Camden and Islington NHS Foundation Trust

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

Inspection report

St Pancras Hospital
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Ratings

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

Our findings

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

Good ↑

We carried out this unannounced inspection because, at our last inspection, we rated acute wards for adults of working age as requires improvement.

Camden and Islington NHS Foundation Trust has 9 acute wards for adults of working age and 2 psychiatric intensive care units (PICUs). The wards are situated across two sites: Highgate Centre for Mental Health and St Pancras Hospital. During the inspection, we visited Rosewood and Sapphire Wards at St Pancras. We visited Coral (PICU), Opal and Topaz Wards at Highgate Centre for Mental Health. All wards were single sex. Wards at St Pancras had 12 beds. Wards at Highgate had 16 beds. Whilst our inspection activities focused on these wards, most of the data we reviewed covered all 11 wards within this core service.

The previous comprehensive inspection of this core service was in October and November 2019. At that inspection, we rated the service as good overall. We rated the service as 'requires improvement' for the domains of safe and responsive.

Camden and Islington NHS Foundation Trust is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

Our rating of acute wards for adults of working age and psychiatric intensive care units services improved. We rated them as good because:

- The ward environments were safe and clean. Staff managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding
- Staff developed recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. 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 most of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this
- The service was well led and the governance processes ensured that ward procedures ran smoothly

Our findings

However,

- The wards did not have enough permanent nurses
- Less than 75% of staff had completed required training in basic and intermediate life support however there were plans in place for this training to be delivered.
- Staff did not always ensure that clinical equipment was sufficiently checked to ensure readings were accurate
- Staff did not receive specific training to meet the needs of some of their patients, specifically patients with autism and learning disabilities although training was planned.
- Staff did not always inform patients detained under the Mental Health Act of how the Act applied to them and their rights to appeal against detention in a timely manner
- The trust did not have clear policies and procedures on how to address abuse towards staff.

How we carried out the inspection

During this inspection, the inspection team:

- visited five wards, including one ward visited unannounced in the evening
- conducted a review of the environment on each ward and observed staff supporting patients
- spoke with four ward managers
- spoke with 24 staff including registered nurses, support workers and activity co-ordinators
- spoke with the director of hospital services and a Mental Health Act manager
- spoke with 3 doctors
- spoke with 7 patients
- reviewed the records for 14 patients
- reviewed the medication charts for 13 patients
- attended handover meetings, safety huddles, multidisciplinary team meetings and a community meeting
- reviewed other documents, performance data and policies relating to the running of the service

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

Patients were generally positive about the service and felt safe on the wards. They said that it could be frustrating that they were unable to leave the ward whenever they wanted to but, overall, they said the service was good. Patients said that staff were caring and listened to what they said. They enjoyed activities such as reading, art, cooking and music.

Patients said that doctors were good. They were able to give their views on their care and they felt that their treatments were helping them to get better.

Our findings

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped, and well furnished. The wards at St Pancras hospital were old and did not offer a therapeutic environment, but the trust was in the process of building new wards to replace them.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff completed checks of the ward environment each shift. Staff reported any concerns to the maintenance department. Managers completed an environmental risk assessment of wards once a week. On the psychiatric intensive care unit (PICU) staff conducted regular spot checks of patients' bedrooms. Matrons completed a comprehensive environmental audit of each ward once a month.

Staff could observe patients in all parts of the wards. The wards at St Pancras Hospital were small and site lines were not always clear. On all the wards, the service had improved visibility by installing convex mirrors and closed-circuit television (CCTV) in communal areas.

The service complied with guidance and there was no mixed sex accommodation. Since the last inspection, all wards had become single sex.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. All wards were fitted with anti-ligature taps, furniture and window fittings. Staff completed a risk assessment of ligature points on all wards every six months. The assessment identified risks in bedrooms, the shower facilities for disabled patients and in the gardens. Staff mitigated these risks through clinical risk assessments, observations and ensuring all staff were aware of potential ligature points. For example, on Coral Ward, staff supervised patients using the garden and completed a risk assessment when patients used the shower with access for disabled patients. Staff displayed a 'heat map' in nurses' offices showing the location of ligature points. Also in nurses' offices, staff displayed a large sign to indicate where the ligature cutters were kept.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff carried personal alarms. When staff activated alarms, colleagues from nearby wards attended the incident. Alarms were tested each shift.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and, mostly, fit for purpose. The service had replaced the doors on some wards to make them safer and more secure. However, wards at St Pancras Hospital were situated in a very old building. The trust was planning to close these wards at the end of 2023. New wards were being built to replace them. These wards were small and although there was some nice artistic decoration, the environment was tired and not particularly therapeutic. Staff commented that it was hard for patients being cared for in a poor environment.

Our findings

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed an infection control policy, including handwashing. Hand sanitising gel was available from dispensers at the entrances to all the wards. Staff displayed hand washing instructions in all toilets. High touch areas were regularly cleaned.

Seclusion room

The seclusion room on Coral Ward (PICU) allowed clear observation and two-way communication. It had a toilet and a clock. Staff were able to control the lighting and heating from outside the room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic rooms were clean and well maintained. Clinic rooms had equipment for measuring patients' blood pressure, weight and height. There was also a pulse oximeter, thermometer and electro-cardiogram machine. Resuscitation equipment was stored in the nurses' office and checked daily. Wards kept a 'grab bag' of all necessary emergency medicines.

Staff on most wards checked, maintained, and cleaned equipment. Room and fridge temperatures were checked each day. On most wards, equipment, such as electrocardiogram machines and blood pressure monitors were labelled with stickers showing when they had last been serviced. However, on two wards there were no records of equipment used for measuring blood sugar levels being calibrated. This meant that the machines could give incorrect readings that could lead to staff giving incorrect doses of medicines.

Safe staffing

The service did not always have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough permanent nursing and support staff to keep patients safe. Wards at St Pancras Hospital had a capacity of 12 patients. During the day, 2 registered nurses and 2 support workers were assigned to each ward. At night, this reduced to 2 registered nurses and 1 support worker. Staff said that it could be difficult to manage the ward with this number of staff. For example, if a nurse attended a long meeting or a support worker accompanied a patient on leave, there would be very few staff on the ward. Staff explained that on some shifts, the number of staff fell below the number required as it was difficult to arrange cover at short notice. On Sapphire Ward between 17 October and 11 November 2022, there had been only one registered nurse on duty on six occasions. Staff sometimes had to work across different wards to provide cover. For example, on the night shift on 19 October, nurses from 3 other wards worked on Sapphire for 4 hours each to ensure there was always a registered nurse on the ward. This meant that leadership was difficult and patients were often cared for by staff who they were not familiar with and may not have felt comfortable with. At Highgate Centre for Mental Health, most wards had 16 beds. On these wards, staffing levels were slightly higher with 2 registered nurses and 3 support workers during the day. There were 2 registered nurses and 2 support workers at night. On these wards, staff felt the staffing levels were appropriate to meet patients' needs. On Coral Ward, a psychiatric intensive care unit for up to 12 patients, there was a higher staff to patient ratio. On the day shift there were three registered nurses and three support workers. There were two registered nurses and three support workers at night.

Our findings

The service had variable vacancy rates. The average vacancy rate for the acute wards was 17%. On Topaz Ward there were vacancies for 2 registered nurses and 2 support workers. On Coral Ward, there were vacancies for 1 registered nurse and 2 support workers. However, there had been delays in appointing newly qualified staff.

The service had high usage of bank nurses. On the acute wards, the average use of temporary staff in October 2022 was 38%. This figure was over 40% on Jade, Laffan, Opal and Sapphire Wards. The figure for temporary staff rose to 53% on intensive care wards due to additional staff being assigned to enhanced observations.

Managers limited their use of bank staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Induction for bank staff involved an introduction to the building, brief training on observations and information on fire safety. Bank staff received information about each patient during the hand over meeting at the start of each shift. Staff on the PICU received an induction from the security nurse and the nurse in charge. However, during our inspection a bank nurse was leading a night shift on Rosewood Ward. They had started bank work with the trust the previous week. They did not have access to the electronic patient record which made it difficult for them to look-up information about patients. Whilst support was available from the site-manager, bank staff did not receive supervision so there was no formal process the trust could use to thoroughly assess their competency. Between 30 May and 29 November 2022, there were 211 shifts at St Pancras when there were no permanent nurses on a ward. This amounted to 10% of total shifts on acute mental health wards at that hospital. On 42 of these occasions, all nurses were from agencies or NHS Professionals. On 169 of these occasions, at least one nurse was employed by the trust, but usually worked on a different ward. Staff commented that when an inexperienced nurse was leading a shift, more responsibilities fell to support workers who were more familiar with patients and routines of the ward.

The service had low turnover rates on most wards although it was high on some wards. The overall turnover rate was below the trust's target of 16%. On some wards the turnover rate was higher. For example, on Sapphire Ward it was 30% and on Topaz Ward it was 22%. Staff said that many of their colleagues had moved on to posts at higher bands. Staff said the frequent movement of nurses to different posts created instability within teams. In addition to monitoring turnover rates, the trust calculated the stability rate for each ward based on the number of staff who had been employed on the ward for over 12 months. The average stability rate was 83%. Four wards had stability rates below 80%, with Rosewood showing the lowest rate at 63%.

Managers supported staff who needed time off for ill health. The trust granted recovery leave to staff who were injured during incidents on the wards. Managers maintained supportive contact during this time.

Levels of sickness were high. The average rate of sickness across the acute wards was 8.2%. This ranged from 3% on Dunkley Ward to 20% on Laffan Ward. The trust's target for sickness was 3%.

The ward manager could adjust staffing levels according to the needs of the patients. Managers could increase the numbers of staff on the wards if there was more than one patient on enhanced observations or if the level of acuity on the ward was high. During our inspection, the level of acuity and the number of enhanced observations meant there were 12 staff working on Coral Ward, providing a ratio of one member of staff for every patient. The manager explained that this was the maximum number of staff the ward could accommodate.

Patients had regular one-to-one sessions with their named nurse. Each nurse was assigned as the named nurse for specific patients during each shift. Nurses said they frequently spoke to patients individually throughout each shift.

Our findings

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. One member of staff said that there had been times when staff were unable to facilitate escorted leave, but this did not happen often.

The service had enough staff on each shift to carry out any physical interventions safely. Staff explained that when they activated personal alarms, staff from nearby wards responded quickly to assist with the situation. Overall, staff felt safe on the wards.

Staff shared key information to keep patients safe when handing over their care to others. Staff discussed the risks and safety of each patient at handover meetings.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency. All wards had a consultant psychiatrist. Psychiatrists were supported by trainee doctors. Doctors explained that they worked closely with doctors across the service and provided support on other wards to cover short term staff absences. Outside office hours, an on-call duty doctor was available on both sites. Doctors said these arrangements for cover were sufficient. Nursing staff said that it was easy to contact a consultant psychiatrist. They said that doctors responded quickly when they asked for help.

Mandatory training

Staff had completed and kept up-to-date with most mandatory training. Staff completion rates for mandatory training was above the trust target of 90% on 9 out of 11 acute and intensive care wards. Compliance on Jade Ward was 82%. However, compliance on Coral Ward was only 63%. Completion rates for specific courses and modules was above 75% for most courses. However, the completion rate for adult basic life support was 65%. The completion rate for adult intermediate life support was 71%. In order to complete these courses, staff were required to attend a workshop once a year. Senior managers were aware of the poor compliance with life support training and recorded their concerns on the trust-wide risk register. The trust had appointed an external company to provide additional training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The trust programme of mandatory training covered 23 courses including infection prevention and control, health and safety, dealing with violence and aggression, resuscitation and life support and safeguarding. Staff said they found the training in the prevention and management of violence and aggression to be very helpful.

Since 1 July 2022, all registered providers have been required to ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. The trust had not yet begun this training, although plans were in place for this to begin in 2023.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received information once a month showing the level of compliance with mandatory training for each of their staff.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. **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.**

Our findings

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed a risk assessment as part of the initial assessment when patients were admitted to the ward. When patients were admitted at night, they were seen by a consultant psychiatrist the following morning. All patients were subject to intermittent observations every 15 minutes during the first 72 hours of their admission. This allowed time for staff to monitor how the patient had settled onto the ward and thoroughly assess risks within the ward environment. If a patient was very agitated or aggressive on admission to the PICU, they would be nursed away from other patients. However, on some records, the formal risk assessment was not completed until almost a week after the patient's admission to the ward.

Staff used a recognised risk assessment tool. Staff completed the assessment using the standard risk assessment tool on the electronic patient record. Staff updated risk assessments when they completed entries on the electronic incident record.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff placed patients on intermittent observations for the first 72 hours of their admission. This meant that staff checked on the patient four times every hour. The level of observation could be increased if the patient presented a heightened risk. Staff recorded observations of patients on a standard form. This included details of what the patient was doing each time they were observed. When patients were asleep, staff noted the patient's respiration. Intermittent observation took place four times each hour at unpredictable intervals. However, on some patients' records, the risk assessment did not include all the risks set out within the care plan. This meant that some staff may not be aware of this risk.

Staff identified and responded to any changes in risks to, or posed by, patients. Each ward held a 'safety huddle' during each shift. Staff reviewed the risks presented by patients at these meetings. The team could increase or decrease each patients' level of observation and adjust levels of medication according to any changes in the risk they presented. Each ward also discussed risks in daily multidisciplinary team meetings. Staff felt these arrangements for reviewing risk worked well. Night-staff held a safety huddle at 9.30pm, facilitated by the site manager. Staff on the PICU mitigated intrusive behaviour and conflicts through enhanced observations, pro re nata (PRN), as and when, medication and spending more time with patients.

Staff could observe patients in all areas of the wards. For example, on the PICU, a nurse was assigned to remain in the centre of the ward, at a specific point where they could observe the whole of the ward.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff searched patients for prohibited items when they returned from leave. This involved asking patients to empty their pockets and allow staff to look in any bags. Staff could also check for concealed metal items using a hand-held metal detector. Searches took place in a specific room with the consent of patients. If a patient did not consent to a search, their risk level was increased and they were placed on enhanced observations. Staff conducted specific room searches if they believed that a patient had prohibited items. Staff also carried out random rooms searches once a week. These searches were carried out with the patient's consent and, usually, with the patient present. Again, if the patient refused a room search, they would be placed on enhanced observations. If the risk presented was very high, a response team could be called to carry out the search.

Use of restrictive interventions

Our findings

The trust monitored the use of restrictive interventions. Between June and November 2022, staff on the 9 acute wards had secluded patients on 8 occasions. They had administered rapid tranquilisation on 106 occasions. They had restrained patients on 137 occasions, of which 39 involved restraint in the prone position. The use of restrictive interventions on the 2 psychiatric intensive care units (PICUs) was considerably higher. On these wards, staff had secluded patients on 39 occasions. Staff had used rapid tranquilisation 143 times on the male PICU, Coral Ward, and 25 times on the female PICU, Ruby Ward. There had been 105 instances of restraint on Coral Ward and 43 on Ruby Ward. Of these 148 restraints, almost one-third had involved putting patients in the prone position.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The trust had created a violence reduction and reducing restrictive practice team. Staff within the team ensured that all policies were consistent with quality assurance, best practice, statutory guidance and legislation on the use of force in hospital settings. The team provided training on preventing violence and management of aggression and training on security and searches. The team was also involved in providing support and guidance to staff on managing specific patients who presented a risk of violence. This included working alongside staff to create specific management plans for patients highlighting the likely triggers to aggression and guidance for staff on how to manage this. They also reviewed every record of restraint to identify themes and trends, and consider whether the restraint could have been avoided. An expert by experience carried out debriefing sessions with patients after incidents involving restraint. The service had introduced an audit tool for assessing restrictions that applied to all patients. Staff recognised that the use of prone restraint was high and had introduced a quality improvement project on Coral Ward to address this. The project had achieved some reduction from the peak of 14 instances of prone restraint on Coral Ward in May 2022 to an average of 5 instances per month from September to November 2022.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff gave examples of situations where they de-escalated situations and only used restraint as a last resort. Staff said this involved listening to patients concerns and, as far as possible, responding to what patients wanted.

Staff followed National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff kept records of observations of the patient's physical health after rapid tranquilisation was used. Records showed that staff checked the patient's respiration, pulse, blood pressure and oxygen saturation every hour for four hours after the injection. When patients refused these observations, staff recorded the patient's respiration and noted whether they were alert and conscious. This was consistent with NICE guidance.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. In the six months from May to October 2022, staff had placed patients in the seclusion room on 22 occasions. When staff placed a patient in seclusion, the reasons for doing so were recorded on the patient's record. Seclusion of patients was authorised by the multidisciplinary team, including the patient's responsible clinician. Patients in seclusion were reviewed by a nurse every two hours and by a doctor every four hours. The ward operated a protocol for patients to step-down from seclusion. This involved patient spending time on the ward and in their bedroom under close observations whilst having some limited interactions with other patients.

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.

Our findings

Staff received training on how to recognise and report abuse, appropriate for their role. Staff gave details of when they had raised safeguarding concerns. For example, one member of staff told us about when they had raised a concern with the safeguarding hub after a patient made an allegation that they had been assaulted whilst being restrained by staff. They explained how they supported the patient, although no evidence was found to support the allegation. Bank staff from NHS Professionals (NHSP) received safeguarding training as part of their induction to NHSP.

Staff kept up-to-date with their safeguarding training. Staff were required to complete mandatory training in safeguarding. Over 90% of staff had completed training for safeguarding adults. Eighty-nine percent of staff had completed training on safeguarding children.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. For example, staff raised concerns about patients' children or other family members when they appear to be at risk of abuse.

Staff followed clear procedures to keep children visiting the ward safe. Visits for children were arranged with the ward manager.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Each ward displayed information about the safeguarding process in nurses' offices. Staff could seek advice and guidance on safeguarding matters from the safeguarding lead.

Managers took part in serious case reviews and made changes based on the outcomes. All safeguarding matters were discussed in clinical governance meetings.

Staff access to essential information

The service was recovering from a cyber-attack on its electronic patient record. Permanent staff had access to clinical information and the installation of a new system meant it was easy for them to maintain high quality clinical records. However, bank staff did not always have access to patients' records.

Patient notes were comprehensive and most staff could access them easily. The trust's electronic patient records had been disabled by a cyber-attack in August 2022. This had meant staff had been unable to access patients' historic records. This had caused extensive disruption to the service. The service had recently installed a new platform for electronic patient records. Staff had welcomed the new system. However, some bank staff did not have access to patients' records. This meant that these staff had limited information about patients.

Records were stored securely. Staff accessed the electronic patient record using a log-in card, a personal username and a secure password.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. All registered nurses completed an assessment of their competency in managing and administering medicines.

Our findings

Staff completed medicines records accurately and kept them up-to-date. All medicine administration records were up to date. There were no gaps in recording.

Staff stored and managed most medicines and prescribing documents safely. Staff checked and recorded the temperatures of clinic rooms and fridges used to store medicines each day. All sharp objects were disposed of in a secure bin. These sharps bins were not over full. Staff managed controlled drugs well. All wards had a designated, locked cupboard for storing controlled drugs and kept appropriate records for these drugs. Staff had labelled most bottles of medicine with the date on which they were opened, although one bottle on Coral Ward had not been labelled.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The pharmacy service completed a medicines reconciliation when patients arrived at the hospital.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Side effects of medicines were monitored through regular checks of patients' pulse, blood pressure, respiration and oxygen saturation. Any side effects were discussed at the daily multidisciplinary team handover. When the side effects of medication included constipation, staff completed stool charts. A small number of patients were prescribed doses of medication above the limits set in the British National Formulary (BNF). In these situations, staff carried out enhanced monitoring of the patient's physical health, including an electrocardiogram and blood tests. These tests were repeated regularly and whenever the dose of medicine was changed. Staff on the PICU prescribed haloperidol PRN to mitigate risks from patients who were very agitated. Staff completed an electro-cardiogram (ECG) when this was administered. If the patient refused the ECG, staff assessed the risk and increased the level of observation. However, whilst the additional monitoring for patients on high doses of medication was discussed and reviewed in ward rounds, it was not recorded consistently. There were no monitoring charts attached to the medicine administration records or any specific forms within the patients' records.

Track record on safety

There had been one serious safety incident in the six months before the inspection.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

Staff knew what incidents to report and how to report them. Staff recorded the details of incidents on the electronic incident record.

Staff understood the duty of candour. They were open and transparent, and they gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. For example, staff had held a de-briefing session after a patient who was self-harming was restrained without attempting verbal de-escalation first. A reflective session was held to ensure staff were aware of the appropriate de-escalation techniques. On another ward, staff reviewed an incident that led to rapid tranquilisation in a safety huddle.

Our findings

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, a patient's family were involved in an investigation after they made a complaint about their relative being admitted to a general hospital with dehydration.

Staff met to discuss the feedback and look at improvements to patient care. We reviewed minutes of team meetings held on Topaz Ward during 2022. There were four examples of staff discussing incidents and making improvements to patient care. This included discussions about managing verbal abuse and racism from a patient, a serious incident involving a patient experiencing severe side effects from medication and a medical emergency that required staff to use basic life support. Similarly, on Sapphire Ward, staff discussed the learning from 3 serious incidents that had led to investigations at their team meeting in November 2022.

There was evidence that changes had been made as a result of feedback. For example, on one ward a patient experienced respiratory arrest following an incident involving rapid tranquilisation. Learning from this incident was discussed with staff. Systems were introduced to ensure staff checked that dosages were appropriate for the age of the patient. The implementation of this process was checked through regular audits of pro re nata (PRN) medication (this is medicine prescribed on an 'as required' basis).

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

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 reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Initial assessments covered the patient's history, their physical and mental health, an assessment of mental capacity and details of the patient's social circumstances, such as their support from their family and friends. Staff shared details of the assessments of newly admitted patients at handover meetings.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff carried out blood tests, drug screening and electrocardiogram tests shortly after a patient was admitted to the ward. Staff recorded patients' blood pressure, pulse, respiration and oxygen saturation each day. The results of the checks were discussed in the safety huddle and escalated when necessary.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans included specific sections on physical health, medication and education/health promotion. One care plan included a falls assessment. When patients had physical health needs, the care plan indicated the nature of the treatment and monitoring required, including the frequency of observations of the patient's pulse, blood pressure and oxygen saturation.

Our findings

Care plans were personalised and recovery-orientated. Care plans showed that patients had been involved in creating the plan. Care plans included details of leave, psychology and occupational therapy. The progress notes on patients' records showed that the activities set out in care plans were being carried out. However, some care plans were brief and generic. For example, one care plan stated that the patient had autism but there was very little detail about how staff should manage this.

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. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Most patients were admitted to the wards with psychosis, schizo-affective disorder, bi-polar affective disorder or schizophrenia. Some patients were experiencing an emotionally unstable personality disorder. Treatment predominantly involved the use of medicines. Activities co-ordinators facilitated recreational and therapeutic activities for patients. Each ward displayed a weekly timetable of activities.

Staff delivered care in line with best practice and national guidance. Doctors carried out a comprehensive assessment of all patients. Doctors started treatment with non-pharmacological interventions when this was possible. When patients needed medication, doctors started patients on low doses of oral, standard medication. Medication was chosen on the basis of the patient's physical and mental health. For example, doctors would choose specific antipsychotic medication if a patient had diabetes or hypertension. The service had provided training for staff on trauma informed care.

Staff identified patients' physical health needs and recorded them in their care plans. For example, staff knew that a patient was diabetic and provided appropriate monitoring, care and treatment to manage this. Staff completed observations of patients' physical health each day and record this on a form. The data entered on the form was used to calculate an overall score that would indicate whether any of the readings needed to be escalated to a doctor. The scores of these observations were discussed in safety huddles and handover meetings.

Staff made sure patients had access to physical health care, including specialists as required. For example, one patient had been supported to attend a specialist hospital for the treatment of an eye condition.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. On each ward, a member of staff was allocated to the dining room at mealtimes to have an overview of what patients were eating. Staff told us they had improved the use of food and fluid charts after an incident involving a patient being admitted to hospital with dehydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, staff provided patients with nicotine replacement therapies including nicotine patches and gum.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Matrons completed an environmental audit once a month. On some wards, managers completed an audit of records of daily checks of patient physical health. Staff had carried out a quality improvement initiative to reduce to the use of prone restraint on Coral Ward.

Our findings

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care and had planned further training on learning disabilities, autism and physical health They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the wards. Each ward team included a ward manager, registered nurses, assistant practitioners, support workers, a consultant psychiatrist, junior doctors, occupational therapists, activity co-ordinators and house keepers. A clinical psychologist worked on each ward for at least one day each week.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The trust provided a preceptorship programme for newly qualified nurses. The PICU provided specific training for newly qualified nurses which covered de-escalation techniques, reflective practice and working with patients with personality disorders.

Managers gave each new member of staff a full induction to the service before they started work. All new staff completed an induction to the service. This included completing mandatory training, reading policies and becoming familiar with processes and routines of the wards, including care planning and risk assessments.

Managers supported staff through regular, constructive appraisals of their work. Staff were required to have a formal appraisal once a year. On 8 of the 11 wards, the compliance rate for having had an appraisal in the last twelve months was above 80%. However, compliance rates were noticeable lower on Dunkley Ward, at 59%, Topaz Ward, at 50% and Ruby Ward at 39%. Managers explained that on Dunkley and Topaz, most of these appraisals had been completed since the data was prepared. On Ruby ward, a new manager was in post and had booked a time for all overdue appraisals.

Managers supported staff through regular, constructive clinical supervision of their work. All permanent staff said they received supervision from their manager once a month. Staff were also supported through regular sessions for reflective practices. During supervision, staff talked about clinical scenarios, reflecting on what had gone well and what they could learn for different situations. Staff also discussed patient care, documentation, team working and managing physical health. Occupational therapists and activity co-ordinators received supervision from occupational therapy managers. They also had monthly meetings with their ward manager. Bank staff did not receive supervision. Managers completed a record showing the dates on which supervision for each member of staff had taken place. Whenever a supervision session was missed, they recorded the reason for this, such as the person being off sick or working nights.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. These meetings were well attended. At the meetings, staff discussed patients' feedback, ward acuity, staff morale, lessons learned from incidents, record keeping and forthcoming changes to the ward. On some wards, staff kept a record of actions agreed at team meetings to ensure that these were completed. Records of these meetings were shared with all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, Band 3 support workers had been trained to take blood.

Our findings

Managers did not always make sure staff received any specialist training for their role. Support workers completed care certificate training. Managers said that additional training was available for all staff in managing diabetes, recording observations of physical health, nutrition and supporting patients whose health was deteriorating. However, some staff said they had not received any training except for completing mandatory courses. Staff had not received any specific training on working with patients with autism despite there been one or more patients on most wards with a diagnosis of autistic spectrum disorder. Managers said they planned to introduce this training next year.

Managers recognised poor performance, could identify the reasons and dealt with these. One manager told us they had managed poor performance. Initially, they had spoken to the member of staff about their concerns. This was escalated to a formal meeting to discuss the concerns. The manager and member of staff created a management plan and provided extra support. This led to an improvement in performance.

Managers recruited, trained and supported volunteers to work with patients in the service. For example, a volunteer carried out a debrief with patients after incidents involving restraint. They were recruited, trained and supported by the lead for violence reduction and reducing restrictive practice.

Multi-disciplinary and interagency team work

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 teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Each multidisciplinary team met to formally review each patient at least once a week. These meetings were chaired by the consultant psychiatrist.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff held handover meetings at the start of each shift. During these meetings, staff shared clear information about each patient's presentation, any risks, activities they had been involved in during the previous shift, compliance with medication, incidents that had occurred and a summary of the plans for each patient as they moved towards discharge. When a patient had been admitted to the ward, staff shared the details of the circumstances surrounding the admission, the outcome of assessments, details of risks, the arrangements for communicating with the patient's family and details of any further assessments that needed to be carried out.

Ward teams had effective working relationships with other teams in the organisation. Ward staff worked collaboratively with other teams in the trust including the crisis team, early intervention team, community mental health teams, the personality disorder unit and the discharge facilitation team.

Ward teams had effective working relationships with external teams and organisations. Ward staff had regular contact with staff working in the local authority housing and social services departments. Staff also contacted patients' GPs.

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 on most wards made sure that staff could explain patients' rights to them.

Our findings

Most patients across all the wards were detained under the Mental Health Act 1983. For example, on Rosewood Ward, only one of the 12 patients was informal. Four patients were detained for treatment and 7 were detained for assessment. Similarly, on Topaz Ward, only one patient was informal. A small number of patients were detained under Part III of the Act, relating to criminal proceedings or under sentence.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff were familiar with the requirements of the Mental Health Act 1983 although this did not form part of the programme of mandatory training.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Mental Health Act managers and administrators worked on both hospital sites. Mental Health Act administrators were responsible for accepting statutory documents required for the detention of patients and ensuring that all documents had been completed correctly. Administrators sent reminders to responsible clinicians when the periods of detention, or the initial periods of treatment, were due to expire. They gave support and advice to staff. Mental Health Act managers received support and advice from the Mental Health Law Manager for the trust. For complex matters, the trust sought advice from their solicitors.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. This included policies on community treatment orders, holding powers and patients being absent without leave.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. A local organisation provided an Independent Mental Health Advocacy service. Information about this service was displayed on notice boards.

Staff usually 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. However, on Coral Ward we noted that either this was not being done or staff had failed to record this on the patient's record. For example, one patient's record showed that staff had explained their rights to them two months after admission. An audit of 4 patients' records in October 2022 found no evidence of staff telling patients about their rights. Concerns about the findings of this audit were discussed with staff at the following team meeting.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff held a daily planning meeting with patients to agree the times and arrangements for taking patients on leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff kept copies of certificates authorising medication for patients detained under the Mental Health Act next to the patient's medicines administration record.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Mental Health Act administrators scanned all statutory documents relating to detention and treatment and uploaded these to the electronic patient records. Staff on the wards could access these records at any time. Original documents were held in locked filing cabinets in the Mental Health Act office.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Our findings

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Mental Health Act managers completed weekly audits to check the expiry dates of detentions were correct. They also carried out audits to check that information entered on their monitoring system was correct.

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 of at least the five principles. Staff were familiar with the requirements of the Mental Capacity Act 2005 although this did not form part of the programme of mandatory training.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff recorded an assessment of each patient's mental capacity to agree to admission and treatment at the initial assessment. This assessment was updated at multidisciplinary ward rounds.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. During our observations of the wards, we noted that patients approached staff on several occasions to talk to them. On each occasion, staff responded immediately, kindly and positively. We saw a member of staff and a patient enjoying a game of football together in a ward garden. The overall atmosphere on the wards felt calm and therapeutic although the atmosphere on the PICU became quite pressured during part of the day we were there. Staff consistently spoke calmly, positively and respectfully about patients. When nurses needed to restrain a patient in a communal area, a member of staff was responsible for directing other patients away from the incident to ensure the restraint was done in private.

Staff gave patients help, emotional support and advice when they needed it. Staff said they frequently spoke with patients individually to give emotional support and advice. During the inspection, we saw staff being very supportive to a patient who was carrying out a self-soothing exercise.

Staff supported patients to understand and manage their own care treatment or condition. Doctors discussed patients' care and treatment with them in weekly ward rounds. Doctors also talked to patients about the potential side effects of their medication.

Our findings

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Patients gave very positive feedback about staff. They said that nurses, doctors and managers were all very good. They recognised that, at times, staff had to deal with difficult situations.

Staff understood and respected the individual needs of each patient. Staff across all the wards showed a good understanding of patients' needs, their illnesses and their social circumstances outside the hospital. At handover meetings and safety huddles, staff discussed patients' personal preferences, risks and physical health needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. For example, patient information written on white boards in the nurses' offices could not be seen from outside the office.

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

Staff introduced patients to the ward and the services as part of their admission. When patients arrived on the wards, staff offered them refreshments and showed them around the ward.

Staff involved patients and gave them access to their care planning and risk assessments. Staff discussed treatment plans with patients at every ward round. Doctors said they always encouraged the involvements of patients in these meetings. They said always listened to patients' concerns and were happy to compromise on decisions and accommodate patients' requests whenever possible. Patients' views were clearly recorded in the notes of multidisciplinary team meetings.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). For example, one patient said that staff were supportive and that staff had explained the details of their care plan to them.

Staff involved patients in decisions about the service, when appropriate. Each day, staff held a meeting with patients to plan the day. This involved agreeing the activities and arrangements for leave off the wards. Community meetings facilitated by occupational therapists were held on each ward once a week. At these meetings, staff encouraged patients to give feedback on their care and make suggestions about activities they would like to do. These meetings also provided an opportunity for patients to raise specific concerns about maintenance or incidents. Staff discussed feedback from community meetings at their team meetings.

Staff made sure patients could access advocacy services. Advocacy services were provided by a local voluntary sector organisation. Information on accessing this service was displayed on notice boards.

Involvement of families and carers

Our findings

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Ward managers had regular contact with patients' families and friends. Records showed that patients' family members attended ward rounds and that the doctors discussed the plans for care, treatment and discharge with them.

Staff helped families to give feedback on the service. Staff encouraged visitors to the ward to complete a 'friends and family' survey. Feedback from this survey was discussed at meetings of the quality team.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

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.

Bed management

Bed occupancy on all wards was 100%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The target for the maximum length of stay on acute wards was 28 days, although managers recognised that some patients needed to be on the ward for longer periods of time. On most wards, patients' length of stay was relatively short. For example, on Rosewood Ward, 8 out of the 12 patients had been admitted in the two weeks prior to the inspection. Similarly, on Topaz ward, 10 of the 16 patients had been admitted in the four weeks before the inspection. In the 6 months from February to July 2022, 474 patients had been discharged from the acute wards. Of these, 50% were discharged within the target time of 28 days. A further 26% were discharged in less than 2 months. Eleven percent of discharged patients had been in hospital longer than 3 months. Senior managers reviewed the longest staying patients each month. Patients on PICUs tended to stay for shorter periods of time and were usually discharged to either an acute ward or a rehabilitation unit.

The service had no out-of-area placements. There were no patients in hospitals outside the local area.

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. Doctors said that the flow of admissions and discharges worked well. They said they did not feel under pressure to discharge patients. Staff did not allocate the beds of patients who were absent without leave to other patients until the patient had been absent for more than 72 hours.

Our findings

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. There were two psychiatric intensive care (PICU) wards at Highgate Centre for Mental Health. One ward was for male patients and the other was for female patients. The service had introduced an outreach service from these wards. This involved staff from the PICUs visiting acute wards to assess patients who were acutely distressed and provide advice on how to support and manage these patients. This initiative had reduced the number of referrals from acute wards to the PICUs.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. On most wards, there were no significant delays to discharge. When there were delays, staff escalated the matter to a senior level. Between February and July 2022, the service classified the discharge of 23 patients as being delayed. The discharge of 20 of these patients was delayed due to them awaiting a place in supported living or a care home. A further 3 discharges were delayed due to the patient awaiting a care home placement with nursing care.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff established an estimated discharge date as part of the initial assessment. This date was adjusted during the admission according to the patient's progress. As part of this process, staff address potential barriers to discharge. The trust had created a specialist housing discharge team that helped to make arrangements for patients to be discharged to suitable accommodation.

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, which they could personalise. At our last inspection in October 2019, some patients on Dunkley Ward shared bedrooms. Since then, the service had redesigned the wards to ensure all patients had their own bedroom. On Rosewood Ward, six bedrooms had ensuite facilities. The other 6 patients shared 2 bathrooms.

Patients had a secure place to store personal possessions. Patients could store valuable items in a safe in the nurses' office.

Staff used a full range of rooms and equipment to support treatment and care. Most wards had a quiet room, dining room, clinic room and activities room. On most wards, there were enough rooms to allow patients to have some quiet space away from others but not in their bedroom. Most wards had equipment for playing computer games and a pool table. On Coral Ward, there was a 'chill-out' room with bean bags, blue-tooth speakers and sensory lighting. However, the wards at St Pancras had more limited space. The lounge and dining areas felt small.

The service had quiet areas and a room where patients could meet with visitors in private. All wards had a quiet room where they could meet visitors.

Patients could make phone calls in private. On the acute wards, patients were able to use their mobile phones. On the PICU, access to mobile phones could be restricted based on an assessment of risk. Each nurses' office had a cordless telephone that patients could use.

Our findings

The service had an outside space that patients could access easily. Patients at Highgate Centre for Mental Health had access to a garden. The PICU had a dedicated garden with a high fence for additional security. Some the gardens had gym equipment and outdoor furniture. Wards at St Pancras Hospital had a large balcony.

Patients on the acute wards could make their own hot drinks and snacks and were not dependent on staff. Each ward had a designated area for patients to do this.

The service offered a variety of good quality food. Patients on Coral Ward discussed the food at their community meeting. They said the food was good and they were happy with the portion sizes.

Patients' engagement with the wider community

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

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Whenever possible, consultants granted leave from the ward. Patients used leave to go to their homes, to go shopping and to spend time with their families and friends.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was step-free access to all wards. On most wards, there was a specific bedroom for patients with disabilities. This room was larger than other rooms to allow patients with limited mobility to move around more easily. When transgender patients were admitted to the wards, staff addressed them by their preferred pronouns. The service has plans for meeting the needs of lesbian, gay, bi-sexual and transgender patients in 2023. However, the service did not have any specific initiatives in place to consider national trends about the over representation of black patients under the Mental Health Act.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Wards displayed information about how to make a complaint and how to contact advocacy services.

Managers made sure staff and patients could get help from interpreters or signers when needed. In addition, some members of staff spoke different languages and were able to communicate with patients in the language they felt most comfortable using.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Each ward provided food to meet cultural needs of patients including Halal, Caribbean, Asian and Kosher meals. Wards provided vegetarian food at every meal and vegan food was provided when patients requested this. Meal choices appeared healthy with lots of salads and vegetables.

Patients had access to spiritual, religious and cultural support. Patients were able to access support from religious and cultural leaders. Details of how to access these people were displayed on notice boards. Patients had access to religious texts, such as the bible and Qur'an in the multi-faith room.

Our findings

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, relatives and carers knew how to complain or raise concerns. Between May and October 2022, the service had received 16 complaints. Of these, 3 were upheld and one was partly upheld. Ten complaints were submitted by patients and 6 were from relatives or carers. Patients said they knew how to raise concerns if they needed to.

The service clearly displayed information about how to raise a concern in patient areas. Staff displayed this information on notice boards.

Staff understood the policy on complaints and knew how to handle them. Staff explained that, when they were able to, ward managers tried to resolve patients' concerns as soon as possible. For example, a patient had recently complained about staff observations of patients. This had been resolved informally by the ward manager and the matron.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Twelve complaints related to clinical treatment, 2 related to care pathways, 1 was about staff attitudes and the other was about communication. Managers had investigated each complaint. Investigations included interviews with staff, reviews of patients' records and looking at CCTV footage. Investigations identified areas where practice had not been consistent with policy or standards of professional practice and made recommendations for improvements.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff said that managers engaged well with staff and patients. They said that managers were pro-active and usually present on the ward. They attended staff meetings, community meetings and arranged times to meet with patient's families. Staff told us that current ward managers had made improvements and created positive, supportive cultures within their teams. Many staff said they had progressed their career on the wards. For example, a nurse had been recruited after being a student on the ward. The trust was supporting a support worker to pursue their ambition to become a registered nurse. Staff gave examples of situations when senior managers had supported staff on the ward with specific incidents or assistance in working with specific patients with very complex needs.

Vision and strategy

Our findings

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

Staff felt that the organisation was going in the right direction. Staff gave examples of improvements that had been made in the recent years. This included improvements in physical healthcare, discharge arrangements and engagement with patients on enhanced observations. Staff at St Pancras were looking forward to the service moving to new, modern buildings within the next two years.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Managers said that since the Covid pandemic, the trust had placed a greater emphasis on improving staff well-being. This has led to improvements in facilities for staff, an increase in support for staff from psychologists and more reflective practice. Staff said they felt valued and well-supported by both managers and colleagues. Many staff said morale within their team was good. They said that when they raised any concerns about the service, managers listened to them and responded whenever possible. All staff, including bank support workers, said they felt staff were treated as equals and there were no hierarchies on the wards. Similarly, nurses and support workers said that consultants valued their involvement in clinical matters and always listened to their views on patients' care and treatment. Doctors had regular contact with each other across different wards and felt supported by medical directors. Student nurses said that staff on the wards had been very supportive. Staff from black and minority ethnic communities said they were treated fairly and were not aware of any instances of discrimination from the trust. However, some staff said they received racist or homophobic abuse from patients. Whilst staff said their colleagues and managers were supportive in these situations, the boundaries around behaviour and protocols for responding were not always clear. Staff said they were not aware of any formal procedures to address abuse towards staff.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers held clinical governance meetings once a month. Managers provide feedback on safeguarding, complaints and incidents at team meetings. These meetings involved detailed discussions and consideration of how services could be improved. The service had a specific governance committee on positive and pro-active care. The trust was aware of where improvements were needed and were working to address this. For example, building work was underway to replace the wards at St Pancras Hospital.

Management of risk, issues and performance

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

The hospitals division of the trust maintained a register of operational risks. The highest risks related to violence and aggression from patients, high vacancy rates for registered nurses and concerns about the transfer between acute hospitals and mental health wards. These risks were consistent with the concerns raised by staff during the inspection. The risk register included a risk score to indicate severity. The register also included controls in place to reduce the level of risk and details of actions that will be taken to address the risk.

Our findings

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The loss of the electronic patient record in August 2022 had caused enormous difficulties. The wards had acted quickly to establish interim measures for recording patients' notes and installing a new records system. However, it was very difficult for staff to access information about patients' histories. For example, on Rosewood Ward, staff met together to remember the work they had done in the past with a newly admitted patient. Some staff were concerned that progress on resolving the problems was taking a long time.

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.

Staff were engaged in decision making about the ward through discussions at team meetings and clinical governance meetings.

The trust had entered into a formal alliance with the neighbouring trust. This meant that, amongst other things, they supported each other with bed management, including having a joint pathway for the female PICU.

Learning, continuous improvement and innovation

The service had carried out quality improvement projects to reduce the number of referrals to the PICU, reduce the length of time patients were subject to enhanced observations and reducing the use of prone restraint.

The service was part of the Quality Network for Inpatient Working Age Mental Health Services (QNWA), facilitated by the Royal College of Psychiatrists. This network had developed 7 quality standards for services including standards for care and treatment, patients and carer experience and governance.

Our findings

Outstanding practice

We found the following outstanding practice:

- The service had a team dedicated to violence reduction and reducing restrictive practices. This team was proactively involved in reducing the levels of violence and restrictive interventions on the wards. This included analysing all incidents involving restraint and giving advice to staff on how to work with patients who presented a high risk of violence behaviour.

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:

Core service: Acute ward for adults of working age

- The trust must ensure that there are sufficient staff assigned to all wards to ensure the safety of patients and quality of care (Regulation 18(1))

Action the trust SHOULD take to improve:

Core service: Acute ward for adults of working age

- The trust should ensure that checks, services and calibration of medical equipment are carried out regularly on all wards and clearly recorded
- The trust should ensure that staff complete mandatory training in basic and intermediate life support
- The trust should ensure that all staff leading shifts have access to electronic patient records
- The trust should ensure that formal risk assessments for each patient are completed shortly after their admission to the ward
- The trust should ensure that all identified risks are recorded in the risk assessment
- The trust should ensure that all bottles of medicines are clear labelled showing the date on which they were opened
- The trust should ensure that all staff have an annual appraisal
- The trust should ensure that staff receive the planned training in autism and learning disabilities
- The trust should ensure that staff take steps to ensure patients understand the provisions of the Mental Health Act that apply to them, and their rights to appeal to the tribunal, as soon as is practicable after their detention begins
- The trust should ensure there are clear policies and procedures to address abuse towards staff

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 inspection managers,3 CQC inspectors and a specialist advisor with a professional background in nursing for patient using acute mental health services.

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 18 HSCA (RA) Regulations 2014 Staffing