East London 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	Inspected but not rated
Are services safe?	**Requires Improvement**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

East London NHS Foundation Trust provides a range of mental and physical healthcare services for adults and children in East London, mainly in the London Boroughs of Newham, City and Hackney, and Tower Hamlets. The trust also provides mental and physical healthcare services for adults and children in Luton and Bedfordshire. Across these regions the trust provides inpatient services delivering 24-hour care and treatment for patients who are experiencing an acute mental health episode which cannot be managed in the community due to the degree of risk.

This inspection was of acute mental health wards for adults of working age. We carried out an unannounced focused inspection of 4 acute wards for adults of working age across the trust as we were aware of a number of self-harm related deaths and serious incidents for patients who were detained under the Mental Health Act (MHA). Between January 2019 and January 2023 there were 6 deaths and 2 serious incidents for MHA detained patients from self-harm. For each serious incident the trust investigation processes identified a series of care and delivery recommendations and actions to improve care and treatment. We wanted to see how the trust implemented these improvements to care and treatment to ensure patient safety and minimising the repetition of poor practice. We also wanted to review if learning from serious incidents and specific recommendations and actions had been fully completed and embedded across the services.

We inspected the following 4 wards, Gardner Ward in City and Hackney, Roman Ward in Tower Hamlets, Willow Ward in Bedford and Coral Ward in Luton.

The core service is registered to provide the following regulated activities: treatment of disorder disease or injury; diagnostic and screening procedures; and assessment or medical treatment of person admitted under the Mental Health Act (MHA) and nursing care.

The acute wards for adults of working age and psychiatric intensive care units for Luton and Bedfordshire were last inspected in 2019 and for Tower Hamlets, Newham and City and Hackney in 2016. The overall rating for the core service was outstanding. Safe was rated as good, effective was rated as good, caring was rated as outstanding, responsive was rated as outstanding and well-led was rated as outstanding. The trust also had a well-led inspection in 2021 where it was rated as outstanding overall. At the well-led inspection in 2021 safe was rated as good, effective as good, caring as outstanding, responsive as good and well-led as outstanding.

This was a focused inspection. We looked at aspects of the safe and well-led domains. We did not rerate the overall service as a result of this inspection. The previous rating of outstanding remains which was the rating at the last comprehensive inspection in 2016.

We limited the rating for safe at this inspection to Requires Improvement as we found a breach of regulation. The well led domain was not rated at this inspection. We did not inspect the whole acute wards for adults of working age and psychiatric intensive care service.

We found:

Our findings

- This was a focused inspection. We looked at aspects of the safe and well led domains. We did not rerate the overall service as a result of this inspection. The rating of this overall core service remained outstanding.
- Ward environments were safe and clean. The wards had enough nurses and doctors. Escalation processes for staff when they were short staffed or needed additional staff had improved.
- Service improvements had taken place as a result of learning from serious incidents. Wards applied identified recommendations and completed actions in a timely manner. On all wards the observation, ligature risk mitigation and patient search processes had improved.
- In response to a number of incidents where observation procedures were not followed and practice fell below expected standards the trust rolled out a trust wide quality improvement project to understand the challenges in this area. This led to individual teams across the services working on a range of project areas around observations exploring local solutions.
- Most staff were well informed about incidents. Staff knew about previous serious incidents going back several years. The trust developed a suite of online training covering suicide prevention, ligatures, observations, and patient searches to support staff in learning lessons from previous incidents.
- Senior staff investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust worked closely with family members and offered family members to option to feed into the service improvement and development processes. This had a powerful impact in understanding and how the application of operational processes played a vital role in patient safety.

However:

- This inspection identified a breach in Regulation 12, safe care and treatment. The trust did not always meet its targets for compliance with mandatory training.
- This inspection also identified a breach in Regulation 18, staffing. Managers did not support all staff through regular, constructive clinical supervision of their work. The services' supervision completion rates did not always meet the trust's supervision target.
- The trust did not always conduct and record the environmental checks to ensure the safety of ward environments to a consistently high standard.
- The trust did not always ensure that serious incident action plans were updated to reflect further changes in the actions needed to carry out the changes successfully.
- The trust did not always ensure that actions from serious incident reports were fully discussed between staff responsible for delivering those actions and the senior managers and central serious incident team to ensure actions were correctly interpreted.

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Our findings

Safe and clean care environments

Most wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. However, on Gardner Ward staff did not always consistently conduct and record environmental checks, the ward's ligature audit did not include all ligature risks and not all staff where aware of learning from ligature related serious incidents across the trust.

Safety of the ward layout

We inspected 4 acute wards for adults of working age in 4 locations. Most staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. Daily checks of the environment were carried out by the designated staff on most wards. However, on Gardner Ward environmental checks were not being conducted and recorded consistently. Ensuring environmental checks were carried out and recorded was highlighted as an action to be taken in the 48 hour report following a serious incident on Gardner Ward in 2022. Records showed that after the incident in February 2022 staff had reimplemented daily environmental checks, however since October 2022 only 10 daily checks had been recorded. Staff felt that patient acuity and staff shortages over the last year led to an increased focus on direct patient support and care which in turn reduced the focus on environmental checks. Staff reported they were often called to support patients while trying to conduct environmental checks. Patients confirmed that staff were accommodating when requests for support was made. Implementation of the actions from the 48 hour report were monitored locally. Without appropriate environmental checks staff were not able identify and address any patient safety risks in the environment. This was escalated to the service management during the inspection and an environment audit was completed immediately. The daily environmental audits were added to daily shift planner as an allocated task to ensure completion. This was also added to the weekly matrons' audit tool to ensure they also review the environmental audits from the preceding week for assurance on completion and escalation of any issues.

All wards had up to date fire risk assessments. However, the fire panel for the Gardner Ward site showed multiple errors on the day of the inspection and staff contacted the fire maintenance contractors to carry out maintenance and repairs on the panel. Homerton Healthcare NHS Foundation were responsible for the fire alarm provision and maintenance of the system as they managed the City and Hackney Centre for Mental Health site. During the inspection they confirmed to East London NHS Foundation trust that all fire alarm call points and automatic detectors were inspected and confirmed to be working. The fire alarm system was due to be replaced and Homerton Healthcare NHS Foundation had allocated funding for a replacement programme. The fire alarm and detection system was on the departmental managers team risk register and a standing agenda item at the City and Hackney clinical risk and health and safety group bi-monthly meetings. East London NHS Foundation trust's fire safety team conducted regular ward visits and produced a monthly fire safety management report which fed into local health and safety meetings and local estates meeting where fire safety matters and risks were be escalated. These fire safety reports were also forwarded to the trust's health, safety and security committee.

Staff could observe patients in all parts of the wards. Wards had CCTV and convex mirrors in place covering communal areas and corridors as this improved visibility at blind spots. Ward managers and senior staff were able to access CCTV to review incidents as part of investigation processes. Staff increased the frequency of observations for patients assessed as being at risk.

The ward complied with guidance and there was no mixed sex accommodation. On all wards, patients had their own bedrooms.

Most staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Each ward had a completed a ligature audit. Ligature audits included a comprehensive list of ligature risks, a risk rating and details of

action the staff should take to protect patients. Action included increased observations by staff, ensuring staff visually checked bedroom doors, and ensuring rooms such as kitchens and storage rooms were locked when not in use. On Roman Ward and Gardner Ward, the window handles in most bedrooms posed a potential ligature risk as an anchor point. As part of the trust wide ongoing ligature work programme the bedroom windows at these sites are due to be replaced with anti-ligature windows during Summer and Autumn 2023. The current risk mitigation on the ward include staff checking bedrooms as part of the observation procedure. Patients' risks including self-harm and suicide are discussed with the multi-disciplinary team at handover meetings every morning and management plans are formulated according to individual patients' risks. All staff on Roman Ward and Gardner Ward were aware of this risk. The ligature folder on Roman ward included pictures of the window handles to highlight the risk. On Roman Ward there were 5 bedrooms that have ligature free windows. On Gardner Ward there were 2 bedrooms that had ligature free windows. Patients were assessed on admission and if they were deemed to be of significant risk, they would be supported in these bedrooms. However, on Gardner Ward the ligature audit did not include the risk of bedroom doors being used as an anchor point. This was raised with staff on the day of the inspection. A full ligature audit on the ward took place the following day which included risk mitigation for the potential risk of bedroom doors being used as an anchor point. The trust also completed a full ligature audit for all units on the City and Hackney Centre for Mental Health site. A summary of the ward and unit ligature risks and mitigation plans was added to the daily handover and monthly team meetings. As part of the trust's ongoing ligature work programme bedroom doors across the Luton and Bedfordshire acute inpatient wards were being reviewed. The trust was planning to use the findings from this review to inform ligature risk management across the trust.

The trust had developed a training video for staff that focused on ligature risk and risk mitigation along with learning lessons' sessions drawing on a review of completed suicides in the trust. This was part of the trust's development of a suite of online training covering suicide prevention, ligatures, observations, and patient searches. This was completed as one of the recommendations from a serious incident on Coral ward in 2022. An additional recommendation from the same incident led to the piloting of a life signs monitoring system. The adoption of this system was being explored at the Luton Centre for Mental Health within their seclusion room. The pilot data was due to be reviewed at the patient safety forum for consideration as to whether life signs monitoring should be installed within all bedrooms.

Most staff were able to identify ligature risks and describe what to do if a patient created a ligature and said these issues were discussed as a team in team meetings and awaydays. Staff on Coral Ward, Willow Ward and Roman Ward were aware of ligature risk related serious incidents across the other wards. For example, Coral Ward had pictures of unusual ligatures found at other sites to inform staff of how to remove them and team meeting and awayday meeting minutes for Willow Ward and Roman Ward showed discussion of ligature risk mitigation and learning from serious incidents on other wards across the trust. Staff were also familiar with the trust's safety bulletins and lesson learnt emails highlighting learning from serious incidents. However, not all staff on Gardner Ward were familiar with any learning from ligature risks and serious incidents from other wards across the trust. This posed a potential risk that staff on Gardner ward were not fully up to date on their knowledge and management of ligature risks across the trust. To address this the service managers confirmed a local bulletin would be developed to disseminate learning from incidents locally and trust wide and share improvements and developments. This was also added to the wards team meeting agenda. Ligature risks awareness and management, alongside competency training and assessments were added to the team's awayday for May 2023. All staff were aware of where the wards' ligature cutters were located with wards having at least two sets, one in the staff office and one in the clinic room. However, on Gardner ward the ligature folder in the staff office that contained the ligature cutters was missing some of the supplementary items such as the laminated floor plan, photos of ligature risk and hot spots, and a copy of the most recent ligature audit. This was raised with staff at the time of the inspection and missing items were replaced. All staff on the ward were also booked on to refresh their suicide awareness training for inpatient staff, which include aware and risk management of ligatures.

Our findings

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were given personal alarms at the start of each shift. Patients' bedrooms and communal rooms such as lounges and activity rooms had nurse call points installed. Staff were able to describe how the nurse call system was tested. Patients told us that staff quickly responded when they pressed the call button.

All wards displayed staff pictures and details of daily staffing levels. Notice boards contained all the information patients were likely to need, such as details of advocacy services, how to complain, activities and patients' rights.

Patients could access outdoor space on most wards with access to garden spaces. Roman ward did not have its own garden so staff escorted patients to another outdoor space on the Mile End hospital site.

Maintenance, cleanliness and infection control

Most ward areas were clean, well maintained, well furnished and fit for purpose. We observed that wards were kept visibly clean. Staff and patients on Coral Ward, Willow Ward and Gardner Ward told us that any faults or repairs were identified and addressed quickly. However, on Roman Ward some areas of the ward were awaiting repairs such as the communal kitchen where the lino flooring needed securing, and 3 patients' ensuite shower rooms were not draining correctly. Barts Health NHS trust provided the majority of maintenance support for the ward, and this created some difficulty for ward staff in tracking maintenance jobs. The ward kept a maintenance log but this was not always kept up to date with the tracking system Barts Health NHS trust staff used. To improve tracking and completion of maintenance jobs the ward had recently established a weekly review with the facilities officer from Barts Health NHS trust to escalate outstanding issues and facilitate a quicker response.

Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff were cleaning the ward throughout our inspection. Domestic staff signed cleaning rotas to confirm they had cleaned all areas of the ward.

Staff followed infection control policy, including handwashing. The wards had standard operating procedures for hygiene, cleanliness and infection control. Staff followed infection control principles including the use of personal protective equipment.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff had access to emergency equipment. If medicines were required out of hours, staff could access these medicines via an on-call pharmacist.

Staff checked, maintained, and cleaned equipment. Emergency equipment was checked daily. Staff attached stickers to equipment showing when it had last been cleaned and when it was due to be calibrated.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, not all staff had kept up-to-date with their mandatory training and managers did not support all staff through regular, constructive clinical supervision of their work.

Nursing staff

The service had enough nursing and support staff with the right qualifications, skills,

training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff described the wards as being safe. Patients received consistent care that met their needs.

Our findings

Most wards had reducing vacancy rates. Willow ward had no vacancies. Coral Ward had 3 registered mental health nurse (RMN) and 5 life skills and recovery worker vacancies. Roman Ward had 2 RMN vacancies and 2 life skills and recovery worker vacancies. Gardner Ward had 5 RMN vacancies. Ward managers were able to over recruit for some roles to fill vacancies for examples Coral Ward had over recruited by 2 additional senior life skills and recovery workers to cover some of their vacancies in the life skills and recovery workers. All the vacancies were being advertised at the time of the inspection. To support recruitment the trust was continuing to work with City University in London and Bedford University for Luton and Bedfordshire to increase student nursing placements. The trust was also working with an international recruitment agency to recruited 15 mental health nurses to be applied across their services by the end of 2023. In addition, they were exploring direct recruitment from South Asia with an aim to recruit 100 additional adult and mental health nurses in 2023 and 2024.

Wards used bank and agency staff to cover all vacancies, leave, absences and sickness. Gardner Ward and Roman Ward did not use agency staff. Bank and agency staff were familiar with the service and knew the patients they were supporting. Patients across the wards said they knew most staff on the wards. Staffing numbers were displayed on each ward in their communal areas. Managers made sure all bank staff had a full induction and understood the service before starting their shift. Bank staff received the same access to supervision and training as permanent staff.

Staff stated they were supported by senior staff when shifts were short staffed due to unforeseen circumstances. Addressing staffing shortages was identified as a recommendation from a serious incident on Roman Ward in 2021. Additional processes were put in place for staff on shifts, particularly night shifts, to escalate when they were short staffed or needed additional staff due to patient acuity or increased observation levels. Staff said this worked well and made it easier to obtain support when needed. Staff discussions of these processes were demonstrated in awayday team meeting minutes and agenda records for the borough lead nurse safety meetings.

The service had enough staff on each shift to carry out any physical interventions safely. Staff on all the wards could call for assistance from colleagues on adjacent wards if extra staff were needed to carry out physical interventions.

Managers did not support all staff through regular, constructive clinical supervision of their work. The trust's target for supervision rates was 90%. The supervision completion rate for Coral Ward for January 2023 was 97%, December 2022 was 0% and November 2022 was 100%. The supervision completion rate for Willow Ward for January 2023 was 47%, December 2022 was 0% and November 2022 was 47%. The supervision completion rate for Willow Ward for January 2023 was 47%, December 2022 was 0% and November 2022 was 47%. The supervision completion rate for Roman ward for January 2023 was 42%, December 2022 was 13% and November 2022 was 94%. The supervision completion rate for Gardner Ward was 0% for January 2023, December 2022 and November 2022. Without appropriate supervision staff were unable to get developmental support and reflect on their practice. Managers and staff were not able to discuss patient care and treatment, patient safety issues, service developments and staff performance in a one to one setting. Staff felt that ward pressures such as patient acuity often led to supervision session being postponed. Managers were aware of their supervision rates and action plans were in place to address this. Gardner Ward had an improvement plan in place and this issue was on the service risk register. The improvement plan ring fenced time for scheduled supervision sessions for each staff member. Clinical practice lead nurses were given protected management days to allow them to complete supervision. A new supervision form had been developed to support the process. The deputy borough lead nurse had dedicated meetings with matrons to address challenges in delivering supervision. Across, Coral Ward, Willow Ward and Roman Ward senior staff had ring fenced time for ongoing supervision sessions. Borough lead nurses also set monthly reviews with matrons and managers to review supervision rates and address challenges. All wards had reflective practice sessions on awaydays.

Our findings

Most managers supported staff through regular, constructive appraisals of their work. The trust's target for appraisal rates was 90%. The appraisal completion rate was between 94% and 100% for Roman, Coral and Willow Wards. For Gardner ward it was 48%. An action plan was in place on Gardner Ward to complete all outstanding appraisals by the end of March 2023. Without appropriate appraisals staff on Gardner were unaware of suitable individual level performance objectives to develop their practice and further support patients.

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. All wards had a consultant and a duty doctor cover. Patients said they were able to see the consultant and doctor when needed. Staff reported there was always sufficient medical cover. Staff said they would call an ambulance if a patient needed urgent medical attention.

Managers said they could arrange locums when they needed additional medical cover and all locum staff would have a full induction before starting their shift.

Mandatory training

Not all staff had kept up-to-date with their mandatory training. The trust set a target of 90% compliance with mandatory training. At the time of the inspection, for basic life support training Willow Ward was 67%, Coral Ward 94%, Roman Ward was 76%, and Gardner Ward was 76%. For immediate life support training compliance Willow Ward was 60%, Coral Ward 86% and Roman Ward and Gardner ward 88%. For invention and prevention for the management of violence and aggression training Coral Ward was 61%, Willow Ward was 70%, Roman Ward was 76% and Gardner Ward was 88%. Managers were aware of issues with staff training compliance and all staff were booked on training sessions to ensure full compliance by April 2023. Managers were not able to easily monitor mandatory training. Due to a recent change the trust wide training platform managers had difficulty pulling off training data to confirm staff training compliance. Managers had created their own local training records to ensure they knew which staff were compliance with training and managed rota to ensure all shifts that adequately training staff. The trust was aware of these challenges for the wards. The trust had recently introduced a new trust wide training platform to make it easier for staff to complete their mandatory training. However, this system experienced some initial data errors which resulted in staff training data not being updated and staff not receiving training prompts to remain compliant. An action plan was recently put in place to address these issues. The learning and development team were working on the data flow between the previous training system and the new system and were updating the system daily and meeting with the new training platform provider to address data issues. Additional training sessions in basic life support training, immediate life support and invention and prevention for the management of violence and aggression were commissioned through March and April 2023. The learning and development team were providing reports to the services, borough directors, and leads nurses on directorate compliance on a weekly basis to allow them to manage local requirements and provide oversight of compliance in their directorates. Training reports were also being provided to the service delivery board and trust board to ensure a trust wide governance of compliance, on a monthly and bi-monthly basis.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well.

Assessment of patient risk

We reviewed 11 care records across the wards. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. When patients arrived at the ward, a doctor and nurse completed an initial risk assessment. A more comprehensive risk assessment was completed within 24 hours of admission. These risk assessments were regularly updated.

Our findings

Staff used a recognised risk assessment tool. Risk assessments were recorded on a standard form in the electronic patient record. This form included the patient's risk history, potential risks, and most patient records included support approaches to reduce the likelihood of incidents occurring. The trust had recently moved to a new patient records system and the new standardised form did not include a dedicated risk mitigation section. Most staff were including risk mitigation within the form, however, the level of detail within this area varied. Managers were aware of this, and this was include as part of the wards' records audits. A lead nurse was working across the services to ensure risk mitigation was include in all patient risk assessments.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff shared key information to keep patients safe when handing over their care to others. Shift changes, handovers and multidisciplinary meetings included all the necessary key information to keep patients safe. Staff in multidisciplinary team meetings discussed individual patient's needs and demonstrated an understanding of each patient. Staff on the wards met each day to discuss any changes to patients risks and to assign risk management activities to each member of staff.

Staff identified and responded to any changes in risks to, or posed by, patients. All patients presented risks in relation to their mental health. Many patients also had physical health risks. Staff used their knowledge of patients to understand and predict patient risk behaviour and triggers and intervened with suitable support. Patients confirmed they were involved in their risk management plans. Staff monitored physical health risks through frequent observations. Staff monitored the physical health of patients regularly using the observation chart for the National Early Warning Scores (NEWS2). This is a tool that aids the detection and response to clinical deterioration in adult patients. Staff were trained in the use of the NEWS2 chart to identify deteriorating patients. Staff said they were confident about using it and escalating issues as appropriate. Staff knew where the emergency grab bag was kept.

Staff could observe patients in all areas and observed patients in line with the trusts policies and procedures. Staff checked all patients at least once during every hour. When patients presented a heightened level of risk, this was increased to four times within one hour or continuous observations.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Safeguarding

Staff understood how to protect patients from abuse. Staff recognised abuse and they knew how to report it.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were confident in identifying and making safeguarding referrals and knew who to inform if they had concerns. We observed a handover meeting where a safeguarding concern was discussed. Staff took a holistic approach and included reflection on the patient's views and understanding.

Patients said they felt safe on the wards. Staff understood their responsibilities to ensure that patients were protected from bullying and harassment. Examples included where staff thought one patient was targeting others, instances of patients being aggressive towards other patients. Patients reported they could raise any concerns at community meetings or confidentially in one to one meetings.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Our findings

Patient notes were comprehensive, and all staff could access them easily. Records relating to patients' care and treatment were stored on an electronic patient record. Staff recorded hourly observations on paper. These were stored in the nurses' office and uploaded to the electronic records. Staff were able to access paper and electronic records quickly.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic records could be accessed by anyone working within the trust.

Records were stored securely. Staff needed to enter a personal identification name, a password and an identity card in order to access the electronic patient record.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff used an electronic system to prescribe and record the administration of medicines. They also used another electronic system to maintain patient care and treatment records. Medicines were dispensed centrally and delivered to each ward. If medicines were required out of hours, staff could access some medicines via an on-call pharmacist and an emergency drug cupboard. Access to medicines storage areas was appropriately restricted.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Ward staff could access advice from a clinical pharmacist on weekdays. Staff working out of hours could access the trust on-call pharmacy service for medicines advice. Ward rounds took place weekly or fortnightly dependent on patient need and medicines were discussed and reviewed. There were also daily handover meetings where urgent medicines concerns could be raised. Patients confirmed that they were able to discuss medicines and get advice when needed.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All information relating to medicines was stored electronically and only accessible via password protected laptops. All paperwork relating to medicines and equipment were stored in locked clinic rooms or in offices accessible only to staff or accessible when staff were present.

Staff learned from safety alerts and incidents to improve practice. Medicines incidents were reported using an electronic system. The trust had a system to manage medicines safely alerts. Alerts were forwarded to relevant staff.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff ensured each persons' physical health was monitored regularly. They made use of the National Early Warning Scores to improve detection of and response to clinical deterioration. Staff tried to encourage patients to participate in physical health checks and this was documented.

Track record on safety

There had been 4 serious incidents on the wards we inspected in the 12 months before the inspection. Two incidents involved the unexpected death of a patient, one was related to a sudden physical health deterioration and one was related to self-harm. In both instances, staff completed a report of the circumstances surrounding the incident within 48 hours and referred the matters for a more comprehensive investigation.

Our findings

Reporting incidents and learning from when things go wrong.

Service improvements were applied as a result of learning from serious incidents. Wards applied identified recommendations and completed actions in a timely manner. Staff recognised incidents and reported them appropriately. However, not all actions from serious incident investigations were correctly updated and tracked.

There was evidence that changes had been made as a result of serious incident investigations. Recommendations and actions from 4 specific serious incidents, 3 deaths and 1 serious injury, spanning September 2020 to February 2022 were reviewed for each ward visited during this inspection. General themes, such as observations, communication, handover and recording of information from the other 3 deaths and 1 serious incident for MHA detained patients from self-harm between January 2019 and January 2023 were also reviewed.

The trust had a central serious incident team that collated and tracked serious incident action plans, recommendations and actions once a serious incident investigation report was completed. This team liaised with lead nurses and senior staff at each service to oversee progress. Actions were then delegated to approach staff at service and ward level.

Wards applied identified recommendations and completed actions in a timely manner meeting action plan timeframes. On all wards the observation, ligature risk mitigation and patient search processes had improved as a result of applying recommendations and actions identified from serious incidents. Across Willow, Coral and Roman Wards all staff had completed their observation competency assessments, ligature training competencies assessments and patient search competency assessments. On Gardner Ward most staff had completed these competency assessments with those who had not completed their assessments either on long term absence or booked on to complete they assessments by the end of February 2023. Patient care records showed an improvement in recording observation levels with observation codes being clearly highlighted in records. This helped staff quickly confirm patients' observation levels and any changes in those levels. Observation codes were now included in safety huddles, handover and ward round meetings when discussing patients. Staff said this significantly improved communication around patient observation levels. At the time of the inspection observation audits for the wards showed no significant gaps in observations. Staff felt this improved over the last year as a result of the focused work in this area. The accurate completion of observation records was a particular issue the trust identified from a serious incident on Roman Ward in 2021. Managers and senior staff now audited observation records daily to address errors in observation entries and to ensure individual staff members are not placed on observation duty for excessive lengths of time. Over the last year the trust had increased it focus on improving supportive observations as they identified this area as a theme across serious incidents. They identified a number of incidents where observation processes were not constantly followed by individual staff members and on these occasions practice fell below expected standards. The trust felt that the focus of observations shifted to visibility rather than therapeutic engagement. As part of understanding the challenges and to engage staff and patients in making observations part of the therapeutic process, the trust tasked local services to review their current systems of work to include environmental and human factors that impact on observations being successfully undertaken. They adopted a quality improvement (QI) approach to improving observations with the main aim of the work focussing on therapeutic engagement and observations. In September 2022 the trust deputy CEO facilitated a workshop for staff across all directorates to acknowledge the challenge and complexity of this issue. Teams were invited to share their experiences and proposed solutions, with each directorate formulating their own QI projects progress work locally. The session had representation from all disciplines and service user representation. The trust also engaged colleagues from City University to share current research on therapeutic engagement and observations. There was particular focus and investment on understanding local challenges, engaging wider multidisciplinary teams in thinking about challenges and solutions and gaining the service user experience and expectations of observations. Their focus as part of the improvement was resurrecting the therapeutic engagement element that comes with observations. Existing systems and environments were reviewed, and they explored adherence to policy on observations and introduced daily online audit tools to enable spot checks audits of observation records and annotations for reasons when observations are not

completed. The review engaged staff on the wards to identify themes in their experience of factors inhibiting their ability to carry out observations. The trust was holding ongoing workshop and conference sessions with staff to share that tested what each service sharing their QI project ideas and results. Creative examples included an observation folder relay to ensure the folder was never put down ensuring a member of staff was always focusing on observations. Another novel idea was the application of high visibility jackets for staff that highlighted they were carrying out observations. This ensured staff were not pulled away from observation duty to assist other staff members.

There were additional improvements across the wards as a result of serious incident investigations. The process for booking additional staff when needed to support increased patient observations, and patient acuity, and staff shortages across the wards was improved. This allowed junior staff to access additional staff and support quickly from service managers without administration and authorisation processes slowing it down. On Coral Ward, staff said the communication and documentation of observations was significantly improved between doctors and nurses as a result of actions identified in a serious incident in 2022. A protocol was established to ensure doctors update patient records immediately and handover information to nurses as soon as they have reviewed patient observation levels. This was also added as fixed item on doctor inductions and awaydays. On Roman Ward as a result of recommendations identified in a serious incident in 2021, the service developed and applied a standard operating protocol with the London Ambulance Service for medical emergency management. This was shared with the London Ambulance Service and Barts Health NHS trust and staff said this greater improved emergence services access to the Tower Hamlets Centre for Mental Health. Another improvement for the service was the development of a sudden death protocol to ensure immediate support for families and carers from senior trust staff in the event of a patient death. On Gardner Ward staff developed their understanding of cultural awareness of Shabbat customs and how to improve their support of Jewish patients with help from a local Jewish charity as part of the recommendations from a serious incident in 2022.

However, as actions and recommendations evolved in order to be correctly applied this was not always correctly updated on serious incident action plans. For example, on Willow Ward from a serious incident in 2020 the action was for staff to wear lanyards to identify when they were on observation duty. When this was applied it was found that the lanyards were not visible enough so not effective. Staff addressed this by adopting high visibility jackets instead which they reported as a better solution for ensure staff were not called away from observation duty. The action was not updated with this information which meant that the learning of could not be accurately shared across the trust. In addition to this, on one occasion an action from a serious incident investigation were misinterpreted. Following a serious incident on Coral Ward in 2022, and action was to produce and put in place a protocol to direct, when needed, doctors to ensure they seek patient records from external organisations within 7 days of a hospital admission. This protocol was to be shared in a memo with medical, nursing and administrative staff. This was misinterpreted and instead an email was shared with doctors advising of the need to request patient records from external organisations within 7 days of a hospital admission. This action was not reviewed or confirmed via the serious incident actions and recommendations tracking processes. This was raised with the senior managers for the service at the time of the inspection and they confirmed a protocol as stipulated would be created and applied. Senior managers also confirmed that the issue of ensuring those responsible for actions discussed them with managers and the central serious incident team to address any misinterpretation.

Managers debriefed and supported staff after any serious incident. Senior staff investigated incidents thoroughly. The trust asked external experts to be part of their investigation processes and sometime lead investigations. This included professionals from other NHS trusts and professional within the trust’s integrated care systems. Patients and their families were involved in these investigations. The trust worked closely with family members and offered family members to option to feed into the service improvement and development processes. For example, speaking with staff

Our findings

during workshop sessions about their experience with the trust and highlighting positives and negatives with the care and treatment their loved ones received. Staff said this had an extremely powerful impact of their understanding of serious incidents and deaths involving patients and how the application of operational processes and procedures such as observations played a vital role in patient safely.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff and patients met to discuss the feedback and look at improvements to patient care in team and community meetings, and the clinical improvement groups. Most staff were well informed about incidents. Staff knew about previous serious incidents on the wards and in the service going back several years. This included staff who were not working in service at the time of the incidents. Staff on Roman, Coral and Willow Wards were well aware of recent incidents that occurred across the trust. For example, staff could describe some of the learning and improvements from other areas such as the review of all smoke detectors after an anti-ligature smoke detector in the City and Hackney health-based place of safety was dismantled and the wiring used to create a ligature.

Staff received feedback and a debrief following simulations of emergency scenarios and this informed staff training needs. Emergency scenarios included a range of medical, psychiatric and environmental situations, such as patients experiencing as a cardiac arrest, or patients tying a ligature. Each service had an emergency scenario schedule with wards on average experiencing a simulations every 6 months.

Staff knew what incidents to report and how to report them. Staff recorded incidents on an electronic incident record.

Staff raised concerns and reported near misses, incidents and serious incidents clearly and in line with trust policy. Staff said there was an open culture in which all safety concerns raised by staff and patients were valued as being integral to learning and improvement. All staff were encouraged to participate in learning to improve safety.

Staff understood the duty of candour. They were open and transparent, and patients said staff discussed and explained incidents.

Is the service well-led?

Inspected but not rated

Culture

There was a strong organisational commitment and effective action towards improving the service quality and learning from incidents.

Staff described an open culture where learning was encouraged, and people were supported to be open and share their views. They felt respected by managers and peers and there was a safe space to discuss learning from serious incidents and care and treatment problems.

Governance

Our findings from the other key question demonstrated that most governance processes operated effectively to monitor and apply learning from serious incidents. However, some recommendations and actions were misinterpreted or not fully updated on action plans, and some actions form 48 hour reports were not always.

Our findings

The trust monitored most serious incident action plans to ensure the standards of care continually improved and patient safety was not compromised. Directorate leads, lead nurses and matrons then monitored local level recommendations and improvements. However, on one occasion recommendations and actions from serious incident investigations were misinterpreted or not fully updated on action plans. In addition, oversight of 48 hour reports which included initial actions and recommendations were not always centrally monitored and were at risk of not being put into place until the serious incident investigation report action plan came into effect. This could lead to a delay in actions and recommendations being applied. Challenges and barriers to improvements were fed in both directions between the board and the wards. Staff were clear about their roles and responsibilities in relation to patient safety.

Management of risk, issues and performance

Risk management was comprehensive across most wards. Most serious incident processes

Each ward had a risk register and most lead nurses and ward managers were aware of the key risk areas on their wards. The risks were discussed at team meetings. Risks recorded included concerns with the environment, supervision compliance and training compliance, alongside actions taken to mitigate each risk. At a local level, each day ward teams reviewed the risks for their wards and patients. The ward teams knew the patients very well and were able to support patient manage their risks.

Most staff were well informed about incidents. Effective systems were in place to monitor action plans and apply actions and recommendation to improve patient care after serious incidents.

Information management

The services used data to support performance.

The trust had systems to collect data from the service. The trust provided dashboards for ward managers which had accurate information on care planning and incidents. The trust was able to identify issues within their data systems, such as the new training platform and put in measures to address those issues.

Learning, continuous improvement and innovation

Quality improvement initiatives were strongly embedded within the service. Staff were encouraged to lead the quality improvement initiatives in the trust. Leaders supported staff and patients in developing the service. For example, lead nurses and matrons supported ward managers, staff and patients, and gave them the autonomy to explore local quality improvement ideas such local observations projects. Most staff were familiar with the process and methodology of quality improvement. There were quality improvement projects on observations in progress at each site with local level data being collected. While the trust staff acknowledged the challenges in ensuring patient safety and at time patient safety processes were not constantly followed by individual staff members and on occasions practice fell below expected standards, there was a strong commitment to improve and continuous learn lessons from serious incidents.

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 the services meet its targets for compliance with staff supervision (Regulation 18(2)(a)).
- The trust must ensure that staff meet its targets for compliance with mandatory training, in particular basic life support, immediate life support and invention and prevention for the management of violence and aggression training (Regulation 12(2)(c)).

Action the trust Should take to improve:

- The trust should ensure that daily ward environmental checks are completed and recorded consistently in line with the service's protocols to ensure ward environments are safe.
- The trust should ensure Gardner Ward's ligature audit and risk assessment includes all potential ligature risks and associated risk mitigation.
- The trust should ensure that Gardner Ward staff are informed by any learning from ligature risks and serious incidents from other wards across the trust.
- The trust should continue its work to ensure maintenance issues on Roman Ward are addressed quickly.
- The trust should ensure that staff on Gardner Ward meet its targets for compliance with staff appraisals.
- The trust should continue its work to ensure that risk mitigation is included in all patients' risk assessments.
- The trust should ensure that where actions from serious incident reports evolve to be successfully applied the relevant action plans are updated to include any changes.
- The trust should ensure that actions from serious incident reports are fully discussed between staff responsible for delivering those actions and the senior managers and central serious incident team to ensure actions was correctly interpreted.
- The trust should continue its work on serious incident governance systems to ensure actions and recommendations from serious incident 48 hour reports and serious incident investigation reports are correctly understood, applied and monitored.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors and a specialist professional advisor.

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 Diagnostic and screening procedures 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing