and uploaded into the electronic record for every patient, and where a wrist worn alarm is indicated, an electronic care plan completed to reflect this. All patients had a paper risk assessment but not all paper copies had been scanned into the electronic patient record. At the time of our inspection 19 patients had been assessed to require or had requested a wrist worn alarm. We reviewed 13 electronic records and found staff had reflected the need or use of a wrist worn alarm in one electronic care plan. This was on Aston ward.

Our findings

Is the service caring?

Requires Improvement 

We did not re-rate caring at this inspection. The previous rating remains.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Patients had enough storage for personal belongings.

We saw staff knock on patient bedroom doors before entering. There were fixed, yellow perspex signs on every bedroom door to remind staff to knock before entering. Staff told us the signs were useful prompts for temporary staff who were not familiar with the ward. However, some patients told us some agency staff did not always knock on doors before entering.

We saw built in blinds on doors which could not be operated by patients from inside their bedrooms. Staff had a key to open or close the blind from the outside. On Beaumont ward staff had made laminated signs for patients to use, with a large "STOP" symbol to alert staff they are attending to personal care for example showering and not to enter their bedroom. One patient told us they had told staff they preferred to have their blind left open for safety reasons so staff could always see them. One other patient said they wanted the blind open as the noise of staff opening it at night woke them up.

We saw staff were discreet, respectful, and responsive when caring for patients. Patients said staff treated them well and behaved kindly.

Involvement in care

Involvement of patients

Records showed patients were involved in the initial risk assessment for a wrist worn alarm but had not always signed a copy of the paper risk assessment. One patient on Heather ward told us if they were thinking about injuring themselves by head banging, staff had told them to press the wrist alarm, which reassured them.

On Thornton ward we saw five examples of patients with collaborative care plans. Patients who did not have capacity to decide on the need for a wrist worn alarm, we saw two best interest care plans were completed. One patient who had a wrist alarm had signed a receipt form.

On Watermead, five of seven paper-based risk assessments reviewed had been signed by patients to say they had been involved in the risk assessment.

On Aston ward, all six paper-based risk assessments had been signed by patients to say they had been involved in the risk assessment.

Staff had involved patients in the environmental changes to the wards into single occupancy rooms. We saw feedback the Trust had collated from patients on the new ward environments. Patients had been asked their views on the new ward layouts and single occupancy bedrooms. Eight patients said it was much improved and the privacy of a single room was much better.

Our findings

Is the service responsive?

Good 

The rating of responsive has improved since our last inspection. We rated it as good.

Facilities promoted comfort, dignity and privacy

The Trust had addressed concerns identified at the last inspection around dormitories where we found several patients slept in dormitories and had to share toilet and bathroom facilities. Patients now had their own bedrooms and were not expected to sleep in bed bays or dormitories.

The Trust had developed an action plan, in response to the enforcement action we issued at the last inspection. Within the 'Dormitory Action Plan', the Trust produced, staff had completed a Privacy and Dignity environmental checklist and annual check carried out in August to September 2021 on each ward.

On all wards, except Aston ward, all patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. At the time of our inspection, Aston ward were in the process of moving to a newly refurbished ward with single occupancy rooms, Ashby ward.This was due to take place week commencing 07 March 2022. Aston ward was due to start refurbishment to single occupancy rooms, which meant all wards at the Bradgate Mental Health Unit were single occupancy with ensuite facilities. The Trust was on track with their timeline to eradicate dormitories.

There were fixed wardrobes and cupboards to store belongings on wards. Every single room now had a floor to ceiling wardrobe with between five and seven shelves and a chest of drawers or bedside unit with up to five shelves. Patients told us they had enough space to store their belongings. Storage had much improved since our last visit, now with single occupancy bedrooms.

Each patient now had their own bedroom, which they could personalise. On Watermead, Heather and Beaumont wards, patients could lock their rooms with a wrist band that had been electronically set to allow access to them alone. On Thornton ward, staff had to lock bedroom doors for patients, but patients could lock themselves in from the inside.

Patients now had a secure place to store personal possessions. Patients had access to lockable storage in a storeroom on the ward, separate to their bedroom. Patients asked staff for access to this room which was controlled by a key. Each locker had a separate key which was identified by a checklist next to the lockers. On Watermead ward, the lockers were small and were intended only for small valuables. The ward manager told us they would look to source larger lockers for larger personal items such as play stations and laptops.

Thornton now had individual lockers. We saw patients asking staff to open lockers and stored their possessions. For larger items they had a patient storage room with labelled bags for patients' belongings.

On Beaumont ward patients now had access to lockers, storage room, and a locked tray in the nursing office.

On Aston ward patients now had a locked tray in the nursing office for mobile phones.

Patients on Aston and Watermead also now had access to additional storage in larger, clear plastic boxes, stored on shelves in a room on the ward. Staff gave patients access to the room on request.

Our findings

Managers on Heather ward told us they had put in a capital bid for a room to remove a bath and provide an additional storage room. The patients' storage room to store patients' belongings were cluttered and disorganised with items of patients' belongings together with ward equipment on shelves and on the floor.

Is the service well-led?

Requires Improvement 

We did not re-rate well-led at this inspection. The previous rating remains.

Governance

The Trust had introduced and implemented governance processes at ward level regarding patient alarm systems. Not all systems had been embedded at the time of our inspection.

Following our last inspection in 2021, the Trust produced two action plans in response to our findings. One action plan was to address shared sleeping arrangements and address how staff protected the privacy and dignity of patients. The second action plan detailed how the Trust could significantly improve ways in which patients could summon held in an emergency.

The Trust was unable to amend and bring forward their timescales for physical building work to the Bradgate Mental Health Unit and The Evington Centre to remove dormitories. This was due to many external and financial constraints.

The Trusts' first action plan, detailed how they would address issues around shared sleeping arrangements, relating to privacy and dignity. The Trust was able to plan and action significant improvement to the provision of storage space for patient belongings, and work on improving privacy and dignity issues highlighted for immediate action at our last inspection. This has been detailed in our findings above.

We saw Trust board meeting minutes which regularly reviewed progress of building work to remove shared sleeping areas and convert all wards to single occupancy bedrooms. The Trust risk register contained the dormitory eradication programme, and the risk register was regularly reviewed within board meetings.

At this inspection, we saw all but one ward at the Bradgate Mental Health Unit were now single occupancy and the final ward was due to start building work imminently. Plans to remove dormitories at The Evington Centre were due to start in March 2022.

In August 2021, the Trust completed an environmental audit across all wards, and results were fed back to the Trust's Quality Forum meeting, under their formal governance structure. This analysed all aspects of privacy and dignity within environments and staff behaviour. As a result, the Trust held engagement events with staff and patients to decide how to implement changes to the environment and develop staff behaviours to promote and uphold patient privacy and dignity.

We saw staff briefing documents, written by senior leaders, which filtered information to ward level about progress against the dormitory eradication programme. The briefings were clear, short and provided on a regular basis. Staff we spoke with, told us they had seen these briefings.

Our findings

Senior managers produced 'Learning Boards', which were circulated via emails and during staff meetings and MDT meetings. Staff we spoke with told us they had felt communicated to about the work the Trust had done in response to the inspection in 2021. The 'Learning Board' was a simple one-sided information sheet which highlighted actions the Trust took to address previous inspection findings. This included provision of clear plastic storage boxes, new furniture options in bedrooms, daily checklists to ensure curtains and blinds were in place and permanent signs to remind staff to knock before entering bedrooms.

The yellow perspex signs to remind staff to knock before entering patient bedrooms was co-designed with patients and resulted from the patient experience groups' views and ideas put into action. We saw emails following ward community meetings which fed back patients' comments and ideas to the forum.

The Trust produced an environmental checklist to be competed daily, to ensure actions implemented from the Trust action plan were embedded. This checklist included tasks for day and night staff to complete during their shift to ensure wards areas were clean, tidy and action taken if not. During the inspection, one senior manager explained they planned to include wrist worn alarms tests to be added to the checklist, following our findings that not all wards carried out daily tests of alarms.

The Trust produced a second action plan in response to our findings at the last inspection regarding call alarms. The Trust planned and delivered significant improvement on how patients could summon help in an emergency. The Trust provided wrist worn alarms to patients who needed or requested them. The Trust had developed a policy guidance document to advise staff how to assess and document the need for patients to have wrist worn alarms and visitors to be provided with alarms. The document also included regular testing of the alarms was required. Not all wards had embedded the testing of alarms, which did not comply with Trust policy. Not all wards had embedded the care planning process within electronic patient record when a patient had been risk assessed for needing a wrist worn alarm, which did not comply with Trust policy.

Senior managers produced 'Learning Boards,' which were circulated via emails and during staff meetings and MDT meetings. Staff we spoke with told us they had felt communicated to about the work the Trust had done in response to the inspection in 2021. The 'Learning Board' was a simple one-sided information sheet which highlighted actions the Trust took to action inspection findings. This included scoping of fixed or mobile alarms, developing a risk assessment process and guidelines for alarm use. This process was approved through the Trust Quality Forum and reported through to board level for approval. The guidelines on how to risk assess for alarms was circulated and amended following feedback. Amendments included how the risk assessments could be clearer to document patient capacity to decide whether they wanted or needed an alarm.

Management of risk, issues and performance

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

The Trust delivered a communication event in August 2021 which involved staff to generate ideas to resolve the issues identified at our last inspection. The Trust produced a two action plans as a result of the event. Staff were informed via email, staff and team meetings, briefings and Learning Boards to share progress of the actions the Trust planned to take. Staff told us they had seen at least one form of the communications from senior leaders of the Trust.

Our findings

Staff contributed to a monthly magazine called The Bradgate Times. Staff submitted stories and news items about projects, work completed, and news from around the Unit. This magazine included updates to staff about the actions senior leaders planned to take in response to the inspection in 2021. In each monthly magazine staff were given updates about progress on the call alarm system, building work and work to improve privacy and dignity of patients.

Ward matrons and senior staff had been involved in the development of checklists and knew what to look for when completing environmental audits and privacy and dignity checklists. Actions taken were shared within team meetings and staff gave feedback if amendments to processes were needed.

The Trust board continued to monitor progress of action plans at board meetings. The Trust provided regular updates to teams via the 'staff room' on the Trust intranet and via briefings from board members. Staff told us they watched the 'blogs' from the chief executive which gave updates on what the Trust was doing to improve the environment.

Staff we spoke with knew the Trust had given priority to improving the environment at The Bradgate Mental Health Unit.

Our findings

Areas for improvement

Action the Trust MUST take is necessary to comply with its legal obligations. Action a Trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the Trust MUST take to improve:

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

- The Trust must ensure that staff carry out regular testing of patient wrist worn alarms and fixed room alarms and that this is recorded as per Trust policy. Regulation 12(1)(2).
- The Trust must ensure that risk assessments for wrist worn alarms are uploaded into the electronic patient care record as per Trust policy. Regulation 12(1)(2).
- The Trust must ensure that for each patient who wears a wrist worn alarm a care plan is in place for its' use in the electronic patient record, as per Trust policy. Regulation 12(1)(2).

Action the Trust Should take to improve:

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

- The Trust should ensure that lockable storage is large enough for the storage of patients' property.
- The Trust should continue to keep pace with the timescales to eradicate shared sleeping arrangements (dormitories) across other locations.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manager and one other CQC inspector. The inspection team was overseen by Craig Howarth, Head of Hospital Inspection.

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