South London and Maudsley NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

We carried out an unannounced, out of hours, focused inspection of Nelson Ward – the trust's female acute ward. We carried out this inspection following concerns we had about two serious incidents that happened on the ward in June 2022.

During this inspection we only looked at specific areas concerning assessing and manging risks to patients, learning from serious incidents, safe staffing, staff compassion and kindness and governance arrangements. We did not rate the service at this inspection as we only inspected parts of three key questions on one ward.

We found that:

- Staff did not always record observations of patients in line with the policy. Intermittent observations were recorded at regular and predictable intervals. There was a risk that the patients would know when observations would take place and they could plan any actions around this.
- Staff did not always record action taken as a result of deterioration in a patient's physical health or why no action had been taken in response to elevated results. Some patients had high risk physical health issues. There was a risk that staff could not safely identify when a patient's physical health was deteriorating.
- The ward layout was safe, but parts of the ward needed some maintenance and repair work. Plans to move the acute wards to a new location were in place for next year.
- Our findings from the other key questions demonstrated that whilst governance processes operated effectively at team level, improvements were still needed. Staff needed to ensure the audit regarding engagement and observations was enhanced to include how intermittent observations should be carried out.

However,

- The ward had enough nursing staff, who knew the patients and received training to keep people safe from avoidable harm.
- The service managed patient safety incidents appropriately. Staff recognised incidents and reported them suitably. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Patients told us staff treated patients with compassion and kindness. Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Is the service safe?

Inspected but not rated

Our findings

Safe and clean care environments

Most of the ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. The ward layout was safe, but parts of the ward needed some maintenance and repair work. Plans to move the acute wards to a new location were in place.

Safety of the ward layout

Staff completed an up-to-date ligature risk assessment to manage and reduce the risk of ligature points. The ligature risk assessment clearly outlined the ligature risk and how staff should mitigate these risks. However, a copy of the up-to-date ligature risk assessment was not clearly displayed in the nurses' office.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The trust had taken steps to reduce the number of ligature points on the ward by fitting bedrooms and bathrooms with anti-ligature fittings such as collapsible curtain rails and anti-ligature door handles. Staff were aware of the ligature cutters and where to access them. These were in an easily accessible place for staff.

Staff could observe patients in all parts of the wards. Staff managed the risk of blind spots through regular safety checks, convex mirrors, observations and engagement with patients. There was closed circuit television (CCTV) monitoring in communal areas.

Staff had easy access to alarms and patients had easy access to nurse call systems. In addition, staff used radios to raise the alarm in the emergency.

Maintenance, cleanliness and infection control

The service was visibly clean in communal areas but not well maintained in all parts. Some communal areas and patient bedrooms had not been adequately maintained or kept clean. For example, in the garden, wiring and taps fixed to the wall were covered by a metal locked box. Two of these boxes were broken and were visibly hanging off the wall. This created a risk of harm to patients. Staff said they had reported this, but it had not been fixed. Staff were always present in the garden with patients to mitigate the risk.

One patient's bedroom had privacy and dignity issues due to the window not having any curtains or blinds. The patient had already raised this with staff, and we raised this with the trust. The trust informed us that they had put measures in place to ensure patient safety and privacy.

Safe staffing

The ward had enough nursing staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, reduced staffing could impact on patients escorted leave and seeing their named nurse regularly.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The ward had a low number of vacancy rates. As of June 2022, the ward had a vacancy rate of 20% for registered nurses. There were three vacancies for registered nurses and one vacancy for non-registered nurses at the time of the inspection. These vacancies had been covered by locum, bank and agency staff.

Our findings

The manager used the provider's 'safer staffing' tool to calculate the number of staff needed for each shift. The day shift consisted of three registered nurses and two non-registered nurses. At night, the ward allocated two registered nurses and three non-registered nurses.

The ward manager could adjust staffing levels according to the needs of the patients. At the time of our inspection there were seven nursing and support staff allocated to the evening shift. The ward had an extra two nursing staff to support with the two patients on enhanced observations.

The ward used regular bank and agency nurses as additional support to keep the ward safe and to cover staff sickness and annual leave. We reviewed the safer staffing data for the ward between June and July 2022. For the month of June, the ward reported a fill rate of 118%, by July this had reduced to 81%. In June, 57% of the workforce was bank staff and in July it increased to 59%.

The ward manager requested staff familiar with the service and made sure all bank and agency staff had a full induction to understand the service before starting their shift. The ward employed five regular bank staff. New staff read and completed an induction booklet containing policies and important information about the service. Staff signed to confirm they had completed it with the nurse in charge.

Staff did not record regular one-to-one sessions in patients' care records. We reviewed the records for five patients and saw that there was no record when these were offered or took place, despite this being an action in patient care plans. We spoke to 11 patients. Two patients said they had not received regular one-to-one sessions since they were admitted, and another patient did not know who their named nurse was.

Patients rarely had their escorted leave or activities cancelled, but leave could be delayed or rescheduled when the ward was short staffed. Two patients reported that weekend activities and escorted leave could be delayed when the ward did not have extra support staff.

Staff shared key information to keep patients safe when handing over their care to others.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. It included topics such as physical restraint, safeguarding and intermediate life support training.

Assessing and managing risk to patients and staff

Improvements were needed in the monitoring and recording of patients' intermittent observations and physical health observations. However, staff assessed and managed risks to patients and themselves well.

Assessment of patient risk

We reviewed five patient's risk assessments. Staff completed risk assessments for patients on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments included a patient's physical, mental and social risk history.

Management of patient risk

Improvements were needed in how staff monitored and recorded patients' physical health. We looked at six patient physical health records. Staff recorded patients' vital signs on an electronic monitoring device to make it easier for staff

to complete. Staff checked patients' vital signs to ensure there was prompt identification of potential physical health problems. The results of the checks were recorded on electronic early warning score charts. Staff used a specific modified early warning score system and undertook these checks daily in the first 72 hours of admission and then weekly (minimum) or more regularly depending on the patient's care plan.

Three patient's physical health observations showed gaps in the recording of their vital signs and escalation of early warning scoring. For one patient they were only completed on sporadic days and less than the minimum requirements for that individual. For another patient staff had not recorded their vital signs for two weeks. In addition, two patients' electronic observation charts had higher scores and it was not clear what escalation staff had taken. We found that one electronic chart had a score of three and another patient had a score of two and it was unclear whether the appropriate escalation had taken place. This meant there was a lack of assurance that patients had received the right response to their physical health presentation/condition and their safety ensured.

Whilst staff followed the procedures to minimise risks to patients through regular observations, staff did not always carry out intermittent level observations on patients in line with trust policy. All patients were checked once per hour. Some patients were on continuous observations which meant a member of staff was always allocated to be with the patient, for their safety or the safety of others. Other patients were on intermittent observations, which involved staff checking in with them four times per hour. We looked at three patients on intermittent observations, the records showed that staff only observed patients at regular and predictable times. The trust policy stated that intermittent level observations should be undertaken at unpredictable times so that patients are unaware of when the observation would take place. Predictable times mean that patients can become aware of the time the staff would check them and did not minimise the risk of self-harm. Audits of the observation records had not identified this.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. The multidisciplinary team reviewed the risks presented by patients daily in handover meetings. Plans to manage or mitigate individual patient risks were in place, although these were mostly short term and did not always include longer term goals such as identifying and enhancing individual protective factors. Short term plans included placing the patient on continuous observation to address their own behaviour or the behaviour of other patients on the ward. For one patient, although their risk assessment marked them as vulnerable to a certain risk, the management plan did not include ways for staff to educate and support the patient about this in the long term.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff understood how to protect patients and children from abuse and the service worked effectively with other agencies to do so.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave examples of where they had identified a patient at risk of suffering avoidable harm. Records showed staff had reported an incident of abuse where a patient had suffered harm.

Staff followed safe procedures for children and adults visiting the wards.

Our findings

Staff access to essential information

Information was available to all relevant staff when they needed it. Staff used a combination of electronic and paper files to store and record patient care and treatment records. These were stored securely on each ward.

Track record on safety

Between May 2022 and June 2022 there were two serious incidents reported by the ward. In June 2022 the trust had reported a death of a patient whilst under the care of the ward. The investigation had not been concluded yet. However, the trust had completed an immediate fact-finding investigation with actions and learning for staff. Actions included staff using the correct trust engagement observation sheet, as per their policy.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Incidents included self-harm, physical restraint and violence and aggression. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff were able to tell us about recent incidents and the learning from them. There was evidence that changes had been made as a result of feedback. After a serious incident in June, senior nursing staff completed a Service Quality Review on the ward to identify areas of improvement. Actions included staff undertaking competency training for carrying out enhanced observations on patients and for staff to use the correct enhanced observation forms as per trust policy. At the time of the inspection, staff had completed this training and were completing the updated forms.

Staff understood the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers debriefed and supported staff after any serious incident. Staff reported debrief meetings occurred after any incident or restraint, but these were not always recorded. Reflective practice sessions on the wards allowed staff a space to discuss their thoughts following incidents.

Is the service caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 12 patients and their families, including three discharged patients. We mostly received positive feedback from patients about the quality of care they received. Patients said staff treated them well and behaved kindly. Patients praised the support of the nursing staff and the occupational therapist. Patients felt that staff involved them in their care planning and risk assessments.

Our findings

Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care treatment or condition. One patient said that a nurse had reassured them after an incident and chatted with them until they felt better. Another patient said they felt they were going in the right direction.

Most of the negative feedback we received was about the issues with patient on patient conflicts on the ward. Two patients commented on the negative use of medicines to treat their mental health. Patients felt that staff mainly used medicines to treat them. Another patient commented that often patients all turn up at the same time to collect their medicines outside the clinic room in the communal corridor. During the inspection, we observed several patients queuing for their medicines outside the clinic room. This did not maintain privacy and dignity.

Staff told us they felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Staff did not display any of the patient's personal information in communal areas.

Staff made sure patients could access advocacy services. Patients said they could access advocacy support and that an advocate was present on the ward.

Is the service well-led?

Inspected but not rated

Governance

Our findings from the other key questions demonstrated that whilst governance processes operated effectively at team level, improvements were still needed. Staff needed to ensure a robust auditing programme was in place to monitor patient care and treatment on the ward.

Whilst staff participated in local clinical audits, the ward's audit system did not pick up the areas of improvement we identified during the inspection. Staff did not audit patient intermittent observations to ensure that they were being carried out randomly. Although staff we spoke with were able to explain their training in patient engagement and observation and how intermittent observations should be carried out. This had not yet embedded in the team and records we looked at showed staff were carrying these out at predictable times.

The audits that staff did carry out, however, were sufficient to provide assurance of those specific areas and staff acted on the results when needed. Audits were carried out on areas of care such as care planning, risk assessments and infection control.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at service level. The senior nursing team had completed a service quality review in response to incidents that occurred on the ward. The team had identified several issues and areas of concerns to improve safety and quality of care. The improvements included ensuring staff use the correct patient observation forms, risk assessments were updated, and evidence of patient one to one therapeutic time is recorded. However, the senior management team had identified the clinical safety audits completed by staff should include evidence of patient one to one therapeutic time with their named nurse. This action had been marked as completed, but it had not been implemented yet with no timescales by the ward staff of when this will be started.

Our findings

Areas for improvement

MUSTS

- The trust must ensure that staff on Nelson Ward undertake intermittent observations of patients in line with the trust's observation policy. **Regulation 12 (1)(a)(b)**
- The trust must ensure that staff complete patients' physical health care in line with trust policy. Staff must ensure that early warning scores are recorded accurately onto the electronic system to ensure that it can be followed up quickly when concerns are identified. **Regulation 12 (1)(a)(b)**

SHOULDS

- The trust should ensure staff keep up-to-date and accurate records of one-to-one sessions that are offered to or carried out with patients.
- The trust should continue to further improve and embed governance arrangements so that the auditing and monitoring of patient engagement and observations is robust.
- The trust should ensure they maintain the fixtures and fittings on the ward for patient safety.

Our inspection team

The team that inspected the service comprised of two CQC (Care Quality Commission) inspectors. An expert by experience supported the inspection remotely making telephone calls to clients.

During this inspection, the inspection team:

- visited the ward, observing the environment and how staff were caring for patients
- spoke with 5 nursing staff including the ward manager
- spoke with 12 patients, three of which had been discharged from the ward previously and one carer and relative
- reviewed five patient care and treatment records
- observed weekly clinical multidisciplinary meetings and a daily handover meeting
- reviewed other documents concerning the operation of the service.

You can find 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.

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

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