Northamptonshire Healthcare NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Insufficient evidence to rate
Are services safe?	**Requires Improvement**
Are services well-led?	**Insufficient evidence to rate**

Our findings

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

Insufficient evidence to rate

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the service. This included receiving feedback from patients, local agencies, and the trusts own reporting of incidents. Incidents reported included an injury sustained to a patient during a restraint and a completed suicide on one of the inpatient wards. The trust had reported both as serious incidents and investigations were ongoing.

We inspected a sample of wards across this core service. This consisted of visiting 2 of the 6 acute inpatient wards and both psychiatric intensive care units (PICU) to assess the safety of care provided, as well as looking at the leadership and governance processes in place to support the quality of care.

Due to the focussed nature of this inspection, we did not examine every key line of enquiry under each key question, we focused upon areas highlighted to us as concerns. At this inspection, we found:

- Some weekly risk reviews were not comprehensive and did not capture incidents in detail.
- Information regarding risk, relating to care planning and daily clinical entries were not always joined up, with some staff having difficulties navigating to specific information.
- Three of the four wards did not have the most up to date ligature risk reduction plans visible for staff.
- Marina ward was in need of some redecoration despite the ward being decorated in February 2023, due to damage to the environment caused by incidents.
- Five patients told us they had not been involved in discharge planning.

However:

- Most patients we spoke with were positive about their care and treatment and felt safe.
- Each ward had comprehensive ligature risk reduction plans in place which staff were aware of, with actions to minimise risk.
- Each ward had accessible resuscitation equipment, emergency medicines and ligature cutters which staff checked regularly.
- Staff were aware of individual patient risks and reviewed these regularly.
- Staff managed incidents by using de-escalation skills, with physical interventions being a last resort.
- Senior staff investigated incidents in line with trust policy and shared lessons learnt across the core service and the trust.
- Staff and patients told us there was usually enough staff, despite the service having numerous vacancies.

How we carried out this inspection

- Undertook a tour of each of the four wards visited.

Our findings

- Spoke with 11 staff members – including ward managers, team leaders, staff nurses and healthcare assistants.
- Checked the emergency equipment on each of the four wards.
- Reviewed the ligature reduction assessments on each ward.
- Spoke with 21 patients who were using the service.
- Reviewed a sample of observation records.
- Observed a handover between shifts.
- Reviewed 22 patient records.
- Received feedback from 3 carers of people who were using 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 21 patients who were using the service at the time of inspection. Thirteen patients on the acute inpatient wards and 8 patients receiving care in the PICU wards.

We also received feedback from 3 carers of people who were using the service.

Of the 21 patients we spoke with, 17 mostly felt safe on the wards. Four patients told us they did not feel safe, due to other patients on the wards and some of the incidents that occurred.

Fifteen patients we spoke with spoke very positively about the staff. Describing them as kind and supportive.

Most patients said that there was enough staff on duty. Out of the 21 patients we spoke with, 3 reported there not being enough staff, with 1 patient telling us staff had postponed their leave on occasions due to this.

Six patients told us that staff did not use restraint that often, and when they did, felt it was proportionate to the situation. Most patients told us that staff managed incidents well.

One patient was very unhappy with their care and treatment and had put a formal complaint in to the trust. This complaint included feeling unsafe on occasions, and alluded to some staff sleeping when they were supposed to be observing staff. This was fed back to the trust who discussed this with the patient and agreed their concerns would be fully investigated.

We received feedback from 3 carers of people who were using the service. All three carers told us the care provided was safe.

Is the service safe?

Requires Improvement 

Our findings

Safe and clean environments

Most wards we visited were safe, clean, well equipped, adequately furnished and fit for purpose.

We observed that some areas of the wards would benefit from being re-decorated. On Marina ward, we saw numerous areas of peeling paint, and scuffs to walls and areas of flooring. The trust did have a redecoration plan in place. The ward was last decorated in February 2023. Damage to the environment had been a frequent occurrence through recent incidents.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Managers had identified blind spots across each of the wards visited. Staff reduced risks by using zonal observations. This consisted of staff being seated in areas which allowed clear lines of sight. Additionally, staff observed all patients every 15 minutes. We saw this in place on all four wards we visited. We sampled some observation records which were complete.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. All wards had recent ligature risk assessments and ligature risk reduction plans. Although 3 of the 4 wards visited did not have the most recent assessments displayed for staff. This was bought to the attention of the ward managers, who immediately located the most recent versions. The trust has since confirmed that all wards have the most updated version visible.

On Marina ward, a staff folder in the office held the risk register and ligature audit, with a “read and sign sheet” for all staff. Of the 17 staff listed, only 7 had signed to confirm they had read. The document was undated, so it is unclear how long this had been in place.

Similarly, on Bay ward, a folder in the office showed that only 6 staff out of the 18 listed had signed to confirm they had read the ligature information.

The risk reduction plans were thorough and contained some photographs of potential clinical ligature risks for staff to be aware of. Mitigations in place included enhanced observations, supervised areas, locked areas, anti-ligature fittings where possible, and anti-ligature sensors on doors. As and when an individual risk was highlighted, staff completed individual risk assessments, using the least restrictive option they could, while minimising risk.

Following a serious incident involving a ligature, the trust completed an immediate review of all environmental risks across the core service and put additional mitigations in place for some risk areas identified. Senior managers had been randomly checking wards to ensure staff had adhered to communications around this. The trust had a ligature risk reduction task and finish group, which aimed to continually strengthen the way risk is assessed, using a multi-disciplinary approach. There were plans for this work to be supported by experts by experience.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Ligature cutters were available on each ward, which staff replaced as and when required.

Safe staffing

Our findings

The service had enough nursing and support staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough permanently employed staff but attempted to use bank and agency to ensure adequate staffing on each shift. All staff we spoke with confirmed they have enough staff to meet patient's needs. Most patients we spoke with agreed there was enough staff. Staff worked flexibly across the service to fill gaps and manage risk.

The total number of nurse and support staff posts across the whole core service was 227. Of these, healthcare support staff were budgeted for 112 posts, and registered nurses 115 posts. Of all posts, the service had 54 vacancies: 30 for registered nurses, and 24 for healthcare support staff, which equates to 24%. Recruitment was actively ongoing, with rolling adverts in place.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare support staff for each shift. Managers had autonomy and were able to flex numbers on each shift, dependent upon patient needs.

The trust primarily used bank staff to cover vacancies and absence. Agency staff were used if no bank staff were sourced. Managers limited their use of bank and agency staff where possible and requested staff familiar with the service. Managers made sure all bank and agency staff had an induction and understood the service before starting their shift on their allocated ward. At an observed handover, staff confirmed when each member of staff had last worked on the ward, to ensure relevant information around risk, care and treatment was relayed.

Over the last 6 months, bank and agency staff had been employed to cover 10,786 shifts. Cover had been required across all of the acute and PICU wards month on month. Bank staff had covered the majority of shifts (8,218), and agency had covered 2,568 shifts. The trust were unable to fill 1,270 shifts over this six month period. Clinical team leaders and site managers were aware of any upcoming gaps in staffing. Part of their role was to review and move staff across the service to manage risk and support planned activity.

Staff turnover rates had been variable across the service between July 2022 and June 2023. The acute wards turnover varied between 0% (Cove and Kingfisher) and 14% (Sandpiper). The higher turnover rates had been on the PICU wards, with 19% on Marina and 16% on Shearwater. Some staff had transferred to other roles within the trust, others had left for new opportunities elsewhere.

Sickness rates across this core service between January 2023 and June 2023 was also variable, ranging between 0% on Bay ward, up to 24% on Sandpiper ward. Staff we spoke with talked about numerous incidents of violence and aggression across the service, either patient towards patient, or patients towards staff. This had accounted for some of the sickness. Managers supported staff who needed time off for ill health.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training across this service was consistently above 90% for each subject.

The trusts mandatory training programme was comprehensive and met the needs of patients and staff.

Our findings

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were booked onto available courses at the earliest opportunity. Training consisted of e-learning and face to face.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves by using de-escalation when managing patients expressing feelings or an emotional reaction. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on or shortly following admission, using a trust wide, recognised tool. We reviewed 22 patient records, all of which had risk assessments in place which had been reviewed regularly by staff. Of the 22 records reviewed, we found 4 instances where planned reviews had been late but had been completed within a reasonable time frame.

Staff on each ward completed a “risk screening tool” weekly, which summarised the risks presented by a patient over the previous 7-day period. This demonstrated ongoing assessment of risk. However, not all entries were comprehensive. On Sandpiper ward a recent entry stated a patient had been intimidating towards staff, but with no context or explanation of the situation and what may have caused this. A different entry recorded an incident of deliberate self-harm, with no indication on what the patient had used to harm self.

On Marina ward staff recorded that a patient had made inappropriate comments made towards females, with no further information or context. Staff had also recorded an incident where a patient was banging head against an object, with no detail of what the object was, or if any harm was sustained.

The electronic record system had two different tabs related to risk; risk screening tool (the weekly review) and the all-risk tab. Staff explained that all documents relating to risk would be located within one of the two tabs. While full risk assessments had been completed, detailing historic and current risks, we found that we needed to search the two separate tabs to find a full chronology of risks presented. While staff identified risks on a weekly basis, they did not consistently transfer these into the main patient risk assessment.

Management of patient risk

Staff we spoke with knew about risks to patients and acted to prevent or reduce risks. However, we did not always find the corresponding care plans around risk were sufficiently detailed. For example, one patient had a blood bourne virus with recent incidents of physical aggression towards staff, which could carry a risk of transmission. The care plan did not accurately capture this, nor what actions staff should take to support the patient safely.

On another ward, a patient regularly engaged in deliberate self-harm. The care plan recognised and acknowledged this but did not detail actions staff could take to support. While information was present within records, triangulation between risks, care plans and care notes could have been better.

Use of restrictive interventions

Staff participated in the provider’s restrictive interventions reduction programme, which met best practice standards.

Our findings

There had been no episodes of long-term segregation between 1 July 2022 and 30 June 2023 across this core service. Long-term segregation refers to a multidisciplinary decision to care for patients separate from others on the ward, on a long-term basis, due to risks of harm.

Between 1 July 2022 and 31 July 2023, the trust had used seclusion on 210 occasions, which involved 138 patients. Seclusion was used across all wards, with the higher numbers being on the PICU wards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff and patients we spoke with confirmed this. Staff used the de-escalation areas of the wards regularly, as well as ward sensory rooms if appropriate.

There had been one patient injured during a restraint which the trust was in the process of investigating. Staff across the core service wore body cameras when responding to incidents. The trust confirmed that footage from this incident was being used by senior staff as part of the ongoing investigation.

Between 10 July 2022 and 31 June 2023, the service reported 428 restraints, involving 233 patients. November 2022 had the lowest number of restraints at 24, and the highest was in June 2023 with 48. The higher number of restraints occurred in the PICU wards. Although prone (chest down) restraint had been used, trust data showed that these had reduced. The trust reported in 2021 to 2022 a total of 122 prone restraints, compared to 53 for 2022 to 2023.

Staff were aware of and adhered to The National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquillisation. Staff did not use this routinely. We reviewed three individual patient records and found staff had completed and recorded appropriate monitoring following administration. Between 1 July 2022 and 30 June 2023, staff had administered rapid tranquillisation on 52 occasions across the core service.

Safeguarding

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 received training on how to recognise and report abuse, appropriate for their role. The trust requirement for clinical staff was to attend safeguarding adults and safeguarding of children training at level 2. Level 3 training was for staff in band 6 positions or higher.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward managers regularly reviewed incident forms and followed up any safeguarding concerns to ensure staff had reported as expected. Staff clearly recorded safeguarding concerns within individual patient records, and ensured risks were covered during handover meetings.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were able to send referrals to the Local Authority directly from the trust electronic system.

Track record on safety

Between 1 July 2022 and 30 June 2023, this core service reported three serious incidents, which had occurred on different acute wards. One sadly resulted in a death which the trust was investigating. The other 2 incidents related to the deteriorating physical health and / or injury of a patient.

Our findings

CQC were aware of a patient who had recently sustained a fracture during a restraint. The trust confirmed that this was also being investigated and had been recently reported as a serious incident.

We were aware that staff had contacted the Police on numerous occasions for support in respect of patients absconding from this core service. Between 1 July 2022 and 30 June 2023, the trust reported 199 incidents of patients absconding across this service (8 wards). The numbers of reported absconcian ranged between wards. The lower number of absconded patients reported during this time frame was on Avocet ward (acute), with 14, and the highest number reported was on Bay ward (acute) at 48.

This number of incidents included patients who left the hospital but were returned by staff within a short space of time and therefore did not require support from the Police. For example, out of the reported 48 absconding incidents on Bay ward, 39 on these involved the patient being returned swiftly by staff.

The trust was in the process of updating incident categories to enable a clear distinction between informal patients (missing) and patients detained under the Mental Health Act (1983) who are absent without leave (AWOL).

Staff followed the trust policy with regards to reporting patients they had concerns about, which involved reporting to the Police. Staff undertook risk assessments prior to any patient going on leave, whether detained or informal. This included assessment of mood and mental health and any recent incidents which may have caused concern. Staff recorded what each patient was wearing, recorded any escorting staff, any restrictions, the purpose of the leave, and if the patient had a mobile phone on them.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them.

Senior staff reviewed incidents and reported the severity in line with national guidance. Staff reported serious incidents in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff and patients after any serious incident. Staff we spoke with, as well as a patient who had been on a ward when a serious incident occurred, told us of the support the trust offered. Different members of the multi-disciplinary team had been available to support anyone who required additional time and space to discuss and / or reflect.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations if they wanted to be.

Staff received feedback from investigation of incidents, both internal and external to the service. All staff we spoke with, including bank staff, told us about serious incidents that had occurred and were aware of learning and actions taken as a result of these.

Our findings

Staff met regularly to discuss the feedback and look at improvements to patient care. These consisted of ward meetings, manager meetings, as well as time for discussion during allocated days staff had for training and development.

There was evidence that changes had been made as a result of feedback. For example, staff would ensure they were always present during mealtimes, following an incident of choking. Internal maintenance works and a full review of acute environments had been undertaken by senior staff following an incident of deliberate self-harm. The trust had placed further emphasis upon physical health training compliance around deteriorating patients as the result of previous incidents.

Is the service well-led?

Insufficient evidence to rate

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Ward managers were knowledgeable and had the skills and experience to perform their roles. They had a good understanding about the service they managed. Staff and patients we spoke with told us the ward managers were visible and approachable.

The trust continued to invest effort into the leadership and development of staff. They provided a comprehensive 'Leadership Matters' development programme which consisted of different modules and levels. Subjects covered included leadership development, management development, personal development, skills training and bespoke.

Culture

Staff we spoke with felt respected, supported and valued. They felt proud to work for the trust.

Staff had access to support for their own physical and emotional health needs as and when required, with access to the multi-disciplinary team for support, as well as being able to access counselling externally via occupational health.

The trust held an annual, week long 'wellbeing festival' which staff were aware of and could attend.

Governance

Processes were in place to ensure wards were safe and clean. Housekeeping staff worked regularly across the service, as did maintenance staff. Staff teams reported any issues of concern which were addressed by appropriate staff in the appropriate department.

There were clear escalation procedures in place to address any gaps in staffing. Managers completed the staff duty rotas in advance which enabled any known gaps for absence to be highlighted, with additional staff requested.

Our findings

Clinical team leaders and site managers who worked through the 24 hour period had awareness of any pending gaps in staffing for the following day and moved staff between wards to manage risks.

Additionally, matrons and service managers held daily meetings to review staffing. Staff worked flexibly across the service and moved between wards where required to meet the needs of the service.

Most staff were up to date with mandatory training. Ward managers had systems in place which flagged when staff had upcoming training due.

Staff reported incidents in line with trust policy, investigated as and when appropriate, and shared lessons learnt across the whole service.

Staff understood the arrangements for working with other teams, both within the trust and external to the trust, to meet the needs of the patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register at ward and core service level. Staff were able to escalate concerns to managers.

The service had plans for emergencies – for example, adverse weather or outbreak of virus.

Staff had access to the equipment and information technology to do their work. Notes were electronic which staff were able to navigate, although some staff did not always locate some documents as easily as we would expect. Ward staff supported the inspection team with reviewing records. Some documents, primarily specific care plans relating to risk could not be located at the time of inspection. This was fed back to senior staff, who later confirmed the documents were in place and had been located. We were concerned that bank or agency staff may not manage to locate documents if some regular staff failed to do so.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included performance of the service, staffing and patient care.

Staff made notifications to external bodies as needed, such as to the Local Authority, CQC or the Health and Safety Executive (HSE).

Engagement

Our findings

Staff, patients and carers had access to up-to-date information about the work of the trust through the intranet, internet, bulletins, webinars, newsletters and through meetings.

The trust is part of The East Midlands Alliance for mental health and learning disabilities. This consists of six partner organisations, with focus being upon quality improvement, shared learning, and buddy support.

Learning, continuous improvement and innovation

Staff had opportunities to participate in projects and / or research.

There were three areas of quality improvement projects in progress within this core service at the time of inspection.

On Shearwater ward – staff managed ligature incidents by creating space, time, and support to enable patients to use their existing skills. Staff aimed to encourage patients to take increased responsibility for managing their own emotions and to work with staff positively to promote autonomy. At times, this included patients having access to risk items in their bedrooms, with a view to encourage self-management of behaviours and reactions and to seek help from staff, when necessary, as opposed to taking all risk items away. Staff explained that removing all risk items can reinforce that ligaturing for a patient is a way of coping.

Staff on Marina ward had been focusing upon therapeutic engagement to reduce the level of restrictive practices. The initial stage of the project included having an activity staff member on the ward as a support for the staff team and the occupational therapists. Initial findings had been positive, in that staff had recorded more engagements.

On Bay ward there was ongoing work around reducing self-injurious behaviours, which in turn they hoped would reduce restrictive practices further.

Most wards participated in accreditation schemes relevant to the service and learnt from them. The acute wards participated with Inpatient Mental Health Services (AIMS). Marina participated in the Psychiatric Intensive care units AIMS. Shearwater will commence their accreditation later in 2023.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that risk assessments, reviews, and care plans relating to risk are easily accessible, comprehensive and accurate.
- The trust must ensure that all clinical staff are trained in the safeguarding of children and young people, to a level 3 in line with national guidance.

Action the trust Should take to improve:

- The trust should ensure that wards are regularly decorated.
- The trust should ensure that staff, patients and carers are involved in discharge planning.
- The trust should consider how individual patients' risks are recorded and located to ensure a full chronology of risk is easily accessible for all staff.
- The trust should ensure that any "read and sign" sheets relating to policy are dated and actioned.
- The trust should continue to reduce the number of prone restraints across the service.

Our inspection team

The team that inspected the service comprised of 2 CQC Inspectors, one Nurse Specialist Advisor and one Expert by Experience.

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

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 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