Midlands Partnership University NHS Foundation Trust

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

Inspection report

Trust Headquarters
St Georges Hospital, Corporation Street
Stafford
ST16 3SR
Tel: 01785257888
www.mpft.nhs.uk

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**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

This inspection was a focussed, unannounced inspection of the acute wards for adults of working age and psychiatric intensive care units (PICUs) provided by Midlands Partnership NHS Foundation Trust (MPFT). The inspection was focussed to specific areas of the safe and well led key questions.

At our last inspection we rated the acute wards for adults of a working age and psychiatric intensive care units as inadequate.

As this was a focussed inspection, we have not rated the service.

We carried out this inspection to look at those parts of the service included within the Section 29A warning notice issues following our inspection in November 2022.

The trust provides acute inpatient wards for adults of working age and PICUs at two locations, St George's Hospital in Stafford and The Redwoods Centre in Shrewsbury.

The wards are:

St George's Hospital, Brocton Ward, 20 beds: mixed sex.

St George's Hospital, Chebsey Ward, 19 beds: mixed sex.

St George's Hospital, Milford Ward, 18 beds: mixed sex.

St George's Hospital, Norbury PICU, 11 beds: male only.

The Redwoods Centre, Birch Ward, 16 beds: mixed sex.

The Redwoods Centre, Laurel Ward, 16 beds: mixed sex.

The Redwoods Centre, Pine Ward, 16 beds: mixed sex.

We previously inspected the trust's acute wards for adults of working age and psychiatric intensive care units (PICUs) in November 2022. The November 2022 inspection followed notifications about serious incidents that involved patients from the trust's acute wards for adults of working age during September and October 2022. This included three incidents where patients had taken their own lives during a period of leave from the ward they were admitted to, and four incidents of fire setting that had occurred at The Redwoods Centre. CQC had separately received communication from Shropshire Fire and Rescue Service in relation to their inspection triggered by the fire setting incidents, and by British Transport Police and Staffordshire Police in relation to the deaths of service users whilst on leave.

Our findings

Due to the seriousness of the concerns following our site visits, in November 2022 we used our powers under Section 29A of the Health and Social Care Act 2008 to issue a Warning Notice to the trust. CQC uses Section 29A Warning Notices with NHS Foundation Trusts when it appears that the quality of the health care provided by the trust requires "significant improvement". The notice required the trust to make significant improvement to the areas identified by 16 January 2023. In response to the Warning Notice the trust submitted an action plan to address the areas of concern we identified within the timeframe required.

The purpose of this inspection was to see how much of the action plan the trust had met. Also, to see if the trust had met the requirements of the Warning Notice previously issued.

At this inspection we found the trust had met the requirements of the Warning Notice issued in November 2022. However, we found additional concerns during our site visit, which we have informed the trust of.

At this inspection we did not inspect all areas of the safe and well led key questions because the services had not had time to make the improvements necessary to meet the requirements as set out in the action plan the trust sent us after the last inspection. However, we continue to monitor progress of improvements to services against the action plan and timeframes indicated and will re-inspect them as appropriate.

We did not rate this service at this inspection. The previous rating of inadequate remains. We found:

- The trust's ligature risk assessments identified all areas of potential risk including staff areas and detailed actions to reduce the harm from those risks within all the wards we visited.
- The trust was working in partnership with Shropshire Fire and Rescue Service (SFRS) and had a robust action plan to address actions SFRS had identified in the fire safety risk assessments.
- Managers ensured that all staff working on the wards we visited now had regular supervision. These discussions included staff being able to request additional training as required.
- Managers ensured that all temporary staff had a ward specific induction and agency nurses now had access to the trust's electronic recording system.
- The trust was able to demonstrate that staff working on the wards we visited always assessed patients' mental state at the point of taking leave and recorded these discussions and decisions in patients' records.
- The trust was able to demonstrate how staff working on the wards we visited managed patients' personal property including items deemed to be a risk.

However:

- While staff now managed and had systems in place for patients' personal items of potential risk well. They did not log items of potential risk on the ward that were not specific to a person, for example communal ward lighters.
- Staff did not always respond to, or report incidents of potential risk in a timely way. Staff did not mitigate against the risk of further incidents occurring. Staff did not always hand over incident information at ward handover meetings.

Our findings

Managers did not always use effective audit processes to ensure that all incidents were reported.

Managers did not ensure that effective learning had taken place following incidents of potential harm and that appropriate processes were in place from lessons learnt.

How we carried out the inspection

During our inspection on 27 and 28 June 2023, we visited all of the acute wards for adults of working age and psychiatric intensive care units (PICUs) at St Georges Hospital and The Redwoods Centre.

During the inspection we:

observed how staff cared for patients;

spoke with 20 patients who were using the services;

spoke with 24 staff including; ward managers, nurses, healthcare support workers, engagement coordinator and a quality lead;

looked at the quality of the 7 ward environments and checked to see that improvements and new systems were in place;

reviewed 21 patient records;

reviewed 23 incident records;

reviewed a range of policies, procedures and other documents relating to the running of the services.

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

During the inspection we spoke with 20 patients; Ten at The Redwoods Centre and 10 at St. George's Hospital. We found patients' feedback was positive across both sites. All patients knew what the restricted items were on the wards and all patients felt safe on the wards. No patients had any sexual safety concerns even when they were on mixed sex wards. All patients told us they could access all areas of the wards they needed to but staff areas such as toilets and meeting rooms were locked.

Three patients at St George's Hospital told us the logging in and out of the restricted items was not always completed.

At St George's Hospital 2 patients told us they did not know why certain items were restricted. All patients told us they felt safe, but 5 patients felt their sleep was often disturbed by staff shining lights through their door at night-time when completing therapeutic observations.

Our findings

Is the service safe?

Inspected but not rated

Our rating of safe stayed the same. The previous rating of inadequate remained.

Safe and clean care environments

All ward ligature risk assessment were now up to date and staff knew of ligature risks within the ward areas.

Safety of the ward layout

Staff had completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The trust now had fire safety assessments in place for each ward. In October 2022 at our previous inspection Shropshire Fire and Rescue Service (SFRS), had found the fire safety assessments in place at The Redwoods Centre to be unsuitable and insufficient. They found assessments did not detail fire incidents that had occurred at the service and failed to identify significant building works with the potential to increase fire risks. They also found that not all fire doors at the location were fitted correctly. SFRS had issued the trust with 2 enforcement notices detailing how they failed to comply with the Regulatory Reform (Fire Safety) Order 2005 and the actions required to correct the failures. Since November 2022 the trust has had a downward trend in the number of fire incidents and following a re-inspection by SFRS at The Redwoods Centre in April 2023 the local fire authority has withdrawn 1 of the Fire Safety Enforcement Notices. The trust had complied with some of the conditions set by SFRS and the fire door repair and replacement programme is underway with Birch, Laurel, and Pine wards. A further review of the fire risk assessments will be completed to consider the mitigating improvements relating to the enforcement notice removal and fire door repairs. We are assured the trust has appropriate measures to mitigate risk in place and an action plan to address the remaining actions.

Between December 2022 and May 2023, the trust recorded 23 fire safety and unwanted fire signal incidents across their acute wards for adults of working age and PICU. This was a 52% reduction in the number of incidents within a six month period compared to our previous inspection. Six of these incidents were recorded at The Redwoods Centre and 17 incidents at St George's Hospital. The incidents identified patients' smoking or vaping in ward areas as a common cause of fire alarm activation.

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We found all staff toilets on ward areas were locked and could only be accessed by staff using an electronic fob or key. All wards had their own ward specific ligature risk assessment in place that had been reviewed every 3 months. These ligature risk assessments now included ward areas identified as either 'locked' or 'supervised' but did not detail the specific risks within these areas. This included staff toilets, staff offices, meeting rooms and storage rooms. This meant staff who worked on the ward would now have had information on how to manage an area of the ward which had potential ligature points. All staff we spoke with knew where the ligature cutters were located on the ward. All patients told us they could access all areas of the wards they needed to but staff areas such as toilets and meeting rooms were locked. The trust had not had any incidents in the last 6 months within these restricted staff areas. This was an area of improvement identified within the previous inspection that the trust had now met.

The wards did not comply with same sex accommodation guidance as there was mixed sex accommodation on all of the acute wards for working age adults. While all wards for working age adults had allocated male and female bedroom corridors, we found there were breaches of the single sex accommodation guidance on all 6 mixed sex acute wards for

working age adults. We found males being placed on female corridors or females being placed on male corridors within all wards. The trust mitigated possible patient safety risks by increasing staff presence on these corridors and increasing patient observations. Milford Ward at St Georges Hospital was trialling a new system where a staff member would specifically be placed to observe the corridors at all times. The trust had no complaints raised in the last 6 months in relation to sexual safety concerns. All 20 patients we spoke with told us they felt safe on the wards and did not have any sexual safety concerns. On Laurel Ward we found two occasions where patients had been placed in a room on the opposite sex corridor and staff had recorded a conversation with the patients around this arrangement and that they would move them to the correct corridor as soon as a room was available. However, on Pine Ward at The Redwoods Centre we found 2 patient safety incidents, which did not result in any harm. The trust has assured us they are reviewing their mixed sex accommodation arrangements.

Assessing and managing risk to patients and staff

While staff now had processes in place to manage risk to patients and themselves when patients went on leave, staff did not always manage ward items of risk well.

Management of patient risk

Staff we spoke with reported clear and consistent practices to manage requests from patients to take leave from the ward. This included checking risk assessments, seeking approval from the nurse in charge and recording specific information including clothing, contact number and the time leave commenced. Care and treatment records now demonstrated how staff assessed a patient's mental state and risk presentation at the point of taking leave. This included recording the decision made about leave following any assessment. We reviewed 25 patient records across all acute wards for working age adults and they all demonstrated where an assessment and decision was recorded by a multi-disciplinary team and at the point of leave from the ward being taken. This was an action identified at the previous inspection, which had now been met. This process was now embedded in routine practice.

However, it was not always clear how staff acted to manage items of potential risk on the ward. This included cigarette lighters and razors. At our previous inspection we found the process to manage personal items of potential risk taken from patients going off the ward was not always robust. The trust had now met this, and all wards had a robust system in place to sign in and sign out patient personal items of potential risk. All 20 patients we spoke with knew what the restricted items were and where the signs were displaying these. Three patients at St George's Hospital told us the signing in and out of restricted items form was not always completed. However, records we viewed showed these logs were completed before patients' leave was taken and before they returned onto the ward area. Two of the 10 patients we spoke with at St George's Hospital did not know why some items were restricted. However, we found this information was given to patients as part of their welcome pack.

We found the system in place for communal ward items was not robust. On Laurel Ward at The Redwoods Centre, we found records where a patient was given a disposable razor to use and was asked every 15 minutes to return it to be disposed of. However, systems were not as robust across the other 2 wards at The Redwoods Centre. On Pine Ward at the Redwoods Centre, we found staff gave disposable razors to patients who did not have access to their own re-useable razors. However, staff did not record when they gave these razors to patients for unsupervised use and when they were returned to be disposed of. Records showed on 2 occasions where staff found razors in this patient's bedroom during room searches. This meant we were not assured staff could keep the ward safe of restricted items.

Birch Ward at The Redwoods Centre had a communal lighter used by patients. Staff failed to record when they gave this lighter to patients for unsupervised use and when they had returned it. Before the inspection team left, The Redwoods Centre put an appropriate log in place across all 3 wards to log ward items of risk. However, we are not assured this would have been identified as a risk by managers themselves.

Our findings

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The trust supported staff with policy and procedural guidance when they needed to search patients or their bedrooms to keep them safe from harm. Staff only carried out searches when there were reasonable grounds to suspect a risk of harm to individuals or others, or on suspicion of criminal activity that would compromise the safety of others. However, these searches were not always carried out in a timely manner. Following an incident where a patient was found with a lighter on the ward, staff failed to carry out a room search until the incident was raised by the inspection team. All ward managers we spoke with told us they followed the trust policy when completing patient searches, but recognised the legal limitations they had when completing searches, which left gaps where patients could conceal items to bring them onto the wards.

Patients told us staff completed night-time observation checks as prescribed. However, when giving us feedback on services 5 patients told us this involved them shining a torch into their room which disturbed their sleep. We reviewed the trusts supportive observation intervention and engagement policy, which advised staff to increase lighting if they could not observe patients moving or breathing.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records. Staff employed by the trust, including bank staff, were issued with usernames and passwords to access the trust's electronic systems. The new system in place allowed ward managers to allow temporary users access to systems for the duration of their shift. During our previous inspection we found agency nurses did not have access to the trust's electronic systems. The trust had now provided every ward with generic cards which could be activated for agency staff, allowing them to access the electronic recording system update notes and record incidents. We saw records on every ward that had been made by agency staff. This was an area of improvement identified at the previous inspection, which the trust had now met.

Track record on safety

Although we found a 52% reduction in the number of incidents within the last six month period compared to our previous inspection and robust systems in place to manage patient personal lighters on the wards we found incidents involving lighters on every ward within the last 2 months. The trust had a robust search policy in place. All ward managers we spoke with confirmed they followed the trust policy when completing patient searches, but recognised the legal limitations they had when completing searches, which left gaps where patients could conceal items to bring them onto the wards. Eight of the 23 incident records we reviewed during the inspection involved lighters and none of the forms viewed recorded if staff had asked the patient where they had obtained the lighter from. We were not assured staff completed incident forms and completed actions to mitigate risk effectively after incidents occurred on wards.

Reporting incidents and learning from when things go wrong.

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately.

Staff did not always know what incidents to report. Staff did not always raise concerns and report incidents and near misses in line with trust policy.

Our findings

On Birch Ward at The Redwoods Centre, we found patients were using a communal ward lighter. Staff did not record when they gave this lighter to patients for unsupervised use and when it had been returned for safekeeping. This meant we were not assured staff could keep the ward safe of restricted items.

On Pine Ward at The Redwoods Centre, we found staff gave disposable razors to patients who did not have access to their own re-useable razors. Staff did not record when they gave these razors to patients for unsupervised use and when they had been returned to be disposed of. This meant we were not assured staff could keep the ward safe of restricted items. We reviewed 2 incidents on Pine Ward at The Redwoods Centre where razors were found in a patient's room during room searches. This patient only had access to the ward disposable razors. This meant we were not assured staff could keep the ward safe of restricted items.

On Birch Ward at The Redwoods Centre, the inspection team found an incident within patient daily progress notes where a patient was smoking in the ward garden that had not been reported effectively. The incident occurred on the evening of 27June 2023. We found no incident form had been completed for this. When staff were asked what actions were taken following the incident, we were told the night staff should have completed a room search. However, there was no log of this within patient notes, or within the handover. After this incident had been raised by the inspection team on the morning on 28 June 2023 the staff conducted a room and person search and found a lighter. An incident form was then completed retrospectively on the afternoon of 28 June 2023, but the notes of the incident form still did not reflect that a room search, and person search had been completed and a lighter had been found. We were not assured staff completed incident forms, handover incidents and completed actions to mitigate risk effectively after incidents occurred on wards.

Is the service well-led?

Inspected but not rated

Our rating of well-led stayed the same. The previous rating of inadequate remained.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

The trust had sustained significant improvement in the completion of staff supervision since 2019. Supervision rates across the acute wards and PICU was at an average of 97% across all acute wards for working age adults and PICU wards. All staff we spoke with told us they had regular supervisions and we saw good practice of wish lists for training requested at supervision and completion of these on wards.

The trust was reliant on temporary staff to meet ward staffing requirements. The governance processes now in place provided assurances that temporary staff were always inducted to the ward they worked on and supported to deliver safe care and treatment. Practices to ensure bank or agency staff received a local induction were now robust and well understood by all staff. Every ward had a ward specific induction in place which included details specific to the ward, including the ward ligature risks and how to use the anti-barricade system in place. We spoke with 24 staff including 11 bank or agency workers who all confirmed all staff received a ward specific induction before they started a shift and had a key to activate the anti-barricade system. The trust now routinely provided agency staff with access to the electronic

Our findings

records systems. The new system in place allowed ward managers to allow access to systems for the duration of the individual's shift. This included policy and procedural guidance, actions or learning following incidents, and details of trust values to guide staff practice and conduct with patients. These were areas of improvement identified at the previous inspection that the trust had now met.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care.

We were not assured staff were recording and reporting all patient safety incidents. The trust's systems to monitor and learn from incidents were not always effective. There was no effective auditing tool in place to ensure staff were reporting all incidents in line with the trust policy.

We found incidents were not always reviewed effectively to prevent them from re occurring. The trust had failed to identify effective learning from incidents involving razors to help mitigate the risk of them reoccurring. We were not assured the incident auditing processes identified lessons learnt in an effective and timely manner.

We were not assured staff completed incident forms and completed actions to mitigate risk effectively after incidents occurred on the ward. Handover records did not always include all areas of risk on the ward.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that all staff within the acute mental health wards for working age adults and the psychiatric intensive care units follow trust policy and guidance to manage items on the ward which may present a potential risk to service users. (Regulation 12)
- The trust must ensure that all staff within the acute mental health wards for working age adults and the psychiatric intensive care units log all patient safety incidents in accordance with trust policy and guidance. (Regulation 12)
- The trust must ensure that all staff within the acute mental health wards for working age adults and the psychiatric intensive care units take appropriate actions to mitigate risk after incidents of potential or actual harm occur. (Regulation 12)
- The trust must ensure that all staff within the acute mental health wards for working age adults and the psychiatric intensive care units use effective communication methods to hand over incidents of risk of potential harm. (Regulation 17)
- The trust must ensure that managers within the acute mental health wards for working age adults and the psychiatric intensive care units use effective audit processes to identify all incidents are reported. (Regulation 17)
- The trust must ensure that managers within the acute mental health wards for working age adults and the psychiatric intensive care units are sharing lessons learned following incidents of potential harm. (Regulation 17)

Action the trust Should take to improve:

- The trust should ensure that staff are considerate of patients' needs when completing night-time checks.
- The trust should ensure ligature risk assessments, including staff areas are more detailed around the potential risks within each locked area.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 1 other CQC inspector, a specialist advisor, and an expert by experience. The inspection team was overseen by Andy Brand, Deputy Director of Operations.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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