Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Wards for people with a learning disability or autism

Inspection report

St Nicholas Hospital
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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**

Our findings

Wards for people with a learning disability or autism

Inspected but not rated

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the service. The inspection was prompted by a whistleblowing enquiry which highlighted incidents which had serious impacts on people using the service. While we did not look at the circumstances of the specific incident, we did look at associated risks.

We inspected one ward (Rose Lodge) which was a ward for people with a learning disability or autism. Rose Lodge is a learning disability specialist assessment and treatment inpatient unit based in Hebburn, South Tyneside. Rose Lodge has 10 beds providing assessment and treatment by a multi-disciplinary team to care for adults aged 18 and over with learning disabilities and/or autism and mental health problems or severely challenging behaviour. The unit is a standalone unit which is part of a large mental health trust.

We carried out the inspection over a two-week period. At the time of the inspection the trust had taken the decision to voluntarily close to admissions due to staffing. There were nine people on the ward of which seven were delayed discharges and discussions were taking place with commissioners about the discharge of these people to more suitable placements.

During the inspection we escalated concerns to the trust, and they responded quickly to these concerns. Directly after the inspection CQC met with the trust. Following this meeting the trust submitted a written response confirming what immediate actions had been taken. This included discussions with partners in relation to the current differing needs of the people using the service and their transition and discharge plans.

The letter outlined the immediate action taken and further urgent actions which would be completed by 30 April 2022. Additional clinical leadership support had been identified and began working on the ward from 31 March 2022.

As part of the inspection activity, we re-visited the ward on 6 April 2022 to review incidents on CCTV and check that immediate action had been taken with regards to the physical health needs of people. We found that the immediate action around people's physical health needs had been addressed.

This was a focussed inspection looking at key lines of enquiry in the safe domain. We did not inspect the effective, caring, responsive or well led domains.

We did not rate this service at this inspection. A full comprehensive inspection took place following this focused inspection. The inspection included all wards for people with a learning disability and/or autism across the trust.

We found:

Our findings

- The ward was not providing safe care. There was high use of agency staff with some shifts falling below minimum staffing levels. Staff were not always assessing and managing risk well. The physical health needs of people were not being met and managers had failed to address this.

How we carried out the inspection

During the inspection visit, the inspection team:

- visited the ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for people
- interviewed the hospital manager, clinical manager and both ward managers
- interviewed other members of staff including nurses, support workers, advanced nurse practitioner and the consultant psychiatrist
- spoke with three people who were using the service
- observed the evening handover meeting
- reviewed five care and treatment people records
- reviewed nine incident records including three CCTV and one body cam footage
- Spoke to the commissioners for the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with three people while on inspection. One person said they were desperate to move out but wouldn't/couldn't say why. Another person said the ward was loud and the food was horrible. We saw staff interacted with people in a positive way throughout the inspection.

Is the service safe?

Inspected but not rated

Safe staffing

The service did not always have enough nursing and support staff, who knew people and received basic training to keep people safe from avoidable harm. There were several shifts which were below the minimum staffing levels required to support people.

Nursing staff

The service did not have enough nursing and support staff to keep people safe. The service was using high levels of agency staff. On the evening we started the inspection, the ward was short staffed with only enough staff to cover

Our findings

observations; seven of the 12 staff were agency members of staff. One person was on a three to one observation level, three people required two to one observations and three people were on one to one with the remaining two people on general observation levels. This meant that most staff were involved in the observation of people which meant other tasks could not be completed.

Staff worked across two shifts which were long days (07.30-20.30) and nightshift (20.00-8.00). However, due to flexible working conditions some staff worked compressed hours and so did shorter shifts once every 4 weeks.

In the period 7 March to 3 April 2022 there had been 15 early shifts and 19 afternoon shifts which fell below minimum numbers. There had been seven nightshifts which were below minimum staffing numbers. Managers told us that activity coordinators and managers were sometimes expected to make up the shortfall.

At the time of the inspection there were four band five vacancies and 14 band three vacancies. The service had recruited several new staff to the hospital and staff said that things were starting to improve. During the second week of our inspection, a new clinical manager, with a background in learning disability was now working on the ward. The manager had significant learning disability nursing and managerial experience. A physical health nurse was also new in post that week.

Incident data from January to March 2022 showed three incidents were recorded due to low staffing levels, two detailed that they were unable to cover observations, and one reported that the ward was unsafe. All staff members told us on inspection that they were often short staffed, two staff members told us they had felt unsafe on the ward due to staffing levels and people acuity.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, it was not always possible to fill the shifts to the minimum numbers required. Agency staff were being used who were familiar with the ward.

The service did not always have enough staff on each shift to carry out physical interventions safely. On some days all staff on duty were allocated to observations which meant that there were no staff available to respond to incidents. During the day managers and activity coordinators were available to work on the ward. Training compliance for the prevention and management of violence and aggression was 39%, however for some staff this would have been refresher training. This face to face training had been stood down during COVID-19. Managers requested agency staff who were trained in the prevention and management of violence and aggression. Agency staff we spoke to had completed training.

Handover meetings took place after each shift and staff confirmed that handovers took place. We observed the handover meeting to the night shift staff and found this to be rushed with some staff standing in corridors. Staff we spoke to said that risks were handed over and handover sheets were available in the office. However, some staff could not describe individual people risks.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Our findings

Mandatory training

Staff were not up to date with their mandatory training. Staff training levels were low in prevention and management of violence and aggression (39%); physical health skills (60%); safeguarding level two (71%); immediate life support training (41%); clinical risk and suicide prevention (43%). Staff did not have access to basic life support as part of the mandatory training programme.

Staff compliance for Mental Health Act and Mental Capacity Act was 62%

Assessing and managing risk to people and staff

Staff were assessing but not managing the physical health risks to people well. Risk assessments and risk management plans were not always updated and key information regarding the physical health needs of people was missing.

Assessment of people risk

Staff completed risk assessments for each person on admission, using a recognised tool. We found that although all people had a risk assessment in place, these were not always regularly reviewed, including after any incident. We found two risk assessments that had not been updated. Several people had significant physical health issues that required regular monitoring. We found that this monitoring was not always taking place in four out of the five care records we reviewed. We found that referrals to specialist services were not always followed up and that there was limited oversight of what needed to be completed and when.

Staff were completing food and fluid monitoring charts for three people when we arrived on site. However, all five care plans we looked at outlined that people's food or fluid should be monitored. In four people care plans, there were no specific targets for food or fluid intake levels identified.

For two people with food and fluid monitoring charts in place it was unclear what their daily fluid target was. One of the people had only consumed 250ml of fluids on 22 and 23 March with no indication of prompts from staff.

Concerns had been raised in the Mental Health Act monitoring visit in March 2022 about the follow up of physical health needs.

There was inconsistent shift coordination which meant that it was unclear who had responsibility for tasks being completed. This meant that the responsibility for physical health monitoring was not clear to staff on each shift. We found that there was no audit in place to oversee physical health care monitoring.

Management of people risk

Staff did not always know about all risks to each people and did not always act to prevent or reduce risks. Risk management plans lacked detail on how staff should manage risks and what measures they should take to manage physical health conditions. During the inspection we found that the level of understanding of people risks varied between staff members.

Staff did not identify and respond to any changes in risks to, or posed by, people.

Our findings

Use of restrictive interventions

Staff usually made attempts to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the people or others safe. Staff could describe the different de-escalation techniques that worked for each person. People had a positive behaviour support plan which outlined the individualised techniques and approaches. We reviewed two incidents of restraint on CCTV and observed staff using de-escalation and low-level holds. We saw that staff stopped using holds as soon as it was safe to do so.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, when a person was placed in long-term segregation. Two people were being nursed in long term segregation due to levels of risk. The appropriate safeguards were in place.

Safeguarding

Staff did not always understand how to protect people from abuse. The service did not always work well with other agencies to do so. Some staff were not up to date with training on how to recognise and report abuse.

Staff were not always receiving training on how to recognise and report abuse, appropriate for their role with some staff not up to date with their safeguarding training. Safeguarding level two compliance was 71% and no one had completed level three safeguarding. The trust had recently reviewed this and staff were now being booked onto courses. A safeguarding incident had been raised by a community organisation after a restraint incident observed by their staff. A review of the CCTV showed that the incident happened in an area which could not be seen by CCTV and staff interviews did not support the concerns raised.

Most staff knew how to make a safeguarding referral and who to inform if they had concerns. However, we found two examples of where incidents had not been categorised as safeguarding by staff. This was followed up and actioned appropriately.

Staff access to essential information

Staff had easy access to clinical information, through electronic records. However, we found that not all people notes were comprehensive and did not contain all the relevant information required to meet the physical health needs of people.

Peoples notes were not always comprehensive, around physical health needs. Regular staff could access notes easily and agency staff could review paper files on people.

When people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

Our findings

The service did not manage people safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers did not routinely investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff did not always apologise and give people honest information and suitable support.

During January to March 2022 there had been 143 incidents of violence and aggression. We reviewed nine incidents and found that the quality of the incident recording varied. In one record it lacked detail of what had led to the assault on a staff member. The second incident failed to document the serious nature of the incident.

We reviewed four incidents on CCTV and observed some good practice in staff using de-escalation techniques and low-level holds.

Managers did not routinely review CCTV footage, including after incidents and there was no process in place to trigger further investigation into an incident. We found that those incidents that had been investigated had been done after external intervention. Staff had access to body cameras but there was no clear process in place for when these should be utilised. We reviewed footage from two bodycam incidents and saw that the incidents had been managed well.

Managers debriefed and supported staff after any serious incident. We saw that debriefs had taken place for the nine incidents we reviewed. However, we were not assured that all incidents that required a debrief would be identified. The review of CCTV footage identified an incident of restraint where staff had not pulled the alarms. The staff recording of this incident lacked detail and did not give an account of what had led to the restraint.

Managers did not investigate all incidents thoroughly. The threshold for investigation was not clear. The incidents which had been fully investigated had resulted from an external safeguarding referral and a whistleblowing.

Our findings

Areas for improvement

Action the trust MUST take to improve:

Wards for people with a learning disability or autism

- The trust must ensure that all people have a full physical health assessment and that physical health needs are regularly monitored and reviewed.
- The trust must ensure that the ward has enough suitably trained and qualified staff on each shift.

Action the trust SHOULD take to improve:

- The trust should ensure that incidents are categorised correctly and recorded effectively.
- The trust should ensure that a process is implemented for the use of body cams.

Our inspection team

The team that inspected the service comprised of one CQC lead inspector, and two other CQC inspectors. Due to the immediate response to the issues a specialist advisor and expert by experience could not be identified.