Elysium Healthcare Limited

Pinhoe View

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated it as requires improvement because:

- Staff interaction was not always respectful towards patients. At times staff ignored patients when they sought their attention and support.
- Staff were not always provided with access to the electronic care notes which meant verbal and written handovers were the main form of sharing key information with staff. Handovers lacked detail on how to meet patient's needs.
- Staff referred to patients by room numbers or initials during their discussion.
- The male staff was high in comparison to the female patient ratio
- Not all staff were up to date with mandatory training.
- Care plans lacked patients' preferences on how they wanted their needs to be met.
- Care plans and risk assessments were not always developed for all areas of need. Staff used standard statements for care plans and risk assessments. Although some risks were assessed, risk assessments were not always linked to a care plan.
- Window closures needed attention and frosting on windows obscured patients outlook to the outside.
- Governance processes did not always identify and address risks.

However:

- People were safeguarded from abuse. Staff understood their role in safeguarding adults from abuse and followed the correct procedures when they had concerns.
- The environment was decorated to a good standard, brightly lit and clean. A lift was available to access the upper floors and there were wide corridors ensure patients. Bedrooms were ensuite and patients were able to personalise their space.
- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Patients had access to a range of treatments suitable to the needs which included emotional and social support.
- Staffing levels that were maintained with permanent and with regular agency staff.
- The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff assessed people’s mental capacity appropriately. There was a record of whether the patient had capacity to consent to treatment on admission and regularly thereafter, including at each three-month period.
- People felt confident to approach staff with complaints and the easy read procedure was on display.
- Staff planned and managed discharge and liaised with services that would provide aftercare.
- Staff recognised and reported incidents appropriately.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Pinhoe View

Pinhoe View provides two female acute mental health wards within the hospital. It takes patients over the age of 18 with mental health issues. Patients are either informal or detained under the Mental Health act 1983 and experiencing difficulties that prevent a risk to the wellbeing of themselves.

The hospital has 32 beds and is split into two 16 bed wards. There are plans for 8 flats to assist patients with gaining independence living skills prior to discharge.

The service is registered to provide the following regulated activities:

• Treatment of disease, disorder, or injury

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Diagnostic and screening procedures.

This was the first inspection of Pinhoe View since the hospital opened.

What people who use the service say

Patients felt safe at the hospital.

Patients knew the reasons for their admission and the conditions of their stay. They knew their rights and how they applied to them. For example, leave.

Patients gave positive feedback about the meals. They said their dietary requirements such as vegetarian meals were catered for at the hospital.

Patients feedback about activities was variable. Some patients said there were Occupational Therapist vacancies which impacted on the individual and group activities provided.

Patients overall gave positive feedback about the staff although they raised concerns about the numbers of agency staff working at the service.

Patients felt confident to approach the staff with complaints and gave us examples of complaints

Patients knew about their care and treatment but were not provided with copies of their care plan.

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:

Summary of this inspection

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

This inspection was unannounced before the inspection visit. We reviewed information that we held about the service. This was the first inspection for this service.

- Spoke with 10 patients
- Tour of the environment and checked the clinic rooms
- Looked at a range of policies and procedures related to the running of the service
- Reviewed 10 care records and treatment records
- Interviewed the Regional Director, Ward Manger, and Clinical Lead
- Spoke with 3 nursing staff including agency staff
- Spoke with 7 HCA (health care assistants) including 2 senior HCA - permanent and agency staff
- Spoke to the consultant psychiatrist and Occupational Therapist
- Spoke with 2 housekeepers
- Spoke to the maintenance lead

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

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

- The provider must ensure that patient's rights to privacy and dignity are protected. Staff must acknowledge patients' presence and ensure they are always correctly addressed and not referred to as initials or room numbers. (Regulation 10)
- The provider must ensure privacy frosting does not obscure patients view of the outdoors. This meant that did not have a direct link to the outside community. (Regulation 10)
- The provider must ensure that care plans and risk assessments are developed in a way that ensures patients preferences are detailed. Care Plans must meet Accessible Information Standard (AIS) for patients with sensory loss. (Regulation 9)
- The provider must ensure that all staff have appropriate access to electronic notes. (Regulation 17)
- The provider must ensure that the ratio of female patient to male staff is appropriate to meet the needs of patients. (Regulation 18)
- The provider must ensure the premises are suitable for the purpose being used which must include window closures. (Regulation 15)
- The provider must ensure that all staff have completed appropriate mandatory training. (Regulation 18).
- The provider must ensure that their governance systems and audit programmes are effective in identifying and mitigating risks. (Regulation 17).

Summary of this inspection

- The provider must ensure they complete the actions contained in their improvement plans. (Regulation 17).

Action the service SHOULD take to improve:

- The provider should ensure all staff receive an appropriate induction to the hospital.
- The provider should ensure all staff have knowledge and understanding of the rights of informal patients and those detained under the Mental Health Act (1983)
- The provider should ensure discharge plans are personalised and regularly reviewed.
- The provider should ensure all patients have allocated times to undertake laundry.
- The provider should ensure all staff receive regular supervision sessions.
- The provider should ensure all patients are able to access leave.

Our findings

Overview of ratings

Our ratings for this location are:

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

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

Requires Improvement

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

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

Requires Improvement

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Environmental risk assessments were completed to ensure where risks were identified action was taken to reduce or remove risks to patients and others.

Staff could observe patients in all parts of the wards. The service had close circuit television (CCTV) in wards and in communal areas. Posters on the use of CCTV were displayed in prominent areas. Mirrors were positioned in areas where patients could not be observed easily at a distance by staff. For example, bedrooms and corners.

The ward complied with guidance and there was no mixed sex accommodation. The hospital provided accommodation to females only.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Patients were protected from potential ligature risks or anchor points to prevent patients self-harming. Staff knew the potential ligature points and mitigated the risks to keep patients safe. Ligature cutters were available in an emergency and all staff knew where to find them.

Staff had easy access to alarms and patients had easy access to nurse call systems. The staff were provided with safety alarms and procedures were in place to prevent alarms being removed from the hospital site.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. The ward was clean at the time of our inspection. Housekeeping took pride in keeping the wards clean and odour free. Repair requests raised by patients during community meetings were actioned although the documentation to support the actions were not always completed. Cleaning records were kept up to date and showed all areas were regularly cleaned.

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

Requires Improvement

Staff followed infection control policy, including handwashing. The organisation's guidance to continue with COVID procedure were followed. Staff were wearing masks on site to reduce the potential of COVID outbreaks.

Patients were protected from the spread of infection. Staff followed infection control procedures, including hand washing, and we saw appropriate use of PPE (Personal Protective Equipment). There were adequate supplies of hand sanitising gels. Staff wore masks correctly and the service policy was the continued wearing of masks.

Seclusion room (if present)

The Seclusion room was on Kenn ward, on the upper floor of the hospital, which allowed clear observation and two-way communication. The space used for staff observations was also where the safety pod was located. The placement of the safety pod enabled staff to manoeuvre around the pod and was the least restrictive option.

During our inspection, we witnessed the safety pod being used for a patient who was in seclusion, whilst the seclusion environment was cleaned due to this being an area of need.

The clocks were visible to the patient. The toilet and showering facilities were separate and allowed for the patient's privacy when personal care was taking place.

Clinic room and equipment

The clinic room was clean, well-organised and records clearly marked and available. It was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. All emergency equipment was in working order with portable appliance testing (PAT) completed.

Safe staffing

The service had enough nursing staff on duty. There were vacancies for nursing and medical staff.

Nursing staff

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staffing levels were maintained with permanent, bank and agency staff. Regular nursing and healthcare locums were used to provide continuity of care. For example, there were 6 full and 5 part-time nursing locum and 8 healthcare assistants.

Data provided showed there were 9 vacant posts for nursing staff and 22 for healthcare assistants. For example, on the 28 November only agency staff were covering the night shift in Kenn ward 2. On 30th November 2022, during the day shift a number of permanent of staff were on duty, including staff from a different hospital within the same provider group, 1 bank worker and 1 agency staff member.

The hospital manager could adjust staffing levels according to the needs of the patients. Staffing levels on the wards were reviewed daily at the morning meetings to ensure there were safe numbers of staff on duty. At times shifts were covered with staff deployed from the other ward due to short notice sickness. For example, on the 29 November a member of staff on duty in Kenn ward had to undertake 1: 1 monitoring for a patient in seclusion.

Staff shared information during handovers when there were shift changed. However, agency staff were not provided with log in information to access electronic records. This meant key information about patients was not fully shared with agency staff.

Patients escorted leave or activities were sometimes cancelled or rearranged due to short staffed.

The induction for bank and agency staff was brief and did not cover the expectations of the role. Agency staff said they did not have an induction although they were introduced to patients on their first day shift in the ward. They told us a discussion had taken place with the clinical lead and an induction booklet was to be devised. Staff confirmed an induction booklet was to be developed which included information about security, catering, and NEWS (National Early Warning Score) charts.

Medical staff

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

There was 1 FTE vacancy for a consultant psychiatrist, which was covered by a long-term locum consultant psychiatrist who had been in post since June 2022.

Mandatory training

Not all staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The matrix provided showed the mandatory training staff had to attend which included safeguarding of adults, basic life support, Management of Violence and Aggression (MVA) and MCA (Mental Capacity Act)

The hospital's compliance overall with mandatory training was 84%. However, this was below hospital target of 90%. There were some modules with low compliance, for example National Early Warning Scores 2 (NEWS2) was 67%, safeguarding level 2 and 3 was 75%, safe administration of medicines was 57%, management of violence and aggression was 74%, recognising and managing anaphylaxis was 68% and management of epilepsy was 60%. This meant not all staff could recognise the deteriorating patient.

We were told of a proposed plan to improve the training targets included giving staff protected time to complete the training and raising training at the next meeting to enable staff to raise concerns about meeting training targets.

Assessing and managing risk to patients and staff

Assessment of patient risk

Risks were assessed. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Individual risks to patients were assessed during admission procedures. However, risks were not always detailed in the handover notes, or the actions staff were to take to reduce them.

While risks assessments were completed with more detail for patients on Clyst ward, they lacked detail. For example, on Kenn they were not consistent with other documents. A risk assessment for sensory loss was not completed for a patient on Clyst and for a patient with sensitivity to antibiotics on Kenn ward.

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

Requires Improvement

Blanket restrictions were minimal. The hospital's prohibited items and patients were provided with boxes in the office to keep their personal possessions such as cigarettes and lighters. Patients were provided with their personal items as requested.

Management of patient risk

We spoke with 3 of the 6 permanent staff on duty across Clyst and Kenn wards during our site visits. Electronic copies of risk assessments were in place but not all staff had access to the system. Some risks were not clearly detailed in handover notes. This meant their knowledge of risk was from verbal and handovers notes accessible in the office.

Agency staff were more aware of the risks associated to the individual's levels of observations. For example, self-harm.

We saw examples of positive risk taking. For example, having access to the outdoors in late evening.

Use of restrictive interventions

A member of staff with lead roles for delivering Managing Violence and Aggression (MVA) training and reduction of restraints was deployed to support the staff team on the wards. Staff had to attend a 5-day training course with a yearly refresher before they could participate in managing incidents where physical interventions were used.

We joined a debrief where a safety pod and physical intervention when the room had to be cleaned. The staff involved in the intervention were present and were given an opportunity to express their views. They agreed the plan before undertaking the intervention and this was well executed. The MVA trainer told us a review of the care plans with the patient would follow from the debrief.

The rationale for seclusion was in place as required. However, risk assessments, care plans and observations records lacked detail for patients in seclusion. For example, sensory needs were not part of the care planning documents

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term seclusion. Patients in seclusion had access to a bathroom, sleeping and lounge area. Staff were able to adjust lighting for comfort and a clock was positioned for easy viewing.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff were aware of their responsibilities towards ensuring patients were safeguarded from abuse including how to recognise the signs of abuse, raising safeguarding referrals and who to inform if they had concerns. Patients on the ward told us they felt safe.

Staff access to essential information

Permanent staff had some access to clinical information. However, agency nurses were not given access to electronic records despite overseeing wards.

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

Requires Improvement

Not all staff were provided with access to electronic records. Although some nurses were provided with log in information, they were not able to update information. While the service used a high number of agency staff, they were not given access to electronic records. The manager responded to our concerns and access to log in information was provided to staff on the second day of the inspection.

Verbal and written notes were the primary method of updating staff. Staff made their own notes from the verbal handovers as only one copy of the handover notes was available in the office.

Key information from care notes was not always reflected in the handover notes. Patient's names were not included in the handovers notes which meant that staff used room numbers or initials to refer to patients. For example, there was a lack of detail on how to support a patient that had self-harmed that day nor the sensory needs of a patient in seclusion was not part of the notes.

Medicines management

There was evidence of consent to treatment for 9 treatment records reviewed. T2 and T3 forms were completed by the Responsible Clinician where patients were unable to consent. Staff stored, managed medicines and prescribing documents in line with the provider's policy. We looked at 10 prescriptions charts and records were up to date with no omissions.

Staff followed systems and processes for safe administering, recording, and storing medicines. Individual protocols were in place for patients prescribed with medicines to be taken when required (PRN).

The service ensured patient's behaviour was not controlled by excessive and inappropriate use of medicines. Medication was minimal and only that essential to current health needs was prescribed. For example, overuse of anti-psychotic medications.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Clinical Excellence (NICE) () guidance.

Track record on safety

The service had a good track record on safety.

Managers investigated incidents where they were reported, 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.

Staff understood the duty of candour and gave patients and families a full explanation when things went wrong. Patients and their families were involved in these investigations. We were given an example of a recent incident which involved a joint investigation with a local service.

Reporting incidents and learning from when things go wrong

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.

The service managed safety incidents well.

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

Requires Improvement

Managers maintained patient's safety and investigated incidents and shared lessons learned with the whole team and the wider service. Staff told us they received lessons learned information in handovers and we saw this information was given to staff via email and discussed in the morning meeting.

The service apologised to patients and those important to them when things went wrong. Staff gave honest information and suitable support and applied duty of candour where appropriate. Managers were able to give examples of events that required this level of transparency. Relatives said they were informed about events such as incidents and accidents.

Electronic reporting systems were audited to ensure debriefs with the person and staff involved happened following incidents and accidents.

During the last 12 months there were 10 serious untoward incidents that involved patients using the service. Lessons learned and recommendations were discussed and shared in clinical governance meetings and team in meetings.

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

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were not fully reflective of patients' assessed needs, personalised, holistic or recovery oriented.

Admission assessments were completed for 8 of the 9 records reviewed. However, while risks were assessed, the actions on how to reduce the risk was limited. For example, in one record reviewed, a lack of respect for authority was deemed to be a high risk. This high level of risk was not part of the care plan or within the levels of observations.

Care plans lacked patient preference on how their care was to be delivered. They lacked evidence that patients were part of the planning of their care. The sections were not signed by patients in the sections to demonstrate the care plans had been discussed with them or to be discussed.

Electronic care notes lacked detail, they were inconsistent with other associated care plans and the language used was not person centred. For example, standard phrases were used to describe the identified need, outcome goals were similar for each patient and staff used terms such as "subverting security."

Patients had their physical health assessed soon after admission. Alerts for sensitivity to antibiotics, allergies and asthma were documented but were not part of the physical health or risk management plans for 3 patients.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

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

Requires Improvement

Staff delivered care in line with best practice and national guidance. For example, NICE guidance and reduction of restrictive practice.

Patients' physical health needs were assessed and recorded. Recognised rating scales were used to assess and record the severity of patients' conditions and care and treatment outcomes. For example, NEWS scores.

The vacancy for a part-time occupational therapist had created gaps in the 1:1 sessions and some group activities.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. Managers used results from audits to make improvements. For example, restraint and seclusion audits.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care.

Patients had access to a consultant psychiatrist, associate specialists, psychologists, Occupational Therapists (OT) and a family and carers lead. There was a vacancy for a part-time occupational therapist.

Rotas were organised to ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff.

A corporate induction was attended by new staff which prepared them for the role they were employed. The induction for bank and agency staff was brief and did not cover the expectations of the role. However, the hospital manager confirmed that all bank staff complete a full induction programme upon commencement of the role. The clinical lead was addressing the induction for agency staff. A booklet with key information was in development to supplement the familiarisation tour of the wards.

Staff were not receiving regular management supervisions from their line manager. Staff said the lack of regular supervision was due to nursing and ward manager's vacancies.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Multi-disciplinary meetings consisted of the consultant psychiatrists who chaired the meetings and their team, the patient's psychologist, and inpatient coordinator. Discussions within the team were open and where appropriate with the patient's relative before inviting the patient into the meeting. Patients had an opportunity to discuss the actions and gave their view on the plans.

Ward staff documented the outcomes of MDT meetings. For example, an increase in observations were documented in the MDT notes.

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

Requires Improvement

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Posters displayed in the wards gave information to patients about independent mental health advocacy. Posters were also on display telling informal patients they could leave the ward freely.

Plans for section 17 (permission to leave the hospital) leave were documented in the electronic records. Plans were reviewed regularly and detailed the type of leave along with an assessment of the patient's mood before leave was agreed. Overall patient's section 17 leave was taking place as agreed with the Responsible Clinician and/or with the Ministry of Justice. One patient's leave was not taking place as agreed and short staff was the rationale for their leave not taking place.

We saw sections in the electronic records where informal patients were granted leave. The Responsible Clinician was clear on the principles of an informal status and the appropriate section if the patient were to be detained from leaving. We saw where staff had given leave to informal patients. Staff's comments indicated that they lacked insight into leave for patients with informal status. For example, how to manage situations when patients were not willing to give details about their return to the hospital. The clinical lead and manager acknowledged increasing staff knowledge and understanding was an area for improvement.

Some patients were able to have unescorted leave on the grounds up to 10pm. However, some patients said their leave was not taking place. There were patients that were given leave in the evenings for cigarette breaks without st. However, the hospital was "No Smoking," and the purpose of leave was for therapeutic interventions.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Patients on a pathway to discharge were assessed by Approved Mental Health Professional (AMPH) responsible for organising the assessment.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding on how to support patients with decision making.

Where patients' mental capacity was assessed, the records demonstrated the decisions reached and consent to care and treatment was based on informed choices.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

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

Requires Improvement

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Requires Improvement

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness. They respected patients' privacy. They understood the individual needs of patients

Despite 7 patients telling us the staff were kind, respected their dignity and showed them compassion, we saw instances where staff ignored patients when they sought their attention. Three patients commented that agency staff were not always kind, and some staff were difficult.

Handover notes lacked patient's personal information and only provided staff with room numbers and initials. Agency staff were not provided with access codes to electronic records which meant when they covered shifts, they did not always know patient's names.

In the six-month period leading up to our inspection we received a number of complaints about the number of male staff on shift on Kenn Ward at night. We began the inspection visits at 9pm on 28 November. On the night shift of 28 November 2022, there was 2 female staff on Kenn Ward and 3 male staff. This meant the ratio of male staff to female patients was high. Hourly observations are completed on a rotation and the majority of observations were carried out by male staff and only twice by a female staff member during the night shift

We heard staff referring to patients as room numbers or initials. For example, a member of staff asked what the name was of a patient in a bedroom., Another patient used their room number instead of their name when requesting their cigarette box. We heard the patient ask for the cigarettes by using their room number to identify themselves. Staff told us it was easier to have room numbers on possession boxes instead of patient's name. They said changes to room numbers on possession boxes were less frequent than name changes.

There were occasions when staff in both wards did not acknowledge the presence of patients when they were in the office. For example, although there were three staff in the office when patients made requests for attention, the staff continued with their tasks instead of acknowledging their presence. We observed a member of staff suggested a patient go to the office to gain the contact details for an external professional. This patient's response to the staff member was that they would be ignored. We saw the patient then go to the office seeking support for the contact details of an external professional. We saw staff ignore the patient and when a member of staff responded the advice was not supportive to access the information. The patient finally got a response three hours later despite visiting the office numerous times for the contact information needed. At times we saw a patient show signs of anxiety and frustration and when we looked at the electronic records the patient was likely to place themselves and others at risk of harm whenever they perceived their needs not being met.

Staff facilitated visits with family, but patients were not supported with developing new relationships. For example, young family members.

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

Requires Improvement

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

New staff were introduced to patients on their first day on duty.

While patients were not consistently provided with copies of their care plans, they understood their care and treatment needs. There was praise for psychologist input with developing coping skills.

Patients were given information on how to access advocacy services and about joining psychology groups.

Patients were given the opportunity to attend weekly community meetings to provide feedback on the service. We reviewed community meeting minutes for the two weeks prior to the inspection for both wards. Meetings were well attended by patients and staff, including the hospital manager and psychologists. Advocates are invited to the community meeting, however, are not generally present at the meeting.

Meetings followed an agreed agenda and covered environmental issues and ward life. We saw a topic on respect had been prompted by the occupational therapist assistant and feedback from the patients on how they viewed respect. We saw positive and negative feedback raised at these meetings. For example, positive feedback including praise for an occupational therapy assistant taking a patient to view a property and compliments about the friendliness of staff. Negative feedback included the torches for night-time observations being too bright and the lack of engagement outside of scheduled group activities

The wards displayed 'You said, We did' boards which showed the action taken following feedback about the service. For example, at a recent community meeting patients wanted staff not to rearrange the dining table layout. Staff confirmed the layout had been returned as preferred by patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Patients and those important to them took part in making decisions and planning of their care.

Patients told us they were listened to during weekly multidisciplinary meetings.

Patient's relatives, where appropriate, were invited to join MDT meetings.

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

Requires Improvement

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

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

Requires Improvement

Bed management

Admissions to the hospital were from the local area mainly and patient referrals were assessed for their level of acuity before admissions to the wards took place to ensure they were placed appropriately. However, we found an out of area placement which was having an impact on the patient's family relationships.

The manager told us there were benefits to patients when they were admitted from the local area and where possible they were accepted.

There were two delays in discharge. Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Discharge and transfers of care

Patients discussed their plans for discharge during MDT meetings. Their discharge plans were not always personalised or reviewed.

Staff planned patients' discharge and worked with care managers and coordinators to make sure this went well. For example, a patient told us how their care coordinators were supporting them with securing the best possible onward moving placement.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom with an en-suite shower room. Bedrooms were individually furnished and fit for purpose. At the time of the inspection one bedroom was empty on Clyst ward and there was one bedroom suitable for disabled patients. However, the ensuite bathrooms had the toilet roll holder placed behind the toilet. This meant it was difficult for patients to access and for disabled patient's it was restricting.

Patients told us they could not close the windows in their bedrooms without having to ask a staff member to lock the windows. This was because the magnets were not working. In the main communal areas, all windows were open as there was also a problem with the magnets. This meant the ward was cold during inspection.

All windows had privacy frosting to stop patient's view into the wards and bedrooms. However, this frosting also prevented patient's view of the outdoors. This meant that did not have a direct link to the outside community.

Patients had a secure place to store personal possessions. Patients told us that they could store their possessions in a locked storage area under their bed and had access to a pin code safe.

There was a central communal space which included a TV and dining area, a phonebooth, quiet room, activities room, kitchen, and laundry. However, we were told that there was no allocated laundry time, and this meant some patients could not always wash their clothes.

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

Requires Improvement

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff supported patients with activities outside the service, such as visiting stables, external trips, and facilitating family visits. There was an expectation that patients 1:1 sessions would improve with the recruitment of an Occupational Therapist (OT).

Staff helped patients to stay in contact with families and carers. Families and carers visited the service or used technology to have virtual meetings with the family.

The ward displayed information including a list of useful contacts in the local community that patients could approach for support.

Meeting the needs of all people who use the service

The service met the needs of all patients with mobility needs.

The service could support and adjusted for patients with mobility needs. For example, a lift was available to the upper floors, corridors were wide and wide corridors.

Care plans were not in place for a patient with sensory needs although we were asked to remove our masks when talking with a patient with communication needs. Care plans must meet Accessible Information Standard (AIS) were not being fully met. It is a new national standard that all organisations providing NHS or adult social care are required to implement. The AIS ensures that patients, carers and parents of patients, and visitors who have a disability or sensory loss receive information they can access and understand.

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

Patients had access to spiritual, religious, and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients and those important to them, could raise concerns and complaints easily and staff supported them to do so. The service treated all concerns and complaints seriously, investigated them and learned lessons from the results. They shared the learning with the whole team and the wider service.

Patients and family members raised concerns with managers and staff. Complaints raised were taken seriously and investigated. The manager gave us an example of a complaint made about an agency staff member using inappropriate language towards a patient. The agency member was suspended while an investigation took place which included reviewing staff's expectations. Learning was shared with staff and the patient received a verbal apology from the hospital director.

Compliments about the service were made about specific staff by patients and families. Patients and families praised specific staff for being friendly and caring' and a family member said this is the nicest hospital my daughter has ever been admitted".

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

Requires Improvement

The service used compliments to learn, celebrate success and improve the quality of care.

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

Requires Improvement

Leadership

Although leaders had the skills, knowledge and experience to perform their roles, they did not have a clear plan on how to support staff to deliver outcomes. However, they were visible in the service and approachable for patients and staff.

The ward manager was supported by the regional and operations director. The hospital manager described their style of management and recognised the importance of role modelling to staff and good communications both upwards and downwards. There was awareness of the challenges across the wards which included retention and ensuring suitable staff were employed.

While managers acknowledged already knowing the issues arising from the inspection there was no clear plan on how staff were to be supported to deliver outcomes. For example, the ratio of male staff to female staff remained high despite complaints and respecting patients' rights to dignity and respect.

Leaders understood the impact of limited access to electronic systems, however there was not a clear plan in place how to address this prior to the inspection. During the inspection access was issues to the systems was resolved.

Staff and patients were positive about the hospital manager. They were known to patients, and they had a presence on the wards.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Success included having patient's potential and welfare more centred into the care and treatment delivered by staff, enabling positive risk taking, catering and steps to create a caring team.

Paper copies of guidance and procedures were availed in hard copies or displayed in the office. For example, safeguarding procedures.

Culture

While staff said they were valued and supported, we saw examples when staff's attitude towards patients was not responsive. We raised concerns about staff not acknowledging patients when they were seeking their attention and the hospital manager told us they were already taking steps to ensure staff were giving patients attention when requested. For example, leaving the office door open when staff were in the space to enable patients to approach staff more easily. However, we saw staff ignore patients when they were in the office.

While the provider acknowledged the lack of access to electronic systems was part of the reason for staff using initials and room numbers, patient's individuality was not respected when staff used room numbers and initials to refer to patients. We raised our concerns with the hospital manager. We were assured by the hospital manager that the culture was to be challenged and steps to improve patient's individuality and dignity were to be taken.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance was not always managed well and not all risks were managed effectively.

The hospital manager was supported by senior managers who provided advice and guidance. The hospital manager was aware of some the themes which impacted their wards. For example, lack of electronic records system access, retention of staff and the introduction of a new care planning system.

Governance systems included auditing systems and processes. The hospital manager assessed risk through audits such as environmental, medicine and staffing which they rated and identified themes. However, the governance systems were not effective in developing plans to address the risks identified and improvements needed. For example, records we reviewed were not always detailed or person centred. Electronic notes lacked detail and were inconsistent with care plans associated to the same care need. Care plans lacked patient preferences, and the same standard phrases were repeatedly used to describe the needs for a number of patients. Care plans were not developed for patients with sensory needs. This meant the audits in place were not effectively identifying where improvement was needed.

We were told improvement plans were being developed where shortfalls were identified.

Management of risk, issues and performance

The hospital had a system for identifying risks and plans to address them. The risk register listed the risk, the level, and the actions to reduce the risk. Risk included staff recruitment and retention, ligature risks and failure to return from leave which were rated along with the actions to reduce the level of risk. However, this system was not always effective in planning to eliminate or reduce them. For example, issues such as lack of access to the electronic systems were not detailed as a high-level risk.

An audit system to assess and monitor the standards of care was in place, however, this had not identified issues with care plans. For example, care notes lacked detail, they were inconsistent with other associated care plans and the language used was not person centred.

Processes to manage current and future performance were being developed by the hospital manager. We were told handover documents; audits of observation documents and care plans were to be implemented.

Information management

The records system was unavailable for some staff to use due to them not having access to the system. Staff without access to the electronics record system were dependent on handover notes to give them information on how to meet patient's needs. However, the handover notes were not always accurate and lacked detail. For example, known allergies and historic risks.

Managers engaged actively with other local health and social care providers. The provider shared data securely with the Care Quality Commission and other agencies in accordance with legislation.

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

Requires Improvement

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There were a number of management meetings that took place and included multidisciplinary team meetings (MDT).

The hospital manager engaged with external commissioners. They joined weekly meetings where discharges and referrals for admission were discussed. There was contact with other external agencies such as police to discuss local intelligence that may impact on the current and potential patients.

Learning, continuous improvement and innovation

The hospital manager responded to incidents. They were investigated and there was learning from incidents. There was openness and transparency to ensure the lessons shared was embedded.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider must ensure that patient's rights to privacy and dignity are protected. Staff must acknowledge patients' presence and ensure they are always correctly addressed and not referred to as initials or room numbers. The provider must ensure privacy frosting does not obscure patients view of the outdoors. This meant that did not have a direct link to the outside community.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure that care plans and risk assessments are developed in a way that ensures patients preferences are detailed. Care Plans must meet Accessible Information Standard (AIS) for patients with sensory loss.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure the premises are suitable for the purpose being used which must include window closures.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that all staff have appropriate access to electronic notes. The provider must ensure that their governance systems and audit programmes are effective in identifying and mitigating risks. The provider must ensure they complete the actions contained in their improvement plans.
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that the ratio of female patient to male staff is appropriate to meet the needs of patients. The provider must ensure that all staff have completed appropriate mandatory training.