St Andrew's Healthcare - Womens Service

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

We did not rate this service.

We found:

- The provider had strengthened the implementation of positive behaviour support planning since the last inspection in June 2016.
- All staff we spoke with in learning disabilities services followed positive behaviour planning (PBS) and least restrictive practices. They were knowledgeable about the principles of PBS and were involved in observing behaviour and reporting to the multidisciplinary team to enable planning. PBS care plans were available in paper form for staff to have easy access and in easy read for patients when needed, as well as on the electronic system.
- Staff were caring and keen to do the best for the patients. They were respectful in their approach.
- Staff told us and plans showed that restraint was used as a last resort and staff tried to de-escalate and divert patients who were becoming distressed or agitated. Prone restraint was used only when the patient had requested it in their care planning (some patients prefer to the floor forward instead of backward), the patient had put themselves on in that position or if an injection was required. The patient was turned onto their side or back as soon as possible and the majority of prone restraints lasted less than three minutes. The training department staff supported and trained staff to use other sites for injecting medication to reduce the need for any prone restraint to give medication.
- Data provided showed a downward trajectory in the use of restraint and in the use of prone restraint. Staff reported incidents accurately and in line with the provider's policy.
- Staff received mandatory and specialist training and most were up to date.

We also found:

- The electronic system was difficult to navigate to find key documents such as PBS reports and some plans. Some documents were saved on a shared drive rather than in the electronic system. Staff we spoke with knew where information was, however, information was not consistently in the same place for each record.
- The behaviour observations sheets used codes for behaviour and it was not always clear the exact behaviour to which the code referred. This meant staff may not be clear what behaviour was expected in certain situation.

Summary of findings

- Medical staff raised an issue about completing medical reviews for seclusion at night with only one doctor on duty for the site, and a second doctor available until midnight.

Summary of findings

Contents

Location name here

Services we looked at

Wards for people with learning disabilities or autism;

Summary of this inspection

Background to St Andrew's Healthcare - Womens Service

St Andrew's Healthcare Northampton has been registered with the CQC since 11 April 2011. The services have a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

Northampton is a large site consisting of more than ten buildings, more than 50 wards and has 659 beds.

St Andrew's Healthcare also has services in Nottinghamshire, Birmingham and Essex.

The locations at St Andrew's Healthcare Northampton have been inspected 19 times. The last inspection was in June 2016.

Patients receiving care and treatment at St Andrew's Healthcare follow care pathways. These are women's mental health, men's mental health, autistic spectrum disorder, adolescents, neuropsychiatry and learning disabilities pathways.

The following service was visited:

Wards for people with learning disabilities or autism:

The services for patients with learning disabilities and autism provide inpatient accommodation for patients with learning disabilities over the age of 18 years. We inspected the following wards:

- Sitwell ward, a 13 bed medium secure service for women with learning disabilities and /or autistic spectrum conditions.
- Spencer North ward, a 12 bed low secure service for women with learning disabilities and/or autistic spectrum conditions.

We did not visit:

- Watkins House is a six bedded rehabilitation house, part of the learning disability pathway. Restraint is rarely used. There was one incident in the 12 months prior to the inspection.

The learning disabilities (LD) pathway provides care and treatment for adults with mild to moderate learning disabilities and other neuro-developmental disorders who have offended or display behaviour which challenges. People in the autism services have co-existing conditions such as mental and physical illness or additional developmental disorders such as personality disorder which put themselves or others at risk.

This inspection was a focused inspection looking at the use of restraint in learning disabilities services. We gave the provider a week's notice of our intention to carry out this inspection. We also inspected the LD and autism wards in men's services and the adolescent services.

Our inspection team

Team leader: Margaret Henderson

The team that inspected this service comprised one CQC inspector, one national professional advisor in learning disabilities and a specialist advisor who is a consultant psychiatrist with learning disabilities experience.

Why we carried out this inspection

We carried out this focused inspection following concerns raised by other organisations nationally about the use of restraint in learning disabilities services.

Summary of this inspection

How we carried out this inspection

We carried out this inspection as a focused inspection looking specifically at the use of restraint in learning disabilities services. It was announced a short time before our inspection to enable the provider to provide up to date information.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- interviewed the nurse manager for each of the wards
- spoke with 21 other staff members; including doctors, nurses, healthcare assistants, clinical and forensic psychologists, trainee psychologists
- looked at 23 care plans and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke briefly with six patients. They did not want to talk about restraint in any detail only to say they had been restrained. A patient in an extra care suite said she was fine. Three patients told us there was not enough staff.

We spoke with a carer who told us their relative was a different person since coming to the service a few months back. They had seen a significant improvement and had no concerns about the care they received at St Andrew's. They said they felt they could raise any concerns if they needed to. They said they were kept informed and could speak to their relative at any time.

We reviewed the action plan from a carer's event held in June 2016. The main points were that carer's wanted more information and wanted to be involved more, St Andrew's had taken action to improve these.

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:

- Staffing numbers met establishment levels and extra staff were used to cover increased observation and enhanced care staffing. The provider had their own bank (bureau) and they used regular agency, whenever possible, if needed.
- The provider had strengthened the implementation of positive behaviour support planning since the last inspection in June 2016. All staff we spoke with in learning disabilities services followed positive behaviour planning (PBS) and least restrictive practice. They were knowledgeable about the principles of PBS and were involved in observing behaviour and reporting to the multidisciplinary team to enable planning. PBS care plans were available in paper form for staff to have easy access and in easy read for patients when needed.
- Staff told us and plans showed that restraint was used as a last resort and staff tried to de-escalate and divert patients who were becoming distressed or agitated. Prone restraint was used only when the patient had requested it in their care planning (some patients prefer to go to the floor forward instead of backward) or in some cases if an injection was required. The patient was turned onto their side or back as soon as possible and the majority of prone restraints lasted less than a minute. The training department staff were supporting staff to use other sites for injections to reduce the need for any prone restraint to give medication.
- Data provided showed a downward trajectory in the use of restraint and in the use of prone restraint.
- Staff had received mandatory training and were more than 93% were compliant. They had also received specific training in positive behaviour support planning and managing aggression.
- They reported incidents in line with the provider's policy. The managers reviewed incidents, including the use of restraint and seclusion.

However:

- The electronic system was difficult to navigate to find key documents such as PBS reports and some plans. Some documents were saved on a shared drive rather than in the electronic system.

Summary of this inspection

- The behaviour observations sheets used codes for behaviour and it was not always clear the exact behaviour the code referred to. This meant staff may not be clear what behaviour was expected in certain situations.
- Medical staff raised an issue about completing medical reviews for seclusion at night with only one doctor on duty for the site, and a second doctor available until midnight.

Are services caring?

- Staff were caring and respectful in their approach to patients and showed an understanding of individual need.
- Patients were involved where possible in their care planning. Care plans were available in easy read format. Carers were involved where possible and staff used technology to help patients keep in contact with relatives who lived some distance away.
- Advocacy services were available.
- Patients were involved in training staff in managing aggression.

Wards for people with learning disabilities or autism

Safe	
Caring	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- The seclusion rooms, extra care suites and low stimulation rooms all met required standards of safety, comfort and cleanliness. The seclusion rooms had two-way observation, toilet facilities and a clock. Staff completed cleaning records for the seclusion rooms and undertook environmental risk assessments of the seclusion areas as required.
- Staff used personal alarms and radios to summon assistance if required.

Safe staffing

- Staffing numbers met establishment levels and extra staff were used to cover increased observation and enhanced care staffing. The provider had their own bank (bureau) and they used regular agency, whenever possible, if needed. There were 11.5 vacancy for qualified staff, however unqualified staff were over establishment by six staff members. There were two qualified nurses per day and night shift, and between three and five healthcare assistants. Managers told us the provider was running an 'Aspire' programme which is a 'grow your own' nursing programme where they support individuals to become qualified nurses.
- Over a three month period, between November 2016 and January 2017, the two wards used a total of 2,348 shifts covered by bank or agency staff. Of these, 1,981 (84%) were covered with bank staff. Agency staff covered the remaining 367 (16%) shifts.
- Nursing staff were present in all patient areas. Staff provided individual sessions with patients as per care plan.
- There was one psychiatrist on duty overnight with a second working until midnight for the whole site. This meant that if there were a high number of patients in seclusion across the site the psychiatrist found it difficult to complete the required medical reviews in a timely manner. Two psychiatrists we spoke with raised this as an issue.
- Staff received mandatory training and were more than 93% were compliant. Some staff had also received specific training in positive behaviour support planning. There were also sessions on the ward as part of reflective practice to support staff in PBS.
- Staff were trained in the prevention and management of aggression and violence (PMAV), more than 94% of staff had received this training. In January 2016 the provider had introduced the management of actual and potential aggression (MAPA) training with 50% on Sitwell and 60% on Spencer North having received the training and a programme was in place to train the remaining staff. MAPA places more emphasis on de-escalation and preventing aggression. Staff we spoke with were knowledgeable about the differences in each training and said that the person taking the lead in any restraint situation would direct the staff in how to respond. MAPA is a nationally recognised training. Feedback from staff who attended the course was positive about the content and delivery of the course.

Assessing and managing risk to patients and staff

- The provider had strengthened the implementation of positive behaviour support planning since the last inspection in June 2016. All staff we spoke with in learning disabilities services followed positive behaviour planning (PBS) and least restrictive practice. They were knowledgeable about the principles of PBS and were involved in observing behaviour and reporting to the multidisciplinary team to enable planning. Across LD services 70 staff had been trained in PBS since November 2016 and a further 70 planned before the end of 2017. PBS care plans were available in paper form for staff to have easy access and in easy read for patients when needed. The plans included a pen portrait, skills, needs and plan for each patient. The assistant psychologist checked all information was input onto the system from the behaviour observation forms. The assistant psychologists produced functional analysis reports for staff.
- Care plans identified triggers to certain behaviours, coping skills and how staff could help the patient cope with them. These were discussed at ward rounds and

multidisciplinary meetings. All except two patients had a PBS plan in place and the two were in progress. Managers told us staff had implemented 'calm down' boxes, personalised to individual patients. These boxes contained items chosen by the patient that they had identified would help them to calm down. Staff used these to help patients de-escalate. They had proved to be successful and managers had rolled them out across other wards.

- Staff told us and plans showed that restraint was used as a last resort and staff tried to de-escalate and divert patients who were becoming distressed or agitated. Prone restraint was used only when the patient had requested it in their care planning (some patients prefer to the floor forward instead of backward) or in some cases if an injection was required. The patient was turned onto their side or back as soon as possible and the majority of prone restraints lasted less than a minute. The training department staff were supporting staff to use other sites for injections to reduce the need for any prone restraint to give medication. A report provided to us for this inspection stated that over a third of staff had completed the reinforce appropriate implode disruptive (RAID) training. RAID training is a three day course which aims to promote proactive management of risk behaviours. Staff would need to have basic knowledge around the RAID principles in order to fully understand the PBS. This training also teaches a philosophy to manage behaviour that challenges and to nurture positive behaviour and is nationally recognised.
- Data provided showed a downward trajectory in the use of restraint and in the use of prone restraint. Staff reported any hands on care as a restraint, including guiding someone to a certain area or touching an arm for example. The data did not differentiate between a gentle guiding of a patient and a full restraint.
- The electronic system was difficult to navigate to find key documents such as PBS reports and some plans. Some documents were saved on a shared drive rather than in the electronic system.
- The behaviour observations sheets used codes for behaviour and it was not always clear the exact behaviour the code referred to. This meant staff may not be clear what behaviour was expected in certain situations.
- From 1 January 2016 to 26 January 2017 there were 1,208 restraints in this service across the three wards. One restraint was in Watkins House which is a step down unit for patients nearing discharge, 595 were on Sitwell and 612 were on Spencer North. Of the incidents of restraint on Sitwell 51% were for one patient, of the incidents on Spencer North 54% were for three patients. Of the 595 on Sitwell 511 were for ten minutes or less, on Spencer North 358 of the 612 were for ten minutes or less. St Andrew's Healthcare staff record any hands on contact with patients as restraint.
- Of the 595 incidents of restraint on Sitwell, 221 used the prone position, 58% of these were for the same patient during this time. Prone position was used on 37 occasions to administer medication or on 130 occasions to exit seclusion, with two being patient preference and 37 owing to patient using that position. 139 of the prone restraints on Sitwell were for less than three minutes and 72 were for less than ten minutes. Of the 612 incidents of restraint on Spencer North, 183 used the prone position, over 60% of these were for the same three patients. Prone position was used on 88 occasions to administer medication, on 16 occasions to exit seclusion, and 49 owing to patient using that position. 130 of the prone restraints on Spencer North were for less than three minutes and 45 were for less than ten minutes. Staff told us that the majority were for less than a minute but the system did not capture that time. The data provided had less than three minutes as the minimum time captured.
- Staff injuries occurred on 40 occasions on Sitwell. Of these 16 were caused during the restraint and 22 caused by patient aggression. On Spencer North there were 66 staff injuries, ten during the restraint and 48 caused by patient aggression.
- During the same time period there were 314 episodes of seclusion on Sitwell and Spencer North, 224 on Sitwell and 90 on Spencer North, with 243 lasting over one hour and 40 minutes.
- There were three patients in the women's learning disabilities/autism services subject to Ministry of Justice restrictions at the time of our visit.
- Sitwell was part of a pilot to introduce "safewards" to the organisation. Safewards enables staff to identify ways of reducing the use of restrictive interventions. Sitwell had implemented nine of the ten recommended interventions. Policies have been updated to reflect latest national guidance and the Mental Health Act code of practice.

Wards for people with learning disabilities or autism

Track record on safety

- We looked at incidents related to restraint. There were no serious incidents reported related to restraint. Incidents were investigated and appropriate action taken.

Reporting incidents and learning from when things go wrong

- The incident reporting system had been updated to enable deeper analysis on restraint. Data was provided which included the reason for prone restraint. Episode of restraint was reported as an incident on the electronic system. The ward manager and senior managers received a trigger and reviewed each incident.
- Staff discussed restraint incidents and seclusion at the multidisciplinary meetings (ward reviews). The ward managers received a monthly dashboard which contained information about the incidents of restraints and seclusion. The provider had a least restrictive practice monitoring group which meets monthly to review incidents also.
- The training leads for managing aggression and for positive behaviour support planning attended the wards when requested to help staff learn from incidents and review restraint use. This included how to do things differently if appropriate. We were given a copy of the visit tracker to show visits for December 2016 and January 2017. Closed circuit television was used to review individual incidents when needed.

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- Staff were caring and respectful in their approach to patients and showed an understanding of individual need. They spoke about patients in a respectful manner.

The involvement of people in the care they receive

- Patients were involved in their care planning unless they declined. Care plans were available in easy read format.
- Carers were involved where possible. Staff used technology to help patient keep in contact with relatives who lived some distance away. St Andrew's held a carer's event in June 2016 to look at how carer involvement could be improved. We saw the action plan from this which identified how to improve communication, provision of information to carers and how carers can be more involved in review meetings.
- Advocacy services were available to patients if requested.
- Ex-patients were involved in training staff in managing aggression for the organisation.
- Some patients had advance decisions in place for how they wanted to be restrained if that was needed.
- Patients in the service can access an online feedback webpage and receive a response from the provider. There have been comments by some patients in this service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider reviewing the behaviour observation paperwork to make is clearer and simpler.
- The provider should continue to review the electronic system to ensure information is saved consistently and easy to access.
- The provider should ensure doctors can carry out reviews of patients in seclusion at night.