

Essex Partnership University NHS Foundation Trust

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

## Inspection report

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November 2020  
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## Ratings

Overall rating for this service

Not inspected

Are services safe?

Inspected but not rated ●

# Our findings

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

Not inspected

Essex Partnership University NHS Foundation Trust provide community health, mental health and learning disability services for a population of approximately 1.3 million people across Bedfordshire, Essex, Suffolk and Luton.

Finchingfield ward is a 17 bedded inpatient mental health ward which provides care and treatment for men experiencing acute mental health difficulties which cannot be managed safely in a less restrictive setting. There is no requirement that wards such as this are locked. The ward is included in the Trust's portfolio of acute wards for adults of working age and psychiatric intensive care units. This core service was last inspected from July to August 2019 and was rated as requires improvement overall. Ratings for safe, responsive and well led were requires improvement and the core service achieved good ratings for effective and caring. We issued requirement notices for breaches of regulation 12 (safe care and treatment), regulation 15 (premises and equipment) and regulation 17 (good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We completed this focused inspection of this ward based on concerning information and incidents relating to patient safety. We visited the ward on 29 October 2020. We specifically focused on our safe domain.

During the inspection we:

- completed a tour of the environment
- looked at eight records of patient care, we did this on the ward and via video conferencing
- spoke with five staff
- spoke with three patients
- reviewed closed circuit television footage of two incidents
- and reviewed policies, procedures, data and documentation relating to the running of the service.

Patients told us they felt safe on the wards and that staff treated them with respect. They said staff gave them support when they needed it and they were involved in their care.

We did not rate this inspection.

We identified the following areas of concern:

- Individual staff did not carry out their duties as required by patient care plans and Trust policy. Staff did not carry out observations in the garden area, as required to maintain patient safety. This poor practice contributed to incidents of patient absconsion from the ward. Staff made clinical decisions which were outside of their role and responsibility.
- Staff did not keep accurate high quality records of patient care and managers did not check the quality and accuracy of notes. Staff failed to correctly record patient's mental health act status and they did not always make entries to records in a timely way. Documentation did not support staff in recording accurate times they observed patients.
- The provider did not ensure that there were experienced staff available to meet patients' needs on all shifts.

# Our findings

- Staff did not always reflect patient risk in morning handover meetings.

However:

- Patients gave positive feedback about the ward staff and the environment. They did not raise any concerns relating to their safety or the way staff treated them.
- Managers ensured they planned shift with enough staff to meet the needs of the patients.
- The Trust ensured there was support available to patients and staff following incidents, this included access to senior leaders and psychologists.
- The Trust responded quickly to concerns raised during feedback from the inspection and provided assurance on how they intended to address issues. The trust took immediate actions to address some concerns, including removal of garden shelters and increasing security measures.

## Is the service safe?

**Inspected but not rated** ●

We did not rate this inspection.

We identified the following areas of concern:

- Individual staff did not follow the required actions to maintain patient safety. Garden areas required staff to observe patients due to environmental risks. We witnessed an incident of closed circuit television which showed observing staff were not present and this contributed to an incident of patient absconsion. The ward ligature risk assessment clearly recorded the need for staff to be physically present in the garden when patients went outside. Staff meeting minutes from May, June and August 2020 recorded managers instructing staff to observe patients in the garden.
- Staff acted outside of their role and responsibilities. In one example staff made the decision to reduce the level of patient observations against Trust policy. Their role was not of the required grade to make this type of clinical decision. Staff did not record the rationale for reducing the level of observation in the patients record. On a night shift, where two incidents occurred relating to patient safety, managers had not ensured staff had the right experience to meet patient need.
- Staff could not record accurately when they observed patients. The service provided staff with observation records that had pre-populated time stamps at on the hour intervals. This meant records showed one staff member observed all patients (17 at the time of inspection) at the same time, on the hour every hour. This was not physically achievable due to patients being in different areas of the ward. In an incident of absconsion observation records showed staff took 27 minutes to discover a patient missing from the ward, when closed circuit television footage showed it took 12 minutes for staff to make the discovery.
- Staff did not maintain accurate and timely records of patient care. We looked at eight patient records. In one example staff had not recorded the correct Mental Health Act status of the patient on numerous occasions. This increased the risk that patients may be subjected to restrictions without the appropriate legal frameworks in place. In one example staff had not added a record of multi disciplinary meeting notes in a timely way and information was not completed in full. This increased risk that entries may not accurately reflect the patients care and treatment.

However:

# Our findings

- Staff completed regular risk assessments of the care environment. They identified areas of the ward that may pose a risk to patients and developed ways to mitigate that risk. Staff completed the most recent assessment of the environment in June 2020. Managers recorded the areas of risk and included photographs to support staff knowledge of their environment. Staff mitigated any issues relating to lines of sight using mirrors.
- On the night of the incidents, managers had allocated the required staff numbers to work on the ward. From July 2020 to September 2020 managers had ensured the required number of staff worked on the wards. In all examples staffing was over the planned numbers to ensure staff availability for enhanced support, patient leave and activities. The average shifts filled for July for registered nurses was 104% on day shift and 144% on night shift. For healthcare assistants the average rate for filled shifts was 152% for day shifts and 126% for night shifts. As of 3 November 2020, all staff were up to date with their mandatory training.
- The ward did not use high amounts of bank or agency staff. We reviewed data from July 2020 to August 2020 and the use of bank staff related to 1.3% of shifts and the use of agency staff related to 1.1% of shifts. There were no vacancies in the ward team, although managers identified staff sickness as a challenge due to the coronavirus pandemic and the requirement for staff shielding and isolation. From July 2020 to August 2020 the ward reported an average figure of 8.3%, above the Trust target of 5%.
- We looked at eight patient records. Staff completed a risk assessment on admission in six examples. When an incident occurred, or patients risk changed, staff updated the risk assessment promptly and described ways to support patients and decrease risk. Staff completed risk assessments which contained information relevant to the patients care and treatment daily notes and staff used a recognised risk assessment tool.
- Staff knew what to report as incidents and when to report them. From January 2020 to October 2020 staff reported two serious incidents. The Trust completed a full route cause analysis for one serious incident which occurred in January 2020. Staff identified lessons and shared across teams. Managers were in the process of investigating the second serious incident in line with the timeframes expected by Trust policy. From November 2019 to October 2020 staff reported 282 incidents, the highest categories being: absconsion (47), assault – physical (37), moving and handling (32), anti-social behaviour (27) and assault – verbal (23). Of the 47 reported absconsions, staff recorded seven as absconsions from the ward. Three related to the garden, two related to absconsions through the doors, one related to staff granting leave when it was not authorised and one related to a patient breaking a window. Managers reviewed incidents, identified learning, made environmental changes and shared lessons with the ward team. Managers used standard agenda items in team meetings to share lessons. At the time of inspection managers were reviewing nine incidents and one was under investigation.
- Staff had access to electronic systems to record information about patients care and treatment. Managers ensured bank and agency staff could access systems via the use of guest log ins.

# Our findings

## Areas for improvement

The Trust must ensure that staff observe patients as prescribed by their care plan and in line with mitigation recorded in ward risk assessments (Regulation 12 (2))

The Trust must ensure that staff accurately communicate patient risk in handover meetings (Regulation 12 (2))

The Trust must ensure that staff keep accurate records of patient observations (Regulation 17 (2))

The Trust must ensure that staff keep accurate, timely and contemporaneous records of patient care (Regulation 17 (2))

The Trust must ensure that staff work within their roles and responsibilities (Regulation 17 (2))

The Trust must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed order to meet patient need. (Regulation 18 (1))

# Our inspection team

The team that inspected this service included one CQC Inspection Manager and one CQC Inspector.

This section is primarily information for the provider

# Enforcement actions

## 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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment