Tees, Esk and Wear Valleys NHS Foundation Trust

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

Inspection report

West Park Hospital
Edward Pease Way
Darlington
DL2 2TS
Tel: 01325552000
www.tewv.nhs.uk

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

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

Requires Improvement 

We carried out this unannounced focused inspection to see whether improvements had been made since our last inspection in January 2021. On that inspection, we issued a warning notice under Section 29A of the Health and Social Care Act.

On this inspection, we checked whether improvements had been made to address the concerns identified. These include, the systems to comprehensively assess and mitigate patient risk on the wards, monitor and audit patient risk assessment processes and to learn fully from serious incidents. This is in line with our published guidance to follow up inadequate rating and section 29A warning notices.

The trust has 12 mental health acute inpatient wards and two psychiatric intensive care units located in five hospital locations. The service provides treatment for people who are acutely unwell and whose mental health problems cannot be treated and supported safely or effectively at home.

We inspected the following nine wards from the acute wards for adults of working age and psychiatric intensive care unit services:

- Bilsdale ward – 14 bed male acute admission ward at Roseberry Park, Middlesbrough
- Bedale ward – 10 bed mixed gender psychiatric intensive care ward at Roseberry Park, Middlesbrough
- Overdale ward – 18 bed female acute admission ward at Roseberry Park, Middlesbrough
- Elm ward – 20 bed female acute admission ward at West Park Hospital, Darlington
- Cedar ward – 10 bed mixed gender psychiatric intensive care ward at West Park Hospital, Darlington
- Tunstall ward - 20 bed female acute admission ward, Lanchester Road Hospital, Durham,
- Esk ward – 13 bed female acute admission ward at Cross Lane Hospital, Scarborough
- Ebor ward – 18 bed female acute admission ward at Foss Park Hospital, York
- Minster ward – 18 bed male acute admission ward at Foss Park Hospital, York

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected on 25 to 27 May 2021.

This was a focused inspection looking at the safe and well led key questions. Our rating of this core service improved. We rated them as requires improvement because:

- We rated the safe key question as requires improvement as we have identified a breach of a regulation and issued a requirement notice. The rating will normally be limited to ‘requires improvement’ at best.
- We rated well-led as requires improvement because although the trust had better systems in place to comprehensively assess and mitigate patient risk on the wards, these had not been fully embedded yet.

Our findings

- Patient risks were still not always fully reflected within the written patient safety summaries in a small number of files we looked at.
- Staff had not always flagged current incidents, so these did not pull through into the written overview section of patient records. Information across other parts of the record usually showed that staff were mitigating these identified risks.
- Despite the improvements the trust had made, we found staff were not always following the trust's policy and expectations. We found staff had not locked one window into position on Ebor ward presenting a potential ligature risk; staff had not updated the written environment risk assessment on Tunstall ward to reflect changes to the environment and practice following a significant incident and leaders at Cross Lane Hospital were using a paper file system for safety briefing reports, but this did not include all recent reports and staff were unaware of intranet version of these recent incident reports. The trust addressed these very quickly.
- Staff were not always mitigating the risks of operating mixed sex accommodation to fully promote patients' safety, privacy and dignity as some incidents went unobserved and staff did not always fully consider the grouping of patients when allocating bedrooms.

However:

- We found that the trust had made improvements in the areas in the section 29A warning notice to the extent that we no longer had serious concerns about systemic failings relating to the governance arrangement around the management of patient risks.
- The trust now had better systems in place to comprehensively assess and mitigate patient risk on the wards.
- Staff now had better understanding regarding the risk assessment process and what was expected of them when updating documentation.
- The trust now had mechanisms in place to monitor, audit and ensure oversight of the patient risk assessment process.
- The trust now had an effective procedure and process in place to review and learn from serious incidents.

How we carried out the inspection

On this inspection, we assessed whether the service had made improvements in response to the concerns we identified during our last inspection. We therefore only looked at some of the key lines of enquiry relating to the 'safe' and 'well-led' key questions.

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

During the inspection visit, the inspection team:

- visited nine wards;
- looked at the quality and safety of each ward environment;
- spoke with 16 patients;
- spoke to 41 members of staff including ward managers, a consultant psychiatrist, nurse consultants, qualified nurses, health care assistants, a clinical psychologist; an occupational therapist, activities co-ordinators and a pharmacist technician;

Our findings

- spoke in a focus group with five modern matrons responsible for the acute and PICU wards;
- attended six multi-disciplinary report out handover meetings;
- reviewed 30 patient care and treatment records;
- observed care on the wards; and
- looked at a range of audits, policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke to sixteen patients. We received limited feedback from patients about risk assessments and risk management which was the focus of this inspection. Most of the patients were detained under the Mental Health Act and some felt they did not need to be in hospital and raised concerns about other aspects of being kept on the ward. Patients were aware of their rights as detained patients.

Most patients we spoke with found nursing and support work staff to be supportive and caring. Patients commented that they sometimes found it difficult to cope on the ward as the wards were very busy and some patients were acutely mentally unwell. Patients reported that there were often several incidents each day with, and between, other patients. However, they reported that staff worked hard to keep patients safe.

Eight patients we spoke to said that they felt that the wards were short staffed, especially at night or at weekends. Some reported that staffing levels directly impacted on patient care either because escorted leave was delayed or there were not enough activities available on the wards throughout the day. This was particularly the case at Roseberry Park. We did not specifically look at staffing levels on this inspection as it was a focused inspection. As a result of patient concerns, we asked the trust for information and looked at the trust's safe staffing data. These showed that the wards where most concerns were raised were usually staffed at or above the expected staffing numbers. We also saw that additional staff had been employed or were being recruited to increase the staffing establishment including activities co-ordinators on the wards.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safety of the ward layout

Staff usually completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Each ward had an up-to-date environmental risk assessment which identified and mitigated risks on the wards. The exception we found was that staff had not updated the written environment risk assessment on Tunstall since October 2020. A significant incident occurred in March 2021 and changes to the environment and staff practice had been made which had not been fully reflected in the written environmental risk assessment. The trust addressed this very quickly following the inspection.

Our findings

Staff could observe patients in all parts of the wards.

Some wards had mixed sex accommodation. While all the acute wards were single sex, the two psychiatric intensive care wards were mixed sex wards. Staff were not always mitigating the risks of operating mixed sex accommodation to fully promote patients' safety, privacy and dignity. There were 15 sexual safety incidents in the last six months prior to the inspection. The 15 incidents were of varied seriousness but two were serious incidents. Of these 15 incidents, six incidents went unobserved by staff either through direct or general observations. A further seven involved staff intervening which prevented escalation to a more serious incident. Of the others, one related to a verbal comment and one related to a disclosure in the community prior to the patient's admission. As a result of these incidents, managers introduced zonal observations on the ward.

On one ward, we saw that one patient had been involved in a small number of these sexual safety incidents and staff had intervened to prevent escalation to more serious incidents in each case. However, the patient's risks had not been fully reflected on their written safety summary and reviewed. Other patients on the ward who had been impacted by these incidents had also not been offered any additional support. These were addressed immediately after we escalated these concerns to the trust.

Staff were not fully considering the layout of the ward to try and group patients of the same gender together as much as possible. On the day of the inspection on Cedar ward, we saw there were two females and eight males. Three males were placed at the end of the female corridor (4 bed corridor) and one female patient was on the male corridor.

There was one nationally reported mixed sex accommodation breach over the six months prior to the inspection reported for Ebor ward at Foss Park Hospital. This breach related to the temporary cohorting arrangements needed to manage patients during the coroanvirus pandemic.

The provider had also identified a small number of environmental issues relating to sexual safety. These were the fencing on Esk ward at Cross Lane Hospital as one female bedroom looked out to an area not within the fence boundary of the female side but on the male side. The glass was frosted but the window opened slightly which could compromise patient privacy and dignity. There was a lack of appropriate screening of the facing male and female corridor windows at Foss Park so that patients could see across into the corridors of patients of a different gender. These were being addressed. All wards had en-suite accommodation which assisted with privacy and dignity.

The monthly modern matron quality review included key questions regarding mixed sex accommodation and privacy and dignity but their checks did not routinely consider the grouping of patients. The trust was operating zonal observations on some wards to improve sexual safety. Some wards were also involved in the sexual safety initiative through the mental health safety improvement programme led by NHS England and NHS Improvement. The aim of the programme included improving the sexual safety of patients and staff on inpatient mental health units.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Leaders had worked to make sure that more ligature risks had been removed from the wards since the last inspection through a programme of work and mitigation of existing risks. Staff were clear about the potential ligature risks. Following recent incidents, all staff had good awareness of the need to ensure that windows were locked into position to prevent patients ligaturing and the risks relating to shower curtains. We found one window was not locked into position on Ebor ward, despite a recent safety bulletin requiring windows to be locked into position to prevent patients ligaturing. The window was locked straight away. Staff we spoke with on Ebor ward were very clear about the expectations.

Assessing and managing risk to patients and staff

Our findings

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff had completed risk assessments for each patient on admission / arrival, using a recognised tool, but they were still not always recording that they were reviewing this regularly, including after incidents. There were improved systems to help staff record and understand patient risks. Most patient safety incidents were pulled through into the patient overview area of the patient's record so incidents could easily be found by staff including agency and bank staff.

We identified four recent incidents for four out of thirty patients which had not been fully recorded in the appropriate sections in patient's records. This included deliberate scalding by one patient and self-harm using a different method than the usual self-harming incident for another patient. This was usually because staff had not flagged these incidents in the daily record. This meant that they did not therefore pull through into the incident log in the overview section of the patient written care record. The risks were still mitigated as action was usually recorded elsewhere in care plans, safety plans or other parts of the record. In addition, the risks were fully mitigated in other ways such as through current observation levels, supervising the hot drinking water facility, escorted leave and other arrangements.

Management of patient risk

Staff knew about any risks to each patient but still did not always fully record how they acted to prevent or reduce risks. We looked at thirty records across five locations. From these we identified four care records across three locations where we were not fully assured that staff had reflected significant risks fully and had not recorded fully the measures taken to prevent or reduce the risks. These related to two recent significant safety incidents and two relating to ongoing physical health risks:

- The two significant safety incidents were one patient who presented with sexually disinhibited behaviour and one patient who was a significant risk to others and carried out an assault on a member of staff shortly after being subject to restrictive practices.
- The other two records with significant shortfalls identified that two separate patients were at historical risk of seizures but the record did not provide any detail to fully understand the actual current risk and any measures to mitigate this.

We therefore found much fewer records with significant shortfalls than when we inspected in January 2021 where we found shortfalls relating to nine out of 16 records. The trust had made improvements to the extent that we no longer had concerns about serious systemic failings relating to the management of patient risks and therefore we determined that they had taken sufficient action to remove the s.29A warning notice.

Although we found the service had made many improvements, it did not yet meet legal requirements relating to recording patient risk meaning we could not give it a rating higher than requires improvement.

Staff identified and responded to any changes in risks to, or posed by, patients. Each ward had daily ward safety reviews so that all staff having a shared understanding of risks relating to patients and the ward environment. This included housekeepers, bank and agency staff through to ward managers and modern matrons. Some staff did reflect that patient risks being anonymized in the written ward safety review record was not helpful. At the time of inspection, leaders in the trust were reviewing this to consider the most safe and effective communication to manage patient risks'

Our findings

Some wards were starting to install or implement telehealth systems in patient bedrooms. The system monitored some aspects of patients' vital signs, without staff having to enter their room. It also enabled staff to confirm that the patient appeared safe and provided an alarm so staff can attend and respond appropriately.

Track record on safety

The service had a good track record on safety.

We observed 'report out' meetings and saw risks were discussed and agreed within multidisciplinary teams. At these meetings, staff were making checks on records to ensure that risks, incidents, observation levels and leave decisions were properly and consistently recorded. This helped to ensure that systems were in place so that clinicians had up-to-date and correct information when making decisions to keep people safe and managers could be assured that information they received was accurate.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Most staff reported that they felt well supported through the process of change including with coaching, webinars and supervision to help them improve the recording and understanding of patient risks. There were improved governance checks in place to audit and embed improvements to the recording and understanding of patient risks.

Managers shared learning about incidents with their staff and across the trust. There was improved learning from serious incidents through leaders sending recommendation reports and safety briefings. Most staff could talk about recent incidents and lessons learnt. Leaders at Cross Lane Hospital were using a paper file system for safety briefing reports and recommendations but this did not include all recent reports and staff were unaware of the intranet version of these recent incidents. This was addressed on the day of the inspection.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Governance

Governance processes now operated more effectively at team level and performance and risks were better managed but needed further embedding.

Our findings

We found that the trust had made improvements in the areas in the section 29A warning notice to the extent that we no longer had serious concerns about systemic failings relating to the trust's governance arrangements around the management of patient risks.

The trust now had better systems in place to comprehensively assess and mitigate patient risk on the wards. Leaders in the trust had worked hard to make the improvements to patient safety. This included developing and embedding improved or new systems, records and meetings to oversee, record and manage patient risks at ward level. Leaders had put in systems to ensure that staff were consistently recording patient risks across patient records and safety summaries through improved checks at 'report out' meetings. Although we saw that the systems in place had improved and were largely working well, we continued to see a small number of exceptions (four out of thirty records), which meant that the improvements had not yet been fully embedded.

Ward teams now had easy access to the information they needed to provide safe and effective care. There was clearer guidance to staff on where and how to record risks. Leaders had made improvements to make it easier for staff to record patient risks. Staff could flag safety incidents when writing daily records. This meant that the information recorded in the daily record pulled through automatically into an overview section which highlighted incidents for each patient without staff having to duplicate information. The trust had therefore taken action to ensure their systems and processes supported staff to keep patients safe.

Staff now had better understanding regarding the risk assessment process and what was expected of them when updating documentation. Records from the trust showed that 96% of staff across the acute wards had updated harm minimisation training. Staff we spoke with told us they had also received further training, masterclasses or individual guidance specific to the identification and management of patients' risks.

Most staff reported that they felt well supported through the process of change including with coaching, webinars and supervision to help them improve the consistent recording of patient risks. Most staff were positive about the changes that had been introduced and the emphasis on patient safety.

There were improved governance checks in place to audit and embed improvements to the recording and understanding of patient risks. The trust now had mechanisms in place to monitor, audit and ensure oversight of the patient risk assessment process. The trust had developed its governance meetings to oversee the improvements. We saw that relevant and appropriate issues had been escalated from the daily leadership meeting to the Quality Improvement Board.

There were now audits in place to ensure that the documentation staff used for assessing and mitigating patient risk included checking staff were recording up to date and consistent information. Ward managers were completing detailed weekly assurance checks to see that improvements had been made in the recording and management of patients risks. In addition, modern matrons were completing comprehensive audits which now included checking improvements in relation to patient risks. The trust's checks and audits identified some ongoing shortfalls by their own systems, which were consistent with our findings on inspection. For example, recent audits recorded 77% positive findings. Shortfalls identified included the need for improved recording of patient views especially when patients were too unwell to engage initially, improved physical health risk recording, and gaps in observation charts on some files. Where possible, staff at the trust used this information to make improvements immediately based on any identified specific shortfall.

The trust recognised that there was further work to fully embed the work on patient risks across the acute wards and across trust services. For example, implementing the changes with community teams so they were also using the same recording systems to record an overview of patients' incidents and safety summaries would further embed the changes.

Our findings

On this inspection, we identified that the trust's did not have a fully effective system to properly oversee and mitigate the risks of operating mixed sex accommodation at ward level. For example, the monthly modern matron quality review included key questions regarding mixed sex accommodation and privacy and dignity but did not routinely consider the actual grouping of patients within the ward environment. Staff were not always fully and properly recording on incident records whether the appropriate individual and zonal observations were taking place at the time of each incident relating to sexual safety. This meant that managers could not be fully assured that staff were doing all they could to fully anticipate and prevent sexual safety incidents.

The trust now had an effective procedure and process in place to review and learn from serious incidents. Lessons learned were shared with the service to ensure patient safety and drive improvement. All the staff we spoke to were able to describe recent incidents or communications they had received from leaders to alert them to areas of risk following serious incidents.

Our findings

Areas for improvement

We told the service that it must take action to bring services into line with one legal requirement.

Action the trust MUST take to improve:

The trust must ensure staff fully assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. In particular the trust must ensure

- that staff fully record the mitigation for any identified service user risks,

- they further embed the changes to monitor and mitigate service user risks and

- that staff continue to mitigate the risks of operating mixed sex accommodation and take all appropriate action to anticipate and prevent sexual safety incidents.

[Regulation 12 (1) and (2) (a) and (b) - Safe care and treatment]

Action the trust SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

The trust should ensure they continue to monitor and work to address patients concerns about delayed leave and limited activities on the wards.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, two other CQC inspectors and a specialist adviser. The inspection team was overseen by Brian Cranna, Head of Hospital Inspection.