Southern Health NHS Foundation Trust

# Antelope House

## Quality Report

Antelope House
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Southampton
Hampshire
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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) |
|---|---|---|---|
| RW1GE | Antelope House | Saxon Ward | SO14 0YG |
| RW1GE | Antelope House | Hamtum Ward | SO14 0YG |

This report describes our judgement of the quality of care provided within this core service by Southern Health NHS Foundation 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.

Where applicable, we have reported on each core service provided by Southern Health NHS Foundation Trust and these are brought together to inform our overall judgement of Southern Health NHS Foundation 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

## Contents

# Summary of findings

## Overall summary

Prior to the inspection, in response to concerns raised by patients, staff and the local leadership team regarding the safety and quality of care at Antelope House the trust had made a number of key changes to the staffing structure including new leadership and additional checks on safety and support for staff. The trust introduced these key changes on 11 February 2019 so had only been in place nine days prior to our inspection.

Prior to the new staffing arrangements being implemented the senior management team spent time talking with staff, visiting the wards to ensure they understood the issues facing staff and consider what changes needed to be made to make improvements to the quality and safety of patient care.

Changes had been made to managerial and nursing roles and additional medical support was put in place to support staff. Daily safety huddles were also set up to discuss risks and concerns within Antelope House. Changes were communicated to staff in writing and in person. However, these were new and not fully embedded.

During the inspection, we found:

- Staff had not ensured that risks concerning a patient's physical health had been fully addressed.
- Staffing levels were not always sufficient and fell below the trust 'safer staffing levels' on both wards approximately once per week. There were a number of vacant posts on both wards and a high level of staff sickness. The wards were heavily reliant on bank and agency staff and some shifts were left short by one or two staff members once or twice per week.
- Staff morale on Hamtun ward was low, three staff were off sick and the remaining staff team were feeling under pressure. Staff said that prior to the changes they had felt undermined by senior management regarding admissions to the wards and felt that communication had been poor.

However:

- The trust had recognised that staff morale was low on Hamtun ward and had put in place arrangements to bring about improvements. During the inspection staff told us told us that they felt there had been more support from senior management recently.
- The trust had implemented daily safety huddles to discuss any concerns on the wards and provide additional support to staff and monitor patient safety.
- Staff on Saxon ward felt that morale was good.

# Summary of findings

## The five questions we ask about the service and what we found

**Are services safe?**

• Staff had not identified, monitored and controlled risks relating to patients' physical health. We raised this with managers at the time of the inspection and were given assurances that this would be reviewed and that arrangements would be made to ensure improvements were made immediately.

• On both wards, safer staffing levels were not always met. There were not always two qualified nurses on shift and not all shifts had a full complement of staff, as required by the trust's 'safer staffing' numbers.

• On Hamtun ward, one to two shifts each week could not be filled by either permanent staff, bank or agency staff, therefore, the wards were not safely staffed on days when this happened. Staff sickness levels were high across both wards and staff reported feeling stressed at work. Staff told us that escorted leave was sometimes postponed due to staffing levels or due to the acuity of patients.

• Staff and patients on Saxon ward commented on how the arrangements for smoking were having a negative impact. Staff felt that some incidents that occurred on Saxon ward were related to smoking.

• There was some graffiti on a bedroom door that had not been cleaned off; staff told us this was because it would damage the paintwork.

However:

• Staff had thoroughly identified, monitored and reviewed as necessary, risks relating to patients' mental health.

• Staff received regular reflective practice sessions and debriefs following incidents.

• There was adequate medical cover across the hospital and staff felt doctors were supportive and responsive.

• Both wards were clean and tidy and furnishings had been generally well maintained.

**Are services effective?**

We did not inspect this key question at this time.

**Are services caring?**

We did not inspect this key question at this time.

# Summary of findings

**Are services responsive to people's needs?**

We did not inspect this key question at this time.

**Are services well-led?**

• Staff morale on Hamtun ward was low and staff were feeling under pressure due to low staffing levels, staff vacancies, sickness levels and reliance on agency staff.

• Staff on both wards said that prior to the changes they felt undermined by senior management about decisions made to admit patients and re-open beds. Staff did not always feel consulted with about admissions to the wards.

• Staff felt communication from senior management had been poor. Staff felt able to raise concerns but did not always think they would be dealt with by senior managers.

However,

• The trust had recognised that staff morale was low on Hamtun ward and had put in place arrangements to bring about improvements. During the inspection staff told us told us that they felt there had been more support from senior management recently.

• Multidisciplinary, daily safety huddles had been put in place on the wards to look at any safety concerns and seek the views of staff and patients.

• Staff morale on Saxon ward was good.

# Summary of findings

## Information about the service

Southern Health NHS Foundation Trust provides acute mental health care inpatient units for adults of working age from four sites, Antelope House (in Southampton), Elmleigh (in Havant), Melbury Lodge (in Winchester), and Parklands Hospital (In Basingstoke). It also provides psychiatric intensive care (PICU) from Antelope House and Parklands Hospital.

We visited one of these sites (Antelope House) because the concerns were specifically about the this service.

Antelope House has two acute mental health inpatient wards. These are Trinity, a 21-bed female ward, and Saxon, a 21-bed male ward. It also has a 10-bedded mixed sex psychiatric intensive care unit (PICU) (Hamtun).

Hamtun Ward has three beds for female patients, and seven beds for male patients. We visited both Saxon ward and Hamtun ward but did not visit Trinity ward because we had not received any concerns about that ward.

Following the inspection in June 2018, we served a Requirement Notice and told the trust to make the following improvements in relation to staffing levels:

- The trust must ensure that the safer staffing levels are met on all the wards s to ensure safe care and treatment of patients. This includes consistent medical cover across the wards. (Regulation 18).

We reviewed the outstanding requirement notice relating to safer staffing levels from the previous inspection in June 2018 which following this inspection in February 2019, remains in place.

## Our inspection team

The team was comprised of: two inspectors, one inspection manager and a specialist advisor with experience of working in acute wards and psychiatric intensive care units.

## Why we carried out this inspection

We carried out a focussed inspection of this core service due to concerns noted in the information we collect about the trust and information passed to us from patients, carers and others about staffing levels, assessment of patient risk, cleanliness of the ward environments, staff morale and the leadership of Antelope House.

## How we carried out this inspection

As this was a focused inspection we did not re-rate the service as we only looked at key lines of enquiry. The ratings remain the same as those awarded at the comprehensive inspection in 2018.During the inspection visit, the inspection team:

- visited two of the three wards at Antelope House and looked at the quality of the ward environment
- spoke with three patients who were using the service
- spoke with one ward manager
- spoke with the interim matron
- spoke with nine other staff members
- interviewed the deputy director of nursing and the interim director of operations who had responsibility for these services

We also:

# Summary of findings

- looked at nine treatment records of patients and 15 medicines charts

## What people who use the provider's services say

Two out of three patients we spoke with said the staff were nice, supportive and helpful. Two out of three patients said they were not happy with the smoking arrangements. All three patients said they could access section 17 leave but one patient commented that it is sometimes slow depending upon staffing.

## Areas for improvement

**Action the provider MUST take to improve**
The trust must ensure that there is sufficient numbers of staff with the appropriate skills and experience on both wards at all times to ensure safe care and treatment of patients.

Staff must ensure patients' risks are assessed and monitored to prevent a deterioration in patients' physical health.

**Action the provider SHOULD take to improve**
The trust should ensure that graffiti is cleaned off in a timely manner.

# 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

### Safe and clean environment

**Maintenance, cleanliness and infection control**

Most ward areas were clean and furnishings were well-maintained. Furniture appeared fit for purpose, clean and comfortable. We reviewed cleaning records which indicated that they were cleaned regularly and domestic staff were cleaning the ward during the day. However, on Saxon ward, there was graffiti over one patient's bedroom door. Staff told us that cleaning the graffiti off would damage the paint work. They reported that the estates department had been informed and would repaint the door when the patient left. However, the graffiti was unsightly and extensive. The ward colour scheme on both wards (Grey and white) lacked warmth. There was no art work, or pictures, etc. to break up the white walls on Saxon ward. Staff told us they planned to improve this and that art work was previously displayed but had been damaged by a previous patient.

### Safe staffing

**Nursing staff**

Minimum trust safer staffing numbers were not always met on the wards. The trust had calculated the number and grade of nurses and healthcare assistants required on each shift. According to the safer staffing figures, both wards should have had at least two qualified nurses on duty during the day and one qualified nurse on duty at night. In total, there should have been seven staff working during the day and five staff working at night. Staff were often reliant on agency staff to fill vacant shifts, and where possible, regular agency staff were used. Staff told us and staffing rosters showed, that shifts were short of one or two staff once or twice a week on both wards.

On Hamtun ward, there was a vacancy for one band 3 healthcare assistant and one band 5 registered nurse. There were three staff on sick leave. On Saxon ward there was one band 6 registered nurse vacancy and 2.5 band 5 vacancies. There were no staff on long-term sick leave but there was regular ad-hoc sick leave.

Staff on Hamtun ward told us that whilst escorted leave was considered a priority, it was sometimes postponed or cancelled due to staffing numbers. When this was the case, staff rescheduled leave as soon as possible and explained the reason for this to patients.

**Medical staff.**

There was adequate medical cover on the wards. Junior doctors were shared across all three wards at Antelope House and this was working well. Staff felt they could access medical support quickly and staff felt doctors were responsive to patients' needs.

### Assessing and managing risk to patients and staff

**Assessment of patient risk.**

Staff assessed and managed risks relating to mental health well. Staff on both wards completed a risk assessment for each patient on admission. Staff updated risk assessments regularly and following incidents. We reviewed 17 incidents across both wards which occurred during the month prior to the inspection. Incident forms were completed using the trust's electronic incident reporting system. Actions were identified following an incident, which included a discussion of the incident at the multidisciplinary team meeting. Staff updated care plans when risk levels changed.

Staff received regular reflective practice sessions which were facilitated by the psychology department and had debriefs with management following incidents.

Daily multidisciplinary safety huddles had been put in place on the wards to look at any safety concerns and seek the views of staff and patients.

**Management of patient risk.**

However, on Hamtun ward, an assessment of one patient's physical health had not been sufficiently managed. Whilst food and fluid charts and repositioning charts were completed thoroughly, the risk assessment to assess the risk to a patient's skin integrity had been inconsistently completed and did not reflect the correct risk rating. Body maps were completed erratically. The patients had not been weighed frequently because the ward did not have the correct equipment. This meant that staff did not have

the evidence to ensure that informed discussions took place regarding the need for pressure relieving equipment. There was no escalation plan available to staff about what actions to take if the patient's weight dropped or if diet and fluids were consistently refused. This meant the patient was at risk of pressure damage and/or malnutrition and de-hydration.

On Saxon ward, staff told us the arrangements around smoking were problematic. Patients were not allowed to smoke in the garden as the trust had become 'smoke free'. Staff had to escort patients off the unit to allow patients to smoke at set times. Staff told us some incidents that had happened were related to the arrangements around smoking and use of section 17 leave. Staff said there had been several instances where patients had been smoking in their bedrooms. Two out of the three patients we spoke with were unhappy about the current smoking arrangements. Patients could purchase eburn cigarettes from the trust which they could use on the wards. Patients could also have other forms of nicotine replacement therapy prescribed to them by medical staff.

# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Our findings

**We did not inspect this key question at this time.**

# Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

## Our findings

**We did not inspect this key question at this time.**

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

## Our findings

**We did not inspect this key question at this time.**

# Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Our findings

### Leadership, morale and staff engagement

Prior to the inspection, in response to concerns raised by patients, staff and the local leadership team regarding the safety and quality of care at Antelope House the trust had made a number of key changes to the staffing structure including new leadership and additional checks on safety and support for staff. These key changes had been brought in on 11 February 2019 so had only been in place nine days prior to our inspection. Prior to the new staffing arrangements being implemented the senior management team spent time talking with staff, visiting the wards to ensure they understood the issues facing staff and consider what changes needed to be made to make improvements to the quality and safety of patient care.

Changes had been made to managerial and nursing roles and additional medical support was put in place to support staff. Daily safety huddles were also set up to discuss risks and concerns within Antelope House. Changes were communicated to staff in writing and in person. However, these were new and not fully embedded.

When we visited Hamtun ward we found that staff morale was particularly low. The ward manager on Hamtun had been relocated as had the modern matron for Antelope House. Staff felt that the trust had not handled the relocations and communication very well and were unsure about why the changes were made. However, the trust had communicated the changes both verbally and in writing and also in the hospital newsletter.

Staff told us that within the last week prior to the inspection there had been more support on the ward from senior management and there was less of a 'divide' between ward staff and the senior team. In the week prior to the inspection the trust had relocated a band 8 modern matron to Antelope House who was basing themselves on Hamtun ward to support the staff team and to take an active managerial role. This change appeared to already be having a positive effect on the team.

Staff morale on Saxon ward was good. Staff felt supported by immediate management and worked well as a team. However, staff did not feel that they were involved in decisions and were not listened to or respected by senior managers.

Staff on both wards reported that they were passionate about the job they were doing and worked well as a team. However, staff told us that staffing levels, staff retention and the acuity of patients was causing them to burn out.

Nursing and medical staff on both wards felt that senior managers made clinical decisions about admissions and discharges, often without consultation with them. Staff on Hamtun ward told us they would screen patients for the appropriateness of an admission to a psychiatric intensive care unit (PICU) and senior managers would often override that decision leaving staff feeling undermined. Staff on both wards gave us examples of how closed beds were re-opened without any consultation with staff at any level. There was no discussion about patient acuity on the ward or staffing levels prior to decisions being made.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Staff did not ensure patients' risks were assessed and monitored to prevent a deterioration in patients' physical health** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The trust did not ensure that the safer staffing levels were met on both the wards to ensure safe care and treatment of patients.** |