Humber 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)
RV934	Newbridges	Newbridges	HU9 2BH
RV942	Millview	Millview Court	HU16 5JQ
RV945	Miranda House	Avondale	HU3 2RT
RV945	Miranda House	Psychiatric Intensive Care Unit	HU3 2RT
RV933	Westlands	Westlands	HU3 5QE

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. 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 Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber 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 areas the trust needs to improve:

- Staff did not always carry out physical health monitoring following the use of rapid tranquilisation in line with trust guidance.
- Not all qualified staff on Westlands ward were trained to provide immediate life support
- On Newbridges ward, seclusion exit plans contained a blanket restriction. Patients were required to have a fixed period of settled behavior, which meant seclusion did not end at the earliest opportunity.
- Clinicians did not always carry out the necessary reviews for those patients in seclusion within the timeframes specified by the trust policy.

However, we found the following areas of good practice:

- The service had complied with some of the regulatory breaches identified in the warning notice.
- There were adequate stocks of emergency medicines on all wards. All medicines and equipment were within the expiration date and fit for use. Staff knew where emergency medicines and equipment were located.
- Patients entering seclusion had individualised seclusion care records and exit plans. Staff recorded the justification for the use of seclusion.
- The service had decommissioned those seclusion rooms not fit for purpose.
- Staff observed infection control principles when patients used the seclusion facilities.

Following this inspection, the CQC withdrew the warning notice and issued the trust with a requirement notice to address the outstanding issues identified.

Summary of findings

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

Are services safe?

We found the following areas the trust needs to improve:

- Staff did not always carry out physical health monitoring following the use of rapid tranquilisation in line with trust guidance.
- Not all qualified staff on Westlands ward were trained to provide immediate life support
- On Newbridges ward, seclusion exit plans contained a blanket restriction. Patients were required to have a fixed period of settled behavior, which meant seclusion did not end at the earliest opportunity.
- Clinicians did not always carry out the necessary reviews for those patients in seclusion within the timeframes specified by the trust policy.

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

- Emergency medicines were fully stocked and in date, and staff knew where these were located.
- The trust had introduced an updated resuscitation policy, which was in accordance with national guidance.
- There was an overall improvement in the quality of seclusion care plans, with staff recording the reason for seclusion and the steps needed to end seclusion.

Are services effective?

At the last inspection in April 2016 we rated effective as **requires improvement.** It was not the purpose of this inspection to re-consider the rating.

Are services caring?

At the last inspection in April 2016 we rated caring as **good.** It was not the purpose of this inspection to re-consider the rating.

Are services responsive to people's needs?

At the last inspection in April 2016 we rated responsive as **requires improvement.** It was not the purpose of this inspection to re-consider the rating.

Are services well-led?

At the last inspection in April 2016 we rated well-led as **requires improvement.** It was not the purpose of this inspection to re-consider the rating.'

Summary of findings

Information about the service

Humber NHS Foundation Trust provides inpatient acute and intensive care services for adults of working age with mental health conditions who are admitted informally or detained under the Mental Health Act 1983.

The trust has four acute wards for adults who require hospital admission due to their mental health needs. These wards are:

Mill View Court , which provides assessment and treatment for up to 10 patients, both male and female. The service provides intensive care and treatment for people who are in the most acute and vulnerable stage of mental illness and are unable to be supported at home. The ward is based on Castle Hill Hospital site to the north of Hull.

Newbridges provides assessment and treatment for up to 18 male patients. The service provides care and treatment to men who are experiencing an acute mental illness and crisis. The ward is a standalone unit located in east Hull.

Westlands provides assessment and treatment for up to 18 female patients. The service provides care and treatment to women who are experiencing an acute mental illness and crisis. The ward is a standalone unit located in west Hull.

Avondale is an acute assessment ward for men and women and can accommodate up to 14 patients. The service provides assessment and treatment for a period of up to seven days for adults experiencing acute episodes of mental ill health who cannot be safely treated in other settings. Patients who require care for more than seven days are transferred to alternative services within the trust.

The trust also has a psychiatric intensive care service for people who present higher levels of risk and require greater observation and support. The psychiatric intensive care unit provides secure accommodation for both males and female patients. Both Avondale and the psychiatric intensive care unit are based in Miranda House, which is on the outskirts of Hull city centre.

In April 2016, the CQC carried out a comprehensive inspection of the trust and rated the trust overall as 'requires improvement'. We rated the acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. The CQC issued a section 29A warning notice for the trust to make significant improvements. These related to regulation12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust sent the CQC an action plan for addressing the warning notice, including an update of the progress of actions taken. As of 10 October 2016 the trust had completed all actions in their plan and were monitoring and auditing compliance with regulations. They appointed a rapid interventions team to support and assist adult mental health teams across the trust in changing working practice and culture.

The trust appointed a new interim chief executive officer in September 2016, who had a mental health background. In addition, they appointed two non-executive board members with mental health backgrounds.

Our inspection team

The lead inspector for this service was Jacqui Holmes. The team that inspected this core service comprised three Care Quality Commission inspectors (mental health) and one Care Quality Commission inspector (pharmacy).

Summary of findings

Why we carried out this inspection

We last inspected this core service in April 2016 as part of a comprehensive inspection of Humber NHS Foundation Trust. We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. The safe domain as inadequate, caring as good and the effective, responsive and well-led domains as requires improvement.

We found that significant improvements were required and issued the trust with a warning notice under section 29A of the Health and Social Care Act 2008. We carried out an unannounced focused inspection to find out if the trust had complied with the regulatory breaches identified in the warning notice.

The warning notice told the provider that it must take action to improve the acute wards for adults of working age and psychiatric intensive care units in relation to the following concerns:

- effective governance arrangements were not in place in respect of the use of rapid tranquilisation and on occasions rapid tranquilisation was used inappropriately by staff
- effective processes and procedures were not in place to provide systematic assurance that there was not inappropriate use of seclusion and that safe care was being delivered whilst patients were in seclusion.

The concerns relating to rapid tranquilisation and the use of seclusion were breaches of regulation 12(2) (a) (b) (c) (d),(e),(f) and (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014, safe care and treatment.

How we carried out this inspection

The focus of this inspection was to establish what actions the trust had taken to address and resolve the regulatory breaches identified in the warning notice under section 29A of the Health and Social Care Act 2008. These regulatory breaches occurred in the safe domain. It was not the purpose of this inspection to re-consider the rating.

Before visiting, we reviewed a range of information we hold about the core service. We carried out an unannounced visit on 1 and 2 December 2016. This meant the service did not know that we would be visiting. During the inspection visit, the inspection team:

- visited all acute wards for adults of working age and psychiatric intensive care units, looked at the quality of the ward environments and checked clinic rooms
- observed how staff were caring for patients in order to maintain their safety
- spoke with ten staff members individually; including nurses, nursing assistants and a psychologist
- looked at seclusion care records across the acute wards
- reviewed six monitoring records of patients who had been subject to rapid tranquilisation
- looked at policies and procedures which related to the running of the service.

Following the inspection, we sought assurance from the trust about their commitment to comply with the warning notice. The trust responded with a detailed and candid analysis of their current position, and ongoing actions to achieve compliance with regulatory breaches.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that physical health monitoring is carried out in line with the trust policy, following the use of rapid tranquilisation.
- The trust must ensure that all qualified staff are up to date with immediate life support training.

Summary of findings

- The trust must ensure that clinicians carry out the necessary reviews for those patients in seclusion within the timeframes specified in their policy.
- The trust must ensure there are no blanket restrictions in seclusion exit plans and that seclusion ends at the earliest opportunity.

Humber NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Millview Court	Millview
Avondale	Miranda House
Psychiatric Intensive Care Unit	Miranda House
Newbridges	Newbridges
Westlands	Westlands

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

The trust had four acute wards for adults of working age and one psychiatric intensive care unit, which where standalone units located within different areas of Hull.

At our last inspection, we found the provision of emergency medicines was variable. Not one of the acute wards for adults of working age or the psychiatric intensive care unit met the essential stock requirements set out in the trust's resuscitation policy. This included medicines that should be immediately available when rapid tranquilisation is used. Rapid tranquilisation happens when qualified staff give medicines by injection to a person displaying aggressive or agitated behaviour to help quickly calm them. The trust had a rapid tranquilisation policy, which was due for review in February 2016. They had not reviewed it at the time of our inspection in April 2016. Trusts must review their policies regularly to ensure they are current and take into account most relevant guidance.

The trust put immediate actions in place to replace and replenish emergency stocks during the inspection. However, when we rechecked these stocks on 21- 22 April 2016, one of the required emergency medicines was still not available on Millview Court, while at Newbridges it was out of date.

During this inspection, we were provided with an updated resuscitation policy, which the trust had put in place in September 2016. We reviewed the new policy and found it was in accordance with national guidance.

We checked the provision of emergency medicines and found adequate stocks were available in line with the essential stock requirements set out in the updated policy. Records showed staff carried out regular documented checks to ensure medicines and equipment were fit for use. This showed the service was no longer in breach of regulation 12 (2)(a)(f) and (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014 and complied with this requirement of the warning notice.

Safe staffing

At our last inspection, we found that not all qualified staff had received training in immediate life support. The National Institute for Health and Care Excellence guidance (Violence and aggression: short-term management in mental health, health and community settings, NG10.May 2015) states that staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend in an emergency if restrictive interventions might be used. It is important that all qualified staff have this training so they know what action to take should a patient have an adverse effect from rapid tranquilisation, including the use of emergency medication.

We reviewed the numbers of staff trained in immediate life support during this inspection. The trust had appointed a resuscitation officer and rolled out additional training in immediate life support to staff not yet trained. We found an improvement in the number of staff trained in immediate life support although figures for Westlands were still low. Figures provided by the trust were:

- Mill View Court – Nine of 11 staff trained which is 82%
- Newbridges – Nine of 10 staff trained which is 90%
- Westlands – Seven of 11 staff trained which is 64%
- Avondale – Six of seven staff trained which is 86%
- Miranda House psychiatric intensive care unit – 12 of 14 staff trained which is 86%.

Information provided by the trust showed that those who had not completed their training were booked onto training sessions. All staff should have received appropriate training by 31 March 2017.

Assessing and managing risk to patients and staff

At our last inspection in April 2016, we found staff did not have a clear understanding of what constituted rapid tranquilisation. As a result, staff had not carried out the required physical health checks and observations of patients in accordance with the trust's policy. In addition, the trust policy had not been reviewed in accordance with the schedule.

During this inspection, we checked to see what improvements the trust had made. We found, the trust had updated their rapid tranquilisation policy in September 2016. The new policy clearly set out the monitoring that staff had to carry out following the use of rapid tranquilisation. The policy was in accordance with national

guidance [Violence and aggression: short-term management in mental health, health and community settings, NICE guideline, NG10.May 2015]. The trust policy also stated this monitoring applied to when any 'when required' medicine was given by injection to calm a patient.

We checked patient records and reviewed six episodes where staff had administered medicines by injection. In five of these episodes, we found staff had not carried out the appropriate physical health monitoring as set out in the trust policy. This meant there was a continued breach of regulation 12(2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014 and the trust had not complied with this requirement of the warning notice.

At our last inspection, we found all wards had seclusion rooms although the wards were not using these rooms in line with principles within the Mental Health Act Code of Practice. The seclusion rooms were of a similar design and layout except for the seclusion room on Mill View Court, which had no natural light and there were no blinds on viewing panels for any seclusion rooms. The Mental Health Act code of practice, 26.109 states that seclusion rooms should have windows that provide natural light.

In addition, we found that the seclusion room doors had only one hatch. Patients in seclusion were sometimes denied the use of toileting facilities, even when they displayed settled behaviour. Staff provided patients with bowls via the door hatch to use for toileting. Once used, patients would pass these bowls containing urine and faeces back to staff through the hatch. Staff used the same hatch to pass food and drink to patients. This was against infection control principles.

During this inspection, we found the trust had decommissioned the seclusion room at Mill View Court on 28 November 2016 and it was no longer in use. We found that staff had received instructions not to pass anything other than food and drinks through the hatch on seclusion room doors. The trust was monitoring staff compliance with this instruction. The remaining seclusion rooms were clean, tidy and met the standards required by the Mental Health Act code of practice. This showed the service was no longer in breach of regulation 12(2) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014 and complied with this requirement of the warning notice.

At our last inspection, we found seclusion records did not meet the Mental Health Act code of practice minimum requirement. Patients were observed as being settled for significant periods of time. However, staff had not ended the seclusion. There was no evidence of exit plans for termination of seclusion when seclusion commenced. We found basic care plans for seclusion. These did not detail what the patient needed to do for seclusion to end or what behaviour was required to end seclusion. There was no recorded evidence that staff discussed this with the patient. Nursing reviews for patients in seclusion were not undertaken in accordance with trust's seclusion policy and the code of practice.

The code of practice states, 'A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible' and 'All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped. (The Mental Health Act code of practice 26.126).'

During this inspection, we reviewed seclusion records across the acute wards and found that seclusion care plans included exit plans. Staff recorded the reason for patients being placed in seclusion and the steps they needed to take in order to end seclusion. However, on Newbridges ward, we found six episodes of seclusion where the exit plans clearly showed patients were required to have a four hour fixed period of settled behavior before seclusion could be terminated. There was no rationale for this as patients were not individually risk assessed. This practice was not in line with the Mental Health Act code of practice, which states that seclusion should end at the earliest opportunity. We brought this to the attention of the trust who responded immediately by debriefing the staff concerned and sending a trust wide practice note to all staff highlighting the issue.

The provider had put audits in place to assess the quality of seclusion records. Information supplied by the trust showed that although staff were receiving additional training in the use of seclusion and the Mental Health Act code of practice, not all staff had applied it to their practice. The trust monitored and reviewed episodes of seclusion monthly and gave the wards feedback requiring remedial action where necessary. They identified two occasions in October were this had happed, on Millview Court (before the closure of the seclusion room) and on the psychiatric intensive care unit. Consequently, the trust recognised that

Are services safe?

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

staff needed further support and training to bring about changes in practice and culture on the wards. They set up a rapid intervention team in October 2016, whose aim was to provide staff with coaching and support in dealing with episodes of seclusion appropriately.

We found, there were continued delays in clinicians carrying out and complying with the necessary patient reviews:

- one medical review from Avondale was carried out nearly three hours late and no further medical reviews were completed
- three records from Westlands ward showed no multi-disciplinary reviews were carried out
- three records from Westlands ward showed nursing reviews were carried out by only one nurse
- one record form the psychiatric intensive care unit showed no independent review was carried out.

This meant there was an ongoing breach of regulation 12(2) (a) and (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Track record on safety

We did not assess this during this inspection

Reporting incidents and learning from when things go wrong

We did not assess this during this 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

At the last inspection in April 2016 we rated effective as **requires improvement.** It was not the purpose of this inspection to re-consider the rating

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

At the last inspection in April 2016 we rated caring as **good.** It was not the purpose of this inspection to re-consider the rating

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

At the last inspection in April 2016 we rated responsive as **requires improvement.** It was not the purpose of this inspection to re-consider the rating

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

At the last inspection in April 2016 we rated well-led as **requires improvement.** It was not the purpose of this inspection to re-consider the rating

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 How the regulation was not being met: On Avondale ward, Newbridges ward and Westlands ward, physical health monitoring was not carried out in line with trust policy following the use of rapid tranquilisation. On Westlands ward, not all qualified staff were trained in immediate life support. On Avondale ward, Westlands ward and the psychiatric intensive care unit, staff did not always carry out seclusion reviews within recommended time scales. On Newbridges ward, exit plans required patients to show a fixed period of settled behaviour before seclusion could end. This was a breach of regulation 12 (2) (a) (b) (c) and (g)