Norfolk and Suffolk NHS Foundation Trust

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

Inspection report

Hellesdon Hospital
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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

Norfolk and Suffolk NHS Foundation Trust provides services for adults and children with mental health needs across Norfolk and Suffolk. Services to people with a learning disability are provided in Suffolk. They also provide secure mental health services across the East of England and work with the criminal justice system. A number of specialist services are also delivered including a community-based eating disorder service.

Samphire ward is a mixed sex ward, with 16 beds for acutely unwell adult patients. This ward opened in July 2019 and is based at Chatterton House in King's Lynn, Norfolk. The ward is included in the Trust's portfolio of acute wards for adults of working age and psychiatric intensive care units. This core service was last inspected fully in November 2019 and rated as requires improvement overall. Ratings for safe, responsive, effective and well led were requires improvement and the core service achieved a good rating for caring.

We carried out this unannounced focused inspection of Samphire Ward because we received information giving us concerns about the safety and quality of the service. We visited the ward on 10 May 2021 and carried out remote interviews of staff on 13 May 2021. We focused on specific key lines of enquiry within the safe, caring and well-led domains.

During the inspection we:

- Spoke with the Clinical Director and the Service Manager
- spoke with seven staff
- spoke with eight patients
- spoke with an independent advocate
- spoke with the Freedom to Speak Up Guardian for the Trust
- looked at four care and treatment records
- reviewed closed circuit television footage of 26 observations over six time periods.
- observed the service 'safety huddle'
- and reviewed a range of policies and procedures, data and documentation relating to the running of the service.

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- The service provided safe care. The ward environments were safe and clean. Staff minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- We observed that staff completed 24 out of 26 observations correctly and documented these accordingly. We saw staff interacting with patients whilst completing observations.

Our findings

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Care plans were written using respectful language and included the patient voice, i.e. their views and wishes about their treatment and recovery goals.
- During the inspection, we observed staff treating patients with care and compassion, respecting their privacy and dignity.
- Staff reported receiving regular supervision and valued this opportunity for case reflection and ongoing professional development and we saw that records supported this feedback.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.
- The local leaders we spoke with demonstrated the Trusts' core values. Staff felt able to raise concerns without fear of victimisation.

However:

- One member of staff had signed an observation sheet to say they had completed observations on two occasions; however, when we viewed CCTV, we saw that this was not the case. Observations are undertaken when a decision is made that there is an increase of risk of harm. Therefore, the impact could be of significant harm if staff fail to carry out the observations as prescribed. We escalated the concern to the Trust who took swift action.
- Feedback from patients was mixed with some patients saying that they felt dismissed, not listened to or not believed. However, staff provided opportunities for patients to share their experiences and facilitated access to advocacy.

How we carried out the inspection

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

We spoke with eight patients. Patients we spoke with had mixed views about their care. Six patients told us that staff attitudes varied and while some were very good, some could be uncaring and insensitive in the way they spoke to patients. However, two patients told us that all the staff were kind and caring

Four out of seven patients told us they felt safe on the ward and that staff responded well to patients who became distressed or who presented behaviours that challenged. Two patients told us they sometimes felt safe on the ward and one patient told us they didn't always feel safe as they would have preferred female staff to do their observations.

Is the service safe?

Inspected but not rated

We did not rate this inspection.

We found the following:

- The ward was clean, well equipped and well furnished.

Our findings

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing distressed 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.
- Following a patient death in December 2020, managers had changed the lock on the clinic room door to prevent unauthorised entry and had made a change to the storage of the medication disposal bin to ensure that this was always kept in a locked cupboard within the clinic room.
- 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.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.
- We spoke with seven members of staff. Five members of staff reported receiving regular supervision and valued this opportunity for case reflection and ongoing professional development. Two members of staff reported that a minority of supervision sessions had been missed. We looked at five supervision records and found that these were personalised, respectful of patients and with evidence of discussions about staff development and wellbeing.

However:

- Immediately prior to this inspection we received information of concern that not all staff were carrying out observations correctly. There had also been a death on the ward in December 2020 which raised concerns that some staff may not always carry out safe and robust practices when identifying the need for and undertaking enhanced observations. Whilst we found that on 24 out of 26 occasions observations were carried out safely and according to policy there were two occasions where a member of staff did not follow policy. The trust policy on therapeutic observations states 'Enhanced observations should be a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery'. Observations are undertaken when a decision is made that there is an increase of risk of harm. Therefore, the impact could be of significant harm if staff fail to carry out the observations as prescribed. We escalated the concern to the Trust who took swift action.
- We checked observation sheets for the period between 19 April and 9 May. All the sheets were completed with no gaps, however patient risks were not consistently recorded on all the sheets.
- There was an issue with the heating on the ward which meant that patient bedrooms and ward areas were liable to become too hot. There was a patient death in May 2020 where broken heating/poor ventilation were noted as an issue of concern in the Root Cause Analysis of the death. The Trust advised us that remedial action was taken in August 2020 which was not fully effective. This had still not been resolved at the time of inspection. However, following the inspection, the Trust have assured us that further work has been undertaken.

Is the service caring?

Inspected but not rated

We did not rate this inspection

- During the inspection, we carried out a SOFI (Short Observational Framework for Inspection) on the ward. We saw staff engaging with patients and treating them with care and compassion.

Our findings

- Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates. Staff ensured that patients could continue to access advocacy during the COVID-19 pandemic by providing electronic tablets so patients could communicate with advocates virtually.
- Staff ensured that patients could continue to keep in contact with families and friends during the COVID-19 pandemic by facilitating virtual communication, with the ward electronic tablets if necessary.
- We spoke with eight patients. Four out of seven patients told us they felt safe on the ward and that staff know how to respond to patients who were distressed or presenting behaviours that challenged.
- One patient told us that all the staff were caring and had time for them. Two patients told us that most staff were OK.

However:

- Feedback from patients about staff attitudes was mixed. Four out of seven patients said some staff were caring but others did not have time for them. Six patients told us although some staff were good, some staff made them feel dismissed, not listened to or not believed. However, staff provided opportunities for patients to share their experiences and facilitated access to advocacy.
- One patient we spoke with told us that a member of staff had spoken to them using abusive and disrespectful language. We raised this with managers at the time of inspection who took immediate action to investigate the allegation.
- During the afternoon we observed, on two separate occasions, staff spending time in the ward office rather than in the communal area. This had been raised as a concern prior to the inspection and was also raised as a concern by two members of staff during the inspection process.

Is the service well-led?

Inspected but not rated

We did not rate this inspection

- Leaders had the skills and knowledge to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- The local leaders we spoke with demonstrated the Trust's core values.
- The Trust employed a Freedom to Speak up Guardian (FSUG) who was accessible and available for staff to speak to, in confidence, if they wanted to raise any concerns. The FSUG role offers an additional route for whistleblowing and aims to develop a learning culture where safety concerns are identified and addressed at an early stage. Managers had asked the FSUG to carry out specific listening events for local staff and all the staff we spoke with were aware of the FSUG, although they hadn't needed to contact them.
- We spoke with seven staff. All the staff we spoke with told us that they felt able to raise concerns with management without fear of victimisation.

However:

Our findings

- Some patients had reported that they did not always feel listened to, believed or felt dismissed. These concerns had not been identified by the team so therefore no action had been taken to address them. The negative patient feedback is a warning sign that a closed culture could develop if concerns are not acted upon.
- Some staff told us there was occasional minor conflict between colleagues, a perception that tasks were unfairly distributed, or colleagues spent too much time in the office.
- A patient had been in the Section 136 suite all weekend due to a lack of beds. A Section 136 Suite is additional accommodation which provides a 'place of safety' whilst potential mental health needs are assessed under the Mental Health Act. The 136 suite is not an appropriate environment for a patient long term and it also prevents access to other people requiring this service. Managers told us this was happening more frequently due to an increase of patient acuity and demand for admission. The trust told us that there are workstreams underway aimed at improving patient flow.
- Due to the impact of COVID-19 on staffing and patient acuity, there had been just one whole team meeting in the last 6 months. However, twice daily safety huddles took place and key issues were communicated through ward manager briefings and senior manager briefings.

Our findings

Areas for improvement

SHOULDS

Core service

- The Trust should ensure that there are effective systems and processes in place to be assured that staff undertake therapeutic observations as per their own policy.
- The Trust should improve the systems in place to ensure that patients feel valued, listened to and believed.

Our inspection team

The team that inspected the service comprised a CQC Inspection Manager, lead inspector, one support inspector and a CQC Mental Health Act Reviewer. The inspection team was overseen by Stuart Dunn Head of Hospital Inspection.