Herefordshire and Worcestershire Health and Care NHS 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	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inadequate**

Our findings

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

Inadequate ↓↓

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. Herefordshire and Worcestershire Health and Care NHS Trust is the main provider of community and specialist primary care services across Worcestershire, and mental health and learning disability services across Herefordshire and Worcestershire. Services are integrated with a variety of partners, and work closely with commissioners, voluntary organisations and communities to deliver services.

Hill Crest is a 25 bed mixed gender ward for adults of working age based in Redditch. The ward provides a 24 hour service offering intensive input for patients who experience acute mental health difficulties. It provides care to people age between 18 and 65 who may be detained under the Mental Health Act and have a home address within the catchment area.

We decided to carry out an unannounced inspection of Hill Crest in response to information of concern we had received about it.

How we carried out the inspection

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.

To fully understand the experience of people who use services, we always ask the following 5 questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

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

During the inspection visit, the inspection team:

Our findings

- Carried out structured observations of how staff were caring for patients.
- Attended multidisciplinary meetings on the wards.
- Spoke with the ward manager.
- Spoke with staff members including registered nurses and health care assistants.
- Spoke with patients.
- Looked at the quality of the environment on the ward.
- Reviewed patients' care and treatment records.
- Reviewed documents related to the running of the service.

Overall summary:

We re-rated this core service following this inspection. The overall rating went down and was limited to inadequate for the safe and well led key questions, due to breaches of regulations.

Due to the serious nature of the concerns we had after the inspection, we served a draft Warning Notice on the trust, requiring them to make significant improvements. This was because we were concerned about the trust not ensuring care and treatment was provided in a safe way for service users, that the premises were not clean, properly maintained or suitable for the purposes for which they were being used and that the trust did not ensure systems and processes were established or operated effectively to assess, monitor and improve the quality and safety of the services. The trust responded to the findings from the Warning Notice and implemented an action plan to address the concerns we raised.

We rated this service as inadequate because:

- The trust did not effectively ensure the ward was cleaned and well maintained. During the inspection visit we found areas of the ward that were visibly dirty, including the main food preparation area.
- The trust did not ensure that risk assessments were created and reviewed in a timely way. This included one set of patient notes which had no admission risk assessments or care plans completed, no record of multi-disciplinary team discussions and, specific risks identified in the historic patient record, which had not considered potential risks to other patients on the ward or of self-harm.
- The trust did not ensure substantive staffing levels were adequate to manage the risk on the ward. The ward was carrying high levels of qualified nurse and health care assistant vacancies which had resulted in the constant and extended use of bank and agency staff on the ward.
- The trust did not ensure that the environment was well-maintained and fit for purpose. We found ward areas in a state of disrepair including exposed electrical wire hanging from light fittings and repairs from the removal of ligature points partially completed with exposed metal cap off and fittings not plastered over.
- The trust did not assess, monitor and improve the quality and safety of the services they provided. We found that incident forms were not fully completed or reviewed, and risks were not fully considered. This included incidents of sexual safety being rated as 'low harm', a lack of external oversight and review and follow up actions that were not always appropriate in keeping patients safe.

Our findings

- We were made aware of a serious incident which involved a patient attempting to throw boiling water and sugar at a member of staff. Two boilers that the ward used remained accessible to patients for 3 days after the incident until the fuse was removed. On the day of our inspection 2 boilers were still in use and producing boiling water indicating that lessons had not been learnt and no actions taken to mitigate any future risk.
- We found equipment without in date check stickers attached including fire extinguishers. We also found fire exits blocked by equipment during our inspection visit. Due to safety concerns we addressed the issue with fire extinguishers whilst on site and they were removed the same day.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not always safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

We found a number of risks around the ward area that had not been mitigated including missing skirting and floor coverings. Items were left in front of fire doors blocking exit and fire extinguishers were found on the ward that were out of date. The oldest of these went out of date in 2009.

Staff could not observe patients in all parts of the wards. Hill Crest ward is in a large building with a central hub and four corridors that branch away from the hub. Staff could not supervise all these areas. We also identified a number of blind spots in rooms and corridors around the ward that had not been mitigated with blind spot mirrors or other equipment. There was CCTV but it did not cover all areas of the ward.

The ward was mixed gender. There was a bedroom corridor for males and one for females. There were also 4 rooms in another corridor which we were told could be used for either males or females depending on the mix of patients on the ward. We were told that this area would be either exclusively male or female depending on requirements. We found examples in the incident reporting system, Ulysses, where males had entered the female bedroom corridors and bedrooms in the last six months prior to our inspection. Staff told us that the door between male and female areas was kept open with a towel over the handle to prevent it closing. This was also seen at a Mental Health Act visit the week before our inspection. This meant male service users could access female service user areas, including bedrooms and bathrooms. Sexual safety incidents had occurred– patients were not appropriately observed to prevent male to female sexual exposure, sexual touch, or sexual relationships. We also saw that there was a room allocated as a female lounge. This was a bare room with two armchairs in it. It was not decorated with pictures and did not contain any other furniture. We were told by some of the patients we interviewed that male patients regularly entered this room without being challenged by staff.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. Every room we looked at had a nurse alarm call button in and we observed that all staff were wearing personal alarms to get assistance if required.

Our findings

Maintenance, cleanliness and infection control

Ward areas were not clean or well maintained. We saw that floors had not been cleaned regularly. Walls were damaged in all areas of the ward which meant that bare plaster was showing. There had been some work undertaken to remove lights that had presented a ligature risk and these works had not been completed to a good standard. This meant that the metal blanking plates were still showing and the plaster around these areas was flaking. We saw that there were door frames missing in a number of ward areas which meant that plaster and insulation was exposed. We found that there were electrical works ongoing in the corridor that led to the practice kitchen and exposed wiring was hanging down. We were told by staff that the practice kitchen was still in use which meant that patients were still able to access this area under the supervision of staff. We noted that all ward toilets and bathrooms we visited were visibly dirty and shower pans and curtains had mould growing on them. There were also stains and dirty marks on walls in common patient areas and patient bedrooms.

Staff followed infection control policy, including handwashing. We observed staff wearing masks and using hand sanitiser as they moved between different areas of the building. There were hand cleaning stations available around the ward areas which contained hand sanitiser.

Seclusion room (if present)

The unit did not have seclusion rooms.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff had not always checked and maintained equipment. We found a disabled bath with a lift system had an out of date check sticker attached to it.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The trust approach to staffing numbers was to ensure that there were enough nursing and support staff to keep patients safe. Though we were told by staff and managers that the ward often ran under its trust set staffing numbers.

The service had high vacancy rates. At the time of our inspection the ward had seven vacancies for band five or six qualified nurses and seven vacancies for healthcare assistants. This was out of an overall workforce of 10 qualified nurses and 18 healthcare assistants.

The service had high rates of bank and agency nurses. The ward was using bank and agency nurses at a high rate every day. There were three agency qualified nurses on long term contracts, but the ward could not always guarantee that the agency and bank staff used on the ward were familiar with the hospital or patients.

The service had high rates of bank and agency nursing assistants. The ward used bank or agency health care assistants every day due to the high number of staff vacancies. Though the service made every effort to try and use staff that were familiar with the service, it was not always possible to use staff that had worked at the hospital regularly.

Our findings

Managers often relied on the use of bank and agency staff and were not always able to request staff familiar with the service.

Managers did not always make sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke to bank and agency staff, who had worked a high number of shifts at the hospital. They told us that they had not had a meaningful conversation with the manager or an extended handover when they started working on the ward.

The ward manager could adjust staffing levels according to the needs of the patients. The manger told us that they could bring in staff and adjust the staffing mix if the requirement to cover the ward changed.

Staff did not always share key information to keep patients safe when handing over their care to others. We observed a morning handover that did not contain all information staff might need. There had been an admission to the ward during the night and there was not a detailed handover about that patient. The handover consisted of a short statement about how each patient had presented through the night. There had been no preparation of the coming days activities or leave off site so the staff were not given information specific to patients who would be utilising section 17 leave. Section 17 leave is a legal process that defines how much time and the areas that are identified for a patient to be allowed off the ward whilst detained under the Mental Health Act. Incidents that had occurred throughout the night were not discussed in any detail.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. We looked at the managers dashboard that showed that staff on the ward were up to date with their training. The dashboard showed that there were three members of staff that were not up to date with their training. But on further examination it was established that these staff had left the ward but were still showing in the training matrix. Training for agency staff was managed by the agency. This meant that it was difficult for managers to check on the training status for that section of the staff group.

Managers monitored mandatory training and alerted staff when they needed to update their training. Information about training was presented to managers using a traffic light system on the managers dashboard. Managers could easily see when a staff member was close to their training expiring and could book them onto training

Assessing and managing risk to patients and staff

Staff had not always assessed and managed risks to patients and themselves well or followed best practice in anticipating, de-escalating and managing challenging behaviour. **However staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool, and had not reviewed this regularly, including after any incident. Of the seven sets of patients notes that we examined, only one had a risk assessment in place that had been reviewed and updated. In the case of a patient that had been admitted during our inspection from another acute ward within the rust, there was no risk assessment in place. In the other five sets of notes, we looked at risk assessments and found they were incomplete and had not been updated or reviewed.

Staff used a recognised risk assessment tool. This service used the Galatean Risk and Safety Technology (GRiST) risk assessment tool.

Our findings

Management of patient risk

Staff did not always know about any risks to each patient and acted to prevent or reduce risks. Staff were not always aware of the risks due to incomplete risk assessments and missing information.

Staff could not observe patients in all areas of the ward. The ward area at Hill Crest was very large consisting of a main hub that contained communal rooms. Four corridors branched off from the main hub and contained patients' bedrooms, dining areas and therapy rooms. Due to the size of the ward, it was not possible for staff to monitor all areas of the ward. There was CCTV on the ward which displayed on monitors in the office, but this did not cover all areas.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff were trained to safeguarding level three and the ward manager, who was the identified safeguarding lead for the ward, had received training to safeguarding level four.

Staff kept up-to-date with their safeguarding training. We saw on the managers dashboard that all ward staff were up to date with their training.

Staff access to essential information

Staff had easy access to clinical information but did not always maintain high quality records even though it was easy for them to do so.

Patient notes were not comprehensive. We looked at seven sets of patients notes and found that there were sections that had not been filled in or were partially completed in six of them. All staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff could always access patients notes when they were transferred from another ward in the trust as there was an electronic notes system in place.

Records were stored securely. All patients' notes were electronic, and password protected.

Reporting incidents and learning from when things go wrong

The ward manager investigated incidents thoroughly. When we checked records on the provider's incident recording system, we saw that the ward manager had investigated incidents. During our inspection, we could not see if these investigations had been audited or reviewed upon the conclusion of the investigation. However, the Trust responded by adding additional information about their systems and processes to provide assurance that investigations were reviewed, audited and shared. But we found that where incidents had been raised, the escalation process stopped with the ward manager.

Is the service effective?

Inspected but not rated

Our findings

Assessment of needs and planning of care

Staff had not always assessed the physical and mental health of all patients on admission. They had not always developed individual care plans. Where care plans were in place they were not always reviewed regularly through multidisciplinary discussion and updated as needed.

Staff had not always completed a comprehensive mental health assessment of each patient either on admission or soon after. We found that assessments were missing in five of the seven records we checked.

Patients had not always had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We found that physical health assessments had been undertaken in six of the seven sets of notes we checked. Where there was a physical condition that required regular review, this had been undertaken.

Staff had not always developed a comprehensive care plan for each patient that met their mental and physical health needs. We found that care plans were not always comprehensive and did not always cover all the patient needs. We found missing sections in care plans or needs that were not covered in six of the seven sets of notes we checked.

Staff had not regularly reviewed and updated care plans when patients' needs changed. We found that reviews had not been undertaken in a timely way in six of the seven sets of notes we checked.

Care plans that were in place were personalised, holistic and recovery-orientated.

Multi-disciplinary and interagency teamwork

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multi-disciplinary team meetings happened on the ward weekly. We attended a multi-disciplinary team meeting and found that the information discussed was relevant and useful. The patient was involved in the discussion.

Staff did not always make sure they shared clear information about patients and any changes in their care, including during handover meetings. We attended a morning handover during our inspection and found that not all information was included. There was no discussion about appointments for the day ahead or clear information about how patients had presented during the previous shift. Though a patient had been admitted to the ward during the previous shift, information about them was limited. There was no discussion about medication, ongoing treatment plans or a detailed discussion about the needs of the patient. There were also staff attending the handover who had not worked on the unit before. These staff were not given a more in-depth handover.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Managers made sure that staff could explain patients' rights to them.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was information posted around the unit about how patients could access advocacy services and we were told by patients that they could access advocates regularly if required.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. There was evidence in patient's notes that staff had explained their rights to them. Patients also told us that they had had their rights explained to them on admission.

Our findings

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. We saw that patients were able to utilise section 17 leave. We saw patients using short periods off the ward escorted by staff. We did not see any evidence that section 17 leave had been cancelled due to staffing issues.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Copies of patients' detention papers were stored as part of the electronic medical record but were not always stored in the correct part of the record. This meant that it was difficult to easily see detention paperwork in the records we checked.

Managers and staff did not make sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Is the service responsive?

Inspected but not rated

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom with an en-suite bathroom. There was limited provision for patients to keep their personal belongings safe. There were quiet areas for privacy but these were not welcoming or well furnished. The food was of good quality but patients could not access hot drinks or snacks without a member of staff.

Each patient had their own bedroom, which they could personalise. We found that patient's bedrooms were sparsely furnished with a bed and chest of drawers, there were no wardrobes and we found that patients were keeping their clothes and belongings in bags or stacked in piles on the floor.

Patients did not have a secure place to store personal possessions. Though patients had lockers in a side room, they could not access these without a member of staff present and there was nowhere in their bedrooms that patients could securely store items.

Staff used a full range of rooms and equipment to support treatment and care. The ward area was very large with rooms set aside for therapy and engagement.

The service had quiet areas and a room where patients could meet with visitors in private. There was a visitor's room, but it was sparsely decorated. It was not welcoming and contained seating for a small amount of people

Patients could make phone calls in private. Patients had access to their own telephones that they could use in the privacy of their bedrooms. There was also a ward telephone available if patients did not have their own mobile phone.

The service had an outside space that patients could access easily. We found that these outside spaces were not well kept. Areas had dead or dying plants and the outside courtyard area gave patients access to small objects that they could use to self-harm such as sharp stones

Our findings

Patients could not make their own hot drinks and snacks without being dependent on staff. Patients had to find a member of staff and ask them to open areas where they could make hot drinks. This was due to a former patient using hot water to attempt to scald a member of staff. The temperature of the hot water heater had not been adjusted to reduce it below boiling point.

Meeting the needs of all people who use the service

Staff helped patients with communication, advocacy and cultural and spiritual support.

The service had information leaflets available in languages spoken by the patients and local community. There were noticeboards around the service that contained information on local support services and other services that may have been useful. We were told by staff that these were available in different languages if requested.

Managers made sure staff and patients could get help from interpreters or signers when needed. The trust had a contract with interpreter services which included access to British sign language signers if required.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with knew how to raise a complaint and told us that they felt they would be supported by staff to do so if required.

The service clearly displayed information about how to raise a concern in patient areas. Information about complaints procedures was posted on noticeboards on the ward.

Staff understood the policy on complaints and knew how to handle them.

Is the service well-led?

Inadequate 🔴 ↓↓

Our rating of well-led went down. We rated it as inadequate.

Culture

Staff did not always feel respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear but were not confident that their voices would be heard by senior leaders.

Some staff we spoke to told us that they did not feel respected, supported or valued. We were told that communication between leaders and staff during periods of sickness due to incidents was not good and they had not felt supported. However, following the incident we saw evidence of appropriate contact and support for an individual member of staff following an incident from the trust. Long term agency staff told us that they did not feel as if they were treated as part of the team and that leaders did not know who they were and had not engaged them in any meaningful way.

Not all staff we spoke with felt positive or proud to be working as part of the team. Staff told us that they felt that staffing issues had left them under pressure and that they did not feel that this was fully understood by senior leaders.

Our findings

All staff told us that they felt that they could raise concerns without fear of retribution, but they were not confident that their voices would be heard and that their concerns would be addressed.

All staff we spoke with knew how to use the whistle blowing process.

Managers had dealt with poor performance when required. We saw several examples where the organisation's disciplinary process had been used to address poor performance and in all cases their procedures had been followed.

The manager's dashboard showed staff appraisals had been done. Appraisals included a conversation about career progression and staff development.

Staff told us that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.

The service's sickness and absence rates were higher than trust set targets.

There were systems in place for staff to access support for their physical and mental health. We were told by staff that these systems were not always effective, and staff sometimes had difficulty in accessing support.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Though there was a clear framework of what should be discussed at ward, team or directorate level team meetings we found that these were not always adhered to. We found that the handover meeting we attended did not cover all information required to be effective and there were no audits or checks to ensure that these frameworks were being used correctly.

Care records were not audited or monitored to ensure that they were complete. We found examples where information was missing in all except one of the records that we checked. This had not been identified by managers and there was not a plan in place to address this.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care. Staff maintained and had access to the risk register at team and directorate level and could escalate concerns. We found that where concerns had been escalated because of incidents the escalation process had often ended at the ward manager with a review. There were no processes in place to ensure a review of these measures was undertaken.

Staff concerns matched those on the risk register with the major concerns being around staffing levels and high use of bank and agency staff.

The service had plans in place for emergencies such as adverse weather conditions or flu outbreaks.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Our findings

Staff had access to equipment and information technology that they required to undertake their roles. This included telephone systems and internet that worked correctly and met the needs of the wards.

All records were electronic and information governance systems ensured patient confidentiality.

The ward manager had access to electronic systems to support them in their role. This included access to a managers' dashboard which broke down information on performance, staffing and patient care.

Our findings

Areas for improvement

Core service

MUSTS

- The trust must ensure that the environment on Hill Crest is fit for purpose, clean and well maintained. Regulation 15 (1)
- The trust must ensure incidents on Hill Crest are reported and escalated appropriately. Regulation 17 (a)
- The trust must ensure that care records are accurate, complete, and contemporaneous in respect of each service user including a record of the care and treatment provided to the service user. Regulation 17 (c)
- The trust must ensure that service users on Hill Crest are protected from abuse and improper treatment and that actions are taken to appropriately safeguard individuals at risk. Regulation 13 (1)
- The trust must ensure that the ward has staff with experience, skills, and competence to manage the safety and governance of the ward. Regulation 18 (1)
- The trust must ensure that there is enough support for staff on the ward. This includes supporting staff after an incident. Regulation 18 (2)

Our inspection team

The team that inspected the service consisted of 2 inspectors, an Inspection Manager and 1 specialist advisor, a nurse with experience working in an acute mental health setting.

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 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

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	S29A Warning Notice