Nottinghamshire Healthcare NHS Foundation 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 well-led?	**Inadequate**

Our findings

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

Inadequate 

We carried out this unannounced focused inspection because we received information that gave us concerns about the safety and quality of the services.

We have rated safe and well led following this inspection. The rating at the previous inspection of March 2022 was requires improvement, this inspection shows that the rating has gone down.

We inspected the Acute wards for adults of working age and psychiatric intensive care units as part of this inspection. The trust has 9 wards across 2 locations, Highbury Hospital and Sherwood Oaks. We visited the following wards:

- Highbury Hospital- Redwood 1: acute wards for adults of working age (male) 16 beds.
- Highbury Hospital - Redwood 2: acute wards for working are (female) 16 beds.
- Sherwood Oaks hospital - Elm ward: acute ward for adults of working age (male) 18 beds.
- Sherwood Oaks hospital - Cedar ward: acute ward for adults of working age (male) 18 beds.

Following this inspection, we told the trust they must make improvement to mitigate urgent risks. The trust responded with an action plan to mitigate the risks and we were assured by their response.

Our rating of acute wards for adults of working age and psychiatric intensive care units went down. We rated them as inadequate because:

- There was an inconsistent approach to recording patients details when they accessed their leave from wards.
- There was an inconsistent approach on which documentation to use when recording seclusion observations.
- Observation records completed by staff had been falsified.
- We found incidents of assaults on patients by staff members.
- There were ligature risks which had not been identified but not acted on to reduce the risk of harm to patients.
- There was a high use of agency staff due to staff vacancies.
- Staff did not always share key information to keep patients safe when handing over their care to others.
- Staff did not always raise concerns and report incidents and near misses in line with trust policy.
- The service did not always learn from incidents.
- Management processes did not operate effectively at team level.

However:

- We found all wards were clean well equipped, well furnished.
- Staff made sure cleaning records were up-to-date and the premises were clean.

Our findings

- Staff completed and kept up to date with their mandatory training.
- Patient notes were comprehensive, and all staff could access them easily.

How we carried out the inspection

During the inspection we:

- spoke with 14 patients
- interviewed 15 staff members
- reviewed 7 patient care plans
- reviewed 5 incidents on CCTV
- reviewed 4 seclusion records
- visited 4 wards
- reviewed handover documents
- reviewed section 17 leave documentation on all wards
- looked at environmental risk assessments.

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.

What people who use the service say

People told us that they felt unsafe at night due to the use of agency staff not knowing how to support them.

People told us that they struggled to get answers from staff when they ask questions or wanted something.

People told us that they liked the food.

A patient told us that they felt the night staff was shocking.

People told us that they feel that their observations are not completed properly.

A patient told us that staff do not wear names badges and sometimes they do not tell patients their name.

People told us that they felt their beds were comfortable.

Is the service safe?

Inadequate 

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

Our findings

Safe and clean care environments

All wards were not always safe. Not all ward areas were well maintained or fit for purpose. However, all wards were clean well equipped, well furnished.

Safety of the ward layout

Staff completed weekly environmental checks effectively on Cedar and Elm wards. In addition to these checks, staff completed weekly fire safety checks. Staff had identified issues with some fire doors that were not fit for purpose. We found that the escalation process of these concerns was not effective. This meant the concerns were not resolved in a timely way.

Both Cedar and Elm wards had assigned environmental co-ordinators. We reviewed the weekly checks on both Cedar ward and Elm ward. On Elm ward we reviewed 21 weekly reports. In this time, we found staff had recorded faults on 8 fire doors. The first time fire doors were reported as a concern was on 11 May 2023 which recorded a faulty seal around one door to prevent smoke coming through the gap in the door in an event of a fire. On 16 May 2023, there were a further 3 fire door seals reported as faulty. On 4 July 2023, a further 4 fire door seals were reported as faulty. On our first day of inspection staff told us there were 3 fire doors that did not close automatically. Staff told us they reported maintenance issues to the reception team of the hospital. The weekly checks showed the issues had been reported, but all concerns had not been assessed by maintenance. Managers were aware of the concerns raised. Staff told us they felt unsafe on the wards as they believed the fire safety of the ward was compromised by the issues, they had found with the fire doors. Staff told us they would have prioritised their own safety first in the event of a fire.

We escalated our concerns at the time of inspection to senior managers. They told us that fire door seals met the requirements of fire safety regulations. Maintenance staff and senior managers acknowledged there had been a breakdown in communication between them and ward staff. Maintenance staff actioned one fire door (which did not close properly) on Cedar ward which required fixing once we raised this with them.

Staff could observe patients in all parts of the wards. Closed circuit television (CCTV) was used to observe all areas of the wards. Mirrors were used effectively for observation in parts of the wards where required.

The wards complied with guidance and there was no mixed sex accommodation. Wards were single sex wards with ensuite facilities.

We did not review ligature risk assessments on Cedar and Elm at this inspection, as this was not an area of concern in the information that led to the inspection. However, we did review these on Redwood 1 and Redwood 2. The assessments were completed with no dates of completion or allocated to certain members of staff to complete. We found that on both wards the toilet roll dispensers in patient's bedrooms were noted as a potential ligature risk due to the gaps around the unit. On Redwood 1 we found that all 16 bedrooms had them in place. We were able to check 2 bedrooms whilst on Redwood 2 and they both had toilet roll dispensers. The risk assessment said that these are due to be replaced but at the time of the inspection they were not. We found on Redwood 2 that all toilet roll dispensers had been removed due to the ligature risk. However, this was not documented in the risk assessment and was stated as ‘still open’ for the staff to remove them from bedrooms.

Ligature cutters on all wards were stored in a locked safe, in a locked clinic room, to which only qualified staff had access to with their keys. This meant, not all staff could respond to an incident with a ligature in a timely manner. In these wards, there had been no serious incidents with ligatures which resulted in harm to patients.

Our findings

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, and well furnished. Cedar and Elm wards were new, purpose-built environments. On Redwood 1 and Redwood 2 we found the wards were clean. However, both ward managers told us that the two other wards at Highbury Hospital (there are 4 acute wards and one psychiatric intensive care unit in total at this hospital) had been refurbished and this was happening on these wards. No plans were in place for these wards to be refurbed.

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning staff completed routine tasks to maintain a clean environment.

Seclusion room

Cedar and Elm wards had one seclusion room each. They both allowed clear observation, we found that staff needed to communicate to patients in seclusion by raising their voices as there was no clear two-way communication. They had a toilet and a clock. There are no seclusion rooms on Redwood 1 and Redwood 2.

Safe staffing

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

Nursing staff

The service did not always have enough permanent nursing and permanent support staff to keep patients safe. The service had high vacancy rates and used a high number of agency staff to fill shifts. We saw a lack of interaction between staff and patients, and staff were observed to spend time in the nursing office, or on the perimeter of the dining area.

We reviewed staffing establishment on Cedar and Elm ward. We found that at the time of the inspection there was a vacancy rate of 8.4 WTE (whole time equivalent) staff nurses on Cedar ward and 5.4 WTE staff nurses on Elm ward. The planned establishment for Cedar and Elm wards was 10 WTE on each ward.

Cedar ward had a vacancy rate of 5.3 WTE support staff and 4.5 WTE support staff on Elm ward. The planned establishments for Cedar and Elm wards for support staff was 19.5 WTE on both wards.

Vacancy rates for clinical team leaders on Cedar ward was 3 WTE (from a planned establishment of 4 WTE) and 1 WTE on Elm ward (from a planned establishment of 4 WTE).

Sherwood Oaks had staff 'on boarding' (planned to start in the service). Cedar ward had 3 new qualified staff planned, and 2 support staff planned. Elm ward had 2 new qualified staff planned.

When reviewed the staffing establishments on Redwood 1 and Redwood 2, we found there was a vacancy rate of 5.2 WTE on Redwood 1 and 3.2 WTE on Redwood 2. We were not given the rates for support and clinical staff for Redwood 1. However, there was 1 WTE vacancy for support staff on Redwood 2. Managers informed us there was 2 nurses 'on boarding' for Redwood 1 and 1 support staff 'on boarding' for Redwood 2.

Our inspection of these wards found that the staffing numbers needed to safely support patients was being met, it was however being met with use of bank workers and agency.

The services had high numbers of bank,agency qualified nurses and support staff, but this was slowly decreasing over time. The Trust had an executive led agency reduction programme which had delivered the reduction in the use of

Our findings

agency staff. We reviewed the numbers of agency staff used between July 2023 and September 2023. Across Cedar ward and Elm ward, 327 shifts were covered by agency staff in July 2023 compared to 258 shifts used in September 2023. Managers used regular agency staff to protect continuity and familiarity for patients and staff and made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Staff did not always share key information to keep patients safe when handing over their care to others. On Cedar and Elm wards staff did not always know when patients were due back from their agreed unescorted leave. The wards had a nominated person who was responsible for the 'board.' This was a clipboard held by one member of staff, with a list of patient information including observation levels, escort numbers, Mental Health Act section, and fire safety information for each patient. A second form was kept on this board and staff recorded when patients had left the ward for their leave. Staff completed this task on a rotational basis, so it was not allocated to someone for the entire shift.

We reviewed 4 weeks of completed 'board' sheets on both Cedar and Elm wards. We found gaps where staff had not completed the document correctly. We reviewed 72 entries from the month of September 2023 to the day of the inspection. Out of the 72 entries 58 entries had no section detail against each patient. We found 13 examples of entries where a time that patients were due to return to the ward was missing. This meant that staff allocated to 'the board' did not always know when a patient was due back from leave. We found examples where patients came back from leave up to an hour after they were due back. We also found examples where staff had not recorded how long the leave was to last. This meant staff would not know the whereabouts of detained patients.

During the first day of inspection, we observed an incident on Cedar ward where a patient had been seen walking away from the hospital with another female patient. Staff on the ward appeared not to know when the male patient was due back on the ward. The 'board' stated that the patient left the ward at 15.25pm but no return time was recorded. On the return of both patients to the hospital they were seen to exchange a small plastic bag containing a substance. Staff conducted a drug test on both patients and the male patient tested positive for cocaine.

We reviewed 4 days between 20 to 24 August 2023 of completed 'board' sheets on Redwood 1. Out of 218 entries of leave 145 entries were not completed fully. This meant that during those times the staff did not have the correct information to keep the patients safe.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Training figures for staff on both Cedar and Elm wards had a completion rate of over 76%. However, out of 28 members of staff on Elm ward, 5 (18%) had not completed Fire Training by the set date and 5 had not completed Infection Prevention Control modules by the set date. On Cedar ward, out of the 25 members of staff 5 (20%) had not completed fire safety and 5 had not completed infection prevention control. In the data reviewed there was no explanation of when this will be achieved.

Despite the findings with the training figures, the mandatory training programme was comprehensive and met the needs of patients and staff. It included training in the trusts 'Hospital life support' to be able to support patients in immediate life support.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to a matrix of all staff where each module is colour coded highlighting when training is due soon and when it is out of date.

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. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Management of patient risk

Staff could observe patients in all areas. Staff risk assessed levels of observations for each patient, both for on and off the ward.

During this inspection we found an example where staff had falsified observation records. There had been past serious incidents at Highbury Hospital (where Redwood 1 and 2 wards are based) where staff assigned to observations of patients had not completed observation documentation in line with trust policy.

On Redwood 2 we reviewed an incident that occurred during the evening of the 30 October 2023 where a patient was found in their bathroom with a ligature. This patient had been assessed as requiring 10-minute observations due to the risk of harm to themselves.

We viewed the CCTV footage of the incident alongside the observation record. We looked at observations from 9.30pm up until the time of the incident. The observations were recorded on the electronic patient record as: 9.37pm, 9.46pm, 9.54pm, 9.05pm, 9.16pm, 10.25pm, 10.26pm. When viewing the CCTV footage, we saw the healthcare assistants go towards the patients and open the window observation screen, close it and walk away. The CCTV showed that there were 2 occasions where the patient was not checked, however, staff had recorded that they had been. We also found that the incident record recorded the incident happening at 10.56pm. However, the CCTV showed that the incident occurred at 10.26pm.

The observation records showed that the patient had been seen by two bank, male healthcare assistants. The entries on the electronic patient record were recorded by a female staff member. We were told by managers that the female member of staff had either not logged off the observation record or shared their log in details with the bank staff, which goes against the trusts' policy.

Managers were made aware of the concerns found and acted on them immediately. The staff involved were not to work on the ward and the trust put in place a supernumerary member of senior staff to check each day that observations were being completed against the trusts policy.

Use of restrictive interventions

When a patient was placed in seclusion, staff did not always keep clear records and follow best practice guidelines. We reviewed 4 most recent seclusion records for both Cedar and Elm wards and found staff had not completed them in full and in line with trust policy. We found each ward had a different approach and expectation of the completion of seclusion records. On Elm ward we found that staff should complete paper records. We were informed that the most recent seclusion records (paper) had gone missing. However, the nurse reviews were documented on the electronic system.

On Cedar ward we found staff completed their observations on electronic tablets. However, we could not find these had been uploaded into the patients electronic progress notes and staff told us they did not know where the notes went. This meant that there was an inconsistent approach to record keeping and did not comply with the Mental Health Act Code of Practice.

Our findings

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have training on how to recognise and report abuse but they knew how to apply it.

Most staff kept up to date with their safeguarding training. Staff were trained in both adult and child safeguarding at level 3. Cedar had a 100% completion rate and Elm ward had a completion rate of 96%. Only 67% of staff had completed safeguarding training on Redwood 1 and Redwood 2 wards. However, we saw that safeguarding referrals were made by the hospital, and they worked with the local safeguarding team.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Staff were given passcodes to have access to notes and all wards had hand held tablets to record information also. We found no issues with the internet on all wards so that information can be downloaded effectively. However, due to finding observations records that had been falsely recorded we were not assured that documents were always completed in line with the trusts policy.

Track record on safety

The service had a did not always have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, we are not assured how effective this was. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff did not always recognise incidents and report them appropriately.

Staff did not always raise concerns and report incidents and near misses in line with trust policy. During our inspection we reviewed CCTV recordings where staff had assaulted patients causing physical harm. There had been 4 occasions where 2 patients had been physically assaulted on Elm ward. CCTV footage confirmed the assaults, and we reviewed the documents that went with these incidents, hospital management had suspended the staff involved and investigated the incidents. The incidents showed that staff were not always kind and respectful to patients they cared for.

Whilst reviewing an incident on Cedar ward where a staff member assaulted a patient, we noted that there was a delay in the reporting. Due to this the staff member involved in the incident was on shift on the same ward the next day. This put patients at risk of harm and the patient involved in further harm. However, once the incident was recorded ward managers took action to investigate the incident.

There had been 2 incidents at Highbury Hospital in March 2022 and September 2022, where 2 patients had died. Following police involvement after these 2 deaths the trust subsequently found falsification of records. During this inspection we found on going poor record keeping and we were not assured that the service had learnt from these incidents.

Our findings

Is the service well-led?

Inadequate 

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

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.

Although the ward managers were present on the wards, we did not see them being visible to patients. However, the patients did recognise them, and the ward managers were able to give us detailed information about the patients who they were caring for. Senior leadership were not always visible to patients and staff.

Managers did not have the experience to demonstrate they had full and effective oversight of safe care delivery. We found that managers were not aware that observation records had been falsified and seclusion records were inconsistent. They had not effectively communicated with their teams, that fire safety was in place on the wards. Managers did not have effective oversight of staffing numbers to ensure vacancies and establishments were suitable to meet the needs of patients.

Culture

Staff felt respected, supported and valued. They said the local leaders including ward managers promoted equality and diversity in daily work and provided opportunities for development and career progression. They did not always feel they could raise any concerns without fear. However, we were not assured that staff were always kind and caring and could raise concerns about quality of care to managers.

We were told that the delay in reporting an incident where a staff member had assaulted a patient was due to the staff member being concerned about speaking up.

We were not assured there was a culture of always treating patients with kindness and care. We found incidents of physical assault by staff on patients. Whilst on Cedar and Elm wards, we observed how staff sat on chairs near the nurse's station and not involve patients in their conversations, rather than engaging with patients. However, we did see interactions between staff and patients that were caring.

There was a lack of activities taking place on all wards except Rowan 2. We were not assured that staff were empowered to enable patients to participate in therapeutic activities.

Governance

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

Our findings during this inspection showed that managers did not ensure that safe care delivery followed systems and processes set out in trust policy. We were not assured that trust policy, systems and processes were understood and complied with effectively by staff at ward level and overseen my managers. Highbury hospital had past incidents of

falsification of observation records, managers had acted on this and provided communication to all staff about the importance of observations. However, we found this communication was a letter to staff from trust leaders (dated 2 June 2023) and had been placed on a clip board and hung up in the office in Redwood 1. We are not assured that communication was always effectively disseminated to staff working on the wards, and that lessons were not being learnt swiftly enough to prevent reoccurrence.

Ward managers told us that when an incident occurred the trust would ask managers to produce a 'QUIP' (Quality improvement plan). Ward managers told us they were unsure what happened with the QUIP at a senior level and felt the process was led by paperwork they did not have a full understanding of what happened one the QUIPs had been completed.

Based on our findings at this inspection, patients' safety remained a high risk in this service. Senior trust leaders had placed adult mental health wards on the trusts' risk register and have taken action within patient safety groups, and senior leadership oversight meetings that take place on a regular basis to action findings of this inspection. Immediate action was taken when we raised concerns over the falsification of observations records, and the trust put supernumerary senior nurses on the wards to provide oversight to monitor the effectiveness of observations and to check that records were correct. This action was specific for the wards at Highbury hospital. The trust also introduced observation staff to wear tabards to make it clear to other staff what they are doing.

Managers did not always manage bed occupancy effectively. This was a risk to patients who were on leave and may have needed to return to hospital. On reviewing Redwood 2 we found that 2 of the occupied beds on the ward were already occupied by 2 detained patients who were not utilising them at the time of the inspection. One patient was on home leave and the other was receiving treatment in a general hospital. When we asked if there was a contingency plan for when the patients were to return to the ward and find their bedrooms occupied by others, we were told there were no plans in place.

The incident where drugs had been brought onto the ward, posed a risk to patients who used leave. This was because the local area was a known risk to those who used illegal substances. It was known to patients at Sherwood Oaks and a known risk to staff. This had not been placed on the hospital risk register and was just classed as 'local knowledge' this meant that the risk assessments we reviewed did not have any support plans in place for patients on leave who were at risk of drug taking. This incident was discussed with managers who put actions in place, which included to use a drug detection dog to do regular checks of the grounds. Regular drug screens were also to continue for patients at risk. This risk did not feature on the risk register.

Management of patient leave was a poorly managed risk. We were not assured of patient safety as staff would not always know the whereabouts of patients due to an ineffective system to record patient leave. In addition, the entrance to Redwood 1 where staff and patients congregated to wait for leave records to be complete prior to them leaving the ward, patients waiting to use the clinic and the visitors entrance, meant there was not a robust way in which those returning from eave could be searched safely, and effectively. This issue had not been identified as a risk to safety.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

As detailed above staff did not always have the correct information at hand to provide safe care. We found observational documents that had been falsified. Confusion over which system is the correct one for recording seclusion documents.

Our findings

We found seclusion documents missing from the ward. We found each ward using different signing in and out forms. On Cedar and Elm wards a staff member would be assigned ‘door duty’ and have all the information on patients with them but on Redwood 1 and Redwood 2 this was kept in the nurse’s office so the staff would have to come off the ward to check.

Although the 4 wards are on 2 locations, we would expect that the systems and documents would be the same, we did not find this. There was no consistent approach and wards were being managed as separate units rather than as a whole.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

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

- The trust must ensure that staff are competent to complete observation duties as per trust policy. (Regulation 12).
- The trust must ensure that ligature risks are identified and effectively mitigated. (Regulation 12).
- The trust must ensure that staff complete contemporaneous records in respect of Section 17 Leave and seclusion records. (Regulation 12).
- The trust must ensure that staff conduct appropriate searches of patients returning from leave where known risks identify that items could be secreted onto the ward. (Regulation 12).
- The trust must ensure there are effective systems and processes in place to ensure complete oversight of safe and quality care delivery. (Regulation 17).
- The trust must ensure that leaders of the service have the rights skills, knowledge and experience to have oversight of care delivery. (Regulation 17).
- The trust must ensure that leaders of the service promote a positive and transparent culture to raise issues in relation to poor practice and when safety is compromised. (Regulation 17).

Action the trust Should take to improve:

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

- The trust should ensure that leaders of the service facilitate a two-way communication about key issues on the wards.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspectors.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance