Surrey and Borders Partnership NHS Foundation Trust

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

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Ratings

Summary of findings

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

Summary of this service

This was a focused inspection, so we did not rate this service.

Surrey and Borders Partnership NHS Foundation Trust provides two acute hospitals for adults of working age and a psychiatric intensive care unit. Some patients are detained under the Mental Health Act 1983. Abraham Cowley Unit is one of the locations.

The wards are registered to provide the following regulated activities;

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.

At the Abraham Cowley Unit (ACU) there are three wards:

- Clare Ward is a 20-bed male ward for patients from Elmbridge, Epsom and Ewell.
- Anderson Ward is a 13-bed female ward for patients from Elmbridge, Epsom and Ewell.
- Blake Ward is a 20-bed mixed gender ward for patients from Surrey Heath, Runnymede and Spelthorne.

The unit was last inspected on the 7 January 2020 and the service was found to be good across all key questions. However, we highlighted that the environment at the ACU was not fit for modern mental health care. This was due to the presence of dormitory accommodation which resulted in poor patient experience due to the poor communal bathroom areas, the drab and dreary environment and the overall risks to patient safety presented by the environment.

On 26 June 2020 we conducted an unannounced focused inspection looking at specific areas relating to ligature risks.

During this focused inspection we visited two of the three adult wards at the hospital. We visited Blake Ward and Clare ward at the ACU to inspect the key question ‘are services safe’, with a particular focus on ligature risks. The decision to inspect the hospital was taken following the deaths of two patients on Clare ward on 15 April and 10 May 2020. Both patients had died by means of fixing a ligature to fittings on the ward.

Following this inspection, we wrote to the trust to inform it of our concerns about the management of environmental ligature risks at The Abraham Cowley Unit. We wrote to the trust under section 31 of the Health and Social Care Act 2008. 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. A letter of intent sets out our intention to take urgent action if the provider does not assure us that it will make the required improvements urgently. The trust responded to our letter on 14 July 2020 with an action plan to address the issues.

In the Section 31 letter we told the trust that we were concerned about the management of ligature risks as ligature risk assessments on one of the two wards inspected had not been updated following recent serious incidents. During our inspection on 26 June we found that new risks had been identified on Clare Ward following a re-assessment of ligature risks, but this re-assessment had not been completed for Blake Ward, despite the similarity of the ward environments. At the time of the inspection we were concerned that the learning from the incident reviews on Clare Ward had not been shared across the other adult wards at ACU. We asked the trust to ensure there was a robust system in place to share learning and immediate actions from adverse ligature incidents across the three adult wards. Following our Section 31

Summary of findings

letter, the trust told us all three wards had now completed a full audit of ligature risks as of 12 July and that learning was now being shared through the hospital morning meeting, the afternoon safety call and the Situation Background Assessment Recommendation (SBAR) ward handover process. The SBAR ward handover process had also been revised across all wards to manage ligature risk.

We told the trust we were concerned that there was a lack of timely, pro-active action to address and mitigate the ligature risks identified for the adult wards at ACU. The trust had identified 'quick-win' actions to mitigate ligature risks, which had been completed on Clare Ward. However, the urgent works identified by the trust to remedy the ligature risks in the three categories of 'quick wins', 'more extensive solutions' and 'no obvious solution' had not all been addressed and had not been identified on the other two adult wards. We asked the trust to ensure there was a clear and measurable delivery plan to meet the works required to ensure effective controls in all three categories ('quick win', 'more extensive solutions' and 'no obvious solution') across all three wards. Following our Section 31 letter of intent, the trust confirmed that work required to complete immediate actions would be completed on Clare Ward by the 16 July and Blake and Anderson by the 21 August. It also confirmed that staff on Anderson and Blake had completed the additional training.

We told the trust we were concerned that initiatives to address the ligature risks described in the trust's document, Safety Actions for ACU remained in discussion, in development, or 'to be considered for a trial only' and that these did not have a clear implementation date.

The initiatives described in this document included, but were not limited to, a remote monitoring product that uses infrared and optical sensors to monitor motor movement. This system also contains a medical device for vital signs monitoring that measures breathing and heart rate. The second initiative was a modern style of safety hinge and other visual aids to improve door safety.

We were concerned that effective controls to manage ligature risks remained in discussion with no real time scales for completion of remedial action several months after two serious incidents. We asked the trust to ensure that decisions about initiatives to minimise ligature risks are followed through and put in place in a timely manner. In response to our Section 31 letter the trust told us it would be installing the room monitoring system, a remote monitoring product that uses infrared and optical sensors to monitor motor movement and also contains a medical device for vital signs monitoring that measures breathing and heart rate. A site survey had already been completed and the trust has agreed to proceed with installation on the three wards commencing on 17 July 2020 with a planned completion date of 30 September 2020. The trust response confirmed that decisions had been made to place orders for the room monitoring system and the safe hinges, they stated that subject to board approval the order would be placed by the 17July 2020 and the works completed by the 30 November 2020

In the trust's response to our Section 31 letter the trust told us it was improving the governance of ligature minimisation and this would be overseen by the board, the ligature minimisation policy would be redrafted with a system for checking people are competent. The observation policy had already been re-drafted; this was due to be discussed by the executive board at the next meeting. Both policies were reviewed and approved through the governance processes by 22/07/20 as per the action plan target date.

As our inspection was an unannounced inspection to look at specific issues we have not included a rating and have not altered the previous rating for this core service.

During this inspection, the inspection team

Visited Blake ward and Clare ward

Spoke with the ward manager covering both wards

Reviewed staff rotas

Summary of findings

Reviewed shift handover documents

looked at care and treatment records of patients

Is the service safe?

This was a focussed inspection, so we did not rate this domain. We found that:

- Work to mitigate ligature risks and learning from the deaths of two patients on Claire ward had not been taken forward on Blake ward despite the same risks existing on both wards.
- Although staff completed an annual risk assessment of the ligatures in the ward environment, there were ligature risks on Blake ward that had not been addressed. The ligature assessment on Blake ward had not been updated following the deaths on Clare ward, despite the two wards being very similar, and did not contain sufficient detail of the risks on the ward or how they should be managed. On Clare ward we saw that a number of the 'quick win' work identified by the trust to mitigate ligature risks had been completed. However, on Blake ward the risks identified via the trust's re-assessment on Clare ward had not been addressed nor had any actions to mitigate these been identified. On Blake ward staff were not managing the use of the dormitory shower rooms safely with no consistent process in place to safely ensure patients were accessing the dormitory shower room.
- In Clare ward's ligature assessment, the areas identified as requiring a 'medium' speed of delivery had no identified timescales or allocated costings identified.
- At the time of the inspection there had been ligature and risk specific training rolled out for the staff on Clare Ward however on Blake ward there was no formal training for staff in the management of ligature or environmental risks. Following our Section 31 letter of intent, the Trust confirmed training had been developed for roll out and would be completed by the by the 29 June
- On Blake ward staff were not recording patient observations to the new standards set for staff on Clare ward such as recording more patient detail and completing observations at more random times during the set intervals.
- Safety initiatives were still in the process of being reviewed by the trust. There was not specified dates for completion of the reviews or for when remedial work to address the environmental risks would be completed even though it had been several months after the two serious ligature incidents

However:

- Staffing levels across both wards we inspected were safe and the trust had made the decision, due to the COVID-19 pandemic to cap the patient numbers on each ward at 14
- Following our Section 31 letter of intent, the trust confirmed the training package supplied to the staff on Clare ward had been developed for roll out and would be completed for all wards by the by the 29 June.
- Clare ward was using an updated Situation Background Assessment Recommendation (SBAR) handover process that incorporated discussions of risk and guidance for staff on how to manage the identified ligature risks on the ward.

Detailed findings from this inspection

Is the service safe?

Safety of the ward layout

We toured the two wards and reviewed the ligature assessment with a ward manager who worked across both wards. On Clare Ward the ligature risk assessment had been updated on the 2 May 2020 this was detailed and specific for each of the ward areas. This assessment had specific actions allocated to identified members of the team to ensure these areas were being addressed. This assessment was backed up by a ligature minimisation working party which had been developed and were overseeing the changes. We saw the ligature assessment on Clare Ward had identified a number of "quick wins" which had appeared to have been completed however the areas identified as a "medium" speed of delivery had no identified timescales or costs identified in the risk assessment document.

On Blake ward we also reviewed the most recent ligature assessment and found that the ward, which is identical in its environmental layout, had not had a new ligature audit carried out since before the patient deaths on Clare ward. Ward staff were using an audit from July 2019 which was not sufficiently detailed. The assessment missed multiple ligature risks across the environment and contained a number of errors identifying areas of the ward which did not match the layout of Blake Ward. They had not had the same level of identified and actioned works carried out as Clare ward.

On Blake ward we were told that staff members were aware of when the en-suite doors were being unlocked and the shower used. However, during the inspection, we noted that a patient came out of one of the ensuite shower rooms and left the door open without informing a member of staff. The shower room was left open meaning there was the potential for a patient to access the room unsupervised, resulting in a risk.

Since the inspection, the trust has now implemented a process whereby when a patient is using the shower a member of staff remains present in the dormitory until the shower is no longer in use and the shower is immediately locked afterwards. This was extended to all showers, not just dormitories showers to further share learning from the outcome of the enhanced ligature audit processes.

The Abraham Cowley Unit (ACU) action plan, which the trust developed to address ligature risks on the wards following two patient deaths, had identified a number of initiatives that were being considered by the trust. However, these remained under review with no real time scales for completion of the remedial works required, several months after the two serious ligature incidents.

On Clare ward we found the trust had improved the Situation Background Assessment Recommendation (SBAR) handover process and included a safety briefing which had additional checks including ensuring 72 hour nursing care plans had been completed for all patients and that ligature and suicide prevention risks were discussed for all patients. In addition, the SBAR handover on Clare ward identified guidance around ensuring that all shower doors in the dormitories remained locked and information regarding patients using the shower rooms had to be communicated between staff responsible for locking and unlocking the doors. We did not find that these changes had been added to the SBAR handover on Blake ward.

We reviewed a sample of the observation records on Clare and Blake wards. On both Wards patient observations records for patients requiring 15 minutes checks were being carried out. We saw that on Clare ward observations were more frequently being carried out at a random time within the 15 minute observation window so there was less of a set pattern. This meant that patients were checked intermittently and not every 15 minutes as had been happening previously. This meant there was less of a pattern for the checks which supported more effective observations.

Detailed findings from this inspection

The observation recording forms on Clare ward included, not only the recording of where the patients were, but staff were also completing details around what meaningful activities the patients were carrying out which indicated an additional level of interaction other than just purely checking where patients were. However, this was happening much less frequently on Blake ward. The observation records were being completed but there was seldom a record of what activities the patients were carrying out or evidence that staff were interacting with patients in a meaningful way.

Safe staffing

We reviewed the staffing rotas on Clare and Blake wards over a four week period and found that the safe staffing numbers set by the trust were met on nearly all occasions

Across both wards there were three registered nurses and three support workers rostered on during the day and two registered nurses and three support workers at night. We reviewed the wards staffing rotas and found these numbers were being met and there were safe staffing number for the four weeks prior to the inspection.

The wards had a safety huddle every day to review staffing levels across all wards and to share staff if required. While an interim ward manager was covering Clare Ward the ward manager from Blake was supporting and supervising.

Due to the management of COVID-19 the trust had capped the number of patients that could be admitted to each ward to 14 patients but staffing levels remained the same as if the wards were accommodating 20 patients. This meant there were enough staff available to monitor and maintain the safety of the wards.

Mandatory training

Following the first death on Clare Ward the staff team had received additional training in risk assessments and care planning, observations, ligature minimisation, incident / datix writing, situation background assessment recommendation (SBAR), clinical record keeping, relational security and suicide prevention training.

The trust was planning to roll this training out across the two other acute wards but at the time of inspection, almost two months after the first patient death, this had not been completed on Blake and Anderson. However the roll out of the training had been planned to be completed for all three wards through the month of June. In addition suicide prevention training delivered by the Trust wide suicide prevention lead was provided across all three wards on 05/06/20 with a follow up reflective workshop held on 12/06/20.

We found that on Blake ward the SBAR handover was not as detailed as Clare ward, with the individual suicide related risks and the guidance around the management of the shower room doors not being discussed as effectively and not routinely handed over between teams.

The staff on Blake ward were not as up to date with the trust ligature minimisation protocols and values of relational security that had been taught in the updated training on Clare ward described above. This meant that the staff may not have picked up on the subtle risks and may not have had as full an understanding of the value of therapeutic observations with the patient group as staff on Clare ward. Search training was delivered on 27/05/20 to all three wards to reduce the risk of ligature items being brought into the ward environments.

Assessment of patient risk

Following the death of two patients on Clare ward we found the trust had made changes to the admissions pathway for the adult acute wards. High risk patients were now being admitted to Blake and Anderson ward only. All high-risk admissions to ACU require a senior clinical conversation before any admission is agreed. Out of hours admissions of any patients unknown to the ACU were now going to Farnham Road, the trust's other acute mental health hospital, and only transferred to the ACU following a clinical discussion that the patient could be adequately cared for at the ACU. This meant that high risk patients were not being admitted straight onto Clare ward.

Detailed findings from this inspection

Despite Blake ward presenting an identical environment with the same risks as Clare ward patients who presented a high risk were still being admitted to the ward. Thus being placed in an environment with unidentified ligature risks and being cared for a staff team who may have been less skilled in identifying risk than those who had received additional training on Clare ward.

We found from reviewing completed handover documentation that the SBAR handover on Blake ward contained less risk and clinical detail about patients than we found on Clare ward. It did not have detailed guidance regarding the management of the shower doors and there were several handovers which did not contain any risk information for several patients.

Track record on safety

Our inspection of the wards followed the deaths of two patients on Clare ward in April and May 2020. These deaths were all associated with environmental ligature risks.

Reporting incidents and learning from when things go wrong

Following the deaths of the patients on Clare ward the trust had offered considerable levels of support to staff. This included offering all the staff training and development in recording incidents, recognising risk and patient observations. We found that there were improvements in the quality of staff records in relation to handover information and patient observations. However, on Blake ward we did not find that the same level of learning had been applied to the ward processes or developing staff skills and recording of patient care.

The ward managers across both wards were carrying out audits of the observation records and incident recording which was being overseen by the modern matron this meant there was an additional layer of checks and balances to ensure incidents were reported and followed up.

We found that the learning on Clare ward had not been shared across the other acute wards at ACU. The staff on Clare ward were documenting risk more effectively and discussing environmental risks more regularly in handover with the relevant guidance in place for the shower room doors. However, at the time of the inspection the handover documents on Blake ward did not share this level of learning. This meant that the staff may miss the triggers and risks associated with escalation in patient risk.

Our inspection team

The team comprised of: an inspection manager, an inspector, the deputy chief inspector of mental health and community services.