Surrey and Borders Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXXZ4	St Peter's Site	Anderson ward	KT16 0QA
RXXZ4	St Peter's Site	Blake ward	KT16 0QA
RXXZ4	St Peter's Site	Clare ward	KT16 0QA

This report describes our judgement of the quality of care provided within this core service by the staff of Surrey and Borders Partnership NHS Foundation Trust at the Abraham Cowley Unit at the St Peter's Site. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Surrey and Borders Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Surrey and Borders Partnership NHS Foundation Trust.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found the following issues that the service provider needs to improve:

- The unit had a heavy reliance on temporary staff. Permanent staff had not been co-ordinated and allocated across Anderson ward and Blake ward. Temporary staff may not be as familiar with patients or procedures on the ward as permanent staff. This may potentially have an adverse impact on the quality of care provided to patients.
- Agency staff on Anderson ward were not familiar with the ward procedures and on the day of our inspection did not have access to the patient electronic records. This prevented staff from being able to access patients' care plans and risk assessments.
- During the inspection, we observed nurses discussing confidential patient related information in the presence of other patients.
- There was no evidence of risk assessments undertaken for patients attending the shared dining room. Risk assessments of patients on Anderson ward were not always updated following patient incidents.
- There was no clear management process for staff and patients at mealtimes. It was not clear to staff who remained on the ward, which patients or staff had left the ward to go to the dining room. Some staff allowed all patients to eat in the dining room, whilst others were using RAG (red, amber or green) risk levels to determine which patients were safe to eat the dining room. Staff who escorted patients back to the ward did not communicate their remaining patients' needs or risks to the staff members remaining in the dining room.
- Staff on Blake ward were unclear as to whether windows in the dormitory should be opened or closed and were not all able to communicate the latest policy decisions surrounding the windows.

We fed back our immediate concerns to members of the trust executive team, members of which subsequently provided us with an improvement plan to address the immediate concerns we had raised.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found the following issues that the service provider needs to improve:

- The unit had a heavy reliance on temporary staff, who were not always familiar with the ward procedures and did not have access to the electronic patient records.
- There was no clear management process for mealtimes. Staff gave conflicting information about which patients could go to the dining room.
- There were no risk assessments for patients attending the shared dining room.
- Staff on Blake ward were unable to provide a clear rationale as to whether the windows in the dormitory should be open or closed.
- We found that not all observation records were completed. We were therefore unable to ascertain as to whether these observations had been carried out in accordance with the observation policy for each patient.

Are services effective?

We found the following issues that the service provider needs to improve:

- There were no discussions at Anderson ward or Blake ward morning handovers regarding patients' risks for attending the dining room for meals or moving around the hospital.

However, we also found the following areas of good practice:

- We saw that the SBAR handover document included a picture of each patient, which would be helpful for temporary staff familiarising themselves with the patients on the ward.

Are services well-led?

We found the following issues that the service provider needs to improve:

- Whilst a trust protocol for escorting people from the ward to the dining room during meal times was in place, the senior management had not ensured that risks at mealtimes were being routinely and regularly assessed and mitigated by staff on the wards.

Summary of findings

- The senior management had not ensured that all staff were familiar with the policy for the safe and effective management of the closure of windows in the unit.

Summary of findings

Information about the service

The Abraham Cowley Unit is located on the St Peter's hospital site and is run by Surrey and Borders Partnership NHS Foundation Trust. It is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

The service had both informal patients and patients detained under the Mental Health Act.

Our inspection covered the three acute wards for adults of working age:

- Anderson ward, an acute ward with 13 beds for women.
- Blake ward, an acute ward with 20 beds for both men and women.
- Clare ward, an acute ward with 20 beds for men.

This inspection primarily focused on Anderson ward and Blake ward, although we visited Clare ward too.

We last inspected this service in April 2017 during an unannounced, focused inspection. During that inspection we found that the trust had not ensured that patients' accommodation in dormitories had adequate levels of light and suitable levels of privacy. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (RA) Regulations 2014.

We also observed clinical conversations happening in the dormitory bed spaces while patients were opposite, which meant that conversations were overheard. We looked at the care records and found that 14 of the 23 sets did not have a care plan that was recovery orientated or highlight the individual patient's full range of strengths and weaknesses. In addition, five of the patients on Clare ward did not have any care plans in place. Finally, the modified early warning score (MEWS) was being inconsistently applied to the patients.

Following the inspection in April 2017, the team carried out a follow-up visit to the hospital later in April 2017 to ensure that the immediate issues in relation to safety had been addressed. The issues that were not influenced by changing the environment of the hospital had been addressed. The care plans and risk assessments for patients had all been reviewed and updated and physical health monitoring was taking place and being recorded consistently.

However, the dormitories and the physical layout of the ward remained as described in the last report in 2017.

Our inspection team

The inspection team comprised a Care Quality Commission (CQC) inspection manager, three inspectors and a Mental Health Act reviewer.

Why we carried out this inspection

We received notification of a death on Blake ward at the Abraham Cowley Unit in March 2018. When the patient had been admitted to the ward they were placed on 15 minute observations for their safety. Staff were escorting other patients to the dining room and not all observations were carried out leaving this patient unobserved for 45 minutes. During this time the patient had died by using a ligature point tied to a window in their bedroom, a ligature point is a fixture or fitting that patients can use to suspend themselves from, causing self-injury or ultimately death.

Summary of findings

The circumstances of the death led us to undertake an unannounced, focused inspection, to review the safety of all patients, specifically at meal times, as this was when the death occurred.

Prior to this death, another patient had died on the ward in March 2017 by using a ligature point tied to a window on the same ward.

The Abraham Cowley Unit had a shared dining room for patients from Anderson ward, Blake ward and Clare ward. Patients from the three wards moved to this shared dining room for each meal, rather than receiving their meals on their wards.

As this was not a comprehensive inspection, we did not pursue all our key lines of enquiry. Therefore, this report does not indicate an overall judgement or rating of the service.

How we carried out this inspection

During this inspection we considered areas of the service to make a judgement on the following questions:

• Is it safe?

• Is it effective?

• Is it well-led?

Before the inspection visit, we reviewed information that we had requested from the trust and information that we held about the provider.

During the inspection visit, the inspection team:

- visited Anderson ward, Blake ward and Clare ward to review the quality of the environment and observed how staff cared for patients
- observed the morning staff handover on Anderson ward and Blake ward
- carried out specific checks on the management of meal time arrangements, including patients being escorted from the wards to the dining room and back to the wards
- spoke with two patients who were using the service
- looked at 22 patients' electronic records.
- spoke with six staff members, including qualified nurses and a trainee nurse, health care assistants, ward managers and the matron responsible for all three wards
- looked at a range of policies, procedures and other documents relating to the running of the service

On 3 May 2018, after our inspection, the trust executive team provided us with an urgent improvement plan to address the immediate concerns we had raised.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients are risk assessed to use the dining room and for their movements around the unit and mitigate the identified risks.
- The provider must assess the risks of patients being able to bring cutlery back to the ward from the dining room and mitigate the identified risks.
- The provider must ensure that risk assessments are updated after incidents.
- The provider must ensure there are sufficient skilled staff, who are familiar with the procedures on the ward and who have access to the patients' electronic records.
- The provider must ensure that observations and the observation records are completed.

Action the provider SHOULD take to improve

- The provider should ensure that all staff members understand the protocol for windows, whether they should be open or closed.

Summary of findings

- The provider should ensure that staff at handovers on all wards are ensuring that essential information from the previous shift is handed over.
- The provider should ensure that staff follow their search policy.
- The provider should ensure that all staff consistently apply and understand the policy mitigating ligature risks and keeping patients safe.

Surrey and Borders Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Anderson ward	St Peter's Site
Blake ward	St Peter's Site
Clare ward	St Peter's Site

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.

Patients detained in hospital under the Mental Health Act have the right to leave hospital if they have a leave of absence granted by their doctor. This is known as section 17 leave and it should be recorded on a standardised form and kept with the patient's notes. Staff on Blake ward were unable to provide us with a copy of a patient's section 17 leave form, despite the patient being out on leave. The section 17 leave form was provided to us later that day.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Staff on Blake ward provided inconsistent information to us about whether the toilet doors needed to be locked to maintain safety for all patients. Staff told us that one of the toilet cubicles was kept locked and one unlocked, as we saw was the case. We were informed by ward staff that if two patients were rated high for risk of suicide then all the toilets would be locked. However, at the time of our inspection, contrary to their policy, there were two patients rated high for suicide risk and the toilets were open.
- During our inspection of Blake ward, we observed a staff member standing outside the toilets at all times.
- During the inspection we observed nurses discussing confidential patient related information in the presence of other patients. This meant that patients' privacy and dignity were compromised.

Safe staffing

- We observed that there was a high proportion of temporary staff, rather than permanent staff on the wards. We observed that whilst there was a unit coordinator rota, the staffing had not been coordinated across the wards so that permanent staff were equally allocated to each ward. On the day of our visit only one member of staff on Anderson ward was permanent on the day shift. This staff member left to escort a patient for treatment leaving the ward staffed by agency staff. Temporary staff may not be as familiar with patients or procedures on the ward as permanent staff, lowering the level of care provided to patients. On Blake ward there were three permanent staff members on the day shift. Ward managers told us that they tried to use regular bank or agency staff wherever possible, which would in part, mitigate the risks as regular agency staff would be more familiar with the ward.
- The Matron told us that Anderson ward was understaffed two to three times a week. The trust executive team informed us that the trust was committed to recruiting more staff and that recruitment was underway. We were also informed that some staff were moving over from another service that was closing within the trust.
- Agency staff on Anderson ward did not have access to the electronic patient records. We raised this concern with the hospital managers, who took immediate action to provide those staff with access, by moving a senior staff member from another ward to Anderson Ward. Staff on Anderson ward were not familiar with the ward procedures. We observed that the senior nurse on duty, who was an agency staff member, did not know how to contact the ward doctor.
- All staff and patients were required to walk past the main exit to the unit in order to reach the dining room. As prescribed in the Protocol for escorting people during meal times, wards took it in turn to send a member of staff to stand by the main exit during meal times. During our visit to Blake ward, we were told that it was Blake ward's turn. This meant that there were three staff members off the ward during meals times, two staff members escorting patients to the dining room and one standing by the main exit.

Assessing and managing risk to patients and staff

- We looked at 13 patients' electronic records on Anderson ward and nine records on Blake ward. Whilst all patients had risk assessments, staff had not updated these for two patients on Anderson ward following recent incidents. On Anderson ward, for one patient, there was no clearly documented rationale for why assessed risk levels had been reduced. We raised this with the trust executive team who told us that they were going to take immediate action to check all the patients' risk assessments were updated.
- On the electronic patient notes that we looked at, there was no risk assessment for patients moving to or attending the shared dining room, despite it stating in the trust's protocol that the multi-disciplinary team should conduct risk assessments before patients leave the ward and that concerns should be documented in care plans and risk assessments.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Only a minority of patients from Anderson ward went to the dining room for breakfast or lunch. The ward staff we spoke to during the inspection were unable to articulate what these patients risk levels were and it was not communicated in risk assessments. This could have left both staff and patients vulnerable.
- All patients who attended the dining room had access to the cutlery. We did not see any consideration or risk assessment to prevent cutlery being brought back to the ward, which could be used to cause injury. Or any mitigation of the risks.
- Staff on Blake ward gave conflicting information about which patients could go to the dining room for their meals. Night shift staff thought that all patients could go to the dining room, as we observed at breakfast time. This also included a patient who was on constant observation. Constant observation is when a member of staff remains with a patient at all times, often due to concerns about the patient's own safety or safety to others. Day staff told us that they used a risk rating system called RAG (red, amber, green) and that patients who were rated red or were on constant observations should have their meals on the ward.
- We saw staff escorting patients from the dining room back to their wards after they had finished their meal but we did not see any communications between the staff regarding the remaining patients' from their ward and their needs or risks.
- We observed that no record was kept when patients left the ward to go to the dining room. This meant that the staff were unable to say where patients were.
- Following the death on Blake ward, the windows in the unit were closed in accordance with the policy. However, staff were unable to provide clear rationale as to why the windows were open or closed. During the inspection we were told by staff that the windows on the unit were currently being updated to windows with a safer mechanism. This is to ensure a safer ward environment for the patients as the current windows are a style which could be used as a ligature point.
- The staff on Anderson ward were unable to provide a copy of the ligature risk assessment that identified actions to mitigate the risk. However, after the inspection, the trust provided us with a copy of a ligature risk assessment including mitigation plans, which pre-dated the date our inspection.
- On Blake ward, we observed that staff had failed to record when a patient returned from leave. We raised this with the ward staff at the time, who checked that the patient had returned to the ward and recorded his return time. Staff on Blake ward had also failed to search this patient, who previously set a fire on the ward the night before.
- We saw on both Anderson ward and Blake ward that hourly environmental baseline checks were not always carried out. We also saw on both Anderson and Blake ward that staff had failed to record that observations of patients who were meant to be observed at set intervals in the day, had been completed in accordance with the trust policy.
- The garden on Blake ward could not be directly viewed from the nurses' station and patients had unescorted access with their key fobs until midnight. The most recent risk assessment on Blake ward states that the risks in the garden were said to be mitigated by staff observing the garden. However, the garden did not feature on the ward environment check list, which was completed hourly by staff. There were a number of ligature risks in the garden. Staff assured us that if a patients' risk level required an increased level of observations then this would mitigate risks and ensure their safety in the garden.
- Patients were risk assessed as to their suitability to be placed in the single rooms, rather than the dormitories. The windows in the single rooms were of a style which could be used as a ligature point. We saw that all the windows in the single rooms were locked, as per the trust policy. The work to upgrade the windows to minimise ligature risks was being carried out on Blake ward on the day of our inspection.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at all 13 patients' electronic records on Anderson ward and nine records on Blake ward. The care plans did not always provide detail as to how patients' risks would be managed. We found one that contained the wrong name and others that contained the wrong genders.

Multi-disciplinary and inter-agency team work

- We observed the morning handover between shifts on Anderson ward and Blake ward. The SBAR (situation, background, assessment, recommendation) method was being used to communicate information. There were no discussions at Anderson ward or Blake ward morning handovers regarding patients' risks for attending the dining room for meals or moving around the hospital. This left patients and staff at risk.
- The Anderson ward handover was comprehensive, discussing observation levels, risks, diagnosis and past 24 hour presentation of patients. However, on Blake ward we did not find this was the case and a serious allegation being made by a patient during the night shift was not raised at the handover. On Blake ward, necessary information was not being handed over from the previous shift.
- We saw that the SBAR handover document included a picture of each patient, which would be helpful for the temporary staff to familiarise themselves with the patients on the ward.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Good governance

- Whilst a trust protocol for escorting people during meal times was in place, the senior management team had not ensured that risks at mealtimes were being assessed and mitigated on the wards. The trust protocol detailed the procedure for meal times, such as how many staff from each ward should go.
- The senior management had not ensured that all staff were familiar with the policy for the safe and effective management of the closure of windows in the unit.

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 The trust had not risk assessed patients to use the dining room and for their movements around the unit, nor mitigated the identified risks. The trust failed to assess the risks of patients being able to bring cutlery back to the ward from the dining room and mitigate the identified risks. **This was a breach of Regulation 12(1)(2)(a)(b)** The trust failed to ensure that all risk assessments were updated following incidents. **This was a breach of Regulation 12(1)(2)(a)(b)** The trust failed to ensure that all patient observations were carried out and recorded. **This was a breach of Regulation 12(1)(2)(a)(b)** The trust failed to ensure there are sufficiently skilled staff, who are familiar with the procedures on the ward and who have access to the patients' electronic records. **This was a breach of Regulation 12(1)(2)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The management team failed to assess, monitor and mitigate the risks to patients attending the dining room and moving around the unit. **This was a breach of Regulation 17(2)(b)**