St Andrew's Healthcare, Essex

Quality Report

St Andrews Healthcare,
Pound Lane, Benfleet, Essex, SS12 9JP
Tel:01268 723 800
Website:www. standrewshealthcare.co.uk

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services caring?	

Overall summary

We carried out an unannounced focused inspection of St Andrews Healthcare, Maldon Ward, on 31 March 2015 due to concerns that were raised with the Care Quality Commission. During the inspection we found that:

- The provider had high levels of staff vacancies. This meant the provider used a high rate of bank and agency staff. The provider did not employ regular bank and agency staff to ensure continuity of care for patients. A patient told us the permanent staff treated them with kindness, consideration, and compassion. However, the agency staff did not always treat them with dignity and respect
- The provider did not keep accurate or accessible duty rotas. Duty rotas were duplicated in three different records, some of which were not accessible to ward staff. This meant staff could not be sure who was expected on duty or whether shifts had sufficient staff for safe care and treatment for patients.
- Staff cancelled patient's section 17 community leave due to staffing shortages. Section 17 leave is a controlled, discretionary period of leave given to a person detained in hospital under the MHA. Medical staff granted leave to patients to allow them to access activities, and appointments, and to support their recovery.
- Staff did not always update risk assessments following incidents. Staff recorded incidents on the electronic record system but did not update risk assessments and care plans when risk changed. This meant that staff did not have up to date information to provide safe care for patients. The provider had carried out an environmental risk assessment. However, this did not fully address risks presented by blind spots where staff could not observe patients
- The seclusion room was located on the first floor, which meant that staff have difficulty safely accessing this facility in an emergency.

Summary of findings

However

- Patients had access to an advocacy service. There was information about the advocacy service displayed on posters in the ward area.
- Staff managed seclusions in line with The Mental Health Act code of practice. Doctors were attending within an hour to review patients.
- Patients were involved in developing their care plans. A patient told us they attended regular review meetings where their care plan was reviewed. They had received a copy of their care plan.
- The ward environment was clean and tidy and the furnishings were in good condition. Staff completed cleaning audits that were up to date.

Summary of findings

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Summary of this inspection

Background to St Andrews Healthcare, Essex

Maldon Ward is part of St Andrews Healthcare Essex, a low secure hospital located in North Benfleet, Essex. Maldon ward is a women's six-bed transitional unit focusing on recovery and continued progress towards community re-integration. This includes care for patients with a primary diagnosis of personality disorder, complex needs and dual diagnosis. Patients are admitted, who may have a history of challenging and/or offending behaviour, alcohol, or substance abuse, repeated failed attempts at community integration and/or previous movement between the mental health or criminal justice systems.

All patients are detained under the Mental Health Act (1983).

On the day of inspection, six people were receiving care and treatment on Maldon Ward. The registered manager was Lisa Cairns. The controlled drugs approved officer was Peter McAllister.

The provider is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

The provider was last inspected in September 2014.

Our inspection team

The inspection manager was Vikki Green.

The team leader for this inspection was Lee Sears, inspector, mental health hospitals.

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

The team would like to thank all those who met and spoke with the team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment provided by the service.

Why we carried out this inspection

We carried out an unannounced focused inspection of Maldon ward on 31 March 2015 due to concerns that were raised with the Care Quality Commission.

The concerns included:

- Safe staffing levels, particularly at night.
- Standards of care provided to patients due to high use of agency staff.
- Doctors were not always attending the unit to support patients in seclusion, as per seclusion policy and the Mental Health Act Code of Practice.

How we carried out this inspection

We carried out an unannounced focused inspection of Maldon Ward on 31 March 2015.

For the purpose of this focused inspection, we looked at some areas of the safe and caring domains.

During this inspection, we undertook a tour of the ward and inspected the clinic room. We reviewed three prescription charts and three care records. This included care plans and risk assessments of patients at the service, alongside assessments of capacity compliance with the

Summary of this inspection

Mental Health Act (1983). We also looked at staff duty rotas for the last 2 months because of concerns about staff shortages and the impact of this on the care and treatment of patients.

During the inspection visit, the inspection team;

- Spoke with one nurse.
- Spoke with one health care assistant.
- Spoke with one ward manager.
- Spoke with one patient.

Opportunities to meet with patients were limited due to the inspection taking place overnight.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this domain however we had some concerns which included:

- The provider had high levels of staff vacancies. The provider used a high rate of bank and agency staff. Records showed shifts were often staffed entirely by agency staff. The provider did not employ regular bank and agency staff to ensure continuity of care for patients. A patient told us they found it difficult to talk to new staff in one to one sessions.
- The provider did not keep consistent or accessible duty rotas. Duty rotas for staff reference were duplicated in three different records, some of which were not accessible to ward staff. This meant staff could not be sure who was expected on duty or whether shifts had sufficient staff for safe care and treatment of patients. Patients had leave, granted under section 17 of the Mental Health Act (MHA), cancelled due to staffing shortages. Section 17 leave is a controlled, discretionary period of leave given to a person detained in hospital under the MHA. Clinicians granted leave to patients to allow them to access activities and appointments, and to support their recovery.
- Staff did not always update risk assessments following incidents. Staff had recorded incidents on the electronic record system but did not update risk assessments and care plans when risk changed.
- The seclusion room was situated on the first floor, which meant staff would need to transfer patients, in emergency situations, using a lift or stairs. This is a risk to both patients and staff.
- The provider had carried out an environmental risk assessment. However, this did not fully address risks presented by blind spots where staff could not observe patients.However, patients on Maldon ward were working towards discharge and were likely to pose a lower level of risk.

However:

- The ward environment was clean and tidy and the furnishings were in good condition. Staff completed cleaning audits that were up to date.

Are services caring?

We did not rate this domain however we had some concerns which included:

Summary of this inspection

- A patient told us the permanent staff treated them with kindness, consideration, and compassion. However, the agency staff did not always treat them with dignity and respect.
- Patients did not always get one to one time with their named nurse or their allocated nurse for the shift. Care plans stated that staff should offer patients the opportunity to have one to one time on a daily basis. A patient told us agency staff would not offer one to one time when on shift and they found it difficult to talk to staff they did not know.

However:

- Patients were involved in developing their care plans. A patient told us they attended regular review meetings where their care plan was reviewed. They had received a copy of their care plan.

Detailed findings from this inspection

Forensic inpatient/secure wards

Safe	
Caring	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- The ward had one area that had a blind spot. Staff in the ward office could not easily observe patients in this area. The provider had not installed mirrors to aid staff observations. However, during the inspection, we saw there was always a member of staff in the main ward area, observing patients. This meant that the risk posed by the blind spot was reduced. The provider had undertaken an environmental risk assessment. This did not address the risks posed by blind spots. However, patients on Maldon ward were working towards discharge and were likely to pose a lower level of risk.
- The ward environment had one ligature point (a ligature point is a fixed item to which a patient could tie something for the purpose of self-harm or strangulation). This was located in the corridor outside the office window, which staff could easily observe. There were ligature points in the garden such as the smoking shelter. However, staff supervised patients' access to the garden at all times. The provider had anti-ligature fittings in the bedrooms to promote patient safety.
- The clinic room was clean and tidy. There were separate cupboards for stock and patient medication as well as a controlled drugs cupboard.
- Maldon ward did not have a seclusion room. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. Staff told us they only had one patient who had required seclusion in the past three months. Staff took patients requiring seclusion to Colne ward, which was located upstairs. Staff had difficulty accessing this room safely in an emergency. Staff could observe patients in all parts of the room. There was a two-way communication system so staff could speak to patients. There was access to a toilet and shower. The temperature was controlled and patients had a view of a clock. There was a de-escalation area outside the seclusion room. This allowed staff to attempt to calm the patient and prevent seclusion.
- The ward environment was clean and tidy and furnishings were in good condition. We checked the cleaning record and saw staff completed this on a daily basis.
- The provider operated a pinpoint alarm system and all staff had radios. There were alarm points in various locations around the ward so staff could see where someone had activated an alarm. The provider allocated staff from other wards to respond to alarms across the hospital. Security staff would also respond. Staff on Maldon ward were not expected to respond to other wards at night as they had a smaller number of staff.

Safe staffing

- Maldon ward had a total staff establishment of five nurses and eight health care assistants. Maldon ward had 40% vacancies for nurses and 50% vacancies for health care assistants. This equated to two qualified nurse vacancies and four health care assistant vacancies. Maldon ward's baseline for staff on each shift was one nurse and one health care assistant. During the day, they also had a technical instructor for rehabilitation work and they shared an occupational therapist with other wards. Staff also had access to a clinical psychologist and a social worker. There was evidence in the duty rota that the provider planned increased staffing levels to cover leave and increased activity levels. However, this was inconsistent due to staff shortages. The Care Quality Commission had identified staffing issues within the whole service following inspection in September 2014. The provider was required to review the effectiveness of their current staff recruitment and retention policy and procedures. Senior staff told us they were currently in the process of recruiting more staff and have 12 health care assistants waiting to start once their pre-employment checks have been completed such as references and disclosure barring service (DBS) checks.

Forensic inpatient/secure wards

- The provider had an internal bank system. Regular staff would do extra hours to cover shifts. This meant that staff were familiar with the ward and patients. The provider used agency staff to fill shifts when regular or bank staff were unavailable. Senior staff told us they block booked agency staff to ensure continuity of care for patients. However, this was not reflected in duty rotas and we saw a wide range of different names of staff. We spoke to a patient who told us they found it difficult when there were agency staff they did not know, as they could not talk to them.
- The provider did not keep accurate and up to date duty rotas. Records of staffing were stored on two separate computer databases and the information did not match. Staff showed us one of the databases. This included agency and bank staff booked and the shifts requiring cover. We compared the database and the duty rota and there were shifts when the ward was short of staff. Senior staff told us that they did not update the duty rota regularly and so it was not accurate. This meant it was not clear who was due on shift each day. Managers did not meet the staffing requirements consistently in February and March. For example, five night shifts showed only one member of staff instead of two. On one occasion, there was one health care assistant on a night shift with no qualified nurse. We did not find any days that the provider had met their full staffing establishment. One patient and health care assistant told us that a member of staff from another ward would stay on Maldon ward until midnight increasing the staff to three, they would then return at 06:00. The patient we spoke to felt this put them and the staff at risk. Senior staff told us they had bank and agency staff booked until mid-April and requests until the end of April. We checked these however; they did not cover all the gaps in the rota. The duty rota was not accurate for the night of the inspection.
- A patient told us the provider sometimes cancelled their leave due to insufficient staffing. Staff also told us this happened occasionally due to staff sickness. One patient told us that the provider had cancelled their leave to go shopping. This meant they had not been able to purchase food. Senior staff told us when this happened they provided patients with provisions from the hospital stocks.
- The provider had an on-call system for medical cover out of hours. Doctors were able to be on site within 20 minutes. Staff called an ambulance for medical emergencies.
- Staff mandatory training compliance was 100%. However, managers did not check if agency staff were trained in appropriate ways to manage violence and aggression. Senior staff told us agencies completed a compliance sheet, which showed what training the agency staff had completed. This did not show whether agency staff had completed the same training in managing violence and aggression as regular staff. Therefore, managers could not be sure what type of training agency staff had received, and whether it was consistent with the providers training. There was not a service level agreement for agency staff to attend training through the provider.

Assessing and managing risk to patients and staff

- Staff did not always update risk assessments following incidents. Staff completed comprehensive risk assessments for patients on admission, but staff did not update risk assessments when risk changed. Two care records showed that incidents had occurred with patients and staff did not update the risk assessment. The provider was told they must take action to improve this following their last inspection in September 2014.
- Managers did not provide access to the electronic records to agency staff. Consequently, this prevented some staff accessing information about risk and how to care for patients appropriately. The provider was told they should take action to improve this following their last inspection in September 2014.
- Doctors saw patients who were secluded within one hour, as required by the Mental Health Act code of practice. Doctors recorded reviews in the patient notes in the previous two months of records checked. The provider had improved this practice following a previous Mental Health Act review visit.

Are forensic inpatient/secure wards caring?

Kindness, dignity, respect and support

Forensic inpatient/secure wards

- Opportunities to talk to patients were limited during the inspection as most patients were asleep. One patient told us that there were difficulties with agency staff listening to them. However, they told us that the permanent staff listened to them and were kind, respectful, and polite.
- Patients did not always have the therapeutic support to promote recovery, which could affect their length of stay. One patient told us there was no structure to their day, they felt bored, and the activities on offer were meaningless. A patient told us they did not always get 1-1 time as documented in their care plans when agency staff were on duty. Agency staff did not have access to the electronic care records so would not know necessary information to be able to effectively support patients in 1-1 sessions. Permanent staff tried to provide 1-1 time, but on occasions of staff shortages, this was not always possible.
- Patients had access to advocacy services. The provider used a local advocacy service who attended the ward weekly. The provider displayed information on the service on notice boards around the ward. A patient told us they knew how to access the services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure sufficient staff cover to maintain the safety of the patients. Staff rotas must accurately reflect the staff on duty in order for shifts to be planned safely and for the provider and staff to be accountable for treatment delivered.
- The provider must ensure risk to patients are assessed, reviewed and updated regularly.
- The provider must ensure that agency staff have access to appropriate information about patients to provide compassionate, safe care.

Action the provider SHOULD take to improve

- The provider should ensure that resuscitation equipment can be obtained on all wards in an appropriate time frame.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that patients' risk assessments were complete and updated following reported incidents. This was a breach of regulation 12 (1)(2)(a)(b)

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 The provider had not ensured that agency staff had appropriate access to the electronic care notes system. The provider did not ensure there was an accurate record of staff employed in the carrying on of the regulated activity. This was a breach of regulation 17(2)(c-d)

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 The provider did not make sure there were sufficient numbers of staff to maintain the safety of the ward. This was a breach of regulation 18 (1)