Southern Health 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 effective?	**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 this unannounced, focused inspection at Elmleigh Hospital in Havant to see if the hospital had made the required improvements identified at a previous inspection in April 2021. We visited both wards: red and blue bays. Red bay is a 17 bedded ward for female and blue bay a 17 bedded ward for males.

Following that inspection, we sent the trust a letter of intent under section 31 of the Health and Social Care Act 2008 identifying our serious concerns about the safety of patients at Elmleigh. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. However, a letter of intent asks the provider to set out, in an action plan, how it will address those serious concerns. If the action plan provides us with assurance that the provider will act in a timely manner and if we are assured, we then don't take any further action.

In the report we also identified some additional improvements that the trust needed to make to ensure it met legal requirements. We told the trust it must ensure that patients' physical health care needs were met, that mental health assessments were undertaken prior to section 17 leave, that all patients had access to meaningful activities and psychological interventions, that all incidents must be reported, that staff received an induction and regular supervision, that medicines were managed safely and that there were robust governance arrangements in place to identify risks so that improvements could be made as needed.

In May 2021 the trust sent us an action plan detailing how it would meet the above legal requirements, which detailed what had been done immediately following our inspection to make improvements and what it would do to ensure further improvements were made in a timely manner. This provided us with the assurance we required so we did not take any further action.

At the latest inspection we did not rate this service because we did not look at all the key questions or all the key aspects of the key questions. The previous rating of good remains. It should be noted that this rating related to all of the acute mental health services at Southern Health and not just Elmleigh.

We found that the trust had met the majority of the required improvements but that there were still some further improvements to be made.

At Elmleigh we found:

- Staff provided a range of care and treatment interventions suitable for the patients that were in line with national guidance on best practice. Patients had access to meaningful activities and psychological and therapeutic interventions.
- New staff received a comprehensive and tailored induction to the wards and received regular supervision, including reflective practice sessions and group sessions.
- Staff felt supported and were more confident about raising concerns.

Our findings

- The governance arrangements had improved, and ward managers had implemented additional checks and audits to identify where improvements were still needed and action could be taken promptly.
- Staff ensured that patients' physical health needs were identified and assessed. Patients had appropriate physical health care plans in place which were reviewed regularly.
- Improvements had been made with regards to patients' mental state being assessed prior to taking leave from hospital. However, some patients told us that sometimes their mental state wasn't assessed prior to leave.

However:

- Staff were not increasing physical health observations in line with National Early Warning Score (NEWS2) protocol when patients' health deteriorated. For example, if a score increased from two to three, patients were not having their observation checks increased from every 12 hours to every six hours. Patients' baseline scores were missing and there was no rationale recorded for why these increased observations did not take place.
- Staff were still not always reporting all incidents. For example, if an incident was a regular occurrence or was low risk of harm.
- Although improvements had been made to medicines management, there were still gaps in recording on medications charts.

How we carried out the inspection

During the inspection visit, the inspection team:

- interviewed the ward managers and spoke to the head of operations
- spoke with nine members of staff, including four nurses, one health care assistant, one assistant psychologist, one clinical psychologist, one activity co-ordinator and one HR advisor
- spoke with the user involvement manager for mental health, learning disabilities and specialities services for the trust
- spoke with five patients across both wards
- reviewed a sample of patient care and treatment records
- reviewed all patient medication charts, controlled drug book and physical health observation records across both wards
- reviewed a sample of section 17 leave documentation (permission for a patient to leave the hospital)
- reviewed a sample of incident reports and
- looked at 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

Our findings

We spoke to two patients on blue bay and three patients on red bay. All patients we spoke to said that there were lots of activities to do now but that staff sometimes did not encourage them to take part. Patients told us that they had their mental state assessed prior to leave but sometimes this did not happen. Patients also said that their leave could be cut short due to staff shortages and it was difficult to access leave for regular cigarette breaks.

Is the service safe?

Inspected but not rated

This was a focused inspection, so we did not rate this key question during this inspection. The good rating relates to the rating awarded at the previous inspection and relates to all of the acute mental health services at Southern Health and not just Elmleigh.

At Elmleigh we found that:

- Staff were not increasing physical health observations in line with National Early Warning Score (NEWS2) protocol when patients' health deteriorated. For example, if a score increased from two to three patients were not having their observation checks increased from every 12 hours to every six hours. We reviewed physical health records for all patients and found this consistently across both wards.
- Staff were still not always reporting all incidents. For example, if an incident was a regular occurrence or was low risk of harm. Staff told us they did not always have time to record all incidents that took place during their shift. Staff also told us that if an incident was a regular occurrence, they may not report each incident, for example if a patient had self-harmed multiple times during the day. We were also told that some incidents, such as staff being sexually harassed or subjected to verbal aggression by patients, were not always reported as staff had become desensitised to these occurrences.
- Although improvements had been made to medicines management, there were still gaps in recording on medications charts. This meant that it was unclear whether a patient had received their medication, missed or refused it.

However:

- Staff ensured that patients' physical health needs were identified and assessed. Patients had appropriate physical health care plans in place which were reviewed regularly. The ward managers also reviewed the care plans as part of an audit. Physical health was discussed at multi-disciplinary team meetings and was a regular agenda item. The team had also developed links with their colleagues with specialisms in physical health, for example tissue viability nurses and those with a specialism in diabetes, who they could go to for advice. Weekly training sessions had also been arranged and attended by staff. We found no incidents related to patients who didn't have their physical health observations increased.
- Improvements had been made with regards to patients' mental state being assessed prior to taking leave from hospital and staff described their approach to ensuring leave was taken safely. However, some patients told us that sometimes their mental state wasn't assessed prior to leave. A new template had been developed on the electronic recording system to record mental state assessments but not all staff were using it yet.

Our findings

Is the service effective?

Inspected but not rated

This was a focused inspection, so we did not rate this key question during this inspection. The good rating relates to the rating awarded at the previous inspection and relates to all of the acute mental health services at Southern Health and not just Elmleigh.

At Elmleigh we found that:

- The ward team included a full range of specialists required to meet the needs of patients on the wards. The team now included psychologists, assistant psychologists, occupational therapists, assistant occupational therapists and activity co-ordinators. The psychology team was on the wards five days a week and also offered virtual sessions.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. There was an activity schedule that covered seven days a week, including evenings. This schedule was adapted when needed to meet the requests of patients. The user involvement manager had visited the ward on several occasions since the inspection in April 2021 and sourced a range of activities and resources for the wards, at the request of the patients. This included pool tables, puzzles, games and sport equipment.
- New staff received a comprehensive and tailored induction to the wards and received regular supervision, including reflective practice sessions and group sessions. The induction had been tailored to ward and was structured, involved shadowing shifts and training.

Is the service well-led?

Inspected but not rated

This was a focused inspection, so we did not rate this key question during this inspection. The good rating relates to the rating awarded at the previous inspection and relates to all of the acute mental health services at Southern Health and not just Elmleigh.

At Elmleigh we found that:

- Staff felt supported and were more confident about raising concerns. Since the last inspection, a HR advisor had based themselves on the wards so staff could approach them directly to discuss any concerns. The trust had also arranged 'listening ear' sessions, where staff external to the ward came in and held open door, drop-in sessions with staff.

The governance arrangements had improved, and ward managers had implemented additional checks and audits to identify where improvements were still needed and action could be taken promptly. During the inspection we identified to the managers the concern that patients' physical health observations may have needed to be increased and this hadn't been picked up by the physical health audits. The audit previously checked if the national early warning score (NEWS2) had been completed, but has since been improved to check if escalation has taken place and if the rationale for no increased observations was recorded.

Our findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all patients have their physical health needs assessed, and where physical health needs are identified they must ensure there is a clear plan of care, that patients get the care they need, and this is regularly monitored. (Regulation 12)
- The trust must ensure that all incidents are reported so these can be monitored and improvements made as needed. (Regulation 12)

Action the provider SHOULD take to improve

- The trust should ensure that all patients have their mental state assessed prior to taking leave from hospital and that this is clearly documented.
- The trust should ensure that its medicines management procedures are robust, and that documentation is accurate.

Our inspection team

The team that inspected the service comprised one inspection manager and three CQC inspectors.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment