University Hospitals of Derby and Burton NHS Foundation Trust

Community health inpatient services

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Ratings

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

Summary of findings

Community health inpatient services

Good  

Summary of this service

We carried out this short notice announced focused inspection as a result of concerns relating to patient harm from falls. This was in response to concerns which were initially raised following serious incidents that had happened at the trust. We visited Phillip ward at Sir Robert Peel community hospital and Darwin ward at Samuel Johnson community hospital. During the inspection, we inspected falls assessment and management. We reviewed information and spoke with staff in relation to patient falls.

During this inspection, we used our focused inspection methodology. We had identified concerns in relation to how the provider managed patients' risk in relation to falls. We did not, therefore cover all key lines of enquiry. Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or taken action under our enforcement powers; in these cases the ratings will be limited to requires improvement or inadequate.

Previous ratings were not updated during this inspection.

At the time of our inspection, there were changes to community inpatient services due to the COVID-19 pandemic. We planned to visit Anna ward at Samuel Johnson community hospital, but this ward had been closed for cleaning and they had merged with Darwin ward. There were no plans for this to change after our inspection. Both wards we visited were not operating at full capacity due to a reduction in referrals during the COVID-19 pandemic. There were 15 patients on Phillip ward, which could admit up to 23 patients. There were 13 patients on Darwin ward which could admit up to 26 patients. A number of these patients had a diagnosis of dementia.

We spoke with 17 members of staff, these staff included both registered nurses, nursing assistants, allied health professionals and the matron who oversaw both hospitals. We looked at a random sample of eight patients' care records, visited the ward, attended a ward board meeting where staff discussed patients' care and progression and reviewed a range of documentation related to the care and treatment of patients and the running of the service. Due to risks associated with COVID-19, we did not speak with patients and their families about the care and treatment they had received at the trust.

We found:

- The service had enough staff to care for patients. The service managed infection risks well. They managed safety incidents well and learned lessons from them.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff worked well together for the benefit of patients and supported them to achieve discharge. There was accessible information about falls and dementia for patients and carers.
- Local leaders ran services well and were visible. Managers appraised staff's work performance and held supervision meetings with them.
- The service was focused on the individual needs of patients receiving care and staff were committed to improving.

However:

Summary of findings

- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Not all staff were up-to-date with their training in manual handling and falls prevention. The trust had suspended their training programme due to the COVID-19 pandemic and this was due to restart in September 2020.
- Staff did not manage all risks that could impact on falls, we saw that staff had not labelled walking aids on Phillip ward and on Darwin ward, staff did not always follow bed rails assessments. There were areas on wards where the environment was worn, and floors were uneven, which meant there were potential trip hazards for patients.
- Not all staff were not clear that cohorted patients should be constantly within eyesight.
- The trust had a trustwide action plan for falls. There were actions that needed the trust still needed to embed. However, the COVID-19 pandemic had impacted on these. We saw differences in governance across the wards, which could be confusing for staff who worked across wards. There were missed opportunities for consistency and for sharing good practice
- Not all information in patients' records was easy to locate and nursing assistants did not have access to electronic records and so relied on a limited amount of information.

Is the service safe?

Good

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design and use of facilities kept patients safe. There were high visibility bays for patients who were at a higher risk of falls and wards were uncluttered.
- There were enough staff with the right skills and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

However:

- Staff had not managed all risks well that could impact on falls. On Phillip ward staff had not labelled all patients' walking aids, and this meant there was a risk that patients could try and mobilise with a frame that was not for them and raise their risk of falling. On Darwin ward bed rail assessments were not always up-to-date and a qualified member of staff said that they sometimes deviated from these.
- Not all staff were not clear about how they should supervise cohorted patients, which was for staff to keep patients who required this level of supervision to be in eyesight of staff.
- Staff were not all up-to-date with their training in mandatory for falls prevention and manual handling. The trust had suspended their training programme due to the COVID-19 pandemic and this was due to restart in September 2020.
- The ward environments were worn in some areas and there were uneven floors on Phillip ward, however there were plans to relocate the ward.
- Some information was not easy to locate in records. Nursing assistants did not have access to electronic records, which meant that they were reliant on information from handovers and end of bed records.

Summary of findings

Is the service effective?

Good

- The service provided care and treatment based on national guidance and evidence-based practice.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

However:

- Staff did not always complete mental capacity assessments in line with the Mental Capacity Act. We saw that not all assessments were time and decision specific.

Is the service responsive?

Good

- Staff supported patients to achieve a successful discharge. The multidisciplinary team supported this in a way which best suited patients' needs. There was a clear checklist for patients transferred between wards to ensure patients received effective care and treatment.
- There was accessible and available information about relevant subjects including falls and dementia for patients and carers.

Is the service well-led?

Good

- Leaders had the knowledge skills and abilities to run the service. They understood and managed the priorities related to falls and dementia. They were visible and approachable in the service for patients and staff.
- Overall leaders operated effective governance processes, throughout the service and with partner organisations. Staff had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

However:

- We saw differences in governance across the wards. Processes and recording of activity differed and this could be confusing for staff who worked across wards. There were missed opportunities for consistency and for sharing good practice.
- There were still trustwide actions from falls that needed to be embedded. However, the COVID-19 pandemic had impacted on these.

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. However not everyone had completed it.

We reviewed the falls prevention training, which was comprehensive. The trust offered training sessions about falls at induction, staff then updated falls prevention training every two years. However, we did not find that staff were up-to-date with training that related to falls. At the time of our inspection, 54% of staff on Darwin ward were up-to-date with falls prevention training and 50% of staff were up-to-date with patient handling training. On Phillip ward, 47% of staff were up-to-date with falls prevention training and 34% of staff were up-to-date with manual handling training. The trust had a plan to offer staff training in these areas. They had identified that staff needed to be trained in their falls action plan but the COVID-19 pandemic had meant they had to suspend the programme of training temporarily.

Cleanliness Infection Control and Hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

We observed clinical activity on the ward and spoke to staff about standards of cleanliness and hygiene. The ward had adapted their cleaning schedule in line with COVID-19 guidance. Staff displayed cleaning rotas and recorded when they had completed cleaning. Staff told us, and we observed that they had access to appropriate personal protective equipment and training. There were arrangements in place to ensure the management of patients with a known COVID-19 infection or patients who were awaiting test results for COVID-19. For example, the use of side rooms to isolate patients.

Environment and Equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Staff maintained and used falls related equipment to keep patients safe. Staff knew how to use specialist equipment including hoists for patients who were at risks of falls or who had fallen. There were walking frames for patients, including red coloured frames, which were easier for patients living with dementia to see. Registered nursing staff had oversight of who had completed training for falls related equipment and all staff we spoke with knew how to use this and provided examples of when they done so.

However, on Phillip ward, we saw that there were four walking frames within different patient bays that were not labelled with patient names. This meant that patients attempting to mobilise with them independently could potentially use the wrong size frame and increase their risk of falls. Two staff members told us that it could be difficult to work out which patient should have which walking frame and they had to ask other allied health professionals to help them identify who a frame belonged to. We raised this with the ward manager and saw that the frames had been subsequently labelled with patient names.

The wards had bay areas where a group of patients could be cared for and side rooms for individual patients. The wards also had 'high visibility' bays that were easier for staff to monitor patients in, as they were near the nursing station. This is where patients who had a higher risk of falls were positioned, so that staff could care for them more safely. There was a day room, which had been set up as a café and was a dementia friendly environment. However, staff had closed this due to the COVID-19 pandemic and associated infection risks.

We saw that staff kept the environment safe for patients who were at risk of falls, the wards were uncluttered. Staff checked that the areas around beds were safe for patients.

Detailed findings from this inspection

Ward environments were worn in some areas. On Darwin ward we saw that the nurses' station was in need of refurbishment with areas of chipped and missing paintwork and exposed wood. There was also an area of flooring immediately adjacent to the nurses' station which had peeled away leaving a gap. This could represent an infection control risk as it was not possible to ensure thorough cleaning of these areas. On Phillip ward, the floor was damaged and there was hazard tape to draw attention to the risk from the uneven floor. This could represent an increased risk for falls and was potentially confusing for patients living with dementia. The ward manager told us that there were plans for Phillip ward to relocate to a ward where the environment was in better condition. This was due to happen in August 2020.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and identified and acted when patients were at risk of deterioration.

We reviewed eight patients' care records; for four from Phillip ward and four from Darwin ward.

We saw that there were plans to manage risks. When we spoke with staff, they described how they worked to manage risks positively so that they supported patients to maintain their independence.

Holistic falls assessments and associated risk management plans were updated regularly. Staff completed these weekly for patients or if there were significant changes to the patient's presentation.

Staff completed bed rails assessments. We saw that these were up-to-date and implemented by staff on Phillip ward. However, on Darwin ward, staff did not always follow or update these. We spoke with a registered nurse who told us they did not always follow care plans for bed rail assessments and used bed rails where they were no care plans. For example, using them when they were unable to supervise a patient. On Darwin ward, we saw that in one set of care records, the bed rails assessment recorded rails should be down, but staff had recorded that they were being used. We also observed that that bed rails were in use for a patient in a side room, but on checking the risk assessment in the patient notes, it clearly stated that they should be down. We escalated this to the senior staff, who told us that they needed to update the risk assessment to reflect the patient's wishes to have bed rails up in the day when they slept.

Staff knew patients well and described their specific risk factors and how they managed these. We saw that staff took actions to reduce risks and monitored patients for and changes. The wards were piloting a new assessment tool called the 'enhanced care bundle'. This was a way for staff to assess how much supervision and enhanced care a patient required. These were not in place for all patients; staff used them for patients who were at higher risk of falls. As part of the enhanced care bundle, the staff completed 'ABC' records to understand the antecedent (A) behaviour (B) and the consequences (C). Where patients were identified as being a risk due to challenging or violent behaviour, two members of staff supervised them. There were out-of-hours arrangements about where to seek advice and support for staff and psychiatric assessment for the patient.

The trust had an enhanced care team who supported patients with a diagnosis of dementia, challenging behaviour or risk of falls. They were available to support staff who were present in ward bays during the day where there were higher risk patients and for one-to-one supervision of patients. The team engaged patients with distraction techniques and activities.

On Phillip ward we observed that staff were using a tag system and wore a lanyard when they supervised the bay with cohorted patients. The lanyard was used to signify that the staff could not leave the bay until they could pass the lanyard/tag to another staff member. This ensured that there was always a staff member present in the high visibility bay, for patients who required a higher level of supervision until another member of staff took over.

We asked the trust to provide us with their policy for supervising patients. The policy we received was out-of-date and should have been reviewed in 2018. However, there was also a new draft policy provided (June 2020), which stated that when staff were supervising cohorted patients that they should always have patients in their eyesight.

Detailed findings from this inspection

We asked staff about how they managed a group of cohorted patients when they had to attend to another patient but were supervising more than one patient in the bay. Staff explained that they could ask member of staff to support them if a patient was high risk but that were not always able to keep each of the patients within eyesight. One staff member told us if this took place staff would individually risk assess the situation to decide whether to ask other staff for help. Overall staff said that they could usually find a member of staff who was able to help, but if the ward was busy it could be difficult. One staff member said the staff approach was inconsistent in relation to keeping patients within eyesight, but they always tried to. We asked senior staff about this. They explained that staff should be present when they were cohort nursing. However, they stated the only way to ensure a patient was consistently within eyesight was with the use of one-to-one supervision and this was for high risk patients.

Medical advice was available Monday to Friday from the staff grade or junior doctor assigned to the community wards and from medical colleagues at the acute hospital out of normal working hours.

Staffing

The service had enough staff with the right qualifications and skills. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Nursing staff worked shifts from 7am until 7.30pm and handover took place at the start and end of each shift. Both wards had implemented walking handovers, so that staff walked around the ward and spoke to patients during their handovers. The safe staffing template was for three registered nurses and three nursing assistants to work in the day and two registered nurses and three nursing assistants to work at night. The third nursing assistant was on shift so that staff could safely evacuate in the case of a fire or emergency. Therefore, if there was a second ward operating on either hospital site, for example for winter pressure at Sir Robert Peel hospital, the ward could meet the staffing template with two nursing assistants. Overall, staff felt that there was adequate staffing on the wards. Although they said when numbers dropped to four staff at night, they could feel under pressure depending on the level of supervision patients required. At the time of our inspection, the wards were not at full capacity and the trust had not reduced staffing numbers.

The ward did not regularly use agency staff, they preferred used the trust's nursing bank. Bank staff were suitably trained and often knew the wards and patients.

We reviewed rotas for January 2020 to assess staffing during 'winter pressures'. We saw that across Darwin and Phillip wards there were usually enough staff and there was 11% of shifts where there was a shortfall of either a registered nurse or a healthcare assistant. However, for 4% of these shifts there was one nursing assistant less on Phillip ward. The trust told us this did not affect the staffing template in a way that affected care, as this member of staff was on shift so that they could support evacuation, in case of an emergency.

There were a range of allied health professionals for example; physiotherapists, physiotherapy assistants, occupational therapists and occupational therapy assistants who worked on the wards with patients daily.

Quality of records

There was up-to-date, accurate and comprehensive information on patients' care and treatment, but care records were not always easily accessible.

Care records, used by the registered nurses, doctors and allied health professionals were a mix of electronic records and paper records. Patients had some paper records located in their bed area, including 'all about me' records, to enable staff to understand patients' history, likes and dislikes. However, staff had not completed these for all patients. Some information in the electronic records such as mental capacity assessments was not always easy to locate, this meant not all staff had easy access to important information about patients. Nursing assistants did not have access to electronic records, which meant that they were reliant on information provided at handover and the limited end of bed records.

Detailed findings from this inspection

Medicines

The service used systems and processes to safely prescribe medicines.

Staff told us that doctors reviewed patient's medicines to make sure they were not over prescribed or sedated. The trust had pharmacists that worked for the frail elderly assessment team. They reviewed patients' medicines, with a view to reducing dosages where this was appropriate. We reviewed two electronic medicines records and there was evidence that pharmacists carried out medicine reconciliation and advised changes to patients' medicines when required.

What is the track record on safety

The service managed patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

In the six months prior to our inspection, there had been 18 falls on Darwin ward, two of which caused moderate harm and one of which met the threshold for a serious incident investigation. On Phillip ward, there had been 14 falls and one of these caused moderate harm, which met the threshold for a serious incident investigation. The trust had investigated these incidents and there were recommendations for improvements in both cases. One investigation identified that the falls assessment was not completed, and medicines were not used to reduce risk effectively, but on inspection we saw this had improved. The other investigation identified that staff compliance with falls prevention training was low. The trust had a plan for this, and the training that had been suspended due to the COVID-19 pandemic, was due to recommence.

The trust had identified there was an issue with falls prevention training. There was a trustwide action plan for this to address poor compliance.

Senior staff monitored falls and severity that had taken place, these were reported to the trust falls group who reviewed themes and causes and shared learning from these. Staff understood what to report and how to report and we reviewed incident forms that demonstrated staff reported incidents that needed to be reported. Ward managers told us what incidents would need to be reported to the health and safety executive in line with the Requirements for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

The service used monitoring results to improve safety. The service managed patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with their teams. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff could tell us about learning from investigations and ward managers were able to demonstrate how they had shared learning at team meetings and through local news letters and learning logs.

Staff described learning from incidents and changes that had been made in response to these. For example, following an incident on Phillip ward, staff had introduced a 'tag' system so that there was always a member of staff present in bays where there were patients who had a higher level of supervision need. The trust had made changes to patient beds following incidents and now all beds heights could be changed. In addition, beds also had lighting underneath to reduce falls risks.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice in falls assessments and mitigation plans.

Detailed findings from this inspection

The trust had an up-to-date falls policy in place, which was in line with current national guidance. The trust had a falls group who met monthly and contributed to learning, development and improvement about falls in the trust.

Staff recorded falls care plans on an electronic system. However, these were not always easy for staff to individualise, due to the system that they were recorded on. We reviewed National Early Warning Scores (NEWS 2) and saw that staff recorded physical health observations correctly and took action where required. Staff completed sitting and lying blood pressures to assess patients for postural hypertension.

Staff completed body maps and post falls risk assessments if a patient had a fall and completed actions related to these. For example, neurological observations.

Competent staff

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff told us they were well supported, and managers told us about how they assessed competencies.

The trust offered training sessions about dementia at induction. There was also additional online dementia training for staff to access. The trust planned to introduce new training in dementia in start in September 2020. We requested training data for the wards and this data indicated that on Phillip ward, 94% of staff had completed dementia training and on Darwin ward, 100% of staff had completed this training.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

We saw evidence that there was a multidisciplinary team who worked well to support patients to achieve successful discharge; this included a discharge coordinator who was a social worker. We attended a ward board meeting and observed conversations between staff that demonstrated multidisciplinary decision making.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment and supported patients who lacked capacity to make their own decisions or were experiencing mental ill health . However, this was not always done in line with the requirements of the Mental Capacity Act.

We reviewed patient's records and saw that where required staff had completed mental capacity assessments about specific decisions for patients who were to be discharged. However, we did not see as many mental capacity assessments for decisions in relation to treatment received in hospital.

Not all mental capacity assessment records were completed properly. In two of the eight records this was the case. For example, staff had recorded that a patient did not have capacity, but they had not recorded what they did not have capacity for. The assessment stated, 'does not have capacity.'

We saw a mental capacity assessment that was not dated and had been completed on another ward when the patient had been admitted to hospital. It did not correspond to a specific decision for the current episode of treatment; this meant it was not time and decision specific and not in line with the requirements of the Mental Capacity Act.

Is the service responsive?

Planning and delivering services which meet people's needs

Detailed findings from this inspection

The service planned and provided care in a way that met the needs patients. It also worked with others in the wider system and local organisations to plan care.

The service had an exclusion policy, this meant there was clear guidance for suitable patient admissions. The wards provided care for patients who required palliative care, rehabilitation; for example, following a surgical procedure or a stroke and for patients who required assessment of their needs following discharge.

Staff supported patients to achieve a successful discharge to best suit their needs. We attended a ward board meeting on Phillip ward and observed that staff knew their patients well, supported their independence and assessed where the most suitable place for staff to discharge them to. They worked with other care providers and families to achieve successful discharge.

Access to the right care at the right time

People could access the service when they needed it and received the right care.

There was a checklist in place for patients who were transferred between wards. The checklist included actions for staff in relation to keys areas such as; mobility, mental health status, physical health, medicines, and risk of falls. Ward transfers usually took place between the hours of 9am and 5pm, although one ward manager said that this sometimes happened later in the evening.

There was information about falls and dementia for patients, carers and staff, including wall displays and leaflets and accessible on the ward. There was information for patients and carers about falls and how to lower the risk of falls, posters about bed heights, a checklist for falls (this was in poem form to aid memory) on Phillip ward and there was information about dementia.

Is the service well-led?

Leadership of service

Leaders had the skills and abilities to run the service.

Leaders managed the priorities on the wards and understood patient's needs regarding falls and dementia. They were visible and approachable in the service for patients and staff. Staff were positive about leadership. On Phillip ward the ward manager had been put forward for awards in relation to work they had led on to reduce falls.

Governance, Risk management and quality measurement

Local leaders operated effective governance processes , throughout the service and with partner organisations. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, there were differences in governance across the wards we visited in community services and some trust wide actions contained in the falls actions plan had yet to be embedded.

Staff had regular opportunities to meet, discuss and learn from the performance of the service. The trust falls group met monthly and a wide range of staff attended. Group members included staff from wards and the trust leadership team. The group had not met however during March and April 2020, at the height of the COVID-19 pandemic. The group reviewed individual falls, carried out benchmarking, reviewed themes and causes and disseminated learning. Most staff we spoke with were aware of these meetings and updates from them.

The trust worked with partner organisations; the falls group chair worked with other falls leads from other trusts across the region to ensure a consistent approach in line with the national falls agenda.

The service collected reliable data and analysed it. The trust monitored falls using the safety thermometer and monthly audits. The trust carried out thematic analysis of falls twice a year. This was available at falls group meetings and there

was clear information about what improvements had been made and where there were still areas for improvement. The trust had identified an increase in the number of falls in March 2020, which then reduced as there were less beds occupied due to the COVID-19 pandemic. The trust identified that patients who were in hospital in March 2020 were those patients with a higher risk of falls as they were the more complex patients. The lower risk patients had been discharged where possible to reduce the spread of COVID-19. The trust had a falls action plan that was monitored and reviewed. There were outstanding actions on this, some of which had been delayed due to the COVID-19 pandemic. For example; falls prevention training compliance. The trust held falls conferences twice a year and a 'falls week' was run annually on each site to raise awareness about falls.

The trust had projects in place that were to improve quality. For example, compliance with falls prevention training was not at the desired trust compliance level of 95% and the trust had an improvement plan to address poor compliance. The enhanced care team were reviewing and improving the care they offered, and the falls group were being supported by the quality improvement group, with quality improvement projects to reduce falls. For example, to improve completion of standing and lying blood pressure and improve accessible information for patients about falls. However, not all staff we spoke to knew about quality improvement projects.

Governance across the wards was not always consistent. Processes and recording in relation to falls and patients' care was not consistent across the wards we visited. For example, the wards used a red dot above patients' beds to indicate that there was a specific risk. On Phillip ward this indicated a patient was at risk of falls and on Darwin ward this demonstrated that patients were diabetic. However, after our inspection the trust explained that the process of identifying specific risks in this way in relation to falls and diabetes no longer takes place. Darwin ward staff recorded when they completed 'intentional rounds; these were checks that staff carried out on patients at set times to manage their fundamental care needs. On Phillip ward staff did not consistently record this unless patients were being monitored for skin integrity in which case, they used skin care charts to record their checks. Phillip ward had a tag system to ensure staff did not leave patients who required supervision unsupervised. This was not in place on Darwin ward. These differences in processes on the two wards could be potentially confusing for staff who worked across wards. Staff were more likely to work at different locations due to changes caused by COVID-19. There were missed opportunities for consistency across the wards and for sharing good practice.

Areas for improvement

The trust should:

- The trust should ensure that staff are up-to-date with mandatory training which is necessary for their duties.
- The trust should ensure that patients' walking aids are labelled so that it is clear to staff and patients.
- The trust should ensure that bed rails assessments and care plans are up-to-date, and that staff follow these as set out in patients' care records
- The trust should ensure that staff are clear about their responsibility for supervision of cohorted patients.
- The trust should ensure that ward flooring is safe.
- The trust should ensure that staff complete Mental Capacity assessments for specific decisions including those relating to treatment and that these are recorded fully.
- The trust should ensure that processes and records are consistent when caring for patients and good practice is shared.

Our inspection team

The CQC inspection team at community health inpatient services comprised of two CQC Inspectors. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.