Inadequate

Nottinghamshire Healthcare NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RHABW	Millbrook Mental Health Unit	Lucy Wade Ward	NG17 4JL

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

The Lucy Wade Unit is a 16 bedded mental health acute inpatient unit for women. The ward offers care, assessment, treatment and support to women who are unable to be safely supported in the community.

- We had serious concerns about safety and quality care provided and therefore served a Notice of Decision which required the trust to stop all admissions to the ward until further notice and provide us with an action plan that described how they would make the required improvements in a timely manner. We also required that we were provided with weekly update to enable us to monitor this.
- Whilst we saw that staffing levels for each shift met the required 'safe staffing numbers' for the number of patients on the ward, this did not take in to account the number of patients requiring enhanced observations to keep them safe or the skills, experience and knowledge of the staff. We were not assured that enough staff, with the right skills, knowledge and experience were deployed to meet the needs of the patients safely. Senior managers had not ensured that band 5 preceptorship nurses (newly registered nurses) were supported by suitably experienced staff when on duty.
- Staff failed to follow policies and procedures when observing patients. We found numerous records in which staff had failed to record whether they had carried out observations. In addition, we saw records that highlighted the incorrect amount of staff completing the observations, for example, we saw patients that should have been observed by two members of staff and were only being observed by one.
- We were concerned that managers had not ensured that staff had implemented recommendations from reviews of deaths or incidents that had previously happened in the ward. Staff failed to accurately record all incidents in line with trust policy. Patients clinical notes highlighted that incidents had taken place but we found no incident reports within the electronic reporting system
- Not all managers had the skills, knowledge and experience to perform their roles. Whilst leaders were visible in the service staff reported that not all them were approachable. Although staff felt positive and proud about working for the provider and their team the majority of the staff we spoke with reported they didn't feel respected, supported or valued by all managers.
- Team managers had access to information but it did not support them with their management role as the information was not in an accessible format, was not timely, accurate or identified areas for improvement. We were not assured that there was a clear framework of what must be used, shared and discussed at a ward, team or directorate level to ensure that essential information, such as learning from incidents was used to inform care and improvements in care and practice. Staff we spoke with told us they did not always receive feedback from investigation of incidents, both internal and external to the service.
- Staff attitudes and behaviours when interacting with patients were not always respectful, discreet and did not always provide patients with help, emotional support at the time they needed it.
- We were not assured that all staff, including agency and bank staff, were aware of the potential ligature points or the mitigation in pace to manage these risks appropriately. In addition, we were not assured that staff would be able to easily access ligature cutters in an emergency situation because they were kept in a locked cupboard with a key pad code which was changed regularly and staff weren't always aware of the change.
- Staff had not ensured that emergency medical bags had been sealed with a temper proof seal.
- Managers did not offer debriefings for all ward staff after serious incidents.

However:

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. They worked with other agencies, sharing information across agencies and devised coordinated action plans to keep the patient safe.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Inadequate

- We had significant concerns about the lack of deployment of sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure patients are kept safe and had their needs met on the ward. We were concerned about the impact staffing levels had on patient safety.
- Whilst we saw that staffing levels for each shift met the required 'safe staffing numbers' for the number of patients on the ward, this did not take in to account the number of patients requiring enhanced observations to keep them safe or the skills, experience and knowledge of the staff. We were not assured that enough staff, with the right skills, knowledge and experience were deployed to meet the needs of the patients safely. Senior managers had not ensured that band 5 preceptorship nurses (newly registered nurses) were supported by suitably experienced staff when on duty.
- Staff failed to follow policies and procedures for use of observation. We found numerous records which failed to record whether staff had carried out observations. In addition, we saw records that highlighted the incorrect amount of staff completing the observations.
- We were not assured that all staff, including agency and bank staff, were aware of the potential ligature points or the mitigation in pace to manage these risks appropriately. In addition, we were not assured that staff would be able to easily access ligature cutters in an emergency situation because they were kept in a locked cupboard with a key pad code which was changed regularly and staff weren't always aware of the change.
- Staff had not ensured that emergency medical bags had been sealed with a temper proof seal. Staff had completed checks of the equipment but not taken any action to ensure the bag was sealed correctly.
- Staff failed to accurately record all incidents in line with trust policy. Patients clinical notes highlighted that incidents had taken place but we found no incident reports within the electronic reporting system.
- Staff we spoke with told us they did not always receive feedback from investigation of incidents, both internal and external to the service. However, managers did offer staff debriefings and support after serious incidents for staff that were on shift when the serious incident occurred.

However:

Summary of findings

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. They worked with other agencies, sharing information across agencies and devised coordinated action plans to keep the patient safe.

Are services effective?
Not inspected

Requires improvement

Are services caring?

Requires improvement

- Staff attitudes and behaviours when interacting with patients were not always respectful, discreet and did not always provide patients with help, emotional support at the time they needed it.
- Staff did not always knock on patients' bedrooms doors before entering. Staff locked patient's bedroom doors so that patients could not access their bedrooms when they wished.

Are services responsive to people's needs?

Requires improvement

Are services well-led?

Inadequate

- It was not evident during that inspection that all managers had the skills, knowledge and experience to perform their roles. Whilst leaders were visible in the service staff reported that not all them were approachable.
- Although staff felt positive and proud about working for the provider and their team the majority of the staff we spoke with reported they didn't feel respected, supported or valued by all managers. The nursing and medical teams worked well together but when they raised issues managers did not deal with them.
- We were not assured that there was a clear framework of what must be discussed at a ward, team or directorate level to ensure that essential information, such as learning from incidents was shared and discussed.
- We were concerned that managers had not ensured that staff had implemented recommendations from reviews of deaths or incidents (that had previously happened). For example, a serious incident that had occurred within the last month, the full investigation report of which was yet to be completed, identified definitive lessons that staff could learn from and that managers should have implemented with immediate effect.

Summary of findings

- Team managers had access to information but it did not support them with their management role as the information was not in an accessible format, was not timely, accurate or identified areas for improvement.

Summary of findings

Information about the service

The acute wards and psychiatric intensive care units for adults of working age were provided over three sites in Nottinghamshire. The trust had a total of seven acute wards and one psychiatric intensive care unit.

An acute inpatient ward at Bassetlaw Hospital in Worksop:

- B2 ward with 24 beds for both male and female patients.

Two acute inpatient wards at Millbrook Mental Health Unit at Kingsmill Hospital in Mansfield:

- Orchid Ward - 25 beds for male patients
- Lucy Wade Unit - 16 beds for female patients

Four acute inpatient wards at Highbury Hospital in Nottingham and Willows ward a psychiatric intensive care unit:

- Redwood 1- 16 beds for male patients
- Redwood 2- 16 beds for female patients
- Rowan 1-16 beds for male patients
- Rowan 2- 16 beds for female patients
- Willows ward- 10 beds for male patients.

The service was last inspected 22 January 2019 to 07 March 2019. we rated the acute wards for adults of working age and psychiatric intensive care units for adults of working age as inadequate overall and served requirements notices for the following:

- The trust must ensure there are enough suitable and qualified staff on the ward. There should be sufficient staff on the ward to ensure patients have access to leave and one to one sessions with their named nurse.
- The trust must ensure that staff carry out physical health observations after rapid tranquilisation in line with trust policy and national guidance.
- The trust must ensure that staff carry out checks of resuscitation equipment on all wards to ensure it is safe to use and ensure adrenaline is fit for use and stored in a place where there is immediacy of access.
- The trust must ensure that it reviews blanket restrictions on B2 wards so that patients are individually risk assessed for restrictions relating to accessing sleeping areas and bedrooms.
- The trust must ensure that staff follow physical health care planning and complete physical health observations for patients when required throughout admission.
- The trust must ensure that staff ensure the privacy of patients on the ward when observations are carried out.
- The trust must ensure that it has effective governance structures to ensure that supervision and team meetings take place and that learning from incidents and complaints are recorded.
- The trust must ensure risk assessments are in place and that they contain all relevant risk information.

On this inspection we only inspected Lucy Wade Unit.

Our inspection team

The team that inspected the service comprised of one CQC inspection Manager, three CQC inspectors and a specialist advisor.

Why we carried out this inspection

This inspection was an unannounced focused inspection (staff did not know that we were coming) of Lucy Wade Ward at Millbrook Mental Health Unit to address concerns that had been raised anonymously to the commission after a serious incident on the ward.

Summary of findings

How we carried out this inspection

As this was a focused inspection, we inspected against the following three domains:

- Safe
- Caring
- Well led

During the inspection we carried out the following activities:

- looked at the quality of each of the ward environments and observed how staff were caring for patients
- interviewed the ward manager, service manager and a modern matron and the service
- Reviewed eight handover documents
- spoke with five staff including nurses, healthcare assistants, and doctors.
- spoke with five patients
- reviewed seven care records
- reviewed observation records, CCTV and electronic incident forms.

What people who use the provider's services say

- Patients we spoke with reported that staff attitudes and behaviours when interacting with patients were not always respectful, discreet and did not always provide them with help, emotional support at the time they needed it.
- In addition, we were told that staff did not always knock on patients' bedrooms doors before entering. Staff locked patient's bedroom doors so that patients could not access their bedrooms when they wished.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that they take action to ensure emergency medical bags are sealed.
- The trust must ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure patients are kept safe.
- The trust must ensure that observations of patients are carried out in line with trust policy and recorded fully.
- The trust must ensure that all incidents are fully recorded in patient notes and on the electronic reporting system.
- The trust must ensure that the senior managers have a clear framework of what must be discussed at a ward level to ensure that essential information, such as learning from incidents was shared and discussed.
- The trust must ensure that managers have access to information in an accessible format, that is accurate and identifies areas for improvement to support their management role.

Action the provider SHOULD take to improve

- The trust should assure themselves that all staff can access ligature cutters in an emergency quickly.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Safety of the ward layout

Staff carried out regular risk assessments of the care environment. The ward layout allowed staff to observe all parts of the ward. Where required convex mirrors were in place to support staffs' observations.

We saw some potential ligature points on the ward and there was an up to date ligature risk assessment for the ward. However, we were not assured that all staff including agency and back staff were aware of the potential ligature points or the mitigation in pace to reduce these risks.

The ward only admitted females.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. However, staff had not kept the cleaning records up to date. We found omission in the records on for week commencing the 11 and 25 November 2019, 27 January 2020, 03 February 2020.

Clinic room and equipment

Whilst clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly staff a tamper seal was not in place. Staff had completed checks of the equipment but not taken any action to ensure the bag was sealed correctly. This had been found on inspection of this core service in 2019. In addition to this, the suction machine attachments were uncovered and therefore not sterile and ready for use in an emergency.

We raised concerns with senior manager during the inspection about the management of ligature cutters. The ligature cutters were held behind a looked door in a keypad locked safe, the code was changed regularly. We were not assured that staff, especially agency staff would remember the code and by able to get to the ligature cutters in a timely manner if an incident occurred. Senior managers reported that the decision was made to store the ligature cutters in this wat across the trust following on from lesson learnt from a previous serious incident.

Staff carried out regular risk assessments of the care environment. The ward layout allowed staff to observe all parts of the ward. Where required convex mirrors were in place to support staffs' observations.

We saw some potential ligature points on the ward. Whilst there was an up to date ligature risk assessment for the ward a copy of this was not available during the inspection. We were not assured that all staff including agency and bank staff were aware of the potential ligature points or the mitigation in place to reduce these risks.

The ward complied with guidance on eliminating mixed-sex accommodation as the ward was for female patients only.

Safe staffing

Nursing staff

We had significant concerns about the lack of deployment of sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure patients are kept safe and have their needs met on the ward.

Senior managers were unable to provide the established levels of staff for the ward or additional staffing requirement for enhanced observations. We reviewed the rotas, staffing levels, and designations of staff, including bank agency staff. We were not assured that the level of staff or experience of staff on Lucy Wade Ward was sufficient to provide safe care for patients thereby exposing them to the risk of harm.

Whilst we saw that staffing levels met the required safe staffing numbers, this did not take in to account the number of patients requiring enhanced observations to keep them safe. In addition, the designations of the staff did not always meet the set target for the ward. For example, the ward should have two registered nurses on shift, but between 12 January 2020 and 12 February 2020 14 shifts out of 96 shifts only had one qualified nurse on duty.

We were not assured that the skill mix of staff was sufficient to meet the needs of the patients safely. Senior managers had not ensured that band 5 preceptorship nurses were supported by suitably experienced staff when on duty. A preceptorship nurse is a newly qualified nurse who requires

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Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

support and guidance to transition from student to qualified nurse. On 12, 18, 19 January 2020 and 09 February there were no band 6 staff were on shift. We were also aware that the weekend after the inspection only two band five preceptorship nurses were planned to be on duty with no other registered nurses supporting them and no there were no plans to provide additional cover.

We were concerned about the impact staffing levels had on patient safety. We found evidence in patients case records and the trust electronic incident report that a female patient had harmed themselves as the staff allocated to support them were both male. The patient had a long history of trauma in relation to males and this did not appear to be considered when allocating staff to observations. Patients we spoke with reported that they felt unsafe on the ward and were denied access to their bedrooms due to low staffing levels. Within the electronic incident reports staff had reported four incidents of medication not being administered to patients due to lack of staff on 19 August 2019 and three incident forms due to patient observations not be carried out due to staff shortages. On the day of the inspection a non clinical, non nursing staff member was allocated to escort a patient to a hospital appointment due to staff shortages on the ward.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed a risk assessment of every patient on admission and updated it regularly. Most risk assessments were updated after incidents.

Management of patient risk

Staff failed to follow policies and procedures when using observation. We found numerous records failed to record whether staff had carried out observations. On 27 January 2020 between 08.00-09.00hrs nine patients were omitted from general ward observations.

On 01 February 2020 a patient requiring 2:1 observation received only 1:1 observation for a period of 18 hours in a 24 hour window. The patient required 2:1 observation as a result of significant risks to themselves. We were therefore concerned that staff did not provide the patient with adequate support and engagement to maintain their safety.

Staff failed to accurately record staffing allocations within the morning meetings. Eight handover forms were not fully completed between 25 January to 10 February 2020. We found on 27 January that two patients had no staff allocated to their observations from 1300-1400 despite them being on 2:1 and 1:1 continuous observation. On 25 January 2020 one patient had no staff allocated to their observation from 0000hrs-0700hrs and another patient had not allocated staff from 0500- 0700hrs and 2000-2100hrs despite being on 2:1 and 1:1 observation. We therefore could not be assured that patients had been observed in line with their risk assessment and care plan. As a result, we were concerned that observations were not being carried out properly therefore exposing patients to the risk of harm.

We found examples were staff were on observations in excess of two hours. This was outside of the trust's guidance and policy which states staff members should not undertake more than 2 hours continuous observations. For example, on 02 February 2020 one member of staff was on observations from 2100-0000hrs, 0400-0700hrs and 0500-0800hrs. On 03 February 2020 one member of staff was on observations from 0745-12000 and 1100-1400hrs.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. We found evidence that staff had fully supported a patient that was a victim of domestic abuse and devised robust plans to keep them safe. Staff held multi-agency risk assessment conferences, sharing information across agencies and devised coordinated action plans to keep the patient safe.

Staff access to essential information

All clinical information needed to deliver patient care was available to all staff when they needed it and was in an accessible form. However, this do not include agency staff.

Track record on safety

We did not review all serious incidents due to this being a focussed inspection. However, in the last month a serious incident had occurred on the ward, which resulted in a patient death

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Reporting incidents and learning from when things go wrong

Staff failed to accurately record all incidents in line with trust policy. Patients clinical notes highlighted that incidents had taken place but we found no incident reports within the electronic reporting system. We reviewed 17 incidents from the 12 January to 12 February 2020 and found 16 were not logged within the electronic incident reporting system.

We were concerned that despite requesting details of incidents up to and including the date of inspection managers only provided us with details of incidents from 01 January 2019 to 31 January 2020. Managers were not able to provide us this information during the inspection.

Following the inspection, we received details of further incidents which related specifically to staffing shortages on this ward and which were not included in the original incident log.

Staff we spoke with told us that they did not always receive feedback from investigation of incidents, both internal and external to the service. However, we reviewed minutes of team meetings and found some evidence that feedback was given to the staff.

We were concerned that there was limited evidence to show that changes had been made as a result of feedback. We were aware of a serious incident that took place when staff failed to carry out observations for a patient. This was confirmed by CCTV even though the observation records had been completed stating that the observations had taken place. We reviewed a sample of CCTV and found that staff had carried out general and enhanced observations but failed on occasion to accurately record this.

Managers offered staff debriefings and received support after serious incidents. However, this was only for staff on shift when the serious incident occurred. One member staff member reported that they had asked to attend the debrief as she felt affected by the incident. She was told by a manager that she was not allowed to attend as she was not on shift. The member of staff had received no other alternative support to explore her thoughts and feelings.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Requires improvement

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

Patients we spoke with told us that agency staff were rude and disrespectful and that staff did not always talk to them. Once patient report that a specific member of staff bullied and belittled them. Staff did not provide emotional support at the time they needed it.

Patients said that staff did not always knock on patients' bedrooms doors before entering and locked patient's bedroom doors so that patients could not access their bedrooms when they wished.

Patients we spoke with described their individual experiences of staff not being discreet. They spoke about other patients and staff in front of them, made inappropriate comments linked to the risk posed by an individual patient.

Patients reported that they had been dragged during a restraint procedure by staff. We reviewed their case records and found that the restraint had taken place but no injuries had been noted.

The involvement of people in the care that they receive

Involvement of patients

Staff used the admission process to inform and orient patients to the ward.

Staff involved patients in care planning and risk assessment in the majority of cases. Four out of the five patients we spoke with told us that they had been involved in their care plan, whilst, one reported that had seen a care plan or discussed a care plan with their nurse

Are services responsive to people's needs?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Are services well-led?

Inadequate

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Good governance

We were not assured that there was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents was shared and discussed.

We found little evidence that managers undertook local audits or monitored staff performance. Therefore, managers could not provide assurance that staff had improved their quality of the care to patients or enhanced the patient experience.

Management of risk, issues and performance

We were concerned that managers had not ensured that staff had implemented recommendations from reviews of deaths or incidents. For example, a serious incident that had occurred within the last month, the full investigation report of which was yet to be completed, identified definitive lessons that staff could learn from and that managers should have implemented with immediate effect. Also, ensuring that observations are allocated to staff and that they are carried out and recorded in line with guidance.

Information management

Team managers had access to information but it did not support them with their management role. Information was not in an accessible format, and were not timely, or accurate and did not identify areas for improvement. For example, we asked to see staff rotas, and other safe staffing information but the manager could not provide this us during the inspection. In addition, managers could not provide us with information relating to incidents that had taken place on the ward. We did however, receive this information the day after the inspection but the two documents provided held differing information. We could not be assured which document held the correct information.

Leadership, morale and staff engagement

It was not evident during that inspection that all managers had the skills, knowledge and experience to perform their roles. Although leaders had a good understanding of the services they managed they could not explain clearly how the teams were working to provide high quality care.

Whilst managers were visible in the service staff reported that not all them were approachable.

Culture

Whilst staff felt positive and proud about working for the provider and their team the majority of the staff we spoke with reported they didn't feel respected, supported or valued by all managers.

Although staff felt able to raise concerns without fear of retribution they did feel they would not be listened too.

The nursing and medical teams worked well together but when they raised issues managers did not deal with them. For example, preceptorship staff working without guidance and support from senior nurse.

This section is primarily information for the provider

Enforcement actions

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 This was a breach of regulation 12 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance This was a breach of regulation 17 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing This was a breach of regulation 18 (1)