St Andrew's Healthcare - Womens Service

Quality Report

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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.

Following our inspection, we served an urgent Notice of Decision because of the immediate concerns we had about the safety of patients. We told the provider they must not admit any new patients until further notice; that wards must be staffed with the required numbers of suitably skilled staff to meet patients' needs and to undertake patients' observations as prescribed; that staff undertaking patient observations must do so in line with the provider's engagement and observation policy and protocol and the provider must ensure there is clear documentation to inform staff of the current observation level of all patients. We told the provider that they must provide CQC with an update relating to these issues on a fortnightly basis.

We found the following areas the provider needs to improve:

- Patients were at risk of continuing harm. Staff did not always act to prevent or reduce risks to patients and staff. Staff did not always keep patients safe from harm whilst on enhanced observations. Nine out of fourteen self harm incidents reviewed occurred due to staff not completing enhanced observations as prescribed.
- Staff did not always follow the provider's policy and procedures on the use of enhanced observations when supporting patients assessed as being at higher risk of harm to themselves or others. We found gaps in hourly observation records on 193 out of a possible 1,008 occasions. We found that shift leads allocated staff to complete enhanced observations for the same patient for up to twelve hours and allocated staff to complete observations continually throughout a shift for different patients for up to ten hours. This is not in line with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.
- The service did not have enough nursing and support staff to keep patients safe. We reviewed 26 incidents that occurred between 1 November 2019 and 3 February 2020. Of these, 13 incidents related to a lack

Summary of findings

of suitable or sufficient staff impacting on patients' care. Examples included patients not attending hospital for required emergency medical interventions due to lack of suitable staff to support.

- The provider's board had not authorised the use of mechanical restraint, in line with guidance, and staff had not followed care plans in relation to the reporting and monitoring of mechanical restraint.
- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations, handovers and safety checks. There was no evidence that the provider undertook regular and effective audits of these issues.
- Staff spoken with were burnt out and distressed. Staff told us that they dreaded coming into work and felt professionally vulnerable.
- Senior managers told us the concerns that triggered the focused inspection were not a surprise and that Seacole was on their watchlist. This was concerning as staff told us they had been raising concerns since August 2019 and there was still a high occurrence of self harm incidents on our first day of inspection.

However:

- On our second visit we were assured that senior leaders had started to address the concerns and were providing the ward with the support needed. The provider reported that the frequency of incidents had reduced following our inspection visits.
- The provider had recently changed the local leadership of the ward. The new ward manager and operational lead had recently started in their posts. Staff and patients spoke highly of the new manager and we observed that positive changes had been made on our second visit.
- Managers had recently recruited a new senior nurse and staff were returning from long term sick leave. The ward manager told us that they had block booked agency staff for the next six weeks, to improve consistency in care and they were booking more staff than required.
- The provider recently introduced daily 'safety huddles' involving the whole staff team. Staff discussed current concerns and risk issues for all patients and agreed on actions required.

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Background to St Andrew's Healthcare - Womens Service

St Andrew's Healthcare Women's service registered with the CQC on 11 April 2011. The Women's service is situated on the Northampton site. The other registered locations at Northampton are the Adolescents services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

St Andrew's Healthcare also have services in Birmingham, Nottinghamshire and Essex.

St Andrew's Healthcare Women's service consists of four core services.

St Andrew's Healthcare Women's service has been inspected six times.

St Andrew's Healthcare Women's service is registered to provide the following regulated activities:

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

The service has a nominated individual and a registered manager.

We inspected women's services to follow up on concerning information received through our monitoring processes.

The following services were visited on this inspection:

Forensic inpatient/secure wards:

We inspected the following ward in women's services:

- Seacole ward is a medium secure ward with 15 beds.

All patients receiving treatment in this service are detained under the Mental Health Act (1983).

This service was last inspected in July 2018. The July 2018 inspection was a focused inspection following concerns received through our monitoring processes. The service was not rated, and a requirement notice was issued for breaches of the following regulation:

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

- Managers did not ensure established staffing levels on all shifts. The provider reported that 1,698 shifts were unfilled for the period 2 February 2018 to 30 June 2018. There were not always enough staff to safely carry out physical interventions and provide the required level of patient observations on Sunley ward.
- Managers reduced patients' observation levels due to staff shortages and we reviewed one incident when a patient self-harmed when left unobserved.
- Staff were not trained to provide care to keep patients safe on Sunley ward. There had been an incident where there were no nasogastric trained staff available to administer nasogastric feeds to a patient requiring this intervention. Staff had not reported this to the local authority safeguarding team.
- Staff had not followed the dysphagia care plan for one patient on Sitwell ward, which had resulted in a choking incident.
- The provider was not compliant with the Mental Health Act Code of Practice. In the week prior to the inspection, the CQC conducted a review of seclusion and long-term segregation practices. We reviewed 22 seclusion records. Doctors and nurses were not completing reviews as required by the Mental Health Act Code of Practice. Staff had not completed seclusion and long-term segregation care plans for all patients. The multi-disciplinary team had not conducted reviews as required. Sunley and Bayley ward seclusion rooms had blind spots in the ensuite areas.
- Managers had not ensured a safe environment at the learning disabilities service. Whilst managers and the health and safety lead had completed ligature audits for Spencer North and Sitwell wards within the last six months, there was no hard copy of the ligature audit and assessment available. Staff on Spencer North did not know where to find the ligature audit.

We found issues of immediate concern during the first day of this inspection and issued an urgent Notice of Decision, imposing conditions on the provider. These concerns related to the lack of safe care and treatment, which may result in a serious risk to any person's life, health or wellbeing and a lack of good governance. Details are in the enforcement section of the report.

Summary of this inspection

Following the inspection, the provider informed the CQC that they were planning to close the ward.

Our inspection team

The team that inspected the service comprised two CQC inspectors and one nurse specialist advisor.

Why we carried out this inspection

We undertook this inspection to follow up on concerning information received through our monitoring of St Andrew's Healthcare women's services. The concerns related specifically to Seacole ward.

How we carried out this inspection

We have reported in two of the five key questions; safe 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.

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

During the inspection visit, the inspection team:

- visited Seacole ward and observed how staff were caring for patients;
- spoke with two patients who were using the service;
- interviewed the ward manager for the ward;
- interviewed four senior managers;
- spoke with six other staff members; including nurses and healthcare assistants
- looked at four care and treatment records of patients;
- reviewed 26 incident records;
- 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 two patients. Patients told us they did not feel safe and that there were not enough staff to meet their needs. They told us that staff time was taken up by patients who were more unwell and presenting with behaviour that challenges.

However, they told us that regular staff were excellent and went out of their way to get things done. They said the new manager seems good and that there were some new staff on the ward.

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?

- Patients were at risk of continuing harm. Staff did not always act to prevent or reduce risks to patients and staff. Staff did not always keep patients safe from harm whilst on enhanced observations. We reviewed fourteen incidents of patient self harm between 01 November 2019 and 03 February 2020. Nine of these self harm incidents occurred due to staff not completing enhanced observations as prescribed.
- Staff did not always follow the provider's policy and procedures on the use of enhanced observations when supporting patients assessed as being at higher risk harm to themselves or others. We reviewed 26 completed observation records between 09 October 2019 and 02 February 2020 and found gaps in hourly observations on 193 out of a possible 1,008 occasions.
- We found that shift leads allocated staff to complete enhanced observations for the same patient for up to twelve hours and allocated staff to complete observations continually throughout a shift for different patients for up to ten hours. We found 13 instances of staff allocated to patient observations for between four and twelve hours. This is not in line with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.
- The service did not have enough nursing and support staff to keep patients safe. We reviewed 26 incidents that occurred between 01 November 2019 and 03 February 2020. Of these, 13 incidents related to a lack of suitable or sufficient staff impacting on patients' care. Examples included patients not attending hospital for required emergency medical interventions due to lack of suitable staff to support.
- The provider's board had not authorised the use of mechanical restraint, in line with guidance, and staff had not followed care plans in relation to the reporting and monitoring of mechanical restraint.

However:

Summary of this inspection

- Managers had recently recruited a new senior nurse and staff were returning from long term sick leave. The ward manager told us that they had block booked agency staff for the next six weeks, to improve consistency in care and they were booking more staff than required.
- The provider recently introduced daily 'safety huddles' involving the whole staff team. Staff discussed current concerns and risk issues for all patients and agreed on actions required.

Are services well-led?

We did not rate this key question.

We found the following areas the provider needs to improve:

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations, handovers and safety checks. There was no evidence that the provider undertook regular and effective audits of these issues.
- Staff spoken with were burnt out and distressed. Staff told us that they dreaded coming into work and felt professionally vulnerable.
- Senior managers told us the concerns that triggered the focused inspection were not a surprise and that Seacole was on their watchlist. This was concerning as staff told us they had been raising concerns since August 2019 and there was still a high occurrence of self harm incidents on our first day of inspection.

However:

- On our second visit we were assured that senior leaders had started to address the concerns and were providing the ward with the support needed. The provider reported that the frequency of incidents had reduced following our inspection visits.
- The provider had recently changed the leadership of the ward. The new ward manager had been in post for a week before the first day of the inspection and a new operational lead had been in post for four days. Staff and patients spoke highly of the new manager and we observed that positive changes had been made on our second visit.

Detailed findings from this inspection

Forensic inpatient or secure wards

Safe	
Well-led	

Are forensic inpatient or secure wards safe?

Safe staffing

The service did not have enough nursing and support staff to keep patients safe.

The ward manager reported eight vacancies at the time of the inspection; one clinical nurse lead, two qualified and five unqualified. The ward manager also advised that there were high levels of sickness. We requested staff vacancy data from the provider for the three months preceding the inspection, however this was not supplied.

The provider had not ensured sufficient numbers of staff of the right skills and experience were on shift to meet patient needs. We reviewed 26 incidents that occurred between 01 November 2019 and 03 February 2020. Of these, 13 incidents related to a lack of suitable or sufficient staff impacting on patients' care.

On 24 January 2020 there were 13 staff on shift. Of these, six were agency, one was bank, five were regular staff and the status of one was not recorded. Only six of these staff were trained in management of actual or potential aggression. Staff need to have completed this training to be allocated to observe patients. Seven staff were needed to observe patients on continuous observations and two more were needed to observe patients on five minute observations.

Examples included; an incident on 21 December 2019 when a patient sustained a head injury following an episode of self harm. The patient was reviewed by the physical healthcare team, who advised the patient required an urgent CT scan. Staff were unable to escort the patient to hospital as there were not enough suitable trained staff. The patient did not attend hospital until the following afternoon.

We reviewed another self harm incident on the 23 December 2019. Staff assessed the patient as requiring hospital attendance. However, there were not enough suitably trained staff to escort the patient and they had to postpone until the following day.

During a self-harm incident on the weekend of the 7-8 December 2019, the incident report noted, "Over the weekend there was a notable lack of regular experienced staffing on the ward with a larger ratio of bureau (bank) and agency staff present".

Staff spoken with, including managers, confirmed that the existing shift configuration (A shift and B shift) had contributed to incidents occurring, with the majority occurring on B shift. B shift was under resourced, with no permanent qualified staff and a high proportion of new unqualified staff.

There was a serious incident on 31 December 2019, described as a "mini riot", leading to patient harm, due to staff shortages. The impact of staff shortages resulted in two patients self harming and one patient not receiving emergency medical treatment in a timely manner.

Staff spoken with told us that the ward was not safely staffed and that they did not feel safe working on the ward.

The establishment was for two qualified staff on the ward at all times, however between Mondays and Fridays only one qualified staff was on duty between 4.30pm and 8pm. This was due to one of the nursing team working flexible hours.

Managers told us that they were meeting with staff to discuss the removal of the A and B shift system. The ward manager had put together a trial rota.

Managers had recently recruited a new senior nurse and staff were returning from long term sick leave.

The ward manager told us that they had block booked agency staff for the next six weeks, to improve consistency in care and they were over staffing shifts.

Assessing and managing risk to patients and staff

Staff did not always follow the provider's policy and procedures on the use of enhanced observations when supporting patients assessed as being at higher risk harm to themselves or others.

Staff were not completing observation records in line with the provider's policy and procedures. We reviewed 26

completed observation records between 09 October 2019 and 02 February 2020 and found gaps in hourly observations on 193 out of a possible 1,008 occasions. For one patient on enhanced 2:1 observations, there was nothing recorded on the observation sheet for the whole shift (12 hours) on 13 October 2019. Another patient on the same date had nothing recorded for six hours. For another patient on enhanced observations, there were no records for 19 days between 20 December 2019 and 04 February 2020.

We found that shift leads allocated staff to complete enhanced observations for the same patient for up to twelve hours and allocated staff to complete observations continually throughout a shift for different patients for up to ten hours. We found 13 instances of staff allocated to patient observations for between four and twelve hours. This is not in line with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

Staff did not always keep patients safe from harm whilst on enhanced observations.

We found that staff were not completing enhanced observations of patients, as prescribed in their care plans and risk management plans, resulting in patients engaging in self harm behaviours, requiring emergency medical interventions. We reviewed fourteen incidents of patient self-harm between 1 November 2019 and 3 February 2020. Nine of these self-harm incidents occurred due to staff not completing enhanced observations as prescribed. We reviewed records for one patient, and they had required medical attention for self-harm injuries sustained whilst on enhanced observations on 13 occasions between August 2019 and January 2020. Another incident of self harm record stated, "Allocated enhanced observers not intervening in a timely fashion". We saw an example of the occupational therapist telling a patient's observing staff that they should not be allowing the patient to put her hands under the blanket.

Staff used mechanical restraint as part of one patient's risk management plan. Staff had devised a mechanical restraint plan, however there was no evidence that this had been authorised at board level as required. The plan stated that staff must inform the patient's consultant or duty doctor following the use of mechanical restraint and that 15-minute checks of the patient's mental and physical state must be completed. There was no evidence in the patient's records that staff had done this.

Staff spoken with told us that they did not have enough time to review patient's care and risk management plans.

The ward manager had put together a folder with updated positive behaviour support plans and enhanced observation plans to improve access to information for staff.

The provider told us that they had implemented a new handover process from 22 January 2020 to improve communication in relation to management of patient risks. However, we reviewed the new handover folder on 5 February 2020 and found there were only three handover forms. One was undated, none were fully completed, and one was lacking detail. Senior managers advised that the process was yet to be embedded.

The provider recently introduced daily 'safety huddles' involving the whole staff team. Staff discussed current concerns and risk issues for all patients and agreed on actions required.

Reporting incidents and learning from when things go wrong

We reviewed 26 incidents between 1 November 2019 and 3 February 2020.

Staff had reported 25 of these incidents appropriately. The quality of one incident report was poor and lacked the necessary detail.

We were concerned that staff were not learning from incidents, due to the high number of similar incidents occurring over the past six months.

Are forensic inpatient or secure wards well-led?

Leadership

The provider had recently changed the leadership of the ward. The new ward manager had been in post for a week before the first day of the inspection and a new operational lead had been in post for four days. Staff and patients

spoke highly of the new manager and we observed that positive changes had been made on our second visit. However, for some staff they felt that the changes by senior leaders were, “Too little, too late”.

Culture

Staff spoken with were burnt out and distressed. Staff told us that they dreaded coming into work and felt professionally vulnerable. Staff told us they had been raising concerns about the staffing situation on the ward since the summer, but no one had taken action. Senior managers told us that there were no systems in place to identify when managers were burnt out. Senior managers acknowledged that they had not acted quickly enough to support staff on Seacole ward.

Bank and agency staff told us that they were not involved in debriefs following incidents.

Governance

The leadership, governance and culture did not always support the delivery of high quality, person centred-care.

The providers governance processes had not addressed staff failures to follow the provider’s procedures on enhanced observations. There was no evidence that the provider undertook regular and effective audits of these issues.

Senior managers told us the concerns that triggered the focused inspection were not a surprise and that Seacole was one of four wards across all their locations that was on their watchlist. This was concerning as staff told us they had been raising concerns since August 2019 and there was still a high occurrence of self-harm incidents on our first day of inspection.

However, on our second visit we were assured that senior leaders had started to address the concerns and were providing the ward with the support needed. The frequency of incidents had reduced following our inspection. For example, there had been four incidents reported in the week ending 2 February 2020 and two incidents reported in the week ending 9 February 2020.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure that staff undertaking observations do so in line with the provider's engagement and observation policy and protocol. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that staff complete patient observations as prescribed in their care and risk management plans. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure there is clear documentation to inform staff of the current observation level of all service users': This includes details of any changes to service users' observation levels and risk and that information is clearly recorded and is easily accessible to relevant staff. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff to meet service users' needs and to undertake service users' observations as prescribed. (Regulation 12 (1) (2) (c))
- The provider must ensure use of mechanical restraint is authorised at board level and staff report, record and monitor the use of mechanical restraint in line with patients' care plans. (Regulation 12 (1) (2) (a) (b))

Action the provider SHOULD take to improve

- The provider should ensure that systems are put in place to support staff and reduce staff burn out.

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's board had not authorised the use of mechanical restraint, in line with guidance, and staff had not followed care plans in relation to the reporting and monitoring of mechanical restraint. This was a breach of regulation 12.

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 • Patients were at risk of continuing harm. The service did not always manage patient safety incidents well. • Staff did not always act to prevent or reduce risks to patients and staff. Staff did not always keep patients safe from harm whilst on enhanced observations. • Staff did not always follow the provider's policy and procedures on the use of enhanced observations when supporting patients assessed as being at higher risk harm to themselves or others. • The service did not have enough nursing and support staff to keep patients safe. 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 17 HSCA (RA) Regulations 2014 Good governance • The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations. There was no evidence that the provider undertook regular and effective audits of these issues. This was a breach of regulation 17