Fairhaven

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

This inspection focused on specific concerns regarding patient safety and staff interactions. We did not rate the service on this inspection and only looked at relevant domains which related to our concerns. However, we did find several areas for improvement.

Please see the sections below for more information.

Summary of findings

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Summary of this inspection

Our inspection team

The inspection team comprised of three CQC hospital inspectors, a medicines inspector, a CQC inspection manager and a Mental Health Act reviewer.

Why we carried out this inspection

We undertook this focused, unannounced inspection of the inpatient wards for children and adolescents with a mental health problem at North West Boroughs Healthcare NHS Foundation Trust to follow up on concerns from information we received. This information was in relation to the administration of medicines and the use of restrictive practices at the service. We last inspected the child and adolescent mental health wards in July 2015 and rated them as good overall, and good in all five key questions.

How we carried out this inspection

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

During this inspection, we:

- Visited the inpatient ward.
- Looked at the quality of the ward environment.
- Observed how staff interacted and cared for patients.
- Spoke with the service manager.
- Looked at five care records of current patients.
- Reviewed seclusion records for the last 12 months.
- Looked at recent incident records.
- Spoke with two carers.
- Spoke with two members of staff.
- Spoke with three patients
- Observed lunchtime dining.
- Reviewed prescribing records for all current patients on the unit.
- Conducted a Mental Health Act review of the unit.

Information about Fairhaven

North West Boroughs Healthcare NHS Foundation Trust provides inpatient mental health services at Fairhaven young people's unit in Warrington. Fairhaven is a 10 bed unit which provides in-patient mental health care, support and treatment for children and young people up to the age of 18 years.

The Fairhaven young people's unit was inspected as part of the wider comprehensive inspection of the trust under the Health and Social Care Act in July 2015. There were no compliance actions taken at that time.

Summary of this inspection

What people who use the service say

The patients we spoke to told us they felt safe on the unit, this was echoed by one of the carers we spoke with. Patients said that there were not enough staff when they needed them and that there were not enough activities available for patients, especially during evenings. Patients and carers commented about how the cleanliness of the environment was not always to their satisfaction.

Detailed findings from this inspection

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. The ward team completed annual Mental Health Act e-learning. The ward manager informed us that all staff were either up to date or booked to complete this training.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not look at the Mental Capacity Act on this inspection. This was because our inspection focused on whether safe care and treatment was being delivered.

Child and adolescent mental health wards

Safe	
Effective	

Are child and adolescent mental health wards safe?

Safe and clean environment

Entry on to the unit was through an air lock. Set over two floors, with reception, meeting rooms and patient areas situated on the ground floor, the premises were configured in a circular layout, with a number of areas which were difficult for staff to observe. These blindspots were mitigated using mirrors and regular staff observations of patients during the day. There was child friendly art work and information posted on the walls near reception including artwork developed by the young people admitted onto the unit. There was a multi-disciplinary/ visitors room used for meetings and a large communal lounge which had access to a small enclosed garden area, which patients could access when doors leading to it were unlocked. Snack boxes were kept within the kitchen which was normally locked and patients had to ask to gain access to it and the contents of their snack boxes. There was a seclusion suite at the end of one of the bedroom corridors. This included a de-stimulation room, used for allowing patients who show signs of agitation or stress time and space to relax.

Although cleaning provision was evident the service environment was not well maintained. We found a sink on the corridor that had not been cleaned and another which was out of use. The clinic room was cluttered with many boxes and storage items present amongst the examination couch and emergency equipment. The medication stored in the clinic room was regularly checked and audited. Records for the three months prior to our visit showed that controlled drugs and emergency equipment were routinely monitored along with regular checking of the fridge temperature settings to ensure medicines and supplements were safely stored. Additionally medicines were audited on a weekly basis by a senior member of staff to ensure quantities were correct and medicines were within their safe to use by date. Medication was stored securely.

Ligature risk assessments audits were carried out annually and were subject to spot checking by senior staff from other services in addition to trust wide care quality visits by the trust to ensure these were correct and up to date. Ligature points are places to which patients intent on self-harm might tie something to cause harm to themselves. On the unit there were some ligature points present. These were recorded in the environment risk assessment along with instructions for staff how to mitigate risk where applicable which included increased supervision in those areas where the risk was present.

Personal safety was ensured by staff being provided with personal alarms and patients all having access to call buttons within their bedrooms to call for assistance if they required it.

Safe Staffing

The ward manager reported that the management team had sufficient autonomy to adjust staffing levels as required supplementing numbers with bank or agency staff when needed. The ward manager felt confident in raising any resourcing issues with the trust.

At the time of inspection, the service employed ten qualified nurses and eighteen nursing assistants. There was a management team of three qualified nurses, who were supernumerary so were not routinely allocated onto the shift numbers, but who were available if needed to help on the ward. Shift staffing records for the last three months before our visit showed the minimum intended numbers for the unit of five staff on any day shift and four working on a night shift, were regularly supplemented by bank staff who were employed elsewhere by the trust or agency staff when needed. Over the same period, there had not been any shifts where the minimum numbers had not been covered. On the day of our inspection there were five bank staff supplementing the daily numbers of five substantive staff. During the day there would be a minimum of two qualified nurses on shift and at least one working each night shift.

We were told that the trust policy position was that agency staff should not be left in charge to lead the unit and any such occurrence would be reviewed by Senior Trust

management. This was demonstrated in the incident reporting records for the previous three months, which showed that there had been one occasion where this had happened. This we were told had been the result of extra pressures across the trust, which meant the trust wide contingency of finding permanent staff from other services could not be done on that occasion.

At the time of inspection there were no vacancies at the service. Since 1 September 2017 six staff had left their posts for different reasons including promotion, joining a pilot trust scheme and a change in family circumstances. Staff sickness rates for the same period were just under 8% for both, qualified nursing staff and nursing assistants.

Records showed the management team worked across the week including occasional nights and weekends to cover staff shortages and support staff when needed. Staff told us that the service had seen a number of recent complex admissions and the environment had been challenging impacting on the morale of the established team. To help alleviate this, the service had been utilising bank and agency staff, to ensure enhanced observations were carried out.

A combination of increased observations and ward staff covering the role of the activities co-ordinator, had impacted on staff availability.

The average training compliance rate across the unit was above the minimum 85% expected by the trust and those who had not completed training modules had these pending. Safeguarding Children, Safeguarding Adults and Health and Safety training had the greatest compliance with Safeguarding Children Level 2 training having been completed by all staff. However medicines management and Information governance had the least training compliance amongst mandatory training courses and were both below the trust target with 62% and 69% compliance respectively.

Staff appraisal and supervision are a means of assessing staff performance to ensure an individuals practice is appropriate and effective. They are intended to be used to help create and facilitate plans for rectifying any areas for improvement whilst developing an individual's potential and identifying training. Appraisals should be completed annually. There were 26 staff eligible to complete supervision and figures for each of the last three quarters show on average 85% of staff had these regularly.

Appraisals had been completed by 82% of staff, which was below the 90% trust target. We were given assurances by the trust, that appraisals for those who were overdue, would be completed in the coming weeks.

Assessing and managing risk to patients and staff

Assessment of patient Risk

Evaluating and assessing risk are an integral part of the care process needed to ensure a patients safety, welfare and wellbeing can be maintained effectively. The ward utilised a number of templates and tools to assess, capture and document risk along with routine outcome measures. Staff started to capture risk from the point of receiving the referral which outlined the risks presented by each patient. The unit also utilised the strength and difficulties questionnaire which was used to populate and develop individual risk assessment management plans for each patient. It was intended that the risk plan should be updated at each ward round meeting or when there had been an identified need to add to this due to a change in the patient's behaviour or presentation.

During our visit we reviewed five care records belonging to five different patients. Although all of these had evidence of risk assessments, the amount of detail these gave varied considerably and the language used was not always not respectful. We also noted that where risk information was captured elsewhere, for instance in the separate seclusion file, or in handover documentation, it was not immediately or fully transferred into the risk section in the care record. This was to due to different staff members completed different records for the same event.

Management of risk

During the tour of the unit we noted that there was no separate female lounge for female patients and access around the unit was limited with many locked doors, restricting patient movement. This included access to the garden from the lounge, the therapy room, the quiet lounge, the multi-purpose room, and the activities of daily living kitchen in which patient snacks were stored. This meant patients had to ask to be allowed access to their snacks.

The focused inspection looked at risk in relation to patient behaviour and deterioration in patient presentation whilst within the ward setting. Individual crisis plans were developed during a young person's session with their

named nurse following an assessment of their Gillick competency. Gillick competence is an assessment of a young person's ability to understand and consent to treatment and care decisions. Crisis plans were only developed in relation to section 17 leave to understand the patient's requirements and wishes regarding their leave. Within one of the care records we reviewed, it was noted that conversations regarding developing safety plans for a patient had taken place a month earlier, but these had not been developed further.

The unit ensured there was a designated staff member responsible for checking the security and safety of the unit during each shift.

The current service policy for responding to episodes of sudden deterioration in mental health meant staff would increase patient observations to every 10 minutes depending on each patients individual presentations. De-escalation along with other techniques to promote and support patients in a way that avoids the need for physical restraint should always be used first by staff when assisting a patient. We were told by the manager and staff that sudden deterioration in patient health was managed through both patient observations and de- escalation techniques which relied upon knowing the patients. This was witnessed both in patient records and staff interactions with patients. Staff we spoke to mentioned the use of a variety of de-escalation interventions including engaging through talking with the young person, use of self-soothing boxes and the use of the de-escalation room.

During the visit we looked at care records which gave information about how risk was managed during incidents of challenging behaviour which resulted in seclusion and incidents where the administration of additional medication was needed. In the preceding six months prior to our visit, there had been 15 incidents of seclusion. Seclusion is the process of taking a patient away from the main ward environment into an intensive nursing suite where the patient is secluded from the rest of the ward until it is safe for them to be returned. There were 25 incidents of rapid tranquilisation over the same period. Rapid tranquilisation is the administering of medication to a person who is agitated or displaying aggressive behaviour to help calm them down. Incidents of seclusion and rapid tranquilisation were considerably less than the 111 incidents of patients displaying concerning behaviour which included incidents of aggression or violence recorded towards staff in the preceding 3 months. The records we reviewed showed that staff completed physical health monitoring of patients following rapid tranquilisation to protect the individual's health and identify any signs of deterioration.

Our review of seclusion records within individual patient care records and the seclusion file found that in the main it appeared staff did attempt to initiate other less restrictive measures before resorting to seclusion. However, there were instances where the same members of staff did not mention what other interventions, if any, had been attempted. It was also noted that seclusion records and the care record which included records of the change in risk were not always completed by the same members of staff and consequently the detail captured in both varied. This was shown by the variation in consistency of how staff recorded information and the language used in some instances. This was escalated to the trust to review and action accordingly. Records showed that staff did inform the doctor as soon as it was safe to do so in accordance with the Mental Health Act Code of Practice. Likewise following seclusion there was evidence of discussion with patients regarding the circumstances leading to their seclusion.

Safeguarding

The trust had a named child protection lead and complied with the local Safeguarding Children Board policies, procedures and appropriate national guidance as stated in The Children's Act.

Staff had received training in safeguarding for children and adults, with training completion rates for these above the trusts targets of 85%. Staff had also attended training delivered by the Local Authorities' Designated Officer for Safeguarding. Staff demonstrated an understanding of the trusts policies and procedures and told us they could seek advice and support from the services social worker who was the safeguarding lead for the service.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Those we spoke with showed an awareness of commonly recognised forms of abuse including that categorised as physical, emotional, financial, sexual, neglect and institutional. The unit had raised nine safeguarding alerts over the preceding year.

Child and adolescent mental health wards

Medicines management

Prescribing was undertaken by appropriate professionals at the service who were authorised to do so. As part of the inspection we reviewed prescription records including corresponding care record entries for all the patients present on the unit. Eight records were available, whilst for another patient the prescription record could not be found.

Legal authority for a treatment is required when a patient cannot consent for themselves and is needed before any care or treatment can be initiated. We found that as required medication prescribed for one patient, had not been included on the required legal authority for the treatment. At the time of inspection legal authority documentation was required for two patients. The legal authority had been updated in June 2017, with the as required medication administered at various occasions in November. This was raised both with unit management team and the trust, in order that this could be investigated and addressed. We found that care plans describing the use of as required medication, did not give details about the rationale for the need of and the circumstances when such medication should be administered. The care plan for one patient made no reference to the use of the as required medication. However, it was noted in care progress notes that the doctor had discussed with one patient why as required medicines should be taken, describing when they may be needed.

The prescription charts we looked at were up-to-date and were clearly presented to show the treatment young people had received.

A pharmacist visited the unit to provide clinical support, review and medicines reconciliation advice. The pharmacist was also a member of the ward multidisciplinary team and was available to speak with patients on request.

Staff access to essential information

The service used an electronic care records system for documenting care and used paper prescription records. We were informed by staff that there were difficulties with agency staff and bank staff being able to access the electronic care record which substantive staff from the unit mitigated by sharing access and allowing others to use their login credentials. The unit staff had an awareness about the trust wide information governance procedures to enable them to fulfil their legislative responsibilities and assess whether information was handled correctly. This was escalated with the trust who have started processes for this to be addressed. Patient information was stored across the system in various areas of the care record system, which current ward staff said they found difficult to navigate around.

Track record on safety

Our review of incident records showed over the last three months, the majority of the incidents reported on the unit were classified as concerns relating to individual patient behaviour. During this period there had been three serious incidents reported by unit staff. These included an incident of attempted self-harm through use of a ligature, an incident whereby a patient had not returned as planned from leave and an incident when an agency nurse was the senior nurse on shift rather than a member of permanent staff. All serious incidents were reviewed by the patient safety panel which reviewed the root cause analysis of the incident and the impact of the incident.

Reporting incidents and learning from when things go wrong

We were told staff at the unit were encouraged to report all incidents and staff we spoke to felt confident to report incidents. The incident reporting system showed that during the period September 2017 to December 2017, there had been 151 incidents reported by staff at the unit. The types of incidents reported varied but were mainly about patient behaviour, episodes of violence and aggression and reported attempts of self-harm.

Incidents relating to rapid tranquilisation and seclusion episodes were reported and corresponded to seclusion records we reviewed.

The service manager spoke about how the service shared learning from incidents through discussions in team meetings in addition to discussions with the multidisciplinary team and all involved. We were told about examples of recent learning from incidents which had been used to instigate change within the service. This included the identified need for portable oxygen within the unit, following an incident when the normal oxygen equipment was required and found to be difficult to transfer to the needed location. Following another incident, it had been identified that the anti-barricade key needed to gain access to locations when required had been difficult to locate. The key had been moved to make it easier to find.

Child and adolescent mental health wards

Following the inspection, we escalated the concerns we had identified with the trust, as a result of which the trust started a process to review and rectify the concerns identified.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

We inspected specific key lines of enquiry in relation to how staff interacted with patients.

In the records we reviewed we found that the amount of detail given in both the care records and entries within the separate seclusion file varied when related to the same incident. During our review of records we noted that the language used in some records was not always consistent and was not always mindful of an individual's personhood, dignity and respect. This concern was escalated to the management team for action. Seclusion records did not always evidence whether non-restrictive practices had been attempted.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure all aspects regarding care and any associated risks are documented in the main case notes and not just supplementary documentation.
- The trust must ensure staff complete all mandatory training in the intended timeframe.
- The trust must ensure care planning records including the language used within them, are consistent in terms of the detail given and follow current guidance.

Action the provider SHOULD take to improve

- The trust should ensure care plans document the rationale for the decision to prescribe as required medication and the circumstances when they should be administered.
- The trust should ensure seclusion records detail non-restrictive practices which have been attempted in the first instance before resorting to the need for seclusion.
- The trust should ensure movements around the environment are less restrictive and ensure service users have access to the garden and other regularly used rooms when they need it.
- The trust should work with patients to capture their decisions and wishes in safety plans and advanced statements and have these clearly documented in the care records.
- The trust should ensure patients have access to individual snack boxes without restriction.
- The trust should ensure there is a separate female lounge available for female patients if they require one.
- The trust should regularly review the environment to ensure it is clean and well maintained.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The language used in records was not consistently person centred. Care plans did not in all instances demonstrate the individualised care required by each patient and were not always written to the highest of professional standards. This was a breach of regulation 9 (1) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not always document all risks associated with each patient within the appropriate section of the care record. This was a breach of regulation 12 (2) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not complete all mandatory training within the intended timeframe. This was a breach of regulation 18 (1).

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.