Care Quality Commission

Leeds and York Partnership NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Bootham Park Hospital
Bootham
YO30 7BY
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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)
RGDX4	Bootham Park Hospital	Ward 6	YO30 7BY

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership 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 Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

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

Summary of findings

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

Are services safe?

We inspected Bootham Park Hospital and found the following concerns:

- Safe staffing levels were not maintained. Staffing levels were not in accordance with the trust's establishment levels for the ward. We were told, and saw, in staff rotas there were five vacancies for band five nurses and one vacancy for a band six nurse. Staff told us every effort had been made to recruit staff, including enquiries made with agencies to fill vacancies. However, this had not been achieved. Staff told us this meant the ward was regularly short-staffed, putting patients at risk of unsafe care.
- The environment was not safe; people were put at risk due to ineffective maintenance. On the day of our inspection, we found several areas that had been reported to maintenance and had been waiting some considerable time for repair. There was a leak under the sink in the patients' kitchen. One person's bedroom had a pane of glass missing and the window had been boarded up. We were told this was because there had been a long delay in sourcing a new piece of glass. Hot water temperatures were excessive and posed a scalding risk to patients.
- Areas that had been deemed as unsafe to patients were not kept locked. The conservatory, activities room and laundry were found to be unlocked. Each room had several ligature points (places to which patients intent on self-harm might tie something to strangle themselves) and various items that could be used to cause harm. Bathrooms had several ligature points, some of which could have been remedied without major works.
- Risk assessments did not reflect the current risk to patients. Some risk assessments were not up to date. Where risk had been identified when people were admitted to the service, these were not always reflected in their risk assessments.
- On the last day of our inspection, we noted a crack in the ceiling on the main corridor of the hospital. This was identified to a member of the senior management team. Part of the ceiling subsequently fell down.

Are services effective?

We did not look at the effective domain during this inspection.

Are services caring?

We did not look at the caring domain during this inspection.

Summary of findings

Are services responsive to people's needs? We did not look at the responsive domain during this inspection.	
Are services well-led? We did not look at the well-led domain during this inspection.	

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust had one ward for older people with mental health problems at Bootham Park Hospital. This ward provided care for patients who are aged over 65 who required hospital admission for their mental health problems.

Our inspection team

The team on the first day of inspection comprised:

- four CQC inspectors.

The team on the second day of inspection was comprised of:

- six CQC inspectors
- an estates specialist advisor

Why we carried out this inspection

We inspected this core service as a result of being notified of delays in the implementation of an action plan submitted by Leeds and York Partnership NHS Foundation Trust after an inspection at Bootham Park Hospital in September 2014. The trust during and subsequent to the September 2014 inspection provided documents that outlined their concerns about the premises and the length of time it was taking to complete the agreed works. To find a solution the trust had raised this with the relevant parties, including Vale of York commissioning group and NHS property services who were responsible for the building and the plan of work.

We were concerned for the safety of patients who used the service and the safety of the staff team working at the hospital. The trust closed the hospital to patients on 30 September 2015.

How we carried out this inspection

This was an unannounced inspection.

During this inspection, we looked at the following key question:

- is it safe?

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent to us by the trust. A notification is information about important events that the trust is required to send to us.

During the inspection visit the inspection team:

- visited ward 6 and looked at the quality of the ward environment
- spoke with the ward managers and senior managers
- spoke with four other staff members.

We also:

- looked at seven treatment records of patients
- carried out a specific check of the maintenance of the ward.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure the safety of people who use the service and staff working at the service by completing maintenance in a timely fashion.
- The trust must carry out regular checks of both hot and cold water temperatures.
- The trust must ensure risk assessments are effectively carried out and clearly documented in care files.
- The trust must ensure staffing numbers are at agreed establishment levels and are sufficient to keep people safe.
- The trust must effectively mitigate ligature risks.
- The trust must manage and mitigate the possibility of infection by ensuring infection control measures are implemented and utilised in the laundry area.
- The trust must implement measures to ensure staff have a clear line of sight across all patient-accessible areas of the ward.

Leeds and York Partnership NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 6	Bootham Park Hospital

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

The trust was found non-compliant with Regulation 15 safety and suitability of premises, HSCA 2008 (Regulated Activities) Regulations 2010, on Ward 6 at Bootham Park Hospital in December 2013. Following the comprehensive inspection of Bootham Park hospital in September 2014 the trust sent us an action plan setting out how they intended to ensure the premises at Bootham Park Hospital were safe. The trust told us people from ward 6 would be transferring to a new location by February 2015. However, due to delays in the completion of works at the new location, this had not happened.

Before our inspection, the trust contacted the CQC to tell us they were unable to complete the works required within the timescales we were initially given.

We conducted a tour of ward 6 and found there were significant risks. The ward had a conservatory that we were told was kept locked due to ligature risks. The risks included door closers, which television cables could be looped over to enable strangulation by hanging. On the second day of our inspection, we found the door was unlocked and open. We spoke with the ward manager about our concerns and the removable electrical cables were secured elsewhere. The laundry room contained potential risks. This was accessible to patients and was left unlocked. We monitored the room for 15 minutes and during that time staff did not return. This exposed patients to detergents, electric equipment and various ligature risks. We therefore alerted the ward manager, who locked the room. We found the activity room was also left unlocked. This contained knitting needles, wool, scissors and various ligature risks.

There was no segregation of dirty and clean areas in the laundry. This meant clean laundry was transported through the dirty area for distribution and presented a potential infection control risk.

In one bathroom, we found there was poor ventilation; the extractor fan was not working and had not been reported for repair. Ligature points included bath handles, taps and wash hand basin taps. There was poor silicone sealing to the shower area, which presented an infection control issue. Staff told us bathrooms were kept locked when not in use. We did not see risk assessments in patients' care records relating to using bathrooms safely. Patients were asked to advise staff when they had finished in the bathroom to enable staff to lock the room.

In one patient bedroom, the wash-hand basin water temperature measured 51 degrees centigrade. This presented a significant scalding risk, especially to older patients. The permissible maximum temperature is 42 degrees. In another patient's bedroom, there was a pane of glass missing from the window, which had been boarded up. We were told there had been a long delay in getting a new piece of glass.

We saw in two toilets that extractor fans were not working, which allowed odours to linger. The emergency assist pull cord had been removed to mitigate the ligature risk but this left patients at risk of not being able to alert staff should an emergency arise. There were multiple ligature points in the toilets. The hot water temperature was 51 degrees in one toilet and 53 degrees in another, which again presented a risk of scalding.

The sluice room was locked and secure. The sentinel domestic hot water tap located in the sluice had a measured temperature of 48 degrees centigrade, which was below minimum return temperature.

We looked at four patients' bedrooms and found they all presented multiple ligature risks, such as electrical equipment flexes, taps, handles and, in some cases, the bed structure. The nurse emergency call points were poorly sited away from the bed by the door. Care files did not contain patient-specific environmental risk assessments. This meant facilities had not been assessed to ensure they were safe for patients occupying bedrooms.

There was a small patients' kitchen attached to the patient lounge where we found the sink was blocked and leaking. This was a long-standing problem that had been reported to maintenance but not repaired and represented a health and safety and infection control hazard. The hot water on the sink and hand-wash basin was measured at 54 degrees, again representing a significant scalding risk to patients.

Are services safe?

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

Staff we spoke with were not happy with the environment they were working in. Staff told us they did all they possibly could to ensure the safety of patients. However, this was very difficult due to poor lines of sight throughout the ward and the lack of prompt maintenance meant they were working in unpleasant conditions.

On the last day of our inspection, we noted a crack in the ceiling on the main corridor of the hospital. This was identified to a member of the senior management team. Part of the ceiling subsequently fell down. The debris was cleared away but the area had not been cordoned off, which meant people were still at risk of harm if more of the ceiling had collapsed before the remedial works were done.

Safe staffing

Staffing levels were not in accordance with the provider's establishment levels for the ward. We were told and saw in staff rotas there were five vacancies for band five nurses and one vacancy for a band six nurse. Staff told us every effort had been made to recruit staff and enquiries made with agencies to fill vacancies. However, this had not been achieved. Staff told us this meant the ward was regularly short-staffed.

Staffing levels should be five members of staff on the morning shift, four on the afternoon shift and four overnight.

On the first day of our inspection, there were two registered nurses on duty in the morning and there should have been three. There were also two health care assistants, which was as required. On the afternoon shift, there was one registered nurse rostered to be on duty but the provider sourced other members of staff prior to the shift starting. We found there were 13 patients resident on the ward, one of whom required one-to-one support from staff at all times during the day. This meant there were only three members of staff available to assist other patients during the morning. Another person required two-to-one support for mobilising and personal care. Someone else required one-to-one support for mobilising and personal care. There was also one person who required observations every 15 minutes. This meant it would be difficult for staff to ensure the safety of patients, particularly during busy periods, for example mealtimes and when patients were getting up and going to bed.

One member of staff was required to attend electro convulsive treatment appointments with patients twice a week. We were told the level of staffing had not impacted on patient care and people were still able to leave the ward as agreed. The occupational therapy team generally conducted activities so people were still able to take part in activities. The ward manager told us they carried out a lot of the 'clinical work' and there was an apprentice who worked alongside the associate practitioner. However, the ward manager told us they were concerned they might not be able to carry out their managerial duties adequately if the staffing situation continued.

Staff told us staffing levels were not safe. One member of staff said some people's needs were not being met. We were told that while people were able to have escorted leave, it was not always on time. One member of staff said even the simple things were not getting done. Another member of staff said they often worked longer than their rostered hours as they did not want to leave their colleagues short-staffed.

The ward manager told us when the fire alarm was activated all the six doors into the ward automatically unlocked. Staff were then required to go to each door to ensure people were unable to leave unescorted. However, due to staffing levels this would not always be possible and meant patients and staff were at risk should an emergency occur.

Assessing and managing risk to patients and staff

Staff told us due to reduced staffing levels they were not always able to update people's risk assessments, and admission paperwork had not always been fully completed. We looked at the files of seven people and found five risk assessments had not been completed fully. None of the seven care files included up-to-date risk assessments. One person's risk assessment had not been updated when their health had deteriorated. We saw in another person's care file risks identified before the person was admitted to the ward had not been taken into account when assessing risk to them and others.

Where risk assessment had identified a specific risk to the individual, risk management plans had not been implemented to manage this risk. Examples of risks not managed included those relating to a patient admitted due to risk of self-harm, a patient with a history of arson, a patient with the potential to cause harm to children, and another patient undergoing medical procedures.

Are services safe?

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

Care plans were generic and did not provide staff with the necessary guidance on how to manage and support people they cared for.

Levels of observation were recorded inconsistently. Staff were using different forms to record levels of observation and only four of the seven files we looked at included an appropriate form that provided the rationale for the level of observation.

The ward failed to record section 17 leave (granted to patients held for treatment) in a consistent and safe manner. Staff members stated that if a patient went out on leave it should be recorded in their notes. People's care files we looked at had no evidence of this, and there was no record of clothing descriptions or contact numbers. This meant in the event a patient was absent without leave, there were no records available to state what they were wearing or how to contact them. Out of the seven files we looked at, only one patient had an absconding management plan.

None of the patient files we reviewed contained a risk assessment relating to the environment. This meant people at risk of suicide were not protected with assessments that looked at all areas of risk.

Due to layout of the ward, we found people could be out of the line of staff sight for some significant time. Staffing levels meant staff were unable to monitor people's safety.

We spoke with staff about restraint practices and were told the least restrictive practice was always used. Where possible, verbal de-escalation techniques were used. We were told rapid tranquilisation was used but not very often. There had been an occasion where it had been used recently and under restraint. This had been done while the person was standing.

Track record on safety

We were told about an incident that had resulted in an extended fact-find investigation. As a result of the fact-find, the review process relating to the local risk assessment tool, which is called a safety assessment and management plan (SAMP), had changed to require a nurse and a doctor to conduct the review together.

Reporting incidents and learning from when things go wrong

Staff we spoke with understood how to report incidents. Staff said that while learning from when things went wrong did take place, due to staffing numbers this was not always done immediately.

Are services effective?

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

We did not look at the effective domain during this inspection.

Are services caring?

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

Our findings

We did not look at the caring domain during this inspection.

Are services responsive to people's needs?

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

Our findings

We did not look at the responsive domain during this inspection.

Are services well-led?

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

We did not look at the well-led domain during this inspection.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2)(d) The trust did not take appropriate steps to ensure wards were safe to use for their intended purpose and were used in a safe way.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2)(h) The trust did not assess the risk of infection and prevent and control the spread of infection

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2)(a) The trust did not assess the risks to the health and safety of service users of receiving care or treatment. They did not include arrangements to respond appropriately and in good time to people's changing needs. Risk assessments did not contain plans for managing risks.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2)(b) The trust did not do all that was reasonably practicable to mitigate risk. The trust did not make the required adjustments to premises, process and practices to ensure the safety of people who used the service.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) The trust did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to make sure they could meet people's care and treatment needs.