South West London and St George's Mental Health NHS Trust

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

Inspection report

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Date of inspection visit: 02 August 2021, 03 August 2021
Date of publication: 20/10/2021

Ratings

Overall rating for this service	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Good ➔➔

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services.

The wards we visited were:

- Ward 3 at Springfield University Hospital: a 20 bed mixed gender ward for male and female patients of working age.
- Jupiter Ward at Springfield University Hospital: a 21 bed mixed gender ward for male and female patients of working age.
- Lilacs Ward at Tolworth Hospital: an 18 bed mixed gender ward for male and female patients of working age.
- Lavender Ward at Queen Marys Hospital: a 22 bed mixed gender ward for male and female patients of working age.

The last inspection of this service took place in October 2019. We rated the service as good overall.

We changed the rating of one key question, Safe, following this inspection. The ratings for Effective, Caring, Responsive and Well-led remained rated as good.

Overall Summary

The core service remained Good overall although we limited the rating for safe to Requires Improvement as we identified breaches of regulation. This was a lowering of the rating since the last inspection.

We found:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep patients safe from avoidable harm. Staff received regular supervision and most had received an annual appraisal in the last year.
- Staff listened to patients' complaints and tried to address them. Complaints were shared with the staff teams. Leaflets and posters were displayed on the wards letting people know how to complain, although some patients told us they did not know how to complain.
- We observed staff engaging with patients in a kind and caring way during the inspection. Staff involved patients in their care and asked them to give feedback about their experience.
- Staff felt respected, supported and valued and described an open, compassionate and responsive culture. Staff worked well together and were supportive of each other.

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However:

- Although most patient care records showed that staff were aware of and put in plans to mitigate and address patient risks, on Lavender ward one patient's care plan lacked sufficient detail in respect to their physical health care. Subsequently the patient developed a suspected urinary tract infection. After patients had been seen by a specialist, staff did not always follow up on recommendations the specialist made in relation to the patient's physical health.
- On several occasions records showed that staff completed intermittent observations at regular, predictable intervals. By conducting observations at exactly the same time within a specific time period there was a risk that patients could predict what time staff would be observing them and plan to harm themselves in between times. The trust engagement and observations policy did not set out clear and achievable expectations regarding four times an hour observations.
- Staff did not always report and grade incidents clearly and in line with trust policy.
- Newly introduced electronic physical health monitoring and engagement and observation forms were not completed accurately and consistently by staff. Some staff told us they would like more training.
- Staff did not always complete and record Mental Capacity Act assessments when appropriate.
- Relatives and carers told us it was difficult to contact the wards as their phone calls often went unanswered. The female lounge on Ward 3 was full of furniture and the belongings of former patients making it impossible to use.

How we carried out the inspection

During the inspection visit, the inspection team:

- spoke with four ward managers and one service matron
- spoke with 11 members of staff including occupational therapists, junior doctors and registered and non-registered nurses
- spoke with 19 patients
- spoke with six patient relatives
- observed three staff handovers, and a multi-disciplinary meeting
- reviewed 12 patient care records
- completed tours of the ward areas
- reviewed clinic rooms on each of the wards

You can find further 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.

What people who use the service say

Most patients that we spoke to said that the majority of staff were caring and treated them with respect and kindness. One patient told us that staff seem to really care about patients and felt they could talk to staff. However, patients said

Our findings

that some staff could be abrupt, and staff didn't speak to them in a caring manner. We received a mixed response from patients when asked about if they felt involved in their care and treatment. Some patients felt involved and were aware of their care plan however other patients told us they were not involved and were not aware of their care plan. Nearly all patients that we spoke to felt safe on the ward.

Is the service safe?

Requires Improvement 

Although we did not inspect all the safe key question, we identified breaches of regulation, which limited the rating. Our rating of this service went down. We rated it as requires improvement because:

Safety of the ward layout

All four ward environments were safe and well-maintained. Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff carried out routine checks of the environment during each shift to identify any matters that needed to be addressed.

Staff could observe patients in all parts of the wards. Convex mirrors were in place to help staff observe blind spots more clearly. Communal rooms on Jupiter Ward had large internal windows which meant staff could easily see into the rooms.

The wards were mixed sex. Male and female bedrooms were separated to protect patients' privacy and dignity. Lavender Ward had a female only lounge but on Ward 3 the female lounge was not in use. It was being used to store patients' belongings.

Staff had carried out ligature risk assessments on all wards. These assessments were detailed, highlighted the anchor point risks in each room and identified immediate actions to protect patients. The trust had a ligature risk review group where pre-existing ligature risks on the wards would be discussed and the management of the ligature risks would be reviewed.

The ligature assessment carried out on Lavender Ward in June 2021 identified a number of small actions that needed to be addressed. These were subsequently completed, although not until August 2021. The risk assessment identified that on the day the audit took place two doors on the ward that should have been locked to protect patients had been found unlocked. In addition, the ligature risk assessment stated that the laundry room should be "supervised when in use. Locked when not in use." On the day of the inspection we found that the laundry room was empty and unlocked.

Wards had a ligature risk folder, which included photographs of ward ligature points. All staff were expected to familiarise themselves with this. Each shift had a staff member who was responsible for security and checked ligature points. Staff we spoke with were aware of the ligature risks in their environment and took appropriate actions to mitigate any risks and keep patients safe. On Ward 3 most staff had signed to say they were familiar with the policy and contents of the ligature risk folder.

Staff had easy access to alarms. Staff were issued with alarms at the start of each shift.

Maintenance, cleanliness and infection control

Our findings

Ward areas were, on the whole, visibly clean, well maintained, well-furnished and fit for purpose. Lilacs and Jupiter both had gardens that staff and patients were using for outdoor activities. However, staff on Jupiter and Lilacs Ward were concerned that there were limited facilities for multidisciplinary meetings. On Jupiter Ward, there was some graffiti and coffee stains on the walls of a patient's bedroom that was temporarily closed for repair and redecoration. The graffiti and coffee stains were subsequently removed from the patient's room. Only two bedrooms on Jupiter and 12 bedrooms on Lilacs had ensuite facilities. Staff on Jupiter Ward also said the ward was often very hot in summer and very cold in winter. Staff and patients told us that the laundry room on Jupiter Ward was so hot that staff and patients were unable to use the facilities there.

Between 79% and 96% of staff on the four wards inspected had completed infection prevention and control training.

Staff made sure cleaning records were up-to-date and the premises were clean. The wards employed a specialist cleaning company that cleaned each ward twice a day.

We observed staff following infection prevention and control procedures including hand washing and wearing facemasks. Staff completed an audit of compliance with infection prevention and control procedures each day. Staff carried out hand hygiene audits every week. Patients were required to carry out Covid tests on their first, third and seventh day of admission. Staff tested twice a week. Some patients and a carer told us some staff did not always wear face masks correctly.

The lids of some waste disposal bins in Lavender Ward were stiff and did not open fully, for example the lid of the black bin in the assisted bathroom. There was a risk that people would touch the lids with their hands when depositing rubbish. The trust told us that these have since been replaced.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment. Records showed that staff carried out checks on the equipment every day. FFP3 masks were kept in the emergency bag for use by staff when carrying out chest compressions. Most staff had been fit tested for an FFP3 mask.

Staff maintained and cleaned equipment. Staff had applied stickers to equipment in the clinic when it had been last cleaned. Staff attached labels for equipment showing the date on which it had been tested. All equipment had been tested within the recommended timescale. The temperature of fridges was monitored remotely.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe from avoidable harm.

Nursing staff

Ward managers told us that there were enough staff on shift to keep patients safe. Managers regularly reviewed staffing levels and skills mix and sought support from the on-call manager if they were concerned about staffing levels.

Managers supported staff who needed time off for ill health. For example, staff on Jupiter Ward sent a card and good wishes to a colleague who was off work following an incident on the ward.

Our findings

The ward manager could adjust staffing levels according to the needs of the patients. For example, whenever there was more than one patient requiring enhanced observation, the ward managers were able to assign an additional member of staff for each patient needing one-to-one support.

Staff that we spoke to felt that the wards had become increasingly busy. Staff on Ward 3 told us that it was not always possible to take breaks as planned. On four occasions between 19 July and 1 August there had been one registered nurse on shift, during these occasions the ward manager would step in to support the ward.

Most patients told us that they felt safe on the ward, but some said there were sometimes not enough staff on shift for them to take escorted leave. The wards operated a named nurse system where each patient had an identified member of nursing staff who was their key worker and a member of staff to support them each shift. However, patients told us that they did not have enough opportunities to speak to staff as they were too busy.

The service had enough staff on each shift to carry out any physical interventions safely. Staff explained that they received support from staff on other wards if they had to deal with a particularly difficult situation.

Staff shared key information to keep patients safe when handing over their care to others. Staff held handover meetings at the start of each shift. Staff explained that if they had not been on the ward for more than a couple of days, they would ask the shift co-ordinator for a more detailed update on the patients and ask for time to go through patients' notes. However, during the inspection we observed a handover meeting on Lilacs Ward. There were many interruptions to the meeting. The arrangements for the meeting were not conducive to questions from staff and discussions about patients.

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. For wards at Springfield Hospital, a junior doctor was available on site 24 hours a day. Wards at Tolworth and Queen Mary Hospital (QMH) shared an on-call duty doctor outside office hours. This system was reported to work well and provide enough cover. However, it was noted that this system was stretched during the pandemic with one doctor covering both the QMH and Tolworth Hospital sites. This meant that sometimes the doctor could take up to 45 minutes to reach the ward when travelling from the other site. Staff on Lavender Ward said there could be a delay to get support from medical staff at night but medical support would be provided if urgent. If patients presented an immediate medical emergency, staff would call an ambulance for the patient.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. However, on Lilacs Ward, there had been three locum consultant psychiatrists working on the ward in the six weeks prior to the inspection. This had caused some disruption to the continuity of care.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. Most staff on all the wards had completed adult life support training (between 80% and 100% of all staff on the four wards inspected). Nearly all eligible staff had also completed medical emergency training.

Managers monitored mandatory training and alerted staff when they needed to update their training. All training completed by staff was recorded. This enabled managers to see the training compliance for each member of staff on a training dashboard. Managers discussed mandatory training compliance with staff during supervision.

Our findings

Assessing and managing risk to patients and staff

Assessment and management of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. When each patient was admitted to the ward they were assessed by a junior doctor. The physical assessment involved checking the patient was alert and orientated, listening to the patient's chest, examining their abdomen, checking their skin and assessing mobility. Staff recorded the patient's pulse, temperature, respiration rate and blood pressure. Staff sent samples of blood and urine for testing. Once the doctor completed the basic tests, they carried out an electrocardiogram. In assessing the patient's mental health, the doctor reviewed the reasons for admission and carried out a mental state examination. Staff commented that acuity levels on wards were high and that patients frequently presented risks of self-harm and aggression towards other people. Patients were frequently admitted following periods of self-neglect or using drugs and alcohol

Assessments of patients physical and mental health continued throughout their admission and were reviewed in multidisciplinary team meetings each day. We reviewed the care records of 12 patients from the wards we visited. All patients were offered a physical health as well as a mental health assessment on admission. All patients had a risk assessment in place that had been completed shortly after admission. Staff recognised risks to patients' physical health as well as their mental health. Staff used recognised tools to assess risk of falls and malnutrition. Most assessments recorded patients' risks appropriately except for one falls risk assessment on Ward 3. This risk assessment recorded that the patient had no mobility aids and no difficulty walking when they were in fact using crutches and a wheelchair. When this was identified by the inspection team the risk assessment and care plan was updated by staff.

Staff recorded patients' vital signs at least daily to monitor signs of possible deterioration. The trust had very recently introduced a new electronic form for staff to record patients' vital signs, using the National Early Warning Signs 2 (NEWS2) tool, which helps identify deterioration in a patient's physical health. The NEWS2 scores indicate when a patient's condition should be escalated. Staff completed the electronic forms regularly for all patients, whose records we reviewed. However, the monitoring frequency recorded on each form varied greatly without obvious reason. Sometimes the frequency of monitoring was changed without rationale from daily to one hourly, but the frequency of actual monitoring carried out by staff did not change. This inconsistency of recording monitoring frequency was evident in all records we checked. All staff had completed training in NEWS2, including use of the new electronic recording system but some staff told us that they would like further support and training about the use of the electronic form. We raised this with the trust following our inspection and they said they would review use of the form and staff's understanding.

Patient care records showed that staff were aware of and put in plans to mitigate and address most identified patient risks including risks to their physical health. For example, staff carried out regular blood monitoring for a type 1 diabetic patient and referred them to a diabetic nurse for specialist support. A patient who was not eating and drinking well was referred to and seen by a dietitian.

However, for one patient the care plan addressing an identified risk was not detailed enough. The patient, who was on Lavender Ward, was identified to be at risk of a urinary tract infection as they had a catheter in place. A care plan was in place to address risks arising from the catheter and the patient's diabetes. The care plan lacked detailed in respect of the catheter care. It did not specify whether or how often staff should check the catheter or the signs of possible infection that staff should check for. The patient subsequently developed a suspected urinary tract infection. Following this staff put in place a more detailed plan aimed at preventing a reoccurrence of infection.

Our findings

Staff did not always follow up on recommendations made by a specialist after review of a patient. For example, a patient on Lavender Ward was reviewed by a dietitian. The dietitian recorded specific instructions in the patient's notes following a consultation asking staff to review the patient's bowel pattern as they had reported constipation and to assess the patient using the malnutrition universal screening tool weekly. There was no evidence in the patient's record that either recommendation had been followed in the 11 days between the consultation and the day of the inspection.

Scanned paper records for intermittent observations of a patient on Lavender Ward in June 2021 showed that observations had been carried out at regular 15 minute intervals at 00, 15, 30 and 45 minutes past the hour for a period of 10 hours. For a second patient on Lavender Ward scanned nursing observation records from July 2021 showed another patient on intermittent observations was observed at the same predictable times past each hour for seven consecutive hours. By conducting observations at exactly the same time within a specific time period there was a risk that patients could predict what time staff would be observing them and plan to harm themselves in between times. The trust's engagement and observation policy stated that intermittent engagement and observations meant 'that the patient must be observed at four or more staggered intervals which are no longer than 15 minutes in an hour but occur in a random way'. When we asked staff about intermittent observations, some staff were aware of the risk associated with regular, and therefore predictable, intermittent observations and some staff were not.

The trust had very recently introduced an electronic system for recording patient observation and engagement. All staff had completed observation and intensive engagement training.

We reviewed completion of the electronic observation forms and noted that sometimes staff were recording intermittent observations at fixed, potentially predictable times. For example, for a patient on Lavender Ward, who was observed once every hour the observations were recorded on the hour, every hour from 2 to 5am on one night. For another patient on Ward 3, who was observed once every hour as part of general engagement and observations, the observations were recorded on the hour every hour for four consecutive hours on one occasion. For a second patient on Ward 3 who was observed four times an hour the observations were recorded at fixed 15-minute intervals on seven consecutive occasions.

Staff completed the electronic engagement and observation form inconsistently. The description of the type of observations being conducted sometimes changed without apparent rationale, particularly when patients were on continuous observations or enhanced observations. There was also frequently a discrepancy between the initial time stated at the beginning of the form and another time recorded at the end of the form when it was 'updated'. This discrepancy was sometimes a few minutes but on other occasions it was as much as three or four hours. As a result, it was unclear at what time staff had actually made the observation.

Emergency simulation exercises had stopped during the pandemic and staff were not sure when these would be started again. Staff we spoke to had not attended an emergency simulation exercise recently. The trust told us that simulation exercises had recently restarted. The trust subsequently sent us reports of simulation exercises conducted on all four wards between May and August 2021. Each identified learning for the staff involved in the simulation.

Use of restrictive interventions

Staff made every attempt to avoid using restraint and only restrained patients when de-escalation techniques failed, and it was necessary to keep the patient or others safe. For example, one patient had an infection meaning he was confused and disorientated. We observed staff supporting him by using de-escalation techniques to try and keep him safe and protect his privacy and dignity.

Our findings

Staff followed NICE guidance when using rapid tranquilisation. For example, records showed that staff checked the patient's blood pressure, pulse, temperature and oxygen saturation level after administering rapid tranquilisation given under restraint. Patients were also assigned to one-to-one observations from a member of staff after rapid tranquilisation.

Staff access to essential information

Patient notes were comprehensive and all staff could access them. All information about patient's was stored on an electronic patient record. However, the system for accessing records was often very slow and it could take staff a long time to enter and access information. Staff told us that updating care records was a time consuming process due to frequent IT issues. The Matron informed us that the trust were in the process of ordering new equipment. During our review of records, we were unable to find food fluid charts for one patient covering a period of two weeks.

Records were stored securely. Records could only be accessed by staff entering a username and confidential password.

Reporting incidents and learning from when things go wrong

With regards to serious incidents Ward 3 reported one unexpected death and two incidents resulting in severe harm between April 2020 and July 2021. Lavender Ward reported two deaths due to natural causes during the same time period. Lilacs Ward reported one death and two incidents resulting in moderate harm and Jupiter Ward reported two incidents resulting in moderate harm between April 2020 and July 2021.

Most staff reported incidents in line with trust policy. The trust had systems in place to ensure that all serious incidents were escalated to the director of nursing and discussed by senior managers at a weekly quality review meeting. However, on Lilacs ward staff had not assigned the appropriate level of severity to an incident and this error had not been identified by managers. This meant one incident had not been discussed in the correct forum. However, the incidents were discussed by the ward team and learning from one of the incidents was shared across hospital wards to help minimise risk of reoccurrence.

Business meeting minutes showed that learning from serious incidents was discussed with staff. Business team meetings took place monthly except on Ward 3 where there had been three meetings since December 2020, rather than the expected seven.

Managers debriefed and supported staff after any serious incident. Staff we spoke to told us they had opportunities to debrief and felt supported by management when things went wrong. Senior managers looked after staff wellbeing and attended the ward to provide support when things went wrong. Following a recent serious incident one staff member told us support from management was 'excellent' and they had lots of opportunities to debrief with senior management and peers.

Staff received feedback from investigations of incidents, both internal and external to the service. The trust sent a learning bulletin to all clinical staff. The bulletin in February 2021 included details of incidents involving a patient disengaging with treatment in the community and the risks related to prescribing antidepressants for people with suicidal thoughts. The bulletin included a list of recommendations following investigations into these incidents.

Staff met to discuss the feedback and look at improvements to patient care. Staff routinely discussed incidents and learning outcomes at monthly business meetings attended by nurses, doctors and healthcare assistants.

Our findings

Is the service effective?

Inspected but not rated

Our rating of effective stayed the same. We did not inspect the whole of the key question during this inspection and therefore did not rate the core service. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

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 in multidisciplinary meetings and updated as needed. Care plans were in place for all 12 patients whose records we received.

Best practice in treatment and care

Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Patients were referred to specialist services and professionals when appropriate.

Skilled staff to deliver care

Managers supported staff to develop through yearly appraisals of their work. On most wards staff had an up to date appraisal however on Ward 3 only 55% of staff had an up to date appraisal. One staff member told us his appraisal had felt rushed due to competing work demands impacted by the pandemic.

Managers supported staff through regular clinical supervision of their work. Staff had access to regular supervision through their line manager. Nursing staff had monthly supervision and band 5s supervised their junior colleagues providing them with skills development and learning. Between 70% and 82% of staff on the four wards inspected had completed supervision every month in the last year. Staff told us that it was not always possible to have monthly supervision however they would always be able to speak to their manager as and when required.

Not all staff had received training in autism and learning disabilities. However, they did have access to specialist nurses who could provide support to the MDT around care planning and behaviour support plans, if needed.

One ward manager (Ward 3) had arranged for bite sized learning sessions on Autism spectrum disorder (ASD) / Learning disability (LD) to support with an individual patient. Staff had also completed a specially adapted session on Proactive Physical Intervention (PPI) in patients with ASD developed by the PPI instructor.

Multi-disciplinary and interagency teamwork

Staff held regular multidisciplinary (MDT) meetings to discuss patients and improve their care. This included a weekly MDT meeting and daily handover meetings. We observed a handover meeting on Lavender Ward, which was well attended and discussed individual patient risks, medicines, care needs and discharge plans.

Our findings

Ward teams had effective working relationships with external teams and organisations. For example, each ward had a discharge coordinator who attended handover meetings and who made referrals to social work and housing teams, if needed.

Good practice in applying the Mental Capacity Act

Staff did not always have regard to the Mental Capacity Act when restraining patients. For example, on Lilacs Ward a patient was restrained for the purpose of taking blood for testing. There was no detailed record of an assessment of the patient's mental capacity in relation to this procedure.

On the day of our visit to Lavender Ward an informal patient was administered medicine by intramuscular injection without their consent. The patient's care record stated the medicine had been administered, under restraint, under the Mental Capacity Act, as their capacity was impaired at the time. However, when we reviewed the records the next day there was no record that a formal detailed capacity assessment had been carried out.

Is the service caring?

Inspected but not rated

Our rating of caring stayed the same. We did not inspect the whole of the key question during this inspection and therefore did not rate the core service. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Involvement in care

Involvement of patients

Most patients we spoke with told us most staff were caring and treated them with respect and kindness. One patient told us that staff seem to really care about patients and felt they could talk to staff. They also told us that staff had been flexible with allowing their mother to visit when there were problems with the visitor booking system. However, a few described how some staff were dismissive of and did not listen to patient concerns. For example, one patient felt staff did not like him because he challenged them. Another patient told us they felt 'dismissed' by staff when asking about the reasons for their admission. One carer told us the clinical team did not have the right information about their relative and was dismissive of his concerns.

We observed staff engaging with patients in a kind and caring way during the inspection.

Staff involved patients and gave them access to their care planning and risk assessments. Patients met with their consultant psychiatrist once a week. They also had a weekly one-to-one meeting with their primary nurse each week to discuss their care plans and recovery goals. Staff gave examples of how they had discussed care with patients and how they had incorporated patients' wishes into care plans.

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The wards held community meetings for patients to discuss issues about the ward. Patients had access to a named nurse whose role was to develop support plans personalised to their individual needs. Patients met with staff at community meetings each week. During these meetings patients gave feedback on food, the environment, activities and other matters. Patients could also raise concerns during one-to-one sessions with nurses or through the complaints procedure.

On Lavender Ward there was a screen attached to the wall of the communal lounge that staff told us was a 'feedback live' device. Patients could use the screen to give feedback about their experience on the ward. There was no poster advertising the purpose of the screen near the device and the plug had been removed. However, staff were able to demonstrate that the device worked but said that it had been broken for some time earlier in the year and did not always work. Community meeting minutes on Ward 3 from June 2021 noted that 'feedback live' device on the ward was not working and almost always became faulty soon after it was fixed.

The trust reported that in the period from April 2020 and July 2021 there were 341 'feedback live' surveys completed on Lavender Ward with 1,530 questions answered, of which an average of 50% were in agreement with the questions.

In the same time period there were 130 'feedback live' surveys completed on Ward 3 with 773 questions answered, on Jupiter Ward there were 135 surveys completed with 791 questions answered and on Lilacs Ward there were there were 477 surveys completed with 2,335 questions answered. Responses were analysed in terms of themes and any concerns addressed.

Involvement of families and carers

Each ward had a carers' lead whose responsibility it was to offer support to carers. Wards had notice boards with carer information displayed. Carers could be signposted to carer groups and organisations, or referred for a carers' assessment, if needed. Carers were also discussed in the MDT and handover.

A ward manager told us the psychologist offered specialist family support to one patient's family. Although the patient was unable to engage, they had worked closely with the patient's mother. They hoped to extend this to other families and patients.

Staff supported, informed and involved families or carers in most cases. One carer told us that all the staff on the wards were friendly and that their relative knew every member of staff working on the ward. However, one carer told us they did not feel included their relatives care and treatment. For example, they said they had not been given any information about why their relative had been admitted, what their diagnosis was or what medication was prescribed and why.

Staff invited families and carers to weekly ward rounds. If family members were unable to attend these meetings, staff would telephone them or arrange a video conference. On Lilacs Ward, the consultant psychiatrist allocated time each week to make calls to patients' families and carers.

Carers that we spoke to expressed their frustration with contacting the wards via telephone. Carers told us that it could sometimes take multiple phone calls in one day to get through to ward staff. The matron agreed that this was an area that required improvement.

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Is the service responsive?

Inspected but not rated

Our rating of responsive stayed the same. We did not inspect the whole of the key question during this inspection and therefore did not rate the core service. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Listening to and learning from concerns and complaints

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

Ward managers told us they would speak to patients directly if they complained. One ward manager had his office strategically located so that patients could knock on his door, if they wanted to discuss a concern. Patient concerns and complaints were followed up in business meetings with staff including discussing changes that needed to be made as a result. Business team meeting minutes from Ward 3 showed that complaints had been discussed with staff.

Patients raised any concerns they had about the ward at community meetings and these were followed up.

Notices and leaflets on how to complain were displayed on the wards but several patients told us they did not know how to make a complaint.

The four wards had received 53 formal complaints in total in the last 12 months. The highest number, 19 were received on Lilacs Ward. Most had been acknowledged and responded to within expected timescales.

Is the service well-led?

Inspected but not rated

Our rating of well-led stayed the same. We did not inspect the whole of the key question during this inspection and therefore did not rate the core service. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff acknowledged that work on the ward had been hard during the Covid-19 pandemic. Leaders had worked to provide support to staff during the pandemic.

Staff felt able to raise issues with managers, if required. Managers were visible on the wards, with staff able to raise concerns and issues with the clinical leads and managers. Leaders were in the process of providing more psychological support to staff outside of team meetings, for example increasing the amount of reflective practice available to staff.

Our findings

Staff we spoke with said they enjoyed working for the trust and told us there was an open, compassionate and responsive culture. Staff worked well together and were supportive of each other. Staff told us the trust supported Black, Asian and minority ethnic (BAME) staff well and continually strived for good practice. However, staff were aware that there were few BAME staff in senior positions.

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:

- The trust must ensure that there are appropriate and detailed plans in place to manage patients' physical health risks and that specialist advice is followed after a review of patients' needs. **Regulation 12 (1)(b)**
- The trust must ensure that staff do not complete intermittent observations at regular, predictable intervals. **Regulation 12 (1)(b)**

Action the trust SHOULD take to improve:

- The trust should ensure that staff report and grade all incidents in line with trust policy.
- The trust should review the use of the newly introduced electronic NEWS2 and engagement and observation tools to ensure staff know how to complete it accurately and consistently.
- The trust should review the wording of its engagement and observation policy to ensure expectations regarding four times an hour observations are clear and achievable.
- The trust should ensure that staff complete and record Mental Capacity Act assessments when appropriate.
- The trust should continue to improve the IT system available on the wards.
- The trust should ensure that relatives and carers can contact the ward easily and speak with staff.
- The trust should ensure that female patients can use the female lounge on Ward 3.
- The trust should ensure that patient feedback live devices are kept in good working order.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two CQC inspectors, one inspection manager and one specialist advisor.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment