Pathfinder Group Healthcare Limited

Pathfinder Ashness House

Inspection report

2-6 Jersey Avenue
Stanmore
HA7 2JQ
Tel:

Date of inspection visit: 18 and 21 September 2022
Date of publication: 20/12/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We undertook an out of hours, focused inspection of this service looking only at the safe and well led key questions. The inspection was undertaken following information of concern we received about staffing levels and incidents of violence and aggression on the unit requiring intervention from the police.

Following this inspection, we issued the provider with a s29 Warning notice because of the serious concerns we had about staff not carrying out the required physical health monitoring of a patient after rapid tranquilisation was administered on multiple occasions. The service did not report all incidents of physical restraint of patients and where it did, records lacked sufficient detail. Staff carried out intermittent observations at regular and predictable intervals. There was a risk that the patients would know when observations would take place and plan their actions around this. Staff did not always respond promptly to a deterioration in a patient's physical health. Senior managers did not establish effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. We asked the service to take immediate action to address these issues.

We did not rate the service at this inspection as we have not previously inspected the service and we only inspected parts of two key questions.

We found that:

- We were not assured that staff only restrained patients when de-escalation techniques failed. This was because staff did not report all incidents of physical restraint. Where staff had reported an incident of physical restraint this was not recorded in sufficient detail and in line with the requirements of the Mental Health Units (Use of Force) Act 2018.
- Staff did not always record a patient's physical health observations post rapid tranquilisation as per the provider's policy. Patients receiving rapid tranquilisation are at risk of seizures, airway obstruction, excessive sedation and cardiac arrest.
- Staff did not always respond promptly to a deterioration in a patient's physical health or record why no action had been taken in response to elevated results of checks of their vital signs. There was a risk that serious physical health concerns would be missed.
- Whilst staff followed the procedures to minimise risks to patients through regular therapeutic observations. Staff did not carry out intermittent level observations on patients at irregular and unpredictable times. There was a risk that the patients would know when observations were likely to take place and they could plan their actions around this.
- Our findings demonstrated that governance processes did not operate effectively at service level and that performance and risk were not managed well. Senior managers had not established effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients.
- The service was not able to analyse the frequency that rapid tranquilisation was administered to patients or analyse the frequency that physical restraint was used on patients as not all incidents were recorded, or records of such incidents lacked the required detail.
- Patient care and treatment records were not comprehensive, and they were not easy for staff to access. There was no clear format used in patient care and treatment records to ensure staff could consistently and readily access pertinent patient information.

However:

Summary of findings

- The service had enough nursing and support staff to keep patients safe. Although the unit had a high number of vacancies, the service had enough staff on each shift to support patients safely.
- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.
- Patients said staff treated them well and behaved kindly. All patients said that staff were respectful and went above and beyond to support them. Patients said staff listened to them and treated them with dignity and respect.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Page

Background to Pathfinder Ashness House 6

Information about Pathfinder Ashness House 6

Our findings from this inspection

Overview of ratings 8

Our findings by main service 9

Summary of this inspection

Background to Pathfinder Ashness House

Pathfinder Ashness House is in Harrow, North West London. The service is provided by Pathfinder Group Healthcare Limited and registered to provide the following regulated activities:

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

The service provides long stay/rehabilitation services to male adults of working age with complex mental health issues. The service has 26 beds. Five of the 26 beds are high dependency, supporting those people that need extra support. In addition, the service has two flats for those patients getting ready for discharge. On the days of our inspection, there were 10 patients receiving care at the hospital – with two of these patients admitted to the high dependency unit.

All patients were detained under the Mental Health Act.

The service registered with the CQC in March 2022. As this is a newly registered service, we have not previously inspected this service. At the time of the inspection, there was a registered manager in place, who was on a period of extended leave. The service had appointed an interim service manager to provide cover in the registered manager's absence.

What people who use the service say

We spoke to 3 patients and 3 relatives and carers. Patients said staff treated them well and behaved kindly. All patients said that staff were respectful and went above and beyond to support them. Patients said staff listened to them and treated them with dignity and respect. Patients felt staff built up a good level of rapport with them and got to know them well.

Carers and relatives echoed this saying that staff "are very good" and that staff treat their loved ones "well". Two relatives said staff communicated with them about their loved one's care. They said that staff "always listen to me" and regularly had conversations with them. One relative said staff were very friendly and treated their loved one with respect. Another relative said the service was welcoming and that staff took their loved one out regularly.

However, one family member said that communication with them could be improved. They often called the staff if they wanted to find out about their loved one's care and treatment. If something happened at the hospital involving their relative, they usually found out from them rather than from staff at the hospital.

We observed positive interactions between patients and staff during the inspection.

How we carried out this inspection

The team that inspected this service consisted of two CQC inspectors, an inspection manager and an expert by experience.

As this was a focused inspection, we only asked the following two questions:

• Is it safe?

Summary of this inspection

• Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including onsite visits and remote interviews with some staff.

During the inspection visit, the inspection team:

- visited the service, observing the environment and how staff were caring for patients
- spoke with 3 patients who were using the service
- spoke with 3 family members of those people using the service
- spoke with 16 members of staff including, the interim service manager, the consultant psychologist, nurses, healthcare assistants, the occupational therapy assistant, psychology assistant and the consultant psychiatrist
- reviewed 5 patient care and treatment records.
- checked how medicines were managed and stored, including reviewing 2 prescription charts
- reviewed information and documents relating to the operation and management of the service.

You can find 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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve:

- The provider must ensure that staff report all incidents of physical restraint. **Regulation 12 (1)(a)(b)**
- The provider must ensure that staff report all incidents of physical restraint in detail and in line with the Mental Health Units (Use of Force) Act 2018. **Regulation 12 (1)(a)(b)**
- The provider must ensure staff monitor and record patients' physical health vital signs after the patient has received rapid tranquilisation. This must be recorded in line with the provider's policy of every 15 minutes for the first hour and then every hour until the patient is ambulatory. **Regulation 12 (1)(a)(b)**
- The provider must ensure that staff accurately record patient's vital signs, understand when to escalate physical health concerns and follow up and clearly document actions taken in response to elevated early warning signs. **Regulation 12 (1)(a)(b)**
- The provider must ensure that staff undertake intermittent observations of patients at irregular and unpredictable intervals within each hour. **Regulation 12 (1)(a)(b)**
- The provider must establish clear and effective systems to assess, monitor and mitigate the risks relating to the safety and welfare of patients. **Regulation 17 (1)(a)**

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inspected but not rated

Safe and clean care environments

The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The unit had been recently refurbished with new fixtures and fittings. Staff completed an up-to-date ligature risk assessment to manage and reduce the risk of ligature points. The ligature risk assessment clearly outlined the ligature risks and how staff should mitigate these risks.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The provider had taken steps to reduce the number of ligature points on the ward by fitting bedrooms and bathrooms with anti-ligature fittings such as collapsible curtain rails and anti-ligature door handles. Staff were aware of the ligature cutters and where to access them. These were in an easily accessible place for staff.

The unit extended over 3 floors, with bedrooms/flats on the first and second floors. Staff managed the risk of blind spots in the unit through regular safety checks, convex mirrors, observations and engagement with patients. There was closed circuit television (CCTV) monitoring in communal areas.

Staff had easy access to alarms and patients had easy access to nurse call systems. In addition, staff used radios to raise the alarm in an emergency.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medicines that staff checked regularly. Staff checked, maintained, and cleaned equipment. The clinic rooms had emergency equipment including oxygen masks and tubing. This was contained in an emergency response bag, which staff kept sealed to prevent interference between checks or use. Staff checked the temperature of the fridges in the clinic rooms to ensure medicines were stored at the right temperature.

Both clinic rooms were clean, spacious and included handwashing facilities.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe.

The service had enough nursing and support staff to keep patients safe. Although the unit had a high number of vacancies, the service had enough staff on each shift to support patients safely. As of September 2022, the ward had six

full time vacancies for registered nurses and non-registered nurses. The service had just recruited a deputy nurse manager who was due to start after the inspection. These vacancies were covered by locum, bank and agency staff. For example, whilst the registered manager was away on extended leave the service had appointed an agency nurse manager to work and provide cover in their absence.

The ward manager could adjust staffing levels according to the needs of the patients. The day shift consisted of two registered nurses and three non-registered nurses. At night, the ward allocated one registered nurse and four non-registered nurses. At the time of our inspection there were seven nursing and support staff allocated to the evening shift. The ward had an extra two nursing staff to support with the two patients on enhanced observations.

The ward used regular bank and agency nurses as additional support to keep the ward safe and to cover staff sickness and annual leave. As of September 2022, the ward used 66% agency and bank staff to cover shifts.

The ward manager requested staff familiar with the service and made sure all bank and agency staff had a full induction to understand the service before starting their shift. The ward employed regular bank staff. New staff read and completed an induction booklet containing policies and important information about the service. Staff signed to confirm they had completed it with the nurse in charge.

The service had enough daytime and night-time medical cover and a doctor available to go to the unit quickly in an emergency. The hospital had a full-time consultant psychiatrist working Monday – Friday during office hours. The consultant also provided out of hours support to staff when they needed assistance in a psychiatric emergency.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. Staff did not report all incidents of physical restraint. Where staff had reported an incident of physical restraint this was not recorded clearly and in line with the Mental Health Units (Use of Force) Act 2018. Staff did not always mitigate the risks to a patient receiving rapid tranquilisation. Staff did not always respond promptly to a deterioration in a patient's physical health or record why no action had been taken in response to elevated results of checks of their vital signs. Whilst staff followed the procedures to minimise risks to patients through regular observations, staff did not carry out intermittent level observations on patients at irregular and unpredictable times.

Assessment of patient risk

We reviewed five patients' risk assessments and care records. Staff completed risk assessments for each patient on admission. Risk assessments included a patient's physical, mental and social risk history.

Management of patient risk

Staff did not always identify and respond to any changes in risks to patients. Staff did not always respond promptly to a deterioration in a patient's physical health or record why no action had been taken in response to elevated results. During the inspection, we reviewed four patients' physical health monitoring charts (National Early Warning Score NEWS charts) and the accompanying provider vital observations record sheets. Of these 4 patient records we found gaps in the recording of 3 patient's physical health monitoring and no clearly recorded escalation of early warning scores for one of these patients.

We reviewed the care records for a patient who had been recently admitted to the service. Staff had recorded a score of 3 on the patient's NEWS chart because of their pulse and respiration readings. The next day, staff recorded that the patient had a NEWS score of 3 again due to their pulse and respiration readings. However, we reviewed this NEWS score

with the nurse on duty and found that the patient's NEWS score was incorrect; by correctly following NEWS guidance the physical health vital signs score added up to a score of 4. Two days later staff recorded that the patient's NEWS score had decreased to two. The clinical response to NEWS triggers states that for a NEWS score between 1-4 staff should "inform a registered nurse who must assess the patient and decide if increased frequency of monitoring and/or escalation of clinical care is required" and a minimum of 4-6 hourly frequency of monitoring should be put in place. It was not clear what clinical response staff had taken after the patient had scored within this range as it was not recorded. This was a risk to patients because it meant there was a lack of assurance that patients had received the right response to their physical health presentation/condition and that their safety was ensured.

Whilst staff followed procedures to minimise risks to patients through regular therapeutic observations, staff did not carry out intermittent level observations on patients at irregular and unpredictable times. Some patients were on continuous observations which meant a member of staff was always allocated to be with the patient, for their safety or the safety of others. Other patients were on intermittent observations, which involved staff checking in with them four times per hour. We looked at two patients on intermittent observations, the records showed that staff only observed patients at regular and predictable times. For example, for one patient, staff had recorded observing them at exact 15 minutes intervals each hour. The provider's engagement and observation policy did not include how staff should safely carry out intermittent observations by undertaking them at unpredictable and irregular intervals. There was a risk that the patients would know when observations would take place and they could plan their actions around this.

Use of restrictive interventions

We were not assured that staff avoided using restraint unnecessarily and only restrained patients when de-escalation techniques failed. Staff did not report all incidents of physical restraint. Where staff had reported an incident of physical restraint this was not recorded clearly and in sufficient detail, in line with the Mental Health Units (Use of Force) Act 2018.

We reviewed the care and treatment records of a patient who had been administered rapid tranquilisation 13 times over the period of one month. We found that for 5 of these 13 incidents of rapid tranquilisation, records of the incident of physical restraint had not been completed. Staff could not locate incident report forms pertaining to this patient and the use of physical restraint and administration of rapid tranquilisation on these 5 occasions. Staff did not always record the position in which the patient was restrained. Therefore, the provider could not be assured prone restraint was not in use and patients put at risk of positional asphyxia. By failing to report all uses of force as an incident patients were put at risk of avoidable harm.

Where staff had recorded an incident of physical restraint on a patient, this was not in line with the Mental Health Units (Use of Force) Act 2018. Section 6 of the Act requires that the record of the use of force used on a patient by a member of staff must clearly include certain descriptors of the restraint. For example, the incident report of physical restraint for one patient showed that staff had not recorded the type, or types of force used on the patient, the duration of the use of force and the names and job titles of the staff who used force on the patient. For another patient, staff recorded that they were restrained in the 'supine' position. However, staff only included in the incident report that the patient was placed in "precautionary holds". Staff had not recorded which staff were involved in the restraint or the detail of how they were restrained into this position. Staff did not record the duration of the restraint. This was a risk to patients because staff could not assess whether this was the least restrictive option, which was in the best interests of the patient, or make improvements in care.

Staff did not follow national guidance or the provider's own policy when using rapid tranquilisation. Staff did not mitigate the risks to a patient receiving rapid tranquilisation. Staff did not always record patient's physical health

observations post rapid tranquilisation as per the provider's policy. Rapid tranquilisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. Patients receiving rapid tranquilisation are at risk of seizures, airway obstruction, excessive sedation and cardiac arrest. Therefore, patients need to be monitored closely after they have received rapid tranquilisation medicines

During our inspection, we looked at the records of 13 incidents of rapid tranquilisation administered by injection for one patient. We found in 2 of the 13 incidents of rapid tranquilisation, records of the post administration physical health checks that staff were required to undertake, in line with guidance, were not completed. A further 7 incidents of rapid tranquilisation only documented when the patient first refused their post administration physical health checks and did not always record respirations and level of consciousness every 15 minutes for the first hour after rapid tranquilisation was administered.

For example, we looked at a patients' rapid tranquilisation form, handover notes and other parts of their paper care notes. Staff had administered rapid tranquilisation on 3 August 2022 and staff had not recorded any physical health observations undertaken in the first hour after the patient received the rapid tranquilisation. The same patient was administered rapid tranquilisation again on a separate day. For this incident of rapid tranquilisation staff had not recorded any physical health observations undertaken in the first hour after the patient received rapid tranquilisation medicine.

We found other records for the same patient, where staff recorded the patient had refused observations in the first 15 minutes and then did not always record respirations and level of consciousness every 15 minutes for the first hour after rapid tranquilisation was administered.

For example, the medicine administration record for this patient showed staff administering rapid tranquilisation on 6 August 2022. The patient had refused a request from staff to carry out their physical health observations. There was no record in the patient's paper care notes or the NEWS chart that staff attempted to carry out the patient's vital signs in the first hour after rapid tranquilisation was administered. Staff had not recorded any other vital signs such as respiratory rate or level of consciousness when the patient refused on the paper care notes, NEWS chart or handover records. This was not in line with the provider's rapid tranquilisation policy which stated, "that respiratory rate and level of consciousness should always be obtainable." Staff did not effectively mitigate the risks associated with administering rapid tranquilisation. There is a risk to patients receiving rapid tranquilisation of seizures, airway obstruction, excessive sedation and cardiac arrest. By failing to carry out patients' physical health observations after the administration of rapid tranquilisation, patients were being put at risk of avoidable harm.

Staff access to essential information

Staff did not have easy access to essential clinical information.

Patient notes were not comprehensive, and they were not easy for staff to access. There was no clear format used in patient care and treatment records to ensure staff could consistently and readily access pertinent patient information. Patient records were held in various formats which made it difficult to find important information regarding patients' care. Incident reports were in the patient care and treatment folders and on the provider's electronic file system. Staff recorded patients' post dose rapid tranquilisation physical observations in four different places. This meant that staff, especially agency staff who did not work at the location on a regular basis, could not access pertinent patient information in a timely way. This was a risk to patients because staff could not effectively mitigate any potential risks to them.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Inspected but not rated

Governance

Our findings from the safe key question demonstrated that governance processes did not operate effectively at the unit and that performance and risk were not managed well.

Senior managers had not established effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. The service was not able to analyse the frequency that rapid tranquilisation was administered to patients within the service or the frequency that physical restraint was used on patients within the service as accurate records were not kept.

Senior managers had not identified a number of serious concerns we found during the inspection of the service affecting the safety of patients at the service.

The provider's incident register did not contain all the incidents of physical restraint that had occurred of a patient who had been restrained several times in one month. We found 13 incidents of physical restraint attributed to one patient, whereas the incident register only contained five of these incidents categorised as physical restraint. The service did not have an effective incident reporting system to help support staff to adequately report incidents. This was a risk to patients because there was no assurance that the improvements in patient safety would be implemented, monitored and sustained. The provider's nominated individual said that the service was in the process of acquiring a robust electronic reporting system so that staff could record incidents and the senior managers would be able easily access this data to analyse it to make improvements.

We reviewed the provider's rapid tranquilisation audit for the month of August 2022. The audit was not clear or robust. Not all occasions where a patient had received rapid tranquilisation were included. For example, the audit did not include an incident where a patient was administered rapid tranquilisation on 3 August 2022. The audit did not clearly set out whether post dose physical health monitoring had been carried out in line with the provider's policy. For example, in the column "Was a Further Attempt Made to Take the Physical Observations Within 30 Minutes" the audit states "yes" for every incident. Another incident in the audit recorded in the column for "Was Rapid Tranquilisation Use and Physical Observations documented?" the audit states "N/A". It is not clear why this action does not apply and why the auditor had not ensured whether staff had documented these checks. This meant that the provider had no assurance that improvements in patient safety and quality would be implemented, monitored and sustained. This was a risk to patients because the provider could not adequately monitor the use of rapid tranquilisation to ensure it was administered safely.

There was no clear format used in patient care and treatment records to ensure staff could consistently and readily access pertinent patient information. Staff recorded patients post dose rapid tranquilisation physical observations in four different places. Handover notes did not always contain the necessary information in a format that staff could quickly access. Therefore, staff were unable to see what their top nursing priorities were for the shift. This meant that staff, especially agency staff who did not work at the location on a regular basis, could not access pertinent patient information in a timely way.

The provider's engagement and observation policy did not detail that patient engagement observations should be irregular and unpredictable This meant that staff may not know how to safely support patients who needed observing.

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 • The provider must ensure that staff report all incidents of physical restraint. • The provider must ensure that staff report all incidents of physical restraint in detail and in line with the Mental Health Units (Use of Force) Act 2018. • The provider must ensure staff monitor and record patients' physical health vital signs after the patient has received rapid tranquilisation. This must be recorded in line with the provider's policy of every 15 minutes for the first hour and then every hour until the patient is ambulatory. • The provider must ensure that staff accurately record patient's vital signs, understand when to escalate physical health concerns and follow up and clearly document actions taken in response to elevated early warning signs. • The provider must ensure that staff undertake intermittent observations of patients at irregular and unpredictable intervals within each hour.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must establish clear and effective systems to assess, monitor and mitigate the risks relating to the safety and welfare of patients.

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	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 • The provider must ensure that staff report all incidents of physical restraint. • The provider must ensure that staff report all incidents of physical restraint in detail and in line with the Mental Health Units (Use of Force) Act 2018. • The provider must ensure staff monitor and record patients' physical health vital signs after the patient has received rapid tranquilisation. This must be recorded in line with the provider's policy of every 15 minutes for the first hour and then every hour until the patient is ambulatory. • The provider must ensure that staff accurately record patient's vital signs, understand when to escalate physical health concerns and follow up and clearly document actions taken in response to elevated early warning signs. • The provider must ensure that staff undertake intermittent observations of patients at irregular and unpredictable intervals within each hour.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must establish clear and effective systems to assess, monitor and mitigate the risks relating to the safety and welfare of patients.