St Andrew's Healthcare Men's service

Quality Report

Main Building
Billing Road
Northampton
NN1 5DG
Tel: 01604 616000
Website: www.stah.org

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We did not rate this service.

We carried out this inspection in response to concerning information received through our monitoring processes.

We found the following areas the provider needs to improve:

- Managers had not ensured safe and clean environments. The ward was dirty, cluttered, poorly maintained and in need of redecoration. Staff did not always follow infection control principles. Managers had not ensured the review of ligature assessments in line with the provider's policy. We observed a patient using an area on their own, that managers assessed as requiring staff supervision to mitigate against identified ligature risks. However, on a return visit the provider had deep cleaned and de-cluttered the ward.
- Patients did not have direct access to outside space. Whilst the ward had a garden area allocated, this was located away from the ward and was not easily accessible. Facilities did not meet patient needs; disabled facilities were not easily accessible.
- Leaders and governance arrangements did not assure the delivery of high quality care. Leaders had been planning to move the ward to more suitable premises for over a year. Senior managers had not ensured that the ward environment was safe and clean and were focused on moving the ward at the expense of ensuring the quality of the ward environment was acceptable. We were concerned that the provider had been aware of these issues for a significant period of time and the ward continued to be an unpleasant environment for patients and staff. There was no clear model of service, the provider described the service as 'locked rehab', the service was registered as a ward for older people with mental health problems and senior managers told us the service provided 'specialised nursing'.

However, we found the following areas of good practice:

- The provider had made improvements to fire safety and medicines management following the last inspection and Mental Health Act review visit.
- The provider had agreed actions to improve the environment of the ward and completed a deep clean and de-clutter and stopped using the laundry room as a kitchen between our visits.

Summary of findings

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Background to St Andrew's Healthcare Men's service

St Andrew's Healthcare Men's Service has been registered with the CQC since 11 April 2011. The service has a registered manager and a controlled drugs accountable officer.

This location consists of five core services: acute wards for adults of working age and psychiatric intensive care units; long stay/rehabilitation mental health wards for working age adults; forensic/inpatient secure wards; wards for older people with mental health problems; wards for people with learning disabilities or autism.

We visited the following service on this inspection:

Wards for older people with mental health problems. We inspected:

Foster ward- a locked rehabilitation ward with 15 beds.

St Andrews Healthcare Men's Service is registered with CQC to provide treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act 1983.

This location has been inspected nine times. The last inspection was in March 2018. The location was rated as requires improvement overall; requires improvement for safe, good for effective, good for caring, requires improvement for responsive and requires improvement for well led.

We issued requirement notices for breaches of the following regulations:

Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safe care and treatment:

- The provider had not ensured that medical and nursing staff completed seclusion reviews as required in line with the Mental Health Act code of practice and that staff fully completed seclusion documentation.
- We identified three blind spots in seclusion facilities on the forensic and learning disability wards.
- The provider had not included the secret garden area for the forensic service on the ligature risk assessment.
- On Foster ward staff were unaware of the ligature risk audit. The audit was incomplete and did not include all rooms.
- The provider had not ensured all medical equipment was regularly tested to ensure it was in working order.
- On upper Harlestone ward, we found staff had not regularly tested the oximeter and blood pressure machine.
- The provider had not ensured that patients physical healthcare needs were met in accordance with care plans. There was no out of hours physical health care provision on site.
- The provider had not ensured that all risk assessments and care plans were in place, and updated consistently in line with changes to patients' needs or risks.
- Staff had not created personal emergency evacuation plans for patients on the older adults wards. Staff had limited access to specialist equipment for moving patients with limited mobility down stairs in the event of a fire. The lift was out of order which posed a risk to patients with limited mobility in the event of a fire.
- We found a roll of large orange plastic bags on a shelf in the corridor area on Foster ward. Plastic bags were not allowed on the wards as they presented a risk to patient's safety.
- Staff had not followed safe procedures for the recording of medicines administration.
- The activity kitchen on Prichard ward was dirty with flaking paint on the window sill and the laminate coating had come away from the worktop proving an infection control and food hygiene risk.
- The environment on the older adults wards needed redecorating and refurbishing. The ward and one bedroom had an underlying unpleasant smell. Curtains were hanging off the rail in the main lounge area. Paint was peeling in the dining area.
- There was a burst pipe in the kitchen that had burst previously. A bucket was placed underneath to catch the water.
- We found equipment which had passed its expiry date or safety testing date in 2016.
- There were exposed electrical cables behind the door leading to staff offices.
- Handrails were not in place to enable patients at risk of falls to move around the wards more safely.
- Staff lacked understanding of some of the risk issues.

Summary of this inspection

Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Good governance:

- Managers had not ensured that all patients requiring observation or seclusion had appropriate care plans.
- There were gaps in the recording of observations. This meant that staff were not always aware of the rationale for the observation or seclusion and therefore may not be aware of the risks to patients and staff. If staff were not aware then patients could possibly act in ways which staff were not prepared for causing a risk to themselves or others.
- Managers had not ensured good governance regarding the safe administration of medication. Electronic medication charts were signed after the medication round had finished rather than after each individual administration. This made it more likely that medication errors may arise.
- The provider had not ensured all areas of the service met appropriate standards of cleanliness.

We found that the provider had addressed some, but not all of the issues from the last inspection. The issues that remain are identified later in this report.

Our inspection team

Team leader: Helen Kirton

The team that inspected the service comprised two CQC inspectors.

Why we carried out this inspection

We undertook this inspection to follow up on concerning information received through our Mental Health Act monitoring of St Andrew's Healthcare Men's services.

How we carried out this inspection

We have reported in three of the five key questions; safe, responsive and well led. As this was a focused inspection, we looked at specific key lines of enquiry in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report.

We visited the service initially on 17 July 2019. Based on the environmental issues we found we returned to the service on 24 July 2019 to check if the provider had made changes to improve the patients' living conditions.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited one ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- interviewed three senior managers;
- spoke with five other staff members; including a nurse, healthcare assistants and a consultant.
- looked at three care and treatment records of patients;
- looked at 15 personal emergency evacuation plans;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with three patients who were using the service.

Patients were positive about the staff, telling us they were lovely and helpful.

Patients told us that the food was OK.

Patients told us they would like more access to outside space.

Summary of this inspection

Patients told us that they were only allowed snacks at certain times of the day.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Managers had not ensured safe and clean environments. The ward was dirty, cluttered, poorly maintained and in need of redecoration. Furniture was worn out, the carpet throughout the ward was stained and dirty, the ward smelt strongly of urine and the light in one of the shower rooms was not working. We noted that a vacuum cleaner was left in the lounge area, the foyer was used to store equipment and the equipment storage room was cluttered and untidy. Staff did not always follow infection control principles; the ward had a room that staff and patients used as an activity kitchen and a laundry room and we observed that staff did not clean chairs used by a patient incontinent of urine. However, on a return visit the provider had deep cleaned and de-cluttered the ward and the laundry room was no longer used as a kitchen.
- Managers had not ensured the review of ligature assessments in line with the provider's policy. Managers were due to review the ligature risk assessment in June 2019. However, following our visit we were provided with a copy of a risk assessment completed on 25 July 2019. We observed patients using an area unsupervised, that managers assessed as requiring staff supervision to mitigate against identified ligature risks.
- Staff did not follow the provider's security procedures. Staff left their personal bags in the sluice room, the cleaning cupboard and in the office.

However:

- The provider made improvements to fire safety since the last inspection by updating ward fire procedures, creating personal emergency evacuation plans for all patients, organising fire safety training and fitting an evacuation chair, for moving patients with limited mobility down stairs in the event of a fire.
- The provider addressed an action point issued by the CQC Mental Health Act reviewer in relation to T3 forms being out of date. A T3 form is a second opinion certificate required when a patient does not have capacity to consent or refuses to consent to treatment. On the day of our visit the T3 forms were all in date. The provider advised that they had set up a new system to archive old T3 forms and reviewed the T3 folder in weekly ward rounds to ensure forms were up to date.

Summary of this inspection

Are services responsive?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Patients did not have direct access to outside space. Whilst the ward had a garden area allocated, this was located away from the ward and was not easily accessible. At the time of our visit only three of the 15 patients had unescorted leave. The remaining patients were reliant on staff to escort them to access outside space. Staff told us that they encouraged and supported patients to get outside two to three times a day.
- Disabled facilities were not easily accessible. The disabled toilet and bathing facilities were located at the end of the ward, a long distance away from the main communal area. We were concerned that it was a long way for a patient with limited mobility to travel to use the toilet.

Are services well-led?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Leaders and governance arrangements did not assure the delivery of high quality care. Leaders had been planning to move the ward to more suitable premises for over a year. Senior managers had not ensured that the ward environment was safe and clean and were focused on moving the ward at the expense of ensuring the quality of the ward environment was acceptable. Staff told us that they felt forgotten about and had given up on the idea of the ward being moved. We were concerned that the provider had been aware of these issues for a significant period of time and the ward continued to be an unpleasant environment for patients and staff.
- There was no clear model of service, the provider described the service as 'locked rehab', the service was registered as a ward for older people with mental health problems and senior managers told us the service provided 'specialised nursing'.

However:

- Senior managers told us they had discussed Foster ward at a meeting two days prior to our visit and immediate remedial actions had been agreed to improve the environment. On our return visit, the following week, the provider had completed some of these actions.

Detailed findings from this inspection

Wards for older people with mental health problems

Safe	
Responsive	
Well-led	

Are wards for older people with mental health problems safe?

- Foster ward was based on the first floor of the main building. The building was old and the provider had been in the process of moving the ward to more modern facilities for over a year.
- Managers had not ensured safe and clean environments. Although managers had completed a thorough ligature risk assessment, it was overdue a review. Senior managers advised this was scheduled for 2 August 2019. However, following our visit we were provided with a copy of the assessment completed on 25 July 2019. Staff on duty on the day of inspection described four bedrooms as 'secure' bedrooms that would be used for patients identified as being at higher risk of self harm. We identified ligature points in these rooms. However, senior managers advised that all bedrooms on the ward were treated the same in relation to risk. The dining area had several ligature risks. The provider's ligature risk assessment had identified these risks and recorded as mitigation that staff would supervise patients in this area. However, on both visits we observed patients using this room unsupervised. Staff were aware of the ligature risks on the ward and advised they would closely monitor any patients at risk of self harm.
- The ward layout meant that staff could not observe all areas of the ward. Staff used convex mirrors and close circuit television monitoring to observe communal parts of the ward.
- The ward had access to two working lifts during our visit. One lift, which was bigger and able to accommodate more people and emergency equipment, was located in a disused ward adjacent to Foster ward. The manager had devised a risk assessment and procedure for staff to follow when using this lift.
- The ward was dirty, cluttered, poorly maintained and in need of redecoration. Some of the furniture was worn out. The carpet throughout the ward was stained and dirty. The ward smelt strongly of urine. We noted that there were cobwebs and dead insects between the external glass windows and internal perspex panels. Curtains were hanging off the rail in the dining area during both visits and paint was peeling off the walls. We viewed a patient's bedroom with missing patches of paint on the walls, the patient told us it had been like that since he was admitted over a year ago. The main kitchen and activity kitchen were not clean. The toilets and bathrooms were not clean, with rust stains around the bottom of some toilets and ingrained dirt in corners. The light in one of the shower rooms was not working, this was raised during the first visit and the provider had not rectified when we returned. We noted that staff had left a vacuum cleaner in the lounge area, the foyer was used to store equipment and the equipment storage room was cluttered and untidy. However, when we returned to visit the ward the following week, the provider had completed a deep clean and had de cluttered the ward, improving the environment for patients living on the ward.
- The ward had a room that staff and patients used both as an activity kitchen and laundry room. We observed that laundry baskets full of dirty washing were sat next to the kitchen area where food was prepared. On our return visit the provider told us that this room was now a laundry room and patients were accessing an activity kitchen located off the ward.
- Senior managers told us an external company were visiting to assess cleaning between the windows the day after our initial visit. However, when we returned the following week staff on duty did not know if this visit had taken place.
- Handrails to help prevent patients with mobility problems from falling were not in all communal areas of the ward.
- Staff did not always follow infection control principles. We observed a patient who was incontinent of urine sitting on a variety of chairs during our visit. We did not observe staff cleaning any of the chairs.
- Following the last inspection, the provider had updated ward fire procedures, staff created personal emergency

evacuation plans for all patients, staff completed fire safety training and an evacuation chair was fitted, for moving patients with limited mobility down stairs in the event of a fire. Staff told us about a fire incident that occurred on the ground floor, requiring them to evacuate patients off the ward. The fire service praised the staff for their management of this incident and evacuating all patients safely. We reviewed an internal fire drill and noted that the service had passed in their response to this. However, we noted in the fire safety folder that weekly fire checks had last taken place in January 2019.

- The staff toilet was blocked, very dirty and in a poor state of repair during our visit. Staff told us that there had been a sign displayed advising that the toilet was out of action, but this was not present during our visit. On our return visit the provider had repaired and cleaned the toilet.
- Staff maintained equipment, we reviewed equipment checklists that evidenced that staff had done this.

Assessing and managing risk to patients and staff

- Patients were unable to independently help themselves to hot or cold drinks. The cold water dispenser was located in the foyer of the ward, however, patients were unable to access this area without the assistance of staff. Staff told us that this was due to the risks of two patients. Staff advised that they offered all patients drinks throughout the day and reminded patients that they were able to request a drink at anytime. We saw posters displayed throughout the ward advising patients of this. Patients told us that they were only allowed snacks at set times. However, staff spoken with all said that snacks were offered at set times, but patients could request snacks at any time, unless there were individual dietary needs that would be care planned.
- Staff had left their personal bags in the sluice room and the cleaning cupboard on our visit. During our return visit we observed that the same staff bag was in the sluice room and two staff bags were in the office. We brought this to the attention of the nurse in charge who advised he would rectify this immediately. This was a breach of the provider's security procedures.
- The CQC Mental Health Act reviewer had previously issued an action point in relation to T3 forms being out of date. A T3 form is a second opinion certificate required when a patient does not have capacity to consent or refuses to consent to treatment. On the day of our visit the T3 forms were all in date. The provider advised that they had set up a new system to archive old T3 forms and reviewed the T3 folder in weekly ward rounds to ensure forms were up to date.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

The facilities promote recovery, comfort, dignity and confidentiality

- Patients did not have direct access to outside space. Whilst the ward had a garden area allocated, this was located away from the ward and was not easily accessible. At the time of our visit only three of the 15 patients had unescorted leave. The remaining patients were reliant on staff to escort them to access outside space. Staff told us that they encouraged and supported patients to get outside two to three times a day. The provider reported 1,941 successful leave episodes over the six months preceding the inspection. This was 84% of planned leave.
- Whilst the ward had disabled toilet and bathing facilities, these were located at the end of the ward, a long distance away from the main communal area. We were concerned that it was a long way for a patient with limited mobility to travel to use the toilet.

Are wards for older people with mental health problems well-led?

Governance

- Leaders and governance arrangements did not assure the delivery of high quality care. Leaders had been planning to move the ward to more suitable premises for over a year. Senior managers had not ensured that the ward environment was safe and clean and focused on moving the ward at the expense of ensuring the quality of the ward environment was acceptable. However, senior managers told us they had discussed Foster ward at a meeting two days prior to our visit and immediate actions had been agreed, including a deep clean of the ward, occupational therapy to support

patients to keep their rooms clean, purchasing of new furniture, de cluttering the ward and making changes to the activity kitchen/laundry room. On our return visit the ward had been deep cleaned and de cluttered. However, we were concerned that the provider had been aware of these issues for a significant period of time and the ward continued to be an unpleasant environment for patients and staff.

- Staff spoken with told us that they felt forgotten about and that they had given up on the idea of the ward being moved.
- Senior managers also advised that the executive team had set a deadline for the ward to be moved by 31 December 2019.
- There was no clear model of service, the provider described the service as 'locked rehab', the service was registered as a ward for older people with mental health problems and senior managers told us the service provided 'specialised nursing'.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure safe and clean environments.
- The provider must ensure staff follow security procedures.
- The provider must implement effective governance processes to ensure the delivery of safe, high quality care.
- The provider must ensure the location of the new ward provides patients with direct access to outside space.
- The provider must ensure that facilities meet the needs of patients.

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 · Managers had not ensured safe and clean environments. The ward was dirty, cluttered, poorly maintained and in need of redecoration. Staff did not always follow infection control principles. Managers had not ensured the review of ligature assessments in line with the provider's policy. We observed a patient using an area on their own, that managers assessed as requiring staff supervision to mitigate against identified ligature risks. · Staff did not follow the provider's security procedures. Staff had left their personal bags in the sluice room, the cleaning cupboard and in the office. This was a breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment · Patients did not have direct access to outside space. Whilst the ward had a garden area allocated, this was located away from the ward and was not easily accessible. · Disabled facilities were not easily accessible. This was a breach of regulation 15.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

· Leaders and governance arrangements did not assure the delivery of high quality care. Senior managers had not ensured that the ward environment was safe and clean.

· There was no clear model of service, the provider described the service as 'locked rehab', the service was registered as a ward for older people with mental health problems and senior managers told us the service provided 'specialised nursing'.

This was a breach of regulation 17.