Humber NHS Foundation Trust

Maister Lodge

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)
RV938	Maister Lodge	Maister Lodge	HU8 0RB

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.

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

Contents

Summary of findings

Overall summary

We found the following issues that need to improve:

- When we arrived at the ward, staff showed us into the nurses' office. There were documents and drawers lying on the floor from an incident that occurred in the office earlier in the morning involving a patient. Staff were currently managing the patient through one to one observations.
- Staff told us they were often understaffed, which meant they struggled to meet the high level of observations their complex patient group required. Staffing rotas showed a high use of bank and agency staff and 26% of shifts not filled to the minimum establishment required. There were no senior nurses or managers on duty over the weekend.
- The staffing levels on the day of the inspection were three qualified nurses and three health care assistants on duty. This included the nurse in charge, as the ward manager was not on duty that day. Seven of the patients on the ward required high-level one to one observations and one patient had developed a physical health condition that required immediate attention from a doctor.
- Staff were confused by the introduction of zonal observations to support one to one patient observations. The ward introduced this practice when they implemented the trust's supportive engagement policy. The manager had plans to review how staff were implementing the policy.
- Staff did not routinely report patient restraint as an incident. They documented the use of restraint in individual patient records. This meant there was no way of monitoring the number of restraints occurring daily or identifying any themes arising.

Summary of findings

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

Are services safe?

We found the following issues that need to improve:

- Staffing rotas in the previous three months showed the ward had not filled 26% of shifts to minimum staffing levels.
- There were no senior nurses or managers on duty during the weekend.
- The staffing establishment meant there was not always enough staff to manage the level of one to one observations the patients required.
- Staff did not fully understand how to use the trust's supportive engagement policy.
- Staff did not routinely record restraints carried out on patients as an incident.

Summary of findings

Information about the service

Humber NHS Foundation Trust provides wards for older people with mental health problems.

Maister Lodge is a 16 bed mixed gender ward for older people with organic illness leading to memory problems. It is a stand-alone unit located in east Hull. Only 13 of the beds were operational and on the day of the visit, there were 11 patients residing on the ward. All patients were detained under the Mental Health Act 1983 (MHA). The ward was closed to further admissions due to the complex and challenging behaviours of the patients currently on the ward.

Maister Lodge is registered to carry out two regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease and disorder.

The CQC last inspected the trust in May 2014. There were no requirement notices issued in relation to Maister Lodge. A Mental Health Act reviewer inspected the service in May 2015. The trust lodged an action plan to deal with the issues raised in relation to the MHA.

Our inspection team

The team was comprised three Care Quality Commission inspectors.

Why we carried out this inspection

We inspected this service due to receiving whistleblowing concerns about patient safety.

How we carried out this inspection

The inspection was an unannounced, focused inspection and asked the question of the service:

- Is it safe?

We focused on safe staffing and assessment of risk.

Before the inspection visit, we reviewed information we held about the service including the most recent Mental Health Act review.

During the inspection visit the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the acting manager and senior managers for the ward
- spoke with five other staff members; including nurses and a volunteer
- attended and observed a multi-disciplinary handover meeting.
- reviewed four treatment records of patients
- reviewed policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We were unable to interview any of the patients formally. We utilised the short observational framework for inspection (SOFI) to observe patient interactions in communal area. Due to hectic environment, the SOFI only lasted 20 minutes. However, we did observe staff interactions with patients were kind and respectful.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure sufficient numbers of suitably trained staff are deployed on the ward.

Action the provider SHOULD take to improve

The provider should ensure staff report when they use restraint on a patient as an incident.

The provider should ensure staff fully understand how to use the supportive engagement policy to support patient observations.

Humber NHS Foundation Trust

Maister Lodge

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Maister Lodge	Maister Lodge

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

We will report on this following the scheduled comprehensive inspection in April 2016.

Safe staffing

On the day of the focused inspection, there were ten male and three female patients admitted to the ward. Two patients were taking leave under section 17 of the Mental Health Act 1983 (MHA). All patients were detained under the MHA. The ward was not admitting any further patients due to the complex and challenging behaviour levels of the present patient mix.

Establishment levels for the ward comprised 16.6 qualified nurses and 15.5 health care assistants. The ward had one nurse vacancy and three nurses undergoing preceptorship, which meant qualified nurses supervised them. The manager used regular bank staff that were familiar with the ward to cover sickness levels, vacancies and leave. In addition, the ward also used a small core group of regular agency staff.

The trust monitored how many nursing staff were working on the ward every month and submitted safer staffing information to the board. The required staffing level for both the eight-hour day shift and late shift comprised of two qualified nurses and four health care assistants. Staffing levels for the night shift comprised of one qualified nurse and four health care assistants. In addition, there was a twilight shift worker when needed.

We looked at staffing rotas for the 6-week period leading up to the inspection. The ward used bank and agency nurses on 84% of the shifts, aiming to meet the minimum staff levels needed. These figures did not include the additional twilight shift, which was variable.

However, 33 out of 126 shifts (26%) were not filled to the required minimum establishment level. The nurse in charge for nine night shifts during this period was an agency nurse. The ward could not assure us the agency nurses used to supervise the night shift had specific training in dementia care. This meant the ward did not use sufficient numbers of suitably skilled staff to care for patients.

The day shift comprised of only one qualified nurse on nine occasions and ten occasions on the late shift. On 23 out of 42 early shifts, there was no senior nurse cover. This included every weekend. This meant band 5 qualified nurses were managing the ward without support from senior staff. On the day of the inspection, three qualified nurses and three support workers were on duty. This figure included a nurse in preceptorship and the deputy charge nurse. On several occasions, it was necessary for the modern matron to support the nurses with their duties. Apart from the twilight shift, there was no evidence to show the ward had increased the number of staff on duty to meet any need for increased levels of observation.

The ward had not had any staff leavers in the 12 months prior to the inspection. At the time of inspection, no staff were absent long term.

Patients received weekly one to one time with a nurse but not necessarily their named nurse. Staff reported they cancelled escorted patient leave and activities on occasion. This was due to high levels of observations required or concerns around patient presentation. Most activities took place in the communal area. During our visit, we noted the volunteer providing activities had to abandon their session due to high levels of disruption and challenging behaviour from patients.

The multi-disciplinary team discussed each patient's mental and physical health during the daily multi-disciplinary meeting. On the day of our inspection, nurses had raised a concern about a patient with a chest infection and a GP was attending to this patient's needs. Staff completed patients' physical health checks such as pressure sore prevention checks, pain score and food and nutrition intakes. However, they did not always complete physical health monitoring charts straightaway.

Assessing and managing risk to patients and staff

Maister Lodge did not have a seclusion facility. However, staff had reported four incidents of seclusion in the six months preceding the inspection. When patients presented with seriously challenging behaviour, which posed risks to others, staff used the patient's own bedroom or one of the large communal rooms on each of the corridors. We looked at two seclusion records and found staff had monitored patients in accordance with the MHA code of practice. The

Are services safe?

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

manager initially showed us the out of date seclusion policy that had been under review since 2014. We had to request the new policy, which had recently become available to staff. There were no reports of long-term segregation in the last six months.

Staff documented where they had used restraint on a patient in the patient's notes. They did not routinely or consistently use the trust's electronic reporting system to record the restraint as an incident. This meant the ward could not identify any common themes or learning from these incidents. We looked at eight episodes of physical restraints recorded in patients' notes. We saw staff documented these appropriately, recording the position and duration of the restraint, the restraint location, and the staff member responsible for each body part. Following one episode of restraint lasting for an hour, staff arranged a best interest discussion for later that day. Staff were aware of the policy on the use of restraint of older people and used diversionary techniques and reassurance in the first instance.

There were no reported incidents of the use of prone restraint. Prone restraint is a type of physical restraint that involves holding a person chest down. The managing violence and aggression training focused on identifying de-escalation techniques and using the least restrictive interventions. The ward reported no incidents of rapid tranquilisation.

We looked at four patients' care records. All patient records reviewed contained an up to date risk assessment and risk management plan. The service used the Galatean Risk and Safety Tool (GRIST) to assess patients. This was a web-based decision support system for assessing and managing the risks of suicide, self-harm, harm to others, self-neglect and vulnerability. Staff undertook regular reviews of the GRIST, along with a daily risk assessment of each patient. Patients had a health and wellbeing plan.

The trust introduced and implemented a supportive engagement policy in 2015 to manage observations. This allowed staff to use zonal observations to monitor patients in a given area. Zonal observations meant the patients needed to be in sight at all times. Staff found the use of the policy contradictory with their understanding of close observations, which was the patient should be at arm's length away. Staff assessed patient risk to determine the level of observation required. Staff routinely placed those patients at risk of falls on one to one observations. At the time of the inspection, seven patients were on one to one observation levels. This meant there were not enough staff on duty to facilitate the level of observation required. Staff we spoke with managed zonal observations as well as one to one observations. We discussed this with the senior ward managers because staff seemed confused by the policy. There was already a planned review arranged for the following week to consider further how to improve the implement the policy on the ward.

One member of staff expressed concern about how staff would respond to an incident with the high level of constant observations currently undertaken. There had recently been three episodes of patients assaulting nurses. Staff reported, and a patient's record confirmed, patients were unsettled at night. Poor sleep patterns meant patients would still be up at 3am. This affected their behaviour the next day, as they were tired. Where sleep disturbance was identified in patient assessments there were no care plans to manage the problem.

Staff understood their responsibilities in reporting safeguarding concerns. Training in safeguarding adults and safeguarding children was mandatory and staff were 38% and 65% compliant respectively. Despite this low level of compliance, staff we spoke to had a good understanding of safeguarding procedure. We looked at a safeguarding referral and saw staff had followed trust policy.

We did not inspect medicines management practice. This will be included in the scheduled comprehensive inspection in April 2016.

Track record on safety

We will report on this following the scheduled comprehensive inspection in April 2016.

Reporting incidents and learning from when things go wrong

We will report on this following the scheduled comprehensive inspection in April 2016.

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 18 HSCA (RA) Regulations 2014 Staffing We found the provider had not ensured there where sufficient numbers of suitably skilled staff on duty to provide safe care and treatments. How the regulation was not being met: 26% of shifts did not meet the minimum establishment required level. There was no senior nurse in charge on 23 out of 42 occasions on the day shift. This included every weekend. We were not assured the agency nurses used to supervise the night shift where trained in dementia care. This was a breach of Regulation 18 (1)