Cambridgeshire and Peterborough 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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

We inspected Mulberry 2 ward, a 16 bedded mixed sex acute ward located at Fulbourn hospital, Cambridge.

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services. We received information of an alleged serious sexual assault on Mulberry 2 ward in February 2022, the trust had not informed us of this.

Staff could not observe patients in all parts of the wards. There were no clear lines of sight into each of the bedroom corridors.

Staff had not ensured a patients' bedroom was fit for purpose. We saw the bedroom was in a very poor condition, the floor was very heavily soiled with food and drink spillages. Dirty crockery and debris were visible, and the en suite toilet had dried faeces around the bowl and seat and urine stains on the floor.

How we carried out the inspection

Our inspection team was led by a CQC inspector.

The team included one CQC inspection manager and one assistant inspector.

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

During the inspection visit, the inspection team:

- inspected the environment on Mulberry 2 ward
- looked at six care and treatment records
- looked at 24 significant incident reports
- spoke with the ward manager, clinical nurse specialist, two senior staff nurses and a preceptor nurse
- looked at six weeks of staff rotas
- looked at the minutes of three clinical governance meetings and three business meetings
- looked at mandatory training compliance rates.

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?

Inspected but not rated

Our findings

Safe and clean care environments

Safety of the ward layout

The ward had a dedicated female bedroom corridor and a male bedroom corridor. There were fire doors at the entrance to each corridor which could not be locked enabling male and female patients to enter bedroom areas of the opposite sex. However, the service had introduced a change to the location of staff at night to enhance monitoring.

Staff could not observe patients in all parts of the wards. Whist mirrors were in place in both bedroom corridors there were multiple blind spots. There was a night team base between the bedroom corridors, however there were no clear lines of sight into each of the bedroom corridors. This was also the case during the day also.

Maintenance, cleanliness and infection control

Not all bedrooms were clean, we reviewed daily bedroom checklist for the period 13 April to 23 May regarding bedroom 10. One form on 13 April recorded that the room was clean, tidy and free from clutter. On four occasions staff reported that the room was not clean, tidy or free from clutter. The five most recent checklists recorded that staff had not entered the bedroom due to the patient making accusations against staff or the patient refusing them access. We saw the bedroom was in a very poor condition, the floor was very heavily soiled with food and drink spillages. Dirty crockery and debris were visible, and the en suite toilet had dried faeces around the bowl and seat and urine stains on the floor. Staff we spoke with were aware, however they told us they had made a decision not to clean the room due to fear of the patient making allegations of theft and being angry about staff being in their room. The severity of the lack of cleanliness could be considered an act of neglect by the ward to ensure appropriate hygiene measures were in place. There was limited evidence in the patient care records of attempts to explore with the patient their concerns and address the issue. We raised this concern with the ward and trust immediately.

We saw in the daily bedroom checks that on four occasions there was evidence that the same patient had been smoking in their bedroom. The care records reported that staff had removed a lighter from the patient on one occasion. Staff had not followed trust policies and procedures to search the patients' bedroom to remove any lighters to keep them and others safe from harm.

Seclusion room

The Seclusion room allowed clear observation and two-way communication. It had a toilet and shower, however; it did not have a clock.

Safe staffing

The ward did not always have enough nursing staff, to keep people safe from avoidable harm.

Nursing staff

The ward planned to have three registered staff and two healthcare assistants during the day and two registered staff and one healthcare assistant at night, but we were told this was not always achieved. We saw staff had reported staff shortages on 10 occasions between 1 February and 15 May 2022 via the electronic incident system.

We reviewed the electronic rota from 27 March to 15 May 2022 which showed 91 gaps where shifts had not been filled, of these 51 were for registered nurses, with no documented mitigation of managing the shortfall. Staff confirmed that the

Our findings

ward was short at times with occasions where other teams helped but this was not always possible. The ward did not record all occasions when staff were moved during shift to accommodate cover arrangements, so it was not possible to be assured that there was sufficient staffing at all times. The trust was unable to provide this assurance with their current governance arrangements.

Mandatory training

Compliance rates for mandatory training were variable. Safeguarding Level 2, basic life support and adult infection control rates were 100%.

Moving and Handling Level 2 rates were 78% and Safeguarding Level 2 Children were 71%. Medical Emergency Response Course (MERC), Ligature Removal and Search training were 65% respectively, and physical intervention training rates were 48%.

We asked the trust to provide information regarding training for staff regarding sexual safety on the wards. They confirmed it does not provide formal training on sexual safety, however a recent survey in another part of the trust had identified the need to develop their strategy.

Management of patient risk

We were not assured that staff were always observing patients according to the required standard. There was a lack of assurance of intermittent observations being undertaken and the Trust policy provided insufficient guidance in how this should be recorded. Staff were recording only one entry per hour rather than the required four. Staff confirmed this was how they did things on the ward. This meant that staff could not evidence that observations were undertaken at the correct intervals which put patient safety at risk.

There was a missing observation form of a patient on 14 March 2022 which was when an incident occurred with a male patient twice going onto the female corridor and touching a female staff inappropriately. This follows a loss of observation documentation following a serious incident in February 2022. We raised this matter as a concern with the trust.

The above incident on 14 March was documented as a significant incident and noted as a risk, however there was no evidence of a management plan to ensure safety of female patients and staff or for the male patient.

We found that one female patient who had experienced severe trauma was being supported on 1:1 Level 4 constant within arm's length observations, by a male staff. The ward manager advised that part of the patients 'management plan was not to have 1:1 observation with male staff at the patient's own request. The ward manager was unaware a male was undertaking observations until we informed her of this. The male staff was close to the patient but not within arm's length despite this being part of her management plan. The patient continued to successfully self-harm at frequent intervals.

Use of restrictive interventions. Staff told us about work they were doing to reduce the number of restrictive interventions, this included mapping out incidents to identify themes and trends. We saw active participation and commitment by the ward staff. We observed an excellent response to a patient on the ward who was distressed and attempting to self-harm.

Staff access to essential information

Our findings

We were not assured robust plans were in place to manage paper observation records and to ensure they were uploaded onto the electronic record in a timely way.

We requested observation records relating to two significant incidents, staff were unable to provide either the paper record or the uploaded electronic copies and told us they had gone missing.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team.

Staff we spoke with described what incidents to report and how to report them using the trust policy.

Incident reports were completed, and staff had recorded the incidents as significant events, however, the only action to reduce risk was for staff not to nurse the patient on their own. There was no evidence of any update of the risk assessment, action plan in their treatment records or care plan such as a review of observations or any other therapeutic intervention or conversation.

We reviewed the minutes from the ward clinical governance meetings for November 2021, March and May 2022, there had been no meetings held in December 2021 and January, February and April 2022 due to impact of the pandemic on staff availability.

We saw evidence in the meeting minutes which were available of shared learning where staff had been informed of changes in practice following a recent serious incident where there had been an allegation of a sexual assault by a male patient on a female patient. We also saw the ward top five risks were discussed, these were; ligature points in the seclusion room, no date for when the ward would become smoke free, violence and aggression, COVID-19 and staff shortages. The meeting notes were sparse; however, it was clear that conversations were taking place. The ward manager acknowledged the minimal recording citing ward pressures.

Staff reported serious incidents clearly and in line with trust policy using the trust electronic reporting system. We were told any member of staff could access the system to record an incident.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Culture

Not all staff said they felt respected, supported and valued.

Our findings

We saw some language used by staff within the care records and verbally that could be indicative of development of a closed culture. For instance, one staff member advised ”this is how we do things around here” when questioned about the recording of observations. We saw entries in the clinical records that did not reflect positive language. For instance, “x was demanding and so was refused x”. However, we also observed instances of kind and compassionate care on the ward during our visit.

Staff said they had experienced a prolonged time of intense pressure and did not feel supported by senior managers. In particular they felt there was a lack of communication regarding the decision to temporarily re-provide Mulberry 3 to an external provider. This was because of staff shortages on the ward, and the impact this would have on their patients and service. They reported the ward manager was very supportive. However, they did not feel listened to or acknowledged by anyone above these roles. Staff also told us that black colleagues reported receiving racial abuse from a patient for a sustained period of over two months. Staff raised this with managers during and did receive support from ward team leaders. However, staff raised concerns that this was not listened to or acted upon by more senior colleagues and did not feel supported. We raised this concern with the trust.

Governance

Managers did not ensure regular governance meetings were taking place and the records of the meetings had little detail.

Managers did not ensure a bed was available if patients needed to return to the ward from leave. We were told the ward had 19 patients admitted into 16 beds. Three patients were on home leave which meant those patients may not have access to a bed on the ward if they needed to return to hospital.

We saw there were systems in place to review the quality of the service. However we were told this had not been a priority due to the response to the pandemic. There were less audits and ward to board assurance and oversight. Positive steps were beginning to be introduced to make improvements. For instance, they were using safety crosses to identify and minimise restrictive interventions.

Management of risk, issues and performance

We were not assured that managers had oversight of keeping patients safe on the ward. Staff were not following the requirements of the trust policy when supporting patients on enhanced observation levels, nor were they following the search policy consistently.

Our findings

Areas for improvement

Action the trust MUST take to improve:

- The trust must ensure that staff follow the requirements of the trust policy when looking after patients on enhanced observation levels.
- The trust must ensure there are robust, safe systems to protect patients from sexual harm when residing on this mixed sex ward.
- The trust must ensure that staff follow the trust search policy if there is evidence that patients have restricted items in their possession.
- The trust must ensure that patient bedrooms are well maintained, clean and clutter free.

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Action the trust SHOULD take to improve:

- The trust should ensure plans are in place to ensure a bed is available if patients need to return to the ward from leave.
- The trust should ensure the staffing rota reflects the accurate number and grade of staff on each shift.
- The trust should ensure there is a clock visible for patients whilst in seclusion which the patient can always see.

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
Treatment of disease, disorder or injury	S29A Warning Notice