Barnet, Enfield and Haringey Mental Health NHS Trust

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

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Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

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

Summary of this service

We did not rate acute wards for adults of working age and psychiatric intensive care units at this inspection as we only visited two of the trust's wards. We visited Devon Ward, a 12 bedded male psychiatric intensive care unit (PICU), and Sussex Ward, an 18 bedded male treatment ward. We visited these wards due to concerns we had received from the trust and patients. These concerns related to staffing, risk and incident management, culture and leadership of the wards.

This was a focused inspection of safe, effective, responsive and well-led.

As this inspection took place during the Covid-19 pandemic, we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent on the ward to prevent cross infection. Two CQC inspectors and one CQC inspection manager visited the ward unannounced on 28 September 2020 during the night shift to complete essential checks. Whilst on site we wore the appropriate personal protective equipment and followed local infection control procedures. The remainder of our inspection activity was conducted off the ward. We conducted staff interviews over the telephone on 1, 5, 7 and 12 October 2020. We reviewed patient care records on-site, but off the ward, on 5 October 2020.

We found:

- The service had already made improvements in relation to the concerns. In May 2020, senior leaders completed a review of Devon PICU and identified the need to provide additional support to the ward. They had developed an improvement plan, which clearly identified what action needed to be taken to improve the safety of the ward. This plan was reviewed every two weeks by senior leaders and staff members from the ward. The action plan was still in progress and leaders needed to ensure recent changes made were embedded.
- The staff members we spoke with on Devon PICU felt the ward had improved. Staff told us there had been many positive changes since the action plan had started, particularly around the safety and leadership of the ward. Staff told us that they now felt supported by management.
- The trust had improved senior leadership on Devon PICU. In May 2020, an interim senior nurse was recruited as a PICU practice lead and provided excellent day-to-day clinical leadership to staff on the ward. In addition, a substantive and experienced ward manager was recruited to the ward. All staff we spoke with said the PICU practice lead and ward manager were very supportive and had made a positive impact on the ward. Prior to May 2020, the ward had experienced changes in ward management, which contributed to an instability in leadership on the ward.
- The wards managed patient safety incidents well. Staff recognised incidents, such as restraints and patient assaults, and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff had improved how they assessed and managed risks to patients and themselves. The service had introduced morning safety huddles, which helped staff better understand and manage patients. Each ward now had a security nurse present in communal areas 24/7 to check the safety of the environment. Staff participated in the trust's reducing restrictive practice programme.

However:

Summary of findings

- Staff did not always ensure that physical health monitoring of patients' vital signs was undertaken after every use of rapid tranquilisation, in line with trust policy. Staff were not always clear about the frequency required as outlined in the trust policy. It is important to monitor patients' vital signs post rapid tranquilisation to detect and escalate possible deterioration in physical health.

During this focused inspection, the inspection team:

- Spoke with eleven patients
- Spoke with the ward manager and the PICU practice lead for Devon Ward, the modern matron for Sussex Ward, the night manager, Enfield Mental Health Divisions Managing Director, clinical director and head of nursing.
- Interviewed 26 members of staff, including the consultant psychiatrists, deputy ward managers, registered nurses, healthcare assistants, and an associate mental health worker.
- Looked at six patient care records, including risk assessments and care plans
- Looked at a sample of records relating to patient restraints, seclusion and rapid tranquilisation.
- Looked at other documents relating to the running of the wards, including Devon Ward's improvement programme, incident records, minutes of team meetings and shift handovers.

Is the service safe?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

- Staffing on both wards had improved and had reduced its vacancy rates for registered nurses. During the Covid-19 pandemic, the wards faced challenges with its staffing. However, this was no longer an issue and as a result staff felt they had more time to spend with patients.
- Staff had improved how they assessed and managed risks to patients and themselves. The service had introduced morning safety huddles, which helped staff better understand and manage patients. Each ward now had a security nurse present in communal areas 24/7 to check the safety of the environment.
- Staff participated in the trust's reducing restrictive practice programme. Devon PICU had conducted a quality improvement project to reduce restrictive practice. On Sussex Ward, staff had not used any restraint, seclusion or rapid tranquilisation in September 2020.
- The wards managed patient safety incidents well. Staff recognised incidents, such as restraints and patient assaults, and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

However:

- Staff did not always ensure that physical health monitoring of patients' vital signs was undertaken after every use of rapid tranquilisation, in line with trust policy. It is important to monitor patients' vital signs post rapid tranquilisation to detect and escalate possible deterioration in physical health.

Is the service effective?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

Summary of findings

- Staff received regular supervision. The trust's review of Devon PICU in May 2020 found no evidence of formal supervision or support structures for staff. This was now improving, and all staff told us they had recently received supervision.
- Staff now shared clear information about patients and any changes in their care, during effective handover meetings.

Is the service caring?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

Is the service responsive?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

- There had been improvements in patient flow on Devon PICU. Although staff said there was still work to do to ensure timely access from Devon PICU to acute services and forensic services. This had been identified on the service improvement plan, and senior leaders now attended fortnightly interface meetings with forensic services to address patient pathways. An access and patient flow team also monitored patient flow issues.
- Patients no longer had to share rooms. Sussex Ward had removed the dormitories where patients shared bedrooms and toilets. The elimination of dormitories improved the privacy and dignity of patients on the ward and meant they now had access to a private space.

Is the service well-led?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

- Both wards had made good overall improvements in response to our concerns. Senior leaders had good oversight of the recent patient safety incidents and ensured these were investigated appropriately and lessons were shared. Senior leaders had implemented an improvement plan for Devon PICU in May 2020, which clearly identified the concerns on the ward and how these would be addressed.
- Both wards had excellent leadership. A PICU practice lead was providing day-to-day clinical support to Devon PICU alongside a substantive and experienced ward manager. Staff on both wards spoke positively about the leadership of the wards and felt supported by management.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- On Devon PICU, staff were working towards the accreditation for the National Association of Psychiatric Intensive Care Units.

However:

- The trust had made significant improvements to the quality, safety and leadership of Devon PICU. However, the trust needed to continue to ensure that there were robust systems and processes in place, so the positive changes were embedded.

Detailed findings from this inspection

Is the service safe?

Seclusion room

Both wards had a seclusion room. During our on-site inspection, we observed both seclusion rooms to have an unpleasant odour. We raised this with senior leaders during the inspection.

On Devon PICU, senior leaders had identified the need to improve the robustness of the seclusion room to prevent patients damaging the room. The trust had active plans in place to build a new seclusion on the ward, which would replicate a seclusion room to forensic standards and increase robustness. Senior managers had signed off design plans and aimed for a completion date in Spring 2021. In the meantime, the ward team ensured compliance with the seclusion policy and checked the environment was safe before a patient entered seclusion, and they continued to check the safety of the environment during regular seclusion reviews.

Sussex Ward had made improvements to its seclusion room since the last inspection in July 2019. The seclusion room had been refurbished and now had an area off the corridor where staff could observe patients, which better promoted the privacy and dignity of patients in seclusion.

Safe staffing

Nursing staff

On the night of the inspection, both wards had enough staff to keep patients safe and meet their needs.

During the Covid-19 pandemic, the wards faced challenges with its staffing. Some staff were off sick due to contracting the virus, some staff were shielding, and there was natural turnover of staff. To support staffing on the wards, staff were re-deployed from elsewhere in the trust and bank and agency staff were used to support staffing levels on the wards.

At the time of the inspection, staffing on both wards had improved, and nursing team vacancy rates had reduced.

On Devon PICU, there were two band five registered nurse vacancies, which had been recruited into and the individuals were awaiting a start date. There were three healthcare assistant vacancies.

On Sussex Ward, there was a 0.6 wholetime equivalent band five registered nurse vacancy and one band six registered nurse vacancy. The trust had an advert out for both vacancies.

In the last three months, Sussex Ward used bank or agency staff to cover eight per cent of shifts to cover staff absence and enhanced observations.

In the last three months, Devon PICU, used bank or agency to cover 23% of shifts to cover staff absence and enhanced observations. The reliance on bank and agency staff was set to reduce once the two newly recruited band five registered nurses started.

Staff on both wards said staffing had recently improved, and now allowed them to have regular one-to-one time with the patients.

The staff sickness rate for both wards in the last three months was low. On Sussex Ward it was 2% and on Devon PICU it was 5%.

The staff turnover rate for Sussex Ward was 9% and 11% on Devon PICU.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

Detailed findings from this inspection

Most staff had received and were up to date with appropriate mandatory training.

Overall, staff on Devon PICU had undertaken 75% of the various elements of training that the trust had set as mandatory. On Sussex Ward, staff had undertaken 85% of mandatory training.

The trust had set a target of 90% for completion of mandatory training courses.

Managers told us that compliance levels were affected by the Covid-19 pandemic as there were issues with training venues and trainers being away from work. The trust moved a lot of training online to support staff with their mandatory training.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed six care records during this inspection.

Staff completed a risk assessment of every patient on admission, using a recognised tool and reviewed this regularly, including after any incident.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Individual risks and changing risks were discussed in multidisciplinary meetings, individual reviews, handovers and safety huddles. Each ward had a dedicated security nurse present in communal areas 24/7. Their role was to check the safety of the environment and ensure adequate searches of patients and visitors happened, where required.

The wards had recently introduced safety huddles. These happened at the start of each shift as a way of identifying and managing patient risk. The huddles were attended by representatives from different staff disciplines. Staff shared information that could impact on patient safety and agreed ways of mitigating risks

Staff on Devon PICU told us that they received daily emails in relation to handover updates. This meant they were kept informed on patient risk/safety incidents even on their days off.

Use of restrictive interventions

There had been one episode of long-term segregation on Sussex Ward, which occurred over four weeks in May 2020. This patient was a Devon PICU patient. They were managed in the Sussex Ward seclusion room as the Devon PICU seclusion room was already in use. The trust followed the long-term segregation policy, which included regular reviews by the clinical team to assess least restrictive options, and they followed an appropriate long-term segregation care plan. This patient was then transferred to a medium secure facility to better meet their needs.

Between July 2020 and September 2020 there had been six episodes of restraint on Sussex Ward, and 31 on Devon PICU. Of those restraints, eleven were prone restraints, all which occurred on Devon PICU. Devon PICU is a high acuity ward, where patients are often very unwell and can pose a risk to self or others. We saw evidence of staff using verbal de-escalation techniques before using physical restraint practices. However, staff sometimes assess restraint as being the best option to keep patients and staff safe.

In the month on September 2020, Sussex Ward did not report any incidents of patient restraint, seclusion or rapid tranquilisation. Staff attributed this to the ward's reducing restrictive practice initiatives, and an improvement in staffing levels.

Both wards participated in the provider's restrictive interventions reduction programme, called positive and safe wards. Devon PICU had started a quality improvement project to reduce restrictive practice. This included a review of therapeutic activities, where an additional full-time personal trainer post was created to facilitate exercise sessions with patients on the ward, including evenings and weekends.

Detailed findings from this inspection

Most staff were trained in prevention and management of violence and aggression (PMVA). Ninety-five percent of staff on Sussex Ward and 90% of staff on Devon PICU were PMVA trained.

Staff did not always ensure that physical health monitoring of patients' vital signs were undertaken after every use of rapid tranquilisation, in line with national guidance or trust policy. We reviewed four incidences of rapid tranquilisation on Devon PICU and Sussex Ward. In two of these incidences, staff did not record monitoring of patients' physical health expected in national guidance or the trust's own policy. In one case there was no record that vital signs had been monitored at all. Nursing staff we spoke with on Devon PICU were not always clear about how often patients' vital signs should be observed following rapid tranquilisation. We raised this with senior managers at the time of the inspection who were aware of the need to improve nursing staff's understanding of subsequent monitoring after rapid tranquilisation administration. This had been identified recently as a trust-wide issue. In response to our concerns, the ward manager on Devon PICU had developed a rapid tranquilisation training pack to deliver to the staff team on the ward. This training was being reviewed by the Chief Nurse before being delivered.

We reviewed a sample of seclusion records. Staff used seclusion appropriately and followed best practice when they did so. Staff kept records for seclusion in an appropriate manner.

Track record on safety

In the last three months, there were three serious incidents on Devon PICU and two serious incidents on Sussex Ward.

Two of these serious incidents included a fire on each ward. The trust completed appropriate investigations into each fire incident. Both incidents involved patients using a lighter to set a fire (which is a contraband item). Both fires did not cause any actual harm to patients.

A trust wide review of recent inpatient fires was completed and presented to the executive leadership team, which included an action plan for the whole division. This included staff being trained as fire wardens, staff checking for arson risk on admission, search training for contraband items, and security nurses on the wards. All staff we spoke with were aware of the learning points from these recent fires.

One of these serious incidents involved two patients absconding from Sussex Ward after damaging a window. The trust appropriately investigated this incident, and as a response were replacing the windows on the ward with work due to complete in January 2021. In the meantime, any new patients or patients with an absconcion risk were placed in bedrooms near the nursing office or were courtyard facing (rather than outside). In addition, the ward's security nurse conducted regular environmental checks.

Senior leaders continued to monitor recent serious incidents and they remained on the trust's risk register.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. For example, we saw staff reporting episodes of restraint, seclusion, patient violence and patient damaging ward property.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss feedback. Managers completed after action reviews with staff following an incident to deliver a debrief and discuss learnings.

There was evidence that changes had been made following incidents. For example, on Sussex Ward, the bedroom doors had been changed to anti-barricade doors in response to the recent fire incident.

Is the service effective?

Skilled staff to deliver care

Detailed findings from this inspection

Managers ensured that staff had access to regular team meetings. Staff on Devon PICU now had weekly team meetings.

Staff now received regular supervision. The trust's review of Devon PICU in May 2020 found no evidence of formal supervision or support structures for staff. This was now improving. The percentage of staff that received regular supervision in the last three months was 74% (33% in July 2020, 96% in August 2020 and 93% in September 2020). Staff during the inspection told us they had recently received supervision. Clinical supervision is important to ensure staff feel supported to carry out their duties.

Staff received regular supervision on Sussex Ward. The percentage of staff that received regular supervision was 90%.

Multidisciplinary and interagency team work

On Devon PICU, staff now shared information about patients at effective handover meetings at the start of each shift. The trust's review of the ward in May 2020 found handovers did not always start on time due to lateness of staff and the quality of handovers were variable. All staff we spoke with said handover had improved and staff turned up to their shift on time. We reviewed shift handover minutes, which were concise and informative in regard to patient need and risk.

Is the service responsive?

Access and discharge

There had been improvements in patient flow on Devon PICU. The trust had identified there were issues with patient flow due to bed pressures within the acute services preventing timely transfer to acute services from Devon PICU and at times long waits to access forensic beds. Previously, there had been six patients awaiting forensic admissions at one time; in May 2020, this had reduced to two patients. At the time of the inspection, there was one patient who had been referred to forensic services but was still on the PICU. The issue of patient flow was identified on the ward's improvement plan and action had been taken to improve flow. For example, senior leaders attended fortnightly interface meetings with forensic services to discuss patient pathways. The clinical director for Enfield services had initiated a quality improvement project around access and flow to see how they could further improve it. There was also an access and flow team who monitored patient flow issues.

Facilities that promote comfort, dignity and privacy

Since the last inspection in July 2019, Sussex Ward had now eliminated the dormitories where patients shared bedrooms and toilets. The elimination of dormitories improved the privacy and dignity of patients on the ward and meant they had access to a private space.

Is the service well-led?

Leadership

The trust had improved the leadership on Devon PICU following the implementation of the service improvement programme.The executive leadership team had identified challenges with the leadership of the ward. As a result, the trust recruited an interim senior nurse in May 2020 who was a PICU practice lead. They provided excellent day-to-day clinical support to the staff team.

The ward management structure had also improved on Devon PICU. Previously there had been challenges with recruiting and retaining ward managers and deputy ward managers. This was no longer an issue. The ward now had a substantive and experienced ward manager in post and there were five deputy ward managers in post, compared to two previously. Managers now ensured there was a deputy ward manager on every shift to provide leadership to the staff team.

Detailed findings from this inspection

On Sussex Ward, the ward manager had recently resigned to explore another career opportunity and was due to leave at the end of October 2020. The trust had active recruitment plans in place to recruit a suitable replacement. The modern matron for the ward was very visible on the ward and staff felt supported by them.

There was appropriate leadership during night shifts. Band seven registered nurses provided on-site support to staff and patients on the wards.

Leaders had a good understanding of the service they managed. Senior leaders had close oversight of Devon PICU as they attended the fortnightly meetings to review the ward's improvement plan. In addition, the ward manager, deputy ward managers and consultant psychiatrist now met on a weekly basis to assess the safety and quality of the ward and to discuss any clinical needs that needed to be addressed.

Staff on both wards told us that leaders were visible in the service and approachable for patients and staff. Staff felt supported by management.

Managers identified that band six registered nurses (deputy ward managers) needed support with their leadership skills. The trust had developed a leadership programme, which was being finalised by the learning and development department.

Culture

Staff on both wards felt positive and proud about working for their team.

On Devon PICU, staff told us the morale had recently improved. They reported that the leadership and team working had also improved. They said that they were able to give more time and attention to patients since the bed number reduced from 14 to 12.

On Sussex Ward, staff told us the morale was good. However, staff were sad to see the ward manager leave, and some staff were unhappy about the trust's proposed changes to the shift patterns. However, all staff we spoke with had attended consultation sessions with senior leaders to feedback their concerns and felt listened to.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Teams on both wards worked well together and where there were difficulties manages dealt with them appropriately.

Governance

There was a clear framework of what must be discussed at a ward level in team meetings to ensure that essential information such as learning from incidents was shared and discussed. Staff had implemented recommendations from reviews of incidents at the service level.

Devon PICU had made significant improvements to the overall leadership, culture, quality and safety of the ward. All 15 staff members we spoke with on the ward spoke about the positive changes since the improvement plan had been initiated. Senior leaders continued to have good oversight of the ward.

However, the improvement plan was still in progress and leaders needed to ensure that recent positive changes were embedded to maintain the safety and quality of the ward. Before the improvement plan had been initiated in May 2020, the trust identified that the ward had been chaotic and disorganised with minimal structures in place to support safe and effective care and delivery. Senior leaders attended fortnightly meetings to review the ward's improvement plan and to ensure they were on track to complete actions set. The plan identified areas that needed continued support to improve the ward, such as the ward environment, leadership, risk management and patient flow.

Detailed findings from this inspection

Senior leaders reviewed the need for the PICU practice lead's input to the ward on a month by month basis. The trust wanted to ensure that the positive changes had time to embed and that staff felt adequately supported by management. The trust's longer-term aim was for the ward to safely and effectively operate without the PICU practice lead's direct input.

The trust's brilliant basic programme, which included a workstream around reducing restrictive practice had not identified that not all staff had carried out post-monitoring of physical health following rapid tranquilisation, as set out in the trust policy. The Chief Nurse identified that this would need to be reviewed to ensure effective monitoring.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward level, which then fed into the borough risk register. Staff at ward level could escalate concerns when required.

Staff concerns matched those on the risk register. For example, the seclusion room on Devon PICU.

Senior managers maintained an improvement plan for acute wards and PICU services. In relation to Devon PICU, this included the seclusion room, staffing and leadership development.

Engagement

At the time of the inspection, the trust was looking to change long-day shifts to shorter-day shifts, with the aim to reduce staff burnout and improve the quality of care delivered to patients. Some staff told us they were not happy about this proposed change to shift patterns. However, all staff we spoke with had attended consultation sessions with senior leaders to feedback their concerns and felt listened to.

Learning, continuous improvement and innovation

On Devon PICU, staff were working towards the accreditation for the National Association of Psychiatric Intensive Care Units, which reflect standards that are fundamental of high-quality clinical care. The ward's assessment was due in January 2021.

Areas for improvement

Action the provider MUST take to improve:

The trust must ensure that physical health monitoring of patients' vital signs is undertaken after every use of rapid tranquilisation, and that staff are clear about the frequency required as outlined in trust policy.

Action the provider SHOULD take to improve:

The trust should continue to ensure that robust systems and processes are in place to embed the positive changes made to the culture, leadership, quality and safety of Devon Ward.

Our inspection team

This inspection comprised of three CQC inspectors and one CQC inspection manager.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment