St Andrew's Healthcare - Nottinghamshire

Quality Report

St Andrew's Healthcare Nottinghamshire
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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

Ratings

Overall rating for this location

Are services safe?	
Are services well-led?	

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We conducted an unannounced focused inspection of St Andrew's healthcare in response to intelligence received that gave us cause for concern in relation to the safe and well led domain.

- We found several blind spots on the wards which were not highlighted in the environmental risk assessment or mitigated against by staff observing these areas at all times.
- We found ligature points which were not identified on the ligature risk assessment. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of strangulation.
- We found that the emergency medication cupboard on Thoresby ward contained adrenaline which was out of date. We brought this to the provider's attention and this was removed and a replacement ordered.
- Some patients complained that staff sometimes allowed patients to play fight which made them feel unsafe.
- Issues with equipment and the environment that had been reported for repair were not always fixed in a timely manner. This was also an issue in the last report and had not been rectified.
- We reviewed three seclusion records and found that in all the records four hourly medical reviews were not conducted in line with the provider's seclusion policy.
- The incidents of restraint and prone restraint had increased since the last report.
- Staff did not know who the most senior managers in the organisation were.

However:

- Cleaning records were up to date for all ward areas and we observed wards being cleaned during our visit.
- Staff adhered to infection control principles including hand washing, there were visible signs in bathrooms and kitchens prompting staff and patients to wash their hands.
- All staff and visitors to the ward were given alarms and we observed these to be working during the inspection.
- The hospital had adequate staffing to meet patient's needs.
- The provider employed a dedicated staff team to conduct regular physical health monitoring of patients.
- The provider also employed technical instructors and activities coordinators to support patients with special interests and occupational activities. This hospital had recently received an award from the provider for its walking group.

Summary of findings

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Background to St Andrew's Healthcare - Nottinghamshire

St Andrews Healthcare Nottinghamshire is a 66 bedded purpose built regional centre for men detained under the Mental Health Act 1983. Patients admitted include those with a diagnosis of autism and Asperger's syndrome; and have either established or suspected borderline learning disabilities, who may present reactions to trauma and social deprivation. They may also have additional mental health needs, and a history of offending or challenging behaviour. Referrals are taken from across the United Kingdom. The centre consists of four wards:

Newstead ward is a specialist 16 bedded low secure ward for men who have a primary diagnosis of autistic spectrum disorder.

Wollaton Ward is a 17 bed medium secure ward for males with autistic spectrum disorder.

Thoresby ward is a 14 bed medium secure ward for men with mild or borderline learning disability. Patients may also have mental health needs and/ or a history of offending or challenging behaviour.

Rufford ward is an 18 bed low secure ward for men with autistic spectrum disorder or learning disability.

St Andrews Healthcare Nottinghamshire is registered with CQC to provide treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act 1983. The service was last inspected on 18th June 2015 when it was rated as good.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a CQC inspection manager.

Why we carried out this inspection

We inspected this service in response to concerns from our intelligence and on-going monitoring of the service.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the registered manager and managers or acting managers for each of the wards
- spoke with 12 other staff members; including doctors, nurses, healthcare assistants, psychologist and social worker
- interviewed senior managers with responsibility for running this service
- received feedback about the service from commissioners, the local authority, and the police
- attended and observed a multi-disciplinary meeting
- reviewed 12 staff files
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management on wards

Summary of this inspection

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

What people who use the service say

Most patients we spoke with were positive about the care and treatment they received. Patients we spoke with said the hospital had good facilities and staff supported them to achieve their goals.

However some patients complained that their care plans were not followed as they should be and that staff sometimes allowed patients to play fight which made them feel unsafe.

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 do not rate services as part of unannounced focused inspections.

We found the following areas of concern:

- We found several blind spots on the wards which were not highlighted in the environmental risk assessment or mitigated against by staff observing these areas at all times. An example of this was the kitchenette areas on Rufford ward which could not be easily observed from some parts of the ward.
- We found ligature points which were not identified on the ligature risk assessment. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- We found that the emergency medication cupboard on Thoresby ward contained adrenaline which was out of date.We brought this to the provider's attention and this was removed and a replacement ordered.
- We noted that the seclusion room closed circuit television was not working on Newstead ward, the provider had reported this to their estates team, but staff reported that it was taking a long time to get this fixed.
- Most areas of the ward were clean and well maintained, however the roof top garden area on Rufford ward was closed due to maintenance issues which had been reported five weeks previously.The provider told us that they supported patients to use alternative outside space.
- One of the washing machines on Rufford ward was awaiting repair, there was a second machine on the ward which meant that patients could continue to process their laundry.
- We reviewed three seclusion records and found that in all the records four hourly medical reviews were not conducted in line with the provider's seclusion policy.Some patient's details were not recorded on every seclusion record within the seclusion pack. This meant that if the pack was separated it would be difficult to know if seclusion was monitored safely.
- Patients we spoke with told us that staff allowed play fighting amongst patients which made them feel unsafe.
- The provider reported 34 serious incidents in the 12 months prior to this inspection. Incidents included patient assaults on staff and peers as well as security incidents. The provider had also reported a rise in the number of restraints since the last report. However the provider was monitoring incidents and

Summary of this inspection

meeting regularly to develop plans to prevent further occurrences. Monitoring included mapping the times incidents were most likely to occur and increasing staffing numbers at these times.
- There was often a delay in notifing CQC about incidents.

We also found the following areas of good practice:

- St Andrews hospital admitted only male patients and therefore complied with the guidance on eliminating mixed sex accommodation.
- Cleaning records were up to date for all ward areas and we observed wards being cleaned during our visit.
- Staff adhered to infection control principles including handwashing, there were visible signs in bathrooms and kitchens prompting staff and patients to wash their hands.
- All staff and visitors to the ward were given alarms and we observed these to be working during the inspection.
- The hospital had adequate staffing to meet patient's needs.

Are services well-led?

We do not rate services as part of unannounced focused inspections.

We found the following areas of good practice:

- Staff we spoke with knew and agreed with the organisations vision and values.
- The team objectives reflected the organisation's vision and values.
- Staff we spoke with told us that they felt well supported by their ward managers and the modern matron.
- We observed staff talking positively with and about patients and this was reflected in documentation re reviewed.
- Staff we spoke with told us they were proud of the work they did and were passionate about caring for this patient group.
- The provider supported staff with career development at all levels of the organisation.
- Managers ensured staff received mandatory training.
- Managers ensured staff received monthly clinical and managerial supervision and annual appraisal.

We found the following cause for concern:

- Staff we spoke with did not know who senior managers were within the organisation. However managers we spoke with were new in post and gave examples of their visits to the ward areas and were actively working to build relationships with staff and patients.

Summary of this inspection

- Managers did not ensure the timely maintenance of equipment and patient areas.

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.

We did not explore the provider's adherence to the Mental Health Act 1983 in detail during this focused inspection, however we did find that for three seclusion records reviewed the documentation did not confirm that medical reviews had been conducted in a timely manner in line with the provider's seclusion policy.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not explore the provider's adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards during this focused inspection.

Forensic inpatient/secure wards

Safe	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- We found blind spots on the wards which were not highlighted in the environmental risk assessment or mitigated against by staff observing these areas at all times. An example of this was the kitchenette areas on Rufford ward which could not be easily observed from some parts of the ward.
- We found ligature points which were not identified on the ligature risk assessment. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- St Andrews hospital admitted only male patients and therefore complied with the guidance on eliminating mixed sex accommodation.
- Each ward had a fully equipped clinic room with accessible resususcitation equipment and emergency drugs; however we found that the emergency medication cupboard on Thoresby ward contained adrenaline which was out of date. We brought this to the provider's attention and this was removed and a replacement ordered.
- Equipment was well maintained and stickers were visible to demonstrate regular testing and calibration.
- Each ward had a seclusion room and de-escalation room. We noted that the seclusion room closed circuit television was not working on Newstead ward, staff had reported this to the estates team, but staff reported that it was taking a long time to get this fixed.
- Most areas of the ward were clean and well maintained, however the roof top garden area on Rufford ward was closed due to maintenance issues which had been reported but was still awaiting repair five weeks later. The provider told us that they supported patients to use alternative outside space.
- One of the washing machines on Rufford ward was awaiting repair, there was a second machine on the ward which meant that patients could continue to process their laundry.
- Cleaning records were up to date for all ward areas and we observed wards being cleaned during our visit.
- Staff adhered to infection control principles including handwashing, there were visible signs in bathrooms and kitchens prompting staff and patients to wash their hands.
- All staff and visitors to the ward were given alarms and we observed these to be working during the inspection.

Safe staffing

- The hospital was safely staffed on the days we visited and managers planned staffing around patient need; releasing extra staff to care for patients who had escorted leave or needed extra care. However, some staff we spoke with told us recently it had been difficult to get agreement for agency staff when regular bank staff were not available meaning the wards had run on low numbers on several occasions particularly at weekends.
- The wards were staffed with two qualified nurses and four healthcare assistants during the day and one qualified nurse and four healthcare assistants at night. The provider submitted their staffing census data for the period of 1 July 2017 until 25 September 2017; this showed that the majority of shifts ran to planned staffing numbers with regular staff. Where agency staff had been used staff were familiar with the ward.
- Staff turnover was 4.6 % on Newstead ward, 16.9% on Wollaton ward, 20.5 % on Thoresby ward, and 28.4% on Rufford ward. A number of staff had left to pursue careers in other services recently.The provider told us they were working hard on recruitment of new staff and retention of existing staff by providing nurse training and practice development courses. The provider told us that there had been a higher than normal number of staff off long term sick on Rufford ward, the average sickness rate was 10% across the hospital for the period of the 1 September 2016 until 1 September 2017.
- Mandatory training compliance across the hospital for the past 12 months was 95%.

Assessing and managing risk to patients and staff

- The provider was monitoring the number of incidents and produced a monthly report which included restraints, seclusions, safeguarding and serious

incidents. This report was available for all staff to see and the information had been translated into easy read format for patients to see and was presented on the ward notice boards.

- The provider reported 355 incidents of restraint across the hospital from 1 September 2016 until 1 September 2017. Of these 40 was prone restraint. In the last report the restraint figures from March 2014 to March 2015 were 99 with 18 of these being prone restraint demonstrating a considerable increase across the hospital.
- The majority of restraints occurred on Wollaton Ward, where there were 211 restraints within the same period 29 of which were prone restraint. Prone restraint is where the patient is restrained in the chest down position.
- Restraint was only used after de-escalation had failed and the provider was working to ensure that all staff were trained using the same management of actual or potential aggression technique.
- There was minimal use of rapid tranquilisation and where used staff ensured physical health monitoring was in place following rapid tranquilisation.
- We examined seven patient records. We found comprehensive risk assessments in all records. Care records were held electronically and paper copies were kept in the nursing office.
- Staff undertook risk assessments of patients on admission and we found that these were updated regularly.
- The provider employed a dedicated staff team to conduct regular physical health monitoring of patients .
- We reviewed three seclusion records and found that in all the records four hourly medical reviews were not conducted in line with the provider's seclusion policy. Some patient's details were not recorded on every seclusion record within the seclusion pack. This meant that if the pack was separated it would be difficult to know if seclusion was monitored safely.
- There was a robust medicines management policy in place, staff we spoke with told us that a pharmacist visited the ward weekly and conducted regular medication audits. The provider used electronic prescribing to streamline prescribing.
- Staff were in the process of engaging in safeguarding training provided by the local authority looking at how to report and investigate safeguarding incidents. To date 30 staff had undertaken this training. The provider also had regular meetings with the local multiagency safeguarding hub.

Track record on safety

- The provider reported 34 serious incidents in the past 12 months.
- Incidents included patient assaults on staff and peers as well as security incidents.
- The provider was monitoring incidents and meeting regularly to make plans to prevent further incidents. Incident monitoring included mapping the times incidents were most likely to occur and increasing staffing numbers at these times.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew what incidents to report and how to report them
- Where incidents were reported we found that there were effective procedures for doing so and these had been followed. However there was often a delay in reporting notifications to CQC. We received three notifictaions which were over 6 months old in the period from September 2016 to September 2017.
- Staff we spoke with told us that they received feedback from investigation of incidents both internal and external to the service; this was delivered in the morning meetings, and in individual supervision.
- Staff were offered a debrief after serious incidents and patients were debriefed in individual sessions and at ward community meetings.

Are forensic inpatient/secure wards well-led?

Vision and values

- Staff we spoke with knew and agreed with the provider's vision and values. The provider's vision is transforming lives by delivering world class, holistic care. We saw evidence of St Andrew's Healthcare values compassion, accountability, respect and excellence displayed on notice boards around the wards and staff gave examples of how they implemented these values in their practice.
- The team objectives reflected the organisation's vision and values. Each ward had a dashboard reflecting key

performance indicators for each ward. Managers displayed these in easy read format on the wards for patients and staff to be aware of. Examples of key performance indicators included safe staffing and reducing the number of incidents.
- Staff we spoke with told us that they felt well supported by their ward managers and the modern matron; however they were less knowledgeable about more senior managers within the organisation. The provider had made recent appointments at clinical director and nursing director level, who had undertaken ward visits.
- We observed staff talking positively with and about patients and this was reflected in documentation we reviewed.
- Staff we spoke with told us they were proud of the work they did and were passionate about caring for this patient group.
- The provider supported staff with career development at all levels of the organisation.

Good governance

- Managers ensured staff received monthly clinical and managerial supervision and annual appraisal.
- Managers ensured shifts were covered by a sufficient number of staff of the right grades and experience, although the provider acknowledged that recruitment and retention of qualified staff had been difficult.
- Staff we spoke with told us that they participated in clinical audits or care records and care plans.
- Staff told us that managers shared learning from incidents, complaints and patient feedback and that this learning was acted upon. We saw evidence of this in team meeting and patient community meeting minutes. The provider also held daily morning meetings Monday to Friday where they discussed any incidents and staffing. We attended a meeting and were given access to the minutes of previous meetings.
- Ward managers told us that they had sufficient authority to do their job and administrative support.
- We saw evidence in staff files that the provider had clear and effective processes for managing risks issues and performance.
- The provider monitored its performance with the aim of reducing incidents and had produced a six monthly learning from experience report which detailed the monthly incidents and was shared with staff and patients.
- In some cases there was a significant delay in reporting notifications to the CQC.

Leadership, morale and staff engagement

- Staff we spoke with told us there was good morale within teams and no cases of bullying or harassment. Staff spoke about a culture of team working and mutual support.
- Staff knew the whistle blowing process and said they would be confident to use it if necessary, without fear of victimisation.
- There were opportunities for leadership and development of staff. Staff told us that the provider supported them to maintain professional accreditations and training in evidence based therapies and techniques.
- Staff were open and transparent with patients when things went wrong. We also saw evidence in patient meeting minutes of patient feedback on the service being taken into account.
- Staff and patients were offered the opportunity to provide input into service development.

Commitment to quality improvement and innovation

- The provider was a member of the Royal College of Psychiatrists College Centre for Quality Improvement network which aims to raise the standard of care for people with mental health needs through self and peer review.
- We were also told about the providers plans to offer dynamic deconstructive psychotherapy on Wollaton ward.
- The provider was working towards training staff on the National Autistic Society's SPELL framework for understanding and responding to the needs of people on the autism spectrum. The framework stands for structure, positive approaches and expectations, empathy, low arousal, links.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure seclusion reviews take place and are documented clearly in line with the provider's policy.
- The provider must ensure that all ligature risks are assessed and mitigated against.
- The provider must ensure the timely maintenance of equipment and estates.
- The provider must do more to reduce the incidence of restraint.
- The provider must ensure the timely notification of incidents to statutory bodies.

Action the provider SHOULD take to improve

- The provider should ensure that all staff know the role and responsibility of senior managers.
- The provider should examine the issue of play fighting amongst patients and guide staff on how to deal with it.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Seclusion records were not adequately documented to show that patients received medical reviews in line with the provider's policy. Not all ligature risks were identified, assessed and mitigated against. Maintenance of equipment and estates was not conducted in a timely manner. The incidents of restraint and prone restraint had increased since the last report. This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents There was often a delay in the providers reporting of notifiable incidents to the CQC. This was a breach of regulation 18.