North Staffordshire Combined Healthcare NHS Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RLY88	Harpland's Hospital	Psychiatric Intensive Care Unit	ST4 6TH
RLY88	Harpland's Hospital	Ward 1	ST4 6TH
RLY88	Harpland's Hospital	Ward 2	ST4 6TH
RLY88	Harpland's Hospital	Ward 3	ST4 6TH

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS Trust.

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

Following two serious incidents on the acute wards and psychiatric intensive care unit in January and October 2019, trust investigations had led to recommendations to improve the use of clinical observations and clinical risk management. In the absence of a routine re-inspection of the wards due to Corona Virus the CQC carried out a focused inspection of the service on 17 March 2020 for assurances that these improvements had been put in place. We found:

- Staff assessed and managed risks to patients and themselves well. Comprehensive risk assessments were completed for all patients, regularly reviewed and updated when new incidents occurred.
- Risk information was effectively handed over between staff, verbally at a meeting at the beginning of each nursing shift, in a written handover document and in the main case notes for each patient. The handover information was updated each shift to reflect any changes in a patient's presentation.
- Staff understood the trust's policy on performing supportive clinical observations. They had received training at induction or following the updates made to the trust policy in the summer of 2019. They understood the different levels of observation and how to record their observations and evidence engagement with the patient or signs of life when asleep.
- The approach taken to patients with a history of self harming behaviour in using flexible intermittent observations, as observing patients at predictable times can provide the opportunity to plan or engage in harmful activities, was well understood. We found staff followed the trust policy and recorded observations to reflect the changing times.
- The wards had a good track record on reviewing incidents. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Summary of findings

Information about the service

The acute wards for adults of working age provided by North Staffordshire Combined Healthcare NHS Trust are part of the trust's acute division. Services are provided for patients admitted informally and or detained under the Mental Health Act 1983.

There are three acute wards based at Harplands Hospital:

• Ward 1 is a mixed-sex ward with 14 beds, although at the time of inspection was all male

• Ward 2 is a male ward with 22 beds

• Ward 3 is a female ward with 22 beds.

In addition, a psychiatric intensive care unit (PICU) had opened in October 2018 and provided care for six patients.

During this inspection, we visited all three acute wards and the PICU.

At our last inspection, the wards had one key question (safe) rated as requires improvement and the other key questions (effective, caring, responsive and well led) rated as good.

Our previous inspection between 2 and 4 October 2017 was unannounced (staff did not know we were coming) to enable us to observe routine activity. The report made one requirement on the service to improve the safety of care on the wards:

• The trust must ensure that topical medicines are clearly labelled for the use of a single patient to reduce infection risks and that opening dates of the medicines are monitored.

The provider had subsequently provided written assurances following that inspection that improvements had been made.

Our inspection team

The team that inspected the service comprised three CQC inspectors and an inspection manager.

Why we carried out this inspection

We inspected this service to secure assurance that the service was safe.

This was a focused inspection to ensure that improvements to clinical observations and the recording and communication of risk had been made following two serious incidents on the wards.

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following question of this service:

- Is it safe?

Before the inspection visit, we reviewed information that we held about the location. this included the information the provider had submitted as part of their preparation for the planned well led inspection of the trust in April 2020.

The inspection was unannounced and started at 5.30am in order to allow the inspection team time to interview the night staff and review their contemporaneous record keeping.

During the inspection visit, the inspection team:

- visited all three wards and the Psychiatric Intensive Care Unit at the hospital, and observed how staff were caring for patients;

Summary of findings

- spoke with the managers or acting managers for each of the four wards;
- spoke with 19 other staff members; nine staff nurses, nine healthcare assistants and one student nurse ;
- attended and observed two shift hand-over meetings (Ward 3 and the Psychiatric Intensive Care Unit) and reviewed the hand over notes for the other two wards;
- Looked at 14 care and treatment records of patients including risk assessments and observation records on each ward for the previous week for all patients on all levels of observation.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff use the 24 hour clock in recording the times of observations to maintain consistency and flow, and aid their review and use in audit. (Regulation 17 (2) (c))
- The provider should ensure signs of life are always recorded when observing patients are apparently asleep. (Regulation 12)

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. There had been improvements in the use of clinical observations to ensure that assurances about a patient's wellbeing were accurately recorded and communicated.

Assessment of patient risk.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

All patients had a comprehensive risk assessment that drew on information from the patient's history prior to admission and their presentation on the ward. Staff used a recognised risk assessment tool. We found evidence that risk assessments were updated after incidents.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. As well as updating risk assessments following an incident, there were planned weekly nursing reviews of risk assessments and at the multidisciplinary team meetings.

Staff followed good policies and procedures for use of observation. Staff had a good knowledge of the observation policy and the reason for using different levels proportionate to risk. They knew how to escalate risks and when it was appropriate to use flexible intermittent observations in response to an individual's risk assessments. Observing patients at predictable times can provide the opportunity for them to plan or engage in harmful activities. This was taken into account when determining the frequency of observation required.

All ward staff had received training in the use of supportive clinical observations. This had been recently refreshed on commencement of a new trust wide observation policy in September 2019.

For those patients on level 3, one to one observation, Ward 1 staff kept a copy of the positive behaviour support plan with the observation for reference in case of escalating risk.

One change made following lessons learnt from the serious incident on the Psychiatric Intensive Care Unit (PICU) was for staff to always record signs of life when the patient was sleeping. Previously staff had recorded that patients appeared asleep but did not routinely record the patient was displaying signs of life. We found that staff both understood this requirement and would enter a bedroom to check for signs of life if not immediately obvious from the bedroom door. Where risk indicated they would also check if the airway was clear and there was no ligature. Staff had been issued with specialised red light flashlights to complete these checks and reduce any disturbance to the patient.

We performed an immediate check on observation records at our arrival on the wards during the night shift. We found that all records were up to date and an accurate reflection of the patient's location and wellbeing. Not all records had a sign of life recorded at every check and this was an area for further improvement. Staff gave us verbal assurance that these checks were made.

Staff told us that they would only ever take on intermittent observations for a maximum of two patients. That allowed time for staff to move around the ward to locate patients and opportunity for some engagement with each patient.

In most cases we found clear documentation for the reasons to increase or decrease levels of observation. Observation records were subject to audit and improvements suggested as a result. We found in our review of observation records it was not always clear how sheets followed one another as times were recorded without any indicator of the time being ante or post meridian.

We found that risk information was clearly communicated between shifts. The daily handover report was updated between each shift. Key information about each patient was recorded in the handover record, this included any known allergies, current risks and detail of any recent

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incidents. There was also a note of any current actions and tasks to be completed to progress the patient's care. Physical healthcare risks were also recorded and the need and frequency of any physical observations.

We sat in on two handover meetings from the night to the day shift. In both staff were actively involved in discussion, asking questions to clarify information when required. Any changes in a patient's presentation, risks and care plans were highlighted verbally. On the psychiatric intensive care unit where a patient had been admitted overnight a full summary of risk was presented to the incoming staff.

Staff on all wards carried personal alarms which they could use to summon help in the case of need. Staff would respond if not involved in constant observations and the alarm would also summon help from other wards. Patients could also activate alarms in their rooms and bathrooms to summon help.

Track record on safety

The service had a good track record on responding to and learning from incidents.

Between 1 November 2018 and 31 October 2019 there were three serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'apparent/actual/suspected self-inflicted harm meeting Serious Incident criteria' with two. One of the unexpected deaths was an instance of apparent/ actual/suspected self-inflicted harm meeting SI criteria. Serious incidents where a patient had died were referred for external review. Those reviews followed the national learning from deaths guidance and had input from the families involved and the local clinical commissioning group.

The number of serious incidents reported during this inspection was lower than the 11 reported at the last inspection for the year 1 September 2017 and 31 August 2018. The service had reduced serious incidents resulting from falls and physical healthcare concerns through targeted training for staff and specialist risk assessments for those patients at risk..

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

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 whole team and the wider service. .

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff reported serious incidents clearly and in line with trust policy. Serious incidents were reported to the national Strategic Executive Information System (STEIS) and local clinical commissioning group. The trust board had oversight of serious incidents in the trust.

Managers debriefed and supported staff after any serious incident. Staff on ward 3 reported positively on the support received following the serious incident on that ward.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Lessons learnt from incidents were regularly shared with staff and training was organised to support any new or changing policies.

Staff met to discuss the feedback and look at improvements to patient care. Clinical staff from across the inpatient wards at the Harplands Hospital, which also included older adult and neuro psychiatric care, met monthly to discuss improvements. The patient safety team provided feedback on the progress of any investigations and immediate lessons learnt at the 72 hour report stage following an incident.

There was evidence that changes had been made as a result of feedback. The trust wide policy on the use of supportive clinical observations had been revised to incorporate learning from the serious incident on the Psychiatric Intensive Care Unit following an external review. A new policy had been agreed in September 2019 and training for all staff across the inpatient services had been organised to support it implementation. The changes provided additional clarity of individual roles and responsibilities relating to safe and supportive observation and engagement.

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The local clinical commissioning group reported they had confidence in the approach taken by the trust in responding to serious incidents and participated in meetings of clinical staff to review lessons learnt.

In the last two years, there had been no 'prevention of future death' reports sent to North Staffordshire Combined Healthcare NHS Trust. The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.