Sussex Partnership NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

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

Requires Improvement 

Langley Green is a hospital for people with acute mental health problems. The teams provide assessment and treatment for people across four wards;

- Amber ward, 12 bed psychiatric Intensive Care Unit (PICU),
- Coral ward, 19 bed acute wards for working age adults
- Jade ward, 19 bed acute wards for working age adults and
- Opal ward, 19 bed mixed sex, integrated care for working age adults and older people

We undertook an unannounced, focused inspection at this hospital because of concerns raised due to recent serious incidents at the hospital. These included concerns around poor risk assessments, inconsistent physical health monitoring, poor risk management, poor care planning, inconsistent therapeutic observations and inadequate staffing including the high use of agency staff.

We identified a number of concerns on this inspection and so served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider that we were considering whether to use our powers to urgently suspend, impose variation or remove their registration. The effect of using Section 31 powers is serious and immediate. We told the provider to submit an action plan within five days describing how it would ensure there were always enough staff with the right skills on all of the wards on every shift to meet the needs of all patients and keep them safe and describe how it would ensure that patients physical health care was monitored appropriately, that all staff were aware of their role in relation to monitoring the physical health care of patients and that there was clear oversight of this.

The provider submitted the action plan on time. Following review of the action plan, we felt assured that the provider had sufficiently addressed the concerns around staffing. However, we still had concerns about how well staff monitored the physical health care of patients and whether this was recorded appropriately. Therefore, we served the provider with a Warning Notice under Section 29a of the Health and Social Care Act 2008, telling the provider that it must ensure that it reviewed all risk assessments and care plans of all patients with physical healthcare needs by 10 March 2021 to ensure these appropriately captured and reflected the needs and actions required and that it must audit all care plans and risk assessments by 31 March 2021 in order to ensure physical health care monitoring was completed as required. We will undertake a follow up inspection in due course to see if the provider has met the requirements of the warning notice.

Following our inspection, the trust told us that the reduction of some third-party sector and social care provision during the covid-19 pandemic have had an impact on their services, which had contributed to some of the concerns we saw on inspection. For example, during the covid-19 pandemic, there had been an increase in acuity of patients with mental health needs, increased demands for beds, patients staying longer in services because they could not be discharged when ready as they could not always access the care and support required in community, resulting in increased pressures on staff. Other factors such as social distancing and restrictions in relatives and friends visiting have also impacted on services. The trust reported they had successfully managed covid-19 positive admissions and contained a number of outbreaks, avoiding wide-scale impact upon patients, staff and the service.

Our findings

On this inspection, we focused on specific aspects of the key questions; are services safe, are services effective and are services well-led.

Our rating of services went down. We rated the core service as requires improvement because:

- There was not always enough staff with the right skills on all of the wards on every shift to meet the needs of all patients and keep them safe. Staff at all levels told us they had concerns about staffing levels, the skill and experience of some staff and felt staff could not always respond adequately when the needs of patients changed rapidly. Patients told us their leave had been cancelled on several occasions because there was not always enough staff to facilitate this.
- Staff did not always ensure that patients who had physical healthcare needs and therefore needed their physical healthcare monitoring closely had appropriate care plans and risk assessments in place. For example, two patients had put on significant amounts of weight within a very short period of time and staff did not proactively review them or escalate concerns. Staff did not escalate concerns about patients' poor fluid intake to the multidisciplinary team. Staff did not undertake a specific risk assessment for a patient who was known to be at risk of falls. There was no care plan related to falls so staff were unaware that they needed to observe the patient, record falls and escalate to the multidisciplinary team accordingly so any required action to keep the patient safe could be taken.
- Staff did not consistently complete post rapid tranquilisation physical health monitoring for all patients in line with trust policy and national guidelines.
- The trust's clinical quality audit process was not robust enough to always mitigate or minimise patients' risks. Although audits of patient records had been completed these had not picked up gaps in risk assessments, care plans and other patients records that we identified on the inspection. This could mean gaps in patient care were missed, required action may not have been taken and required improvements in care may not have been made.

However;

- All staff we spoke with were enthusiastic and passionate about working at the hospital and wanted to do a good job. Staff were caring and kind to the patients they looked after. The wards had a new team of managers who could explain clearly how teams worked together to care for patients. Ward managers were supported by senior leaders to perform their roles and there were development opportunities for staff at all levels.
- Staff felt respected, well-supported and valued. They were positive and proud about working for the trust and their teams.
- Staff knew how to report incidents and what incidents to report. Staff received feedback after a serious incident.
- Patients received a comprehensive mental health assessment on admission and staff regularly reviewed them. Staff from different disciplines worked together as a team to benefit patients. Staff held regular multidisciplinary meetings.
- The trust had an improvement plan for Langley Green hospital and had deployed senior leaders within the trust to provide cover for service leads and to support ward managers in their roles as part of their business continuity plan. Since January 2021, the trust had implemented a programme of Enhanced Monitoring for the hospital to ensure there is executive oversight and to support the improvement programme.

The ratings for caring (outstanding) and responsive (good) remain the same as we did not inspect these key questions on this inspection.

The service is registered for:

Our findings

- assessment or medical treatment for persons detained under the Mental Health Act 1983,
- diagnostic and screening procedures and
- treatment of diseases, disorders and injury.

How we carried out the inspection

During this inspection, we interviewed 29 staff including managers, allied health professionals, doctors, nurses, healthcare support workers and non-clinical staff. We spoke to 10 patients, reviewed 11 patient care records, looked at the environment and patient care areas and reviewed policies and procedures and other documents relating to the running of the service.

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.

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- The hospital did not always have the right number of staff with the right skills and experience to keep patients safe. Patients told us there was not enough staff to talk to and there were a lot of new faces. Out of the 10 patients we spoke with, five said their leave had been cancelled on a number of occasions due staff being too busy or because there were not enough staff to facilitate leave. Although staffing levels were discussed on the daily hospital wide "safety huddle", staff told us the nursing teams were too stretched to respond effectively if the needs of patients changed rapidly.
- During the times we spent on the wards we saw that staff did not have time to engage in therapeutic activities with patients. We undertook a specific hour-long observation of ward activities on Opal ward and did not observe any staff interacting with patients because they were involved with other tasks. We fed back our concerns to the trust following the inspection, and the trust informed us that they had identified staffing as a risk during the most recent safeguarding review. The trust informed us they had a detailed recruitment and resourcing programme in place, and as a short-term measure, they had block-booked additional agency staff over an extended period to promote consistency.

However;

- Staff knew how to report an incident and what incidents to report. Staff held a safety huddle following any serious incident and they met to discuss and to share learning. Incidents were also discussed during team meetings, handovers, supervision and reflective practises. Staff and patients were debriefed following an incident and they were offered psychological support when a serious incident occurred. Managers sent personalised messages to check on staff welfare following a serious incident.

Our findings

- Staff received feedback following the investigation of incidents. They met to discuss feedback and we saw evidence of changes made as a result of feedback. For example, following a serious incident which resulted in the death of a patient, the service took steps to improve staff confidence by carrying out immediate life support simulation around the hospital, although this has since been suspended due to covid-19.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not always monitor all aspects of patients' physical health or escalate concerns about patients' physical health to the multidisciplinary teams in line with best practice. Out of 11 patients' records we reviewed, four of them did not have any records of weight for a period of three to five weeks. We saw two of these patients had gained significant amounts of weight in a short period of time, staff had recorded this on the MUST charts and the weight charts but there was no evidence of care planning or escalation to the multidisciplinary team.
- We reviewed two patients' food and fluid charts over a period of approximately 10 days. Both patients had significantly less fluids than the prescribed target amount for eight of the 10 days. Records did not demonstrate that this had been escalated to the multidisciplinary team and there were no specific or personalised care plans created to support patients to drink more fluids.
- Staff did not undertake a specific risk assessment for a patient who was known to be at risk of falls. There was no care plan related to falls so staff were unaware that they needed to observe the patient, record falls and escalate to the multidisciplinary team accordingly so any required action to keep the patient safe could be taken.
- Staff did not always ensure patients' physical health were monitored post rapid tranquilisation in line with trust policy. During our inspection, Staff could not provide us with physical health monitoring records for these patients. The trust told us that at the time of the request, these historical forms were being uploaded to the electronic care record by ward administration staff, some of whom were working remotely to comply with Covid-19 guidelines. However, following the inspection, the records that we were sent by the trust did not give us assurance that physical health protocols were consistently being complied with in line with national guidelines. For example, the records provided by the trust did not clearly show the time of administration of the rapid tranquilisation and when the checks took place. Physical health monitoring is required to ensure any side effects, such as respiratory depression are identified and responded to immediately. Monitoring should take place for a minimum of two hours following the administration of rapid tranquilisation in line with national guidance.

However;

- All patients received a comprehensive mental health assessment on admission and staff regularly reviewed them.
- Staff from different disciplines worked together as a team to benefit patients. Staff held regular multidisciplinary meetings to discuss patients' care and treatment.

Is the service well-led?

Requires Improvement 

Our findings

Our rating of well-led went down. We rated it as requires improvement because:

- The trust's clinical quality audit process was not robust enough to always identify that patients may be at risk of harm which would then allow staff to mitigate or minimise patients' risks. Although audits of patient records had been completed, these had not picked up gaps in risk assessments, care plans and other concerns that we identified on the inspection. This meant that, for those patients whose records we reviewed, some aspects of care was being missed and could mean that other patients where not always getting the care they needed. It could also mean that the required action may not have been taken and required improvements in care may not have been made.
- Managers of the service had not recognised that the audits were not picking gaps in care and therefore did not have clear oversight of the risks to patients and assurance that patients were receiving care that met all their needs.

However;

- The service had a team of new managers who were enthusiastic and passionate about the hospital and working for the trust. They had a good understanding of the service they managed and could explain clearly how teams worked together to care for patients. Staff were proud of their teams and they spoke highly of their managers. Patients and staff told us managers where visible and approachable.
- The trust had an improvement plan for Langley Green hospital and had deployed senior leaders within the trust to provide cover for service leads and to support ward managers in their roles as part of their business continuity plan. Since January 2021, the trust had implemented a programme of Enhanced Monitoring for the hospital to ensure there is executive oversight and to support the improvement programme.
- Staff were able to feedback about the service and they understood the arrangements for working with other teams, such as the crisis teams, to meet the needs of patients.
- The service had a daily safety huddle where managers, professional leads and hospital leadership team met to discuss a range of issues including staffing, planned admissions and discharges, acuity levels on wards and any other patient safety plans or concerns.

Our findings

Areas for improvement

MUSTS

- The trust must ensure there are always enough staff with the right skills on all of the wards on every shift to meet the needs of all patients and keep them safe (Regulation 12).
- The trust must ensure they implement robust systems and processes to monitor the quality of clinical records and care provided (Regulation 17).

Enforcement actions:

We took enforcement action because the quality of healthcare required significant improvement.

S29A Warning Notice

The trust was failing to comply with Regulation 12 (1), 2 (a)(b)(i) Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- The trust did not ensure that patients who had physical healthcare monitoring requirements always had appropriate care plans and risk assessments in place.
- The trust did not ensure that risks such as reduced fluid intake were escalated to the multidisciplinary teams nor did they ensure that appropriate care plans were adequately completed
- The trust did not ensure that staff did adequately and consistently complete physical health monitoring post rapid tranquilisation for patients in accordance with their own trust policy and national guidelines. This was not in line with national guidance (NICE Quality Standard: Violent and aggressive behaviours in people with mental health problems (QS154): Quality statement 4: Physical health after rapid tranquilisation 2017).

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and three other CQC inspectors, three inspection managers, two specialist advisers one expert by experience and a head of inspection.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29A Warning Notice
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	