Humber NHS Foundation Trust

Newbridges

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)
RV934	Newbridges	Acute ward for adults of working age	HU9 2BH

This report describes our judgement of the quality of care provided within this core service by Humber 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 the trust and these are brought together to inform our overall judgement of the 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

Contents

Summary of findings

Overall summary

- There had been six locum psychiatrists in the last six months, which created a level of uncertainty and instability on the ward as staff accommodated different medical styles.
- Some staff lacked assurance in verbal de-escalation techniques.
- Records relating to the seclusion of patients were not timely
- There had been two serious incidents in the last six months.
- The ward filled the beds of those patients taking ward leave when there were no other beds available. Potentially, this meant that if patients did not want to extend their leave the trust would have to transfer them to another ward for non clinical reasons.
- Staff morale was low.

However:

- The unit previously had minimal ligature risks. The bedrooms in the new build had blind spots, where staff could not observe patients. The trust managed these risks by installing mirrors opposite the bedroom doors. This meant staff could observe if patients were safe.
- Staffing levels were reviewed and increased to accommodate the increase in beds.
- The seclusion policy was under review to ensure it adhered to the changes in the MHA Code of Practice.
- The new conversion was clean and bright and increased the facilities available to patients.
- Activities were meaningful and well led. Patients had access to activities at the weekend.
- The provider had made changes to the ward in response to staff concerns that were slowly being recognised. The local managers were actively working towards improved staff morale.

Summary of findings

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

Are services safe?

- There had been six locum psychiatrists in the last six months, which created a level of uncertainty and instability on the ward as staff accommodated different medical styles.
- Some staff lacked assurance in verbal de-escalation techniques.
- Records relating to the seclusion of patients were not timely.
- There had been two serious incidents involving the same patient in the last six months.

However:

- The unit previously had minimal ligature risks. The bedrooms in the new build had blind spots, where staff could not observe patients. The trust managed these risks by installing mirrors opposite the bedroom doors. This meant staff could observe if patients were safe.
- Staffing levels were reviewed and increased to accommodate the increase in beds.
- The seclusion policy was under review to ensure it adhered to the changes in the MHA code of practice.

Are services responsive to people's needs?

- The ward filled the beds of those patients taking ward leave when there were no other beds available. Potentially, this meant that if patients did not want to extend their leave the trust would have to transfer them to another ward for non clinical reasons.

However:

- The new conversion was clean and bright and increased the facilities available to patients.
- Activities were meaningful and well led. Patients had access to activities at the weekend.

Are services well-led?

- Staff morale was low.

However:

Summary of findings

- The provider had made changes to the ward in response to staff concerns that were slowly being recognised. The local managers were actively working towards improved staff morale.

Summary of findings

Information about the service

Newbridges is an 18 bed male only acute inpatient ward for adults of working age. The provider had altered the living space and increased the number of bed spaces from 12 to 18 on this ward in April 2015. On the day of our visit there were 17 patients allocated to the ward. Ten of these patients were detained under the Mental Health Act and seven patients were admitted informally. Three patients were on leave.

The Care Quality Commission inspected Newbridges in May 2014 as part of a trust wide inspection. At the time of this inspection, all acute wards within the trust were compliant with the regulations.

The ward received a visit from a Mental Health Act Reviewer in December 2014 and issues relating to the Mental Health Act (MHA) were identified. At the time of our inspection some of these issues were still being addressed.

Our inspection team

The team was comprised of two CQC Inspectors.

Why we carried out this inspection

We inspected this service following concerns received about the admission of patients with complex needs, over occupancy, staffing levels and the impact these issues had on the care provided to patients. Concerns were also raised about a plan to increase the patient capacity with no indication on how this would impact the staffing levels.

How we carried out this inspection

This was a responsive inspection framed by the concerns we had received. We asked the following three questions of the service and provider:

Is it safe?

Is it responsive?

Is it well-led?

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with eight other staff members; including activity workers, health care assistants, nurses, an occupational therapist and a psychologist.
- spoke with the service manager with responsibility for the ward
- attended and observed a hand-over meeting

We also:

- looked at five treatment records of patients.
- carried out a specific check of the medication management

looked at a range of policies, procedures and other documents relating to the running of the service

Summary of findings

What people who use the provider's services say

We spoke with five patients about the care and treatment they had experienced on the ward. Overall, the comments were complimentary. Patient feedback praised the activities provided by the occupational therapy team.

One patient said he expressed concern about being admitted to an all-male ward but found that the ward environment was calm and relaxing.

We observed positive interactions between patients and staff, which were respectful and empathetic.

Areas for improvement

Action the provider SHOULD take to improve

The Provider should ensure that:

- Patients have a designated bed that is within the ward occupancy levels on admission to the ward.
- Patients returning from leave have a bed available on their return to the ward.
- Patient leave is not extended to accommodate the admission of a new patient to the ward
- Records relating to seclusion of patients provide a clear record of medical and nursing reviews, to ensure these are carried out in accordance with the MHA code of practice.
- Staff trained in the use of de-escalation techniques feel confident putting this training into practice

Humber NHS Foundation Trust

Newbridges

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Acute ward for adults of working age.	Newbridges

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

A review of adherence to the Mental Health Act was undertaken in December 2014 and the trust issued with a report outlining actions that need to be addressed. The provider lodged an action statement detailing the actions they would take and the progress they had made.

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

Summary of findings

- There had been six locum psychiatrists in the last six months, which created a level of uncertainty and instability on the ward as staff accommodated different medical styles.
- Some staff lacked assurance in verbal de-escalation techniques.
- Records relating to the seclusion of patients were not timely.
- There had been two serious incidents involving the same patient in the last six months.

However:

- The unit previously had minimal ligature risks. The bedrooms in the new build had blind spots, where staff could not observe patients. The trust managed these risks by installing mirrors opposite the bedroom doors. This meant staff could observe if patients were safe.
- Staffing levels were reviewed and increased to accommodate the increase in beds.
- The seclusion policy was under review to ensure it adhered to the changes in the MHA code of practice.

Our findings

Safe and clean environment

The ward was purpose-built and was situated in a semi-residential area of Hull. Part of the building had been used as a base for a mental health community team. However, this had recently undergone conversion, increasing ward capacity to 18 beds and providing other office and communal facilities for the ward.

We were admitted to the ward and shown into the nurses' office. We were not asked to sign in or show our identity passes. There were three members of staff present in the office and they were joined not long afterwards by clinical staff that had been off the ward at the time of our arrival. Some members of staff were not wearing identity badges. The ward manager was scheduled to be off site for the day at a meeting. We discussed our concerns about security lapses that could see unauthorised entry on to the ward with the manager when we met. We noticed that the correct protocols were in place by the end of our visit.

The lay out of the ward meant it was not possible for staff to observe all parts of the ward. Routine hourly observations were undertaken to mitigate this risk. Staff would increase the level of observations depending on the needs of the patient. The communal areas of the ward were on the ground floor, with the bedrooms on the first floor. We noted that the original environment had few ligature points. A ligature point is a fixture or fitting which can be used by a patient for the purpose of self-harming by strangulation or hanging.

The bedrooms in the new build had blind spots where staff could not observe patients. The trust managed this risk by placing convex mirrors opposite the bedroom door. As these mirrors would be less effective at night, the trust had also fitted night lights. Staff could control these from outside the room to ensure vision at night.

The clinic room was well maintained. Staff regularly checked resuscitation equipment and emergency drugs to ensure they were fit for purpose and could be used effectively in an emergency. The fridge was monitored daily to ensure medications were stored at the correct temperature and regular medication audits were carried out.

The seclusion room met good practice guidelines and provided a suitable environment.

The ward was clean with well-maintained décor and furnishings. The modern matron carried out a monthly infection control inspection. Patients told us they felt safe on the ward and the ward had a relaxed feel to it. All staff carried personal alarms.

Safe staffing

The ward manager was run by an experienced manager, who had been at the location since December 2014. Staffing levels were not based on any recognised tool. The day shifts were staffed by two qualified nurses and three support workers. The night shift was staffed by two qualified nurses and two support workers.

Are services safe?

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

The trust had recently increased staffing levels for night shifts by one qualified nurse. This was partly due to increased bed occupancy levels from April 2015 and partly as a recommendation following a serious incident earlier in the year. The incident occurred during the night shift.

The actual staffing levels matched the expected staffing levels. There were currently three qualified nurse vacancies. The trust had recruited and appointed staff to these positions but start dates were not until September 2015. The establishment levels provided for two senior nurses although one had been seconded overseas. The trust had responded to this and allocated an experienced senior nurse from within the trust, to support the ward during this period

There was one vacancy among health care assistants. However, sickness levels had been high over the last six months with over a third of health care assistants on long term sick. Two members of staff had recently returned to work and had not been offered a phased return to duty. Bank staff and agency staff was used to fill shifts, the ward used four regular agency staff who were familiar with its policy and procedures.

Staff were supported by a team of activity coordinators and an occupational therapist during the daytime. Concerns were raised over the consistency of medical staffing as there had been six locum psychiatrists in the last six months. This created a level of uncertainty and instability on the ward as staff had to accommodate their different medical styles. The trust were actively recruiting to this role.

The ward filled the beds of those patients taking ward leave when there were no other beds available. Staffing levels were not increased to meet the higher number of patients on the ward because patients who did not have beds were encouraged to remain on extended leave. Following extended leave the patient was reassessed for discharge. Bed occupancy for March was 107.3%, for April 124.2%, and in May 109.7%

The training records showed that staff were generally up to date in training relevant to their role. However, there was poor compliance with fire safety (53%), information governance (33%) and protection of vulnerable adults (66%).

Assessing and managing risk to patients and staff

Staff completed timely risk assessments on the admission of new patients to the ward using a screening tool(GRIST), which identified the individual risks to a person's safety and wellbeing whilst in hospital. These were reviewed regularly and updated after incidents.

Information relating to patients detained under the MHA or admitted informally was displayed on a whiteboard in the nurses' office. The whiteboard was not up to date when we arrived and it was not possible to ascertain from the information how many patients were currently admitted and who was on leave. This was remedied at once.

Staff had received training in management of actual or potential aggression (MAPA). Some staff were comfortable with using verbal de-escalation techniques whereas others were not so confident and had not fully embraced this type of intervention. Three female members of staff said they did not feel safe on the ward unless a male was also on duty, particularly at night.

The seclusion room had been in use the night before our inspection but the notes relating to the incident had not been fully completed. Seclusion records were identified as an area for improvement during a mental health act monitoring visit in December 2014. The ward manager told us that the trust was currently reviewing their seclusion policy to align it with the new MHA code of practice guidance.

Most staff had undertaken mandatory training in safeguarding children but only two thirds of staff were compliant with the training in safeguarding vulnerable adults. Despite this staff had a good understanding of safeguarding procedures and knew how to recognise a safeguarding concern and escalate this to ensure it was dealt with appropriately. All visits to the ward for children were prearranged.

Appropriate arrangements were in place for the management of medicines. The clinic door was kept locked and medications stored securely in line with best practice. The records relating to the administration of medicines were checked and accurate. Physical health charts were kept with prescription charts when necessary. This was because patients prescribed certain medications need to have their physical health observations monitored regularly.

Are services safe?

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

Track record on safety

There were two serious incidents reported in February. One patient had a complex presentation and staff had made an unsuccessful referral to psychiatric intensive care (PICU) prior to the incident. Staff had continued trying to secure a suitable placement for the patient. Previous incidents of aggressive behaviour towards staff and patients had been reported and the patient placed in seclusion during these episodes.

A patient set fire to the patient kitchen, resulting in the evacuation of the ward and fire brigade being summoned to deal with the situation. The evacuation followed trust protocols and nobody was seriously harmed although the kitchen was still out of use, due to fire damage, during our visit. The trust conducted a serious investigation report into the fire and recommended improvements in safety specific to the ward. Staffing levels were reviewed and increased so the night shift included an extra qualified nurse. However, we noted that only 53% of staff were compliant with fire safety training. We also found there was no specialist training offered to staff relating to complex conditions such as autistic spectrum disorder. A review of the pathway from psychiatric to PICU was also recommended.

A second incident related to an episode of open seclusion that resulted in a staff member being assaulted. At the time staff used 'open seclusion' as a step down from seclusion itself. The trust informed us that open seclusion remains current practice on the ward. The trust had undertaken a full investigation into the incident and lessons learned were due to be fed back to staff.

Reporting incidents and learning from when things go wrong

Following the fire incident, staff attended a debriefing session /reflective practice delivered by the ward psychologist. Staff were also sent an email from the clinical lead offering individual support and supervision as well as referrals to occupational health if needed. Staff expected an external source to deliver the debriefing session rather than internal. However, this would not have been in accordance with trust policy.

Lessons learned from this incident were discussed with staff at a team meeting. Lessons learned from the second incident were due to be delivered following completion of the investigation. Some staff we spoke with had not recognised the changes made by the trust.

The staff we spoke with knew how to recognise and report incidents using the trust's electronic recording system. All incidents were reviewed by the ward manager and escalated to senior managers within the trust if required. Feedback from incidents was discussed in team meetings and during hand over.

Are services responsive to people's needs?

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

Summary of findings

- The ward filled the beds of those patients taking ward leave when there were no other beds available. Potentially, this meant that if patients did not want to extend their leave the trust would have to transfer them to another ward for non clinical reasons.

However:

- The new conversion was clean and bright and increased the facilities available to patients.
- Activities were meaningful and well led. Patients had access to activities at the weekend.

Our findings

Access and discharge

Due to bed pressures, the ward filled the beds of those patients taking ward leave when there were no other beds available. In the five months between January and May 2015 the average mean bed occupancy was 110% despite an increase in the number of beds available from April. Staff told us they had to contact patients and ask them to extend their leave. There was no risk based protocol for staff to follow when patients extended their stay. This could impact on the patient's recovery if the leave had not been a positive experience and/or the patient's mental health had deteriorated during this period. We did not see a protocol for staff to follow if this happened. If patients did not want to extend their leave and there was not a bed available to them on their return, they would have to be transferred to another ward although this would be for non clinical reasons. Patients were reassessed after extended leave to see if they were ready for discharge.

On the day of our visit the ward was not over capacity although it was clear from the design of the information white board that the ward expected to accommodate 20 to 21 patients to an 18 bed ward. Admission referrals were made by the admissions ward at Avondale. The manager and staff said they had to accept new admissions, even if the empty bed was for someone on leave. It was not always possible to access beds in the PICU service due to occupancy levels.

One patient was awaiting discharge from the unit but this had been delayed due to a lack of suitable housing.

The facilities promote recovery, comfort, dignity and confidentiality

There were a number of rooms for use including a therapy room, activity lounge, large lounge, regular lounge, smaller quiet lounge and a faith room. Patients used the walls in the activity room for self-expression. In the reception area a discharge tree was painted on wall for patients to express their thoughts as part of 'safewards', an initiative based on ten interventions designed to reduce conflict and constraint.

The dining area could accommodate 16 patients at one sitting and there were plans to extend the room. Rooms in the newly converted area had been identified by staff as belonging to occupational therapy and were under-used. There was a telephone in one of the quiet rooms so patients could make private phone calls.

Patients were positive about the activities available to them and commented they were much better than on other wards. Activities were varied and meaningful. We spoke to patients who were complimentary about a relaxation session they had just attended, finding it calming and beneficial. The session was part of the safe wards initiative. Activities such as the brunch club, were also available at the weekend.

Meeting the needs of all people who use the service

The ward had facilities to accommodate patients with mobility needs. A down stairs bedroom and adapted shower were available.

Information about treatments, patient's rights, advocacy and how to complain were displayed on noticeboards throughout the communal areas. Information was available in different formats and access to interpreter services easily accessed. Patients' dietary and cultural requirements were catered for. For example, Gluten free and Halal food was made available when the need arose. Patients could access spiritual support and a faith room was available to those who wished to use it.

Listening to and learning from concerns and complaints

Patients were able to describe that they knew how to raise complaints and concerns. The ward did not hold community meetings but patients felt able to approach staff with informal complaints, which were usually resolved through discussion.

Are services responsive to people's needs?

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

Posters outlining the formal complaints procedure (PALS) were displayed on information boards. There had been no formal complaints made in the last twelve months.

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.

Summary of findings

- Staff morale was low.

However:

- The provider had made changes to the ward in response to staff concerns that were slowly being recognised. The local managers were actively working towards improved staff morale.

Our findings

Vision and values

Some staff said they felt disconnected from the wider trust because senior managers did not recognise the pressures caused by dealing with over occupancy of beds and complex patients more suited to a PICU environment. Senior managers visited the wards following the incidents earlier in the year. The trust's visions and values were not displayed and we were told this was because they were being updated to reflect individual core services. In the meantime the team had adopted the six C's as their values. The six C's are a set of core nursing values for all staff working in the NHS in England and include: Care, Compassion, Competence, Communication, Courage and Commitment.

Good governance

Systems and processes were in place to ensure that learning from incidents and complaints was fed back appropriately and identify compliance with mandatory training, appraisals and supervision. Clinical supervision had lapsed since the secondment of a senior nurse. However, an experienced senior nurse had recently been temporarily allocated to the ward and supervision dates for staff had been identified.

The provider had reviewed and increased the staffing levels to reflect the increase in the number of beds available on the ward. However, staffing levels were not based on a recognised staffing tool.

Governance arrangements were in place, which ensured the ward manager could monitor key performance information and resolve any issues arising.

The trust was reviewing its seclusion policy and had timed their review to accommodate the revised MHA code of practice published earlier in the year.

The ward manager and clinical lead told us they were supported by senior managers, who could be easily contacted for advice if the need arose. However, there was a lack of autonomy over the admissions process to the ward. This meant that the ward sometimes operated at over occupancy.

Leadership, morale and staff engagement

Sickness levels for health care assistants averaged 37% during the last six months and were linked to the serious incidents that occurred earlier in the year. The sickness level on the day of our inspection had dropped slightly to 22% as two healthcare assistants had recently returned to work. The national NHS average is 4.7% by comparison.

Staff were all familiar with the whistleblowing process and felt enabled to use it. Staff told us they worked together well as a team and were supported by colleagues. However, morale was low although some staff had started to acknowledge that the ward was settling and improving. The provider had responded to staff concerns although staff did not always recognise this. A team away day had been organised by the ward manager for later in the month as a way of moving the team forward

Commitment to quality improvement and innovation

The ward had been awarded the Accreditation of Inpatient Mental Health Services initiative.