Huntercombe Hospital - Stafford

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

The Care Quality Commission carried out a responsive inspection of Huntercombe Hospital Stafford following concerns about patient safety.

We found:

- The hospital managers had failed to protect patients from the risk of abuse. There was no effective system to prevent, report and investigate immediately any allegations of abuse.
- The hospital managers had not reported the incidents in a timely manner to the local authority safeguarding team or the Care Quality Commission (CQC) as is required.
- Safeguarding training was not in place or up to date for the majority of staff.
- There was no reliable system in place to alert senior nursing staff and managers to all incident reports concerning abuse.
- Staff did not follow the safeguards, required in local policy and recommended in the Mental Health Act Code of Practice, to support the rights and well-being of patients during and after restraint, rapid tranquillisation and seclusion.
- Support offered to a newly qualified nurse was inadequate to prepare them for leadership of a shift on a challenging Psychiatric Intensive Care Unit (PICU).
- Managers had not addressed concerns raised in clinical supervision by qualified staff about safety. We found no records of supervision for support workers.
- Reception staff did not consistently request the identification of visitors to the site before entry into clinical areas. This put site security at risk.

However,

- We found that basic pre-employment checks that would provide assurance of the fitness of staff to work with young people were completed.

Summary of findings

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Background to Huntercombe Hospital - Stafford

Huntercombe Hospital-Stafford is a child and adolescent mental health service (CAMHS) for 39 young people of both genders aged 8 to18 years. The hospital can also admit detained patients under the Mental Health Act (1983).

Huntercombe Hospital-Stafford is divided into three separate wards; Hartley, Thorneycroft and Wedgewood wards.

Hartley ward was a Psychiatric Intensive Care Service (PICU) providing 12 beds for male and female patients. The PICU unit at Stafford offers inpatient care to young people suffering from mental health problems who require specialist and intensive treatment to address their needs. The team is led by a consultant child and adolescent psychiatrist and further supported by a team of nurses, therapy and support staff. The unit is a locked secure unit, which means that patients cannot leave or enter the building unless they have authorisation from doctor and the staff are aware of what they are doing. All patients on the PICU are detained under the Mental Health Act (1983).

Thorneycroft ward is a general CAMHS acute assessment unit with 12 beds

for young people aged 12-18 years. The young people treated in this unit had a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm. The team was led by a child and adolescent psychiatrist.

Wedgewood ward has 15 beds and provides a specialist eating disorders service.

The young people treated on the eating disorders unit have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or other similar eating disorders. The team is led by a consultant child and adolescent psychiatrist.

The CQC registered Huntercombe Hospital - Stafford to carry out the following services/activities:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures

The hospital did not have a manager registered with the CQC in post at the time of the inspection.

The CQC last carried out an inspection of the site on 29 May 2014. The hospital did not to meet the standard around safety as building maintenance was not up to date and the wards were not cleaned regularly. The hospital was compliant with four other outcomes the CQC inspected against, including the assessment and management of risk.

Our inspection team

Team leader: Michael Fenwick

The team that inspected the service comprised four CQC inspectors.

Why we carried out this inspection

We carried out an unannounced, focused inspection at Huntercombe Hospital Stafford on 28 April, 29 April and 4 May 2016. This inspection was responsive to information we received in a whistleblowing alert raising significant concerns on 27 April 2016.

The concerns centred on a series of physical restraints on on Hartley ward, of patients detained under the Mental Health Act. Concerns included:

- physical restraint had not been accurately reported

Summary of this inspection

- staff had used restraint which was disproportionate to any risk posed to by the patient
- hospital managers had not informed the local authority safeguarding team in a timely manner as required and no notification was made to the CQC.

Two further significant allegations concerning patient safety were also made and investigated during this inspection: These included concerns that:

- that security around entry to the unit was inadequate
- managers had not carried out pre-employment checks for clinical staff

The CQC had previously announced a comprehensive inspection of the hospital for 16 and 17 May 2016. However, the serious nature of the concerns warranted an unannounced inspection to be organised immediately. The report of that inspection will cover all five domains in detail. This reports highlights our immediate concerns following our responsive inspection.

How we carried out this inspection

On the 28 April 2016, two inspectors visited the unit for an initial responsive unannounced inspection. On follow up visits on the 29 April and 4 May 2016, two more inspectors joined the inspection.

- We reviewed the CCTV footage.
- We reviewed the clinical records including care plans, correspondence, risk assessments and nursing notes.
- We spoke with the Consultant, Psychiatrist, Hospital Director, Head of Quality and Clinical Effectiveness, social workers and ward manager.
- We interviewed staff based at the hospital reception and reviewed the security and visitor policies.
- We examined training records and personnel files for all the staff on duty for Hartley ward that night.
- We examined the personnel files of 28 clinical staff to review that the recruitment team had completed satisfactory pre-employment checks.
- We also looked at safeguarding training rates for clinical staff as a whole. Two of our inspectors reviewed DATIX records for all three wards at the hospital for April. DATIX is the electronic database used at the hospital to record incidents.
- We spoke with the local safeguarding team leader and subsequently the safeguarding lead for the Staffordshire County Council and correlated the number and detail of safeguarding alerts received since January 1 2016. We also attended a safeguarding strategy meeting
- We spoke with commissioners at NHS England and the local police.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found:

- The hospital managers had failed to protect patients from the risk of abuse. There was no effective system to prevent, report and investigate immediately any allegations of abuse.
- The hospital managers had not reported safeguarding incidents in a timely manner to the local authority safeguarding team or the Care Quality Commission (CQC) as is required.
- Safeguarding training was not in place or up to date for the majority of staff.
- There was no system in place to alert senior nursing staff and managers to incident reports concerning abuse.
- Staff did not follow the safeguards, required in local policy and recommended in the Mental Health Act Code of Practice, to support the rights and well-being of patients during and after restraint, rapid tranquillisation and seclusion.
- Reception staff did not consistently request the identification of visitors to the site before entry into clinical areas putting site security at risk.

Are services effective?

We found:

- Support offered to a newly qualified nurse was inadequate to support their leadership of a shift on a challenging Psychiatric Intensive Care Unit (PICU).
- Managers had not addressed concerns raised by qualified staff about safety in supervision. We found no records of supervision for support workers.
- There was a failure to inform external agencies, NHS England and the local authority, of safeguarding concerns about patients at the hospital.
- The policies of the Huntercombe Group and the guidance of the Mental health Act Code of practice was not followed in the use and recording of restrictive practices.

However,

Summary of this inspection

- We found that basic pre-employment checks, that would provide assurance of the fitness of staff to work with young people, were completed.

Detailed findings from this inspection

Child and adolescent mental health wards

Safe	
Effective	

Are child and adolescent mental health wards safe?

Safe and clean environment

- Our informant had reported that reception staff did not check the identity of visitors to the unit and gave them keys that could allow access the wards. We found only one recorded incident to justify this concern in the hospital's incident log. On the 11 April 2016 reception staff gave a set of keys to the wards to a visiting trainer. Reception staff had not asked for the trainer's ID nor escorted him to the meeting room. Potentially he could have had unescorted access to the wards and vulnerable young people.
- An internal investigation found that staff covering the desk at the time were new starters and had not completed an induction to the hospital's security procedures.
- Hospital managers had put in place an action plan to raise levels of awareness of staff to security issues and increase the number of staff on reception. This was to include extending the hours covered by dedicated reception staff. This would remove the need for ward staff to attend to reception duties outside of normal office hours. Managers had recruited two full time receptionists to provide a service from 08:00 to 20:00 seven day a week. They were not in post at the time of our visits and administrative and clinical staff on a temporary rota covered reception.
- We inspected the integrity of the ID checks during our visits to the hospital and found procedures to be in place to check the ID of visitors, issue a visitors badge and require visitors to sign in and out of each building visited.
- However, there was no checklist to demonstrate that reception staff had followed these procedures.
- We found that staff on duty carried out the procedures inconsistently during our visits to the hospital. Reception staff asked the CQC inspectors for ID on only two out of four visits. They never asked us to surrender mobile phones or review the contraband list before going onto the wards.
- We raised these omissions as immediate concerns with the hospital director who assured us she would reinforce the procedures in line with hospital policy.

Safe Staffing

- The night shift on Hartley ward on the 20 April 2016 was made up of one qualified nurse and nine support workers. This nurse was working alone on a unit with a high level of patient activity and occupancy and no further support on site.
- Managers since April 2016 had calculated nurse staffing levels with a new model that had shifted the burden of maintaining close observations (1:1 care) on to the core staff assigned to each shift. At night, the maximum number of staff that this new tool allocated to cover these duties was eight when the ward was full with 12 patients. This eight should have included two qualified staff. Ward managers could request additional staff from senior managers to support 2:1 observations. The patient identified in the whistleblowing complaint was on 2:1 observations. In addition there was a further five patients on 1:1 observations and two on lower level fifteen minute checks. This meant eight of the support workers were constantly involved in maintaining constant observations at 1:1 or 2:1.
- With the one staff nurse attending to medication and other qualified duties, this left one support worker to manage the needs of the six patients not directly supported through close observations. Overall, this compromised the flexibility of the team to manage any emerging risk situations, as only one person was free to support any emergency on the ward.

Assessing and managing risk to patients and staff

- We found that in viewing the CCTV footage on the night of concern that there was evidence to support the

concerns raised by the whistle-blower. On reviewing the clinical notes, we also found omissions in recording the use of restrictive practices, the risk assessment and care plans.

- There was an observation policy in place emphasising the use of supportive observations as a therapeutic intervention to help protect the patient. Staff are required to complete an hourly observation record. In the records for the 48 hours starting 08:00 on the 20 April 2016, ten hours of the record are blank. The observation records make no mention of the use of restraint in the hours that our review of CCTV footage covered. These records include very subjective judgements of the patient's mental state and motivations. For example staff have documented that the patient was 'pushing boundaries' and 'wanting a reaction from staff'.
- Observation levels did not always correlate with individual patient's risks assessments. We found the patient was risk assessed as requiring two to one observations. However, we saw evidence on the CCTV recording that at times they were left with one member of staff. The triggering event to the series of incidents of restraint occurred when one member of staff allocated observations left the patient with one colleague to go into the staff office. When the patient attempted to follow, staff moved immediately to restrain her and move her to the low stimulus suite.
- We did not see staff attempt to distract or explain to the patient why she should not go into the office. The CCTV footage did not include an audio track but our observations were that staff moved to restraint as a first rather than last response. Staff should only use restraint after de-escalation has failed and with approved techniques. Some of the holds we observed staff using were not consistent with the principles of the PRICE (Protecting Rights in the Care Environment) training they had received and the use of restraint appeared disproportionate to any threat posed by the patient.
- Across a range of restrictive practices, staff had not followed local hospital policies, national guidance and the safeguards outlined in the Mental Health Act Code of Practice. For example, we observed that a dose of sedating medicine was giving under the restraint of three people. A fourth member of staff in attendance to secure the head and monitor breathing stood at the feet of the patient talking to their colleague, holding the legs, throughout the procedure. This was a further breach in the established protocol for safe management of a patient requiring restraint.
- Rapid tranquillisation is the use sedative medicines to manage episodes of agitation when other calming or distraction techniques had failed to work. The medicines used may cause risks to the patients well being affecting their breathing and heart function. It is best practice to attempt to record basic physical observations to monitor for these effects. Staff failed to record any of the physical observations required to maintain the safety and well-being of the patient. The nurse had not reported it as a rapid tranquillisation incident using a restrictive practice form or contacted a doctor or senior nurse on call to discuss its appropriateness.
- Hartley ward does have a seclusion room but it was not in use following an internal assessment that it was not safe or compliant with standards set out in the Mental Health Code of Practice. We saw that staff used the low stimulus room to isolate the patient for periods throughout the night. She was left alone in the room and staff standing outside the door held it closed to prevent her exit. Standing outside the door staff had very limited lines of sight into the room and could not observe the patient effectively.
- This was in effect an episode of seclusion e.g. the supervised confinement of a patient in a room, which may be locked. Its sole aim should be to contain severely disturbed behaviour likely to cause harm to others. There is no record to suggest that staff recognised this as further restriction on the patient's liberty requiring medical authorisation.
- In our review of training records we found only 47% of all clinical staff were up to date with Child Protection training on the 29 April 2016. Only 44% of staff overall were up to date with Safeguarding Vulnerable Adults training on the same date. We identified that only two out of seven of the staff on duty on the night of the first incident was up to date with Safeguarding Vulnerable Adult training. We could not find records for the other three members of staff on duty that night.
- The impact of staff not receiving up dates or initial training in safeguarding is that they are less likely to

recognise and report abuse. The hospital managers required that all clinical staff are up to date. Less than half of the clinical staff were compliant with this requirement at the time of our inspection.

- We confirmed that hospital managers had not informed the local authority safeguarding team of potential abuse on the night of 20 April 2016 until 25 April 2016. There was no reasonable explanation available for the delay in making this referral outside of the maximum timescale of 48 hours set by the local safeguarding body. Hospital staff did not submit a notification to the CQC until the evening of 28 April after our inspection visit.
- This meant that hospital managers failed in their duty of care and statutory responsibilities to bring to the attention of external bodies significant concerns about the abuse of a young person in a timely manner. This delayed the response of the local authority to investigate promptly the circumstances and review any physical evidence. This had a negative impact on the patient's right to be protected from harm.
- In reviewing our previous notifications, we contacted the local authority on Friday 29 April 2016 to discuss safeguarding referrals they had received. Since the beginning of 2016, they had received five referrals inclusive of the incident already discussed. The CQC had received no notifications of any of these concerns before the start of our responsive inspection.
- We received a notification of an alleged assault by staff on a patient on the 4 April 2016 on the second day of our inspection (29 April 2016). The young person reported the incident to a nurse on 5 April but hospital staff did not raise a safeguarding referral until 7 April more than 48 hours after the event. The local authority safeguarding team had held a strategy meeting on 20 April to review this incident and recommended further investigation. At that meeting, hospital staff gave a false assurance that they had notified the CQC of the incident on 7 April 2016.
- We also received, by hand, on 3 May, a notification relating to an incident referred to social services in February 2016. The report detailed the complaint made by a patient to her social worker of an incident on 14 February 2016 involving restraint. The hospital manager was not able to provide evidence of any earlier submission date.
- The failures to notify the CQC of these incidents were breaches of the provider's responsibility to inform the CQC of any abuse. The impact is to undermine the ability of the CQC to respond effectively to concerns and monitor the hospital's performance over time in order to protect the safety of patients.
- Huntercombe Hospital Stafford had made only two statutory notifications of incidents to the CQC in 2016 before 29 April 2016. Staff on duty reported both at the time of the incidents and both related to police attendance at the unit. In 2016, there have been no cases of ward-based staff reporting directly a safeguarding alert to the CQC at the time of the incident.

Reporting incidents and learning from when things go wrong

- The hospital managers have a legal obligation to inform the CQC and other external agencies of any concerns about abuse, serious injuries and other specific types of incident that happen within the hospital.
- We found that reporting systems at the hospital were not effective in identifying incidents for immediate investigation and reporting allegations of abuse.
- The system of incident reporting was for ward staff to complete an electronic incident report form on the DATIX system. DATIX automatically forwarded these reports to the consultant psychiatrist for that ward to review and action.
- We could find no evidence that ward incident reports forwarded to medical staff were reviewed on Hartley ward and that the current system produced any actions or learning from incidents.
- Senior managers and clinical nurse leaders on the wards did not receive immediate alerts through DATIX. This meant there was a delay before they received and investigated concerns. The same was true for the social work staff who led on safeguarding within the hospital. The social workers were unable to conduct any immediate investigation through lack of access to the CCTV recordings from the wards. These were only available in the office of the Hospital Director.

Child and adolescent mental health wards

- Managers had not learned of incidents by any effective reporting system but through complaints raised by the patients or chance discovery in the examples we reviewed. The impact of failing to operate an effective system was to put patients at risk of abuse that was not reported, investigated and managed immediately to prevent any further abuse.

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

Skilled staff to deliver care

- The whistle-blower had told us that some clinical staff at the hospital were working without basic employment checks being in place. Checks on an applicants background are required to demonstrate their suitability to work with young people. These would be expected to include evidence of an interview, two references, an ID check and evidence that they had no criminal record that might disbar them from working with children and vulnerable young adults.
- We reviewed 28 personnel files focusing on the ten members of staff on duty the night of the incident, 11 new starters (appointed March/April 2016) and a further seven permanent staff.
- We found all the records to contain evidence of the basic checks outlined above apart from one. In the record of a support worker appointed in 2009, we could find only one reference whilst the local standard is to have two.
- The Human Resource administrator described to us the appointment processes and how interview are manged centrally with primary employment checks completed off site at another of the group's hospital. An appointment checklist was included in all the new files examined and demonstrated that the appointment process would be delayed awaiting receipt of evidence and references.
- Our inspectors also reviewed the experience and qualifications of the staff working on the night of the main incident. The one registered nurse on duty that night was newly qualified on appointment in October 2015. She had her nurse preceptorship competencies signed off as completed in mid Nov 2015. Preceptorship is a period of structured transition for the newly registered nurse during which an experienced nurse supports them, to develop their confidence and skills as an autonomous professional.It would most usually be completed over a period of six months.
- There was no evidence to support the completion of these competencies across the range of nursing practice such as administering medicines. The nurse in question had raised at monthly supervision that they did not feel confident leading a shift alone. There was no evidence that the supervising manager had listened to these concerns.
- We could find no evidence that the Health Care Support Workers on that shift had been receiving any clinical supervision in the previous six months. This fell short of a local commitment in policy to provide regular clinical supervision. The hospital managers were not able to provide any audit results to demonstrate they regularly monitored supervision levels for clinical staff.

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Multi-disciplinary and inter-agency team work

- The night nursing team on 20 April 2016 had failed to pass on to the next shift or management team detail of all the restrictive practices used and the requirement for a medical review and support for the patient. Hospital managers, reportedly, only became aware that there was cause for concern after viewing CCTV footage of the ward when following up the concerns of another patient.
- The hospital failed to inform the case managers at NHS England (the commissioning body) of the use of restraint and rapid tranquillisation. A summary letter to the commissioners written on 21 April 2016 to report on progress in the first 72 hours of admission fails to mention any use of restrictive practices.
- The local authority safeguarding team reported concerns about hospital managers raising safeguarding alerts in a timely manner. In addition, access to evidence required by investigating social workers following a complaint was not always available on request. This further delayed the timeliness and effectiveness of investigations.

Adherence to the MHA and the MHA Code of Practice

Child and adolescent mental health wards

- From our review of the CCTV footage and records of the incidents on 20 April 2016, staff did not comply with the safeguards around restrictive practices as recommended by the Mental Health Act Code of Practice 2015.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital managers must introduce an effective and responsive system to safeguard the children/ young people in its care from abuse.
- On appointment, a comprehensive professional induction process (preceptorship) must be offered to newly qualified clinical staff in line with the recommendations of their professional bodies.
- All staff must have access to regular supervision in line with the Huntercombe Group policy to support reflective practice and professional development.

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
Accommodation for persons who require nursing or personal care 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 Staff had not received appropriate professional induction, training and supervision to ensure that there was always a sufficient number of skilled and experienced staff on duty. This was a breach of Regulation 18 (1) (2a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People who use services and others were not protected from the risk of abuse as the provider failed to operate an effective system to prevent report and investigate immediately any allegations.** This was a breach of Regulation 13 (1) (2) (3)