The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Inspection report

Pensnett Road
Dudley
DY1 2HQ
Tel: 01384456111
www.dgoh.nhs.uk

Date of inspection visit: 20 April 2023
Date of publication: 14/06/2023

Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Russells Hall Hospital

Not inspected

We carried out this unannounced focused inspection of the emergency department as we had concerns about the care of patients with a mental health concern after a serious incident. The inspection team consisted of 1 CQC Hospitals Inspector and 1 CQC Mental Health Inspector.

The inspection concentrated on certain key lines of enquiry in the safe, effective and well-led domains. These included staff training, environment and equipment, assessing and responding to risk, incidents, evidence-based care and treatment as well as leadership, governance, and management of risk, issues and performance. We did not inspect any other services or key lines of enquiry as this was a focused inspection in relation to mental health in urgent and emergency care only. During the inspection we spoke with 13 members of staff including the matron and deputy matron, the lead nurse for mental health and complex vulnerabilities, staff nurses, clinical support workers and a manager. We also spoke to 3 members of the Mental Health Liaison Team. We reviewed 3 patient records, 3 incident reports and relevant policies and procedures. At our last inspection we rated the trust overall and the emergency department as requires improvement overall.

You can find further information about how we carry out our inspections on our website:

What we do on an inspection - Care Quality Commission (cqc.org.uk)

Urgent and emergency services

Inspected but not rated

- Staff generally received mandatory training on recognising and responding to patients with mental health needs, learning disabilities, autism, dementia and the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The design, maintenance and use of facilities, premises and equipment generally kept people safe.
- Staff assessed risks to patients, acted on them and kept accurate care records. They managed medicines well.
- The service managed safety incidents well and learned lessons from them. Managers debriefed and supported staff after serious incidents.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Doctors, nurses and other healthcare professionals generally worked together as a team to benefit patients.
- Staff followed national guidance to gain patients' consent. They knew how to support patients who were experiencing mental ill health.
- Leaders were open, transparent and showed commitment to improving the care provided. They had had a vision for what they wanted to achieve and a strategy to turn it into action.

However:

- The service did not always follow the trust's Care of the Patient Requiring Close Observation policy.
- Information about serious incidents, and subsequent learning, was not always shared with partner services.

Is the service safe?

Inspected but not rated

Mandatory training

The service mostly provided mandatory training in key skills and made sure everyone completed it.

Clinical staff generally completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This also included training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Mental health training completion rates in the emergency department at the time of inspection were 81% for nursing staff, and 71% for medical staff. This was below the trust's compliance target of 90%. However, several staff members were booked to receive training in May 2023. Staff told us that barriers to completion of mandatory training were a high staff turnover rate, and a recent intake of new starters in the department.

We reviewed the contents of a new mental health training package for emergency department staff which had been developed by the lead nurse for mental health and complex vulnerabilities. The package, which staff told us was soon to be rolled out at the time of inspection, included training on mental health triage, understanding and managing behaviours of patients at risk of self-harm and suicide, and actions to take in response to discovering a patient with a ligature.

Urgent and emergency services

Staff told us that security staff received mental health and mental health law training, as well as training on conflict resolution and personal safety.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them.

The design of the environment generally followed national guidance. There were 3 'ligature light' cubicles which where possible were used for patients who attended the emergency department with mental health concerns. The cubicles had removable patient monitors, oxygen and suction fixtures, and curtains were held in place with magnetic anti-ligature rails. The cubicles were in clear sight of staff workstations. Staff told us that managers were in discussion with estates to make 4 more cubicles 'ligature light'. The cubicles proposed were in a side bay of the department, around a central staff workstation. The sink in the toilet assigned for patients using the ligature light cubicles had a tap fixture which could be used as a ligature anchor point. However, staff told us that they had ordered a sensor tap to mitigate this risk.

The service had an interview room for use during patient assessment. There were 2 doors, 1 on either side of the room, an emergency buzzer and a window which allowed staff from outside the room to check on the patient or staff member but still provided a sufficient degree of privacy as per guidance by the Psychiatric Liaison Accreditation Network. The room was sparsely furnished with a sofa and two lighter chairs. Staff told us they generally removed the lighter chairs when the room was in use. There was an electrical box fixed to the wall near the ceiling which could be a potential ligature anchor point. Staff told us that they were in discussion with estates regarding its removal.

There was also a 'sunflower' room across the corridor from the main department. We were not able to view the room during the inspection as it was in use, but staff told us that it was at times used for the assessment of paediatric patients by the Child and Adolescent Mental Health Service and was furnished with bean bags.

The service had enough suitable equipment to help them to safely care for patients.

Many of the staff we spoke to carried their own set of 'tuff cut' scissors which could be used to cut through a ligature. We checked the 3 resuscitation trolleys in the emergency department, and ligature shears were present in all 3. The matron told us that they had recently received an order of hooked ligature cutters. These were not in use at the time of the inspection as specific staff training was required, and managers were considering which staff groups would be best placed to receive this.

Assessing and responding to patient risk

Staff completed timely risk assessments for each patient. They removed or minimised risks and updated the assessments as required. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

There was evidence of risk assessment for patients presenting with a risk of self-harm or suicide from the point of triage. We reviewed the care records of 2 patients who were in the emergency department with mental health concerns at the time of our inspection. We saw triage staff had followed a flowchart informing them to alert the nurse in charge of the patient, document the risk on the patient's electronic record and arrange appropriate observations for the patient. Since the serious incident which triggered our inspection, a proforma of questions for staff to use to inform their initial patient

assessment had been implemented. This included considering whether there was any risk of the patient absconding, whether there were any safeguarding concerns, and if the patient had any property which could be used to harm themselves or others. Staff told us that since the serious incident, all patients presenting with mental health concerns received 1 to1 observation until assessed by the relevant mental health liaison team.

Clinical support workers we spoke with were aware of their responsibilities in the completion of 1 to 1 observations. However, a clinical support worker told us that could often spend extended periods of time conducting patient observations with limited opportunities for breaks. This was not in line with the trust's Care of Patients Requiring Close Observation policy, which stated that observation periods should ideally be limited to 2 hours.

Patients with functional mental health needs that required urgent assessment were referred to the Mental Health Liaison Service who were situated in a unit on the footprint of the hospital grounds, and run by the local mental health trust.

A key performance indicator (KPI) in the Mental Health Liaison Service's Standard Operating Procedure stated that patients in the emergency department should be assessed within 1 hour of referral, however, this did not always happen. In the records reviewed, 1 patient had waited almost 2 hours for an initial assessment by a nurse from the Mental Health Liaison Service, and a further 10 hours to be seen by a doctor from the service before being discharged. We spoke with staff from the Mental Health Liaison Service about barriers to timely assessment of emergency department patients. They stated that demand generally far outstripped capacity, particularly for the duty doctor overnight, who covered 5 wards at the mental health trust, in addition to all wards and the emergency department at Russell's Hall Hospital. Emergency department staff told us that the Mental Health Liaison team did not accept referrals until the patient was deemed medically fit, which could also cause some delays. Staff told us that they were discussing earlier assessment alongside clinical treatment with the Mental Health Liaison team. We saw evidence of a clear internal escalation procedure in flowchart form when patient delays were experienced, up to service director level for the most severe delays.

Patients under the age of 18 who required urgent mental health assessment were referred to the Child and Adolescent Mental Health Services (CAMHS) between the hours of 8am and 8pm, 7 days a week. Staff told us that children and young people tended to be admitted to a paediatric ward overnight while awaiting assessment and were reviewed by CAMHS the following morning. For patients presenting with organic mental health concerns, a trust dementia and delirium team were accessible to the emergency department between 8am and 4pm, 7 days a week. Out of these hours, patients were referred to the Mental Health Liaison Service.

Staff shared key information to keep patients safe when handing over their care to others. We also saw evidence of discussion of information sharing between emergency department staff and the Mental Health Liaison team in minutes from the monthly meeting between the teams in April 2023. An item was added to the action log, to ensure that the Mental Health Liaison team engaged with the nurse in charge before and after patient assessment to ensure the sharing of key information, particularly the plan for the patient after assessment.

Shift changes and handovers included all necessary key information to keep patients safe. Staff told us they were made aware of any patients in the department with mental health concerns during the shift handover 'huddle'.

Medicines

The service used systems to safely store medicines.

Urgent and emergency services

Staff stored and managed medicines safely. Staff we spoke with said that they stored medications belonging to patients at risk of self-harm in the department's controlled drugs cupboard.

Incidents

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

Staff knew what incidents to report and how to report them. Staff we spoke with could describe scenarios in which they had, or would, report incidents relating to patients presenting with a mental health concern. These included calling for support from security, delays in patient assessment and a patient absconding. The incident reporting system was easy to access via the trust's intranet.

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

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from the investigation of incidents. Staff generally met to discuss the feedback and look at improvements to patient care. Staff told us that the serious incident that triggered the inspection and subsequent learning from the incident, were discussed via several channels including a matrons meeting, and were also due to be presented at a trust-wide learning event.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. We reviewed 3 recent incident reports regarding patients who presented with a mental health concern. We saw evidence that managers followed up incidents and put appropriate measures in place to safeguard patients' wellbeing.

Managers debriefed and supported staff after any serious incident. None of the staff who were on duty when the serious incident which triggered the inspection occurred were on duty during our inspection. However, we were assured that the staff involved were well supported, having received wellbeing check-ins with senior colleagues in the department, and offers of counselling and chaplaincy support.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed several policies and standard operating procedures (SOPs) relating to mental health care including the

Care of Patients Requiring Close Observation policy, policy on absconding patients and SOP for patients detained under section 136 of the Mental Health Act 1983. We also reviewed 2 new SOPs awaiting ratification on action to take in the event of discovering a patient with a ligature, and on referral to the correct mental health support team. The policies were comprehensive, up-to-date and contained flow charts for staff to extract key guidance 'at a glance'.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff told us that specialist support could be accessed from a registered mental health nurse employed by a secure transport service for patients who had been sectioned under the Mental Health Act whilst awaiting an inpatient mental health bed. Staff told us this was valuable as there could be significant challenges in finding an inpatient bed in a timely manner. The service member accompanied the patient during their transfer.

Multidisciplinary working

Doctors, nurses and other healthcare professionals generally worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw evidence of monthly meetings between emergency department managers and the Mental Health Liaison Service. Although only introduced 2 months before our inspection, staff told us that the meetings had so far improved the working relationship between the teams.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff followed national guidance to gain patients' consent. They knew how to support patients who were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw evidence in the records reviewed of mental capacity assessment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff clearly recorded consent in the patients' records.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Policies were easy for staff to access via the trust intranet. We noted a display in the emergency department containing guidance on Deprivation of Liberty Safeguards.

Urgent and emergency services

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

Leaders we spoke with during our inspection were experienced managers who were open, transparent and visible in the department, and staff told us they were approachable. They supported staff to develop their skills by providing additional training where required.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Managers we spoke with had a vision of how the service could be further improved to meet the needs of patients attending with mental health concerns, and had strategies in place to achieve this. They told us they had submitted a case to the trust for the recruitment of a band 6 registered mental health nurse to offer specialist support to patients and staff in the emergency department. Managers told us there were ongoing plans for members of the Mental Health Liaison Service to co-locate to a vacant room in the department at night, when demand was typically highest. Managers were also focused on improving training completion rates and told us that staff had recently been given the opportunity to complete mandatory training at home via teleconferencing. Staff were either paid or given time back in lieu, and managers told us there was a high uptake of the training amongst staff.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff we spoke with generally felt valued in their roles and spoke of times where they had been effectively supported by managers, particularly after incidents.

Governance

Leaders generally operated effective governance processes throughout the service. However, partner organisations were not always involved in these processes.

Managers told us that the serious incident that triggered the inspection and subsequent learning from the incident, were discussed via several governance channels including a matrons' meeting and were due to be presented at a trust-wide learning event. We also saw that incident reports involving violence, aggression, patients absconding or the use of restrictive interventions fed into a report which was discussed at the monthly trust divisional governance meeting.

However, members of the Mental Health Liaison team we spoke with told us they were not aware of the serious incident even though the patient had been referred to them, and therefore, were not involved in discussions about the incident or lessons learned.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Since the serious incident that triggered our inspection, we heard about, and saw evidence of, renewed focus on the assessment and management of risk in patients presenting with mental health concerns. We saw evidence of performance monitoring as the nurse in charge filled a 'clinical lead department overview' task sheet at 3 set times during each shift. Tasks on the sheet included checking that patients who presented with mental health concerns were in ligature light cubicles, that they had 1 to 1 observation, that all cubicle curtains were open and that clinical support workers who were carrying out the observations were documenting patients' mood, behaviour and activities on their electronic record hourly. We saw that checks had been consistently completed.

Information Management

The service collected data and analysed it; however we could not be assured it was always reliable. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We spoke with managers regarding the KPI that patients referred to the Mental Health Liaison team were to be assessed within 1 hour of referral. Data from the trust stated that 19% of referred patients were assessed within the hour in March 2023. However, members of the Mental Health Liaison Service we spoke with said that adherence to the KPI was "80%+", suggesting disparities in data collection between the trusts, making performance difficult to accurately assess.

Engagement

Leaders and staff engaged with patients and staff to plan and manage services. They generally collaborated with partner organisations to help improve services for patients.

Staff we spoke with were up-to-date with, and spoke positively about, changes made to the service since the incident which triggered our inspection.

Managers told us that the implementation of a monthly meeting with the Mental Health Liaison team 2 months before our inspection had already fostered improved working relationships between the services, although they were aware that this was an area for further improvement. Since our inspection, leaders in the service told us that they raised our feedback about improving team working at a board-to-board meeting between the services, and as a result, have scheduled regular meetings between executives at both services to work on aligning KPIs and strengthen working relationships.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

All of the staff and managers we spoke with showed commitment to improving the service and were receptive to the feedback from the inspection team. We heard how a senior staff member had acted on feedback from the inspection team on the day of our inspection following a discussion about professional curiosity, and had asked additional questions when carrying out a patient assessment to accurately ascertain their level of risk of self-harm and suicide.

Urgent and emergency services

Areas for improvement

SHOULDS

Urgent & Emergency Care

- The trust should ensure that the trust's Care of Patients Requiring Close Observation policy is followed when assigning staff to 1 to1 observations (Regulation 12).
- The trust should consider fostering a closer working relationship with the Mental Health Liaison team, including information sharing about incidents and lessons learned.

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

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