South London and Maudsley 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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

South London and Maudsley NHS Foundation Trust provides mental healthcare services for adults and children in South London, mainly in the London Boroughs of Southwark, Lambeth, Lewisham and Croydon. This inspection was of acute mental health wards and psychiatric intensive care units for adults of working age. We carried out an unannounced focused inspection of 3 acute wards for adults of working age and 1 psychiatric intensive care unit, in the Ladywell unit in Lewisham, Lambeth hospital and the Maudsley hospital.

We were aware of a number of self-harm related deaths and serious incidents for inpatients at the trust many of whom were detained under the Mental Health Act (MHA). We looked at 8 deaths that were related to self-harm between August 2020 and October 2022. For each serious incident the trust investigation processes identified a series of care and delivery recommendations and actions to improve care and treatment. We wanted to see how the trust implemented these improvements to care and treatment to ensure patient safety and minimising the repetition of poor practice. We also wanted to review if learning from serious incidents and specific recommendations and actions had been fully completed and embedded across the services.

We inspected the following 4 wards, Virginia Woolf ward in the Ladywell Unit, Lewisham; Leo ward at Lambeth Hospital; and ES1 ward and Ruskin ward at the Maudsley Hospital. Following the inspection visits we had video interviews with the ward managers of Jim Birley Unit and John Dickson Ward at the Maudsley Hospital, Gresham 1 ward at the Bethlem Royal hospital, and Clare Ward at the Ladywell Unit.

The core service is registered to provide the following regulated activities: treatment of disorder disease or injury; diagnostic and screening procedures; and assessment or medical treatment of person admitted under the Mental Health Act (MHA). The trust acute wards for adults of working age and psychiatric intensive care units were last inspected in May – June 2021. The overall rating for the core service was good. Safe was rated as requires improvement, effective, caring, responsive and well-led were rated as good. The trust also had a well-led inspection in June 2021 where it was rated as good overall.

This was a focused inspection. We looked at aspects of the safe and well-led domains. We did not rerate the overall service as a result of this inspection. The previous rating of good remains which was the rating at the last comprehensive inspection in May-June 2021. We found:

- We looked at aspects of the safe and well-led domains. We did not rerate the overall service as a result of this inspection. The rating of this overall core service remained good.
- Service improvements had taken place as a result of learning from serious incidents. Wards applied identified recommendations and completed actions in a timely manner.
- Ward environments were safe and clean. There was an improvement in escalation processes for staff when they were short staffed or needed additional support. On all wards the observation, ligature risk mitigation and patient search processes had improved in response to learning from incidents, and there was improved verbal and written communication between staff at shift handovers.

Our findings

- Most staff were well informed about learning from incidents. The trust had developed training and competencies for staff covering ligatures, observations, and patient searches to support staff in learning lessons from previous incidents.
- Considerable work had been undertaken to improve staffing recruitment and retention on the wards, although this remained a challenge.
- Improvements had been made to the Ladywell Unit ward environments and the exterior area including easier access for emergency vehicles.
- Senior staff investigated incidents thoroughly involving patients and their families. The trust had started to implement the new Patient Safety Incidents Response Framework and had plans to improve the timeliness and quality of serious incident reviews.

However:

- The trust did not always meet its targets for compliance with mandatory training in basic and immediate life support, safeguarding training at level 3, the National Early Warning Score, Seni Lewis, and fire warden training.
- There was varied quality and consistency of risk assessments and care plans on Virginia Woolf, Leo and ES1 wards, making records hard to follow for staff not familiar with the wards. For some patients there were no care plans about key areas rated as high risk such as neglect and self-harm. Triggers and protective factors identified in risk assessments, were not always included in patients' care plans.
- On ES1 ward we had concerns about levels of patient violence and aggression towards other patients and staff, and this was impacting on staff and patients' morale.
- The trust did not always complete serious incident reviews promptly, leading to delays in implementing learning from serious incidents. A small number of actions from serious incident reviews had not been completed within the timescales set including providing training to staff on breaking bad news, and regular emergency scenario training on some wards.
- We found staff had less clear knowledge of learning from incidents that had taken place in directorates other than the one in which they worked.
- Staff and patients said that the withdrawal of the activity coordinator role in Southwark, was having an impact on patients' wellbeing on the ward.
- The trust should consider improving support for staff coming back to work after being on leave after an incident.

How we carried out the inspection

This inspection was unannounced. Prior to the inspection, we reviewed records held by the CQC relating to this service. The CQC data analyst team completed a thematic review of deaths and serious incidents resulting from self-harm for patients detained under the Mental Health Act between August 2020 and October 2022. We visited and inspected 3 acute wards for adults of working age, and a psychiatric intensive care ward over 3 locations. This was followed by video call interviews with ward managers from 4 further wards and the deputy chief nurse.

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

During the inspection visit, the inspection team:

Our findings

- toured the service environment
- observed how staff were caring for patients
- observed 2 multidisciplinary handover meetings
- spoke with 6 patients who were using the service
- spoke with the 8 ward managers, a clinical service lead, and a matron
- spoke with 17 other staff members across the multidisciplinary teams including a consultant psychiatrist, registered nurses, clinical support workers, a pharmacist, an administrator, student nurses and bank (as and when) staff.
- reviewed 24 patient care and treatment records
- looked at documents related to the running of the service

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.

Is the service safe?

Inspected but not rated

Safe and clean care environments

Wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Daily checks of the environment were carried out by the designated staff on each ward. The daily environmental audits were included on daily shift plans as an allocated task to ensure completion. We also observed Health and Safety inspection checklists completed twice a month, including detailed checks of the ward including screws, flooring, windows, heating, internal lighting, and equipment, and any action to be taken.

Staff could observe patients in all parts of the wards. Wards had CCTV and convex mirrors in place covering communal areas and corridors as this improved visibility at blind spots. Ward managers and senior staff were able to access CCTV to review incidents as part of investigation processes. Staff increased the frequency of observations for patients assessed as being at risk. The ward complied with guidance and there was no mixed sex accommodation. On all wards, patients had their own bedrooms.

Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. Each ward had a completed a ligature audit. Ligature audits included a comprehensive list of ligature risks, a risk rating, and details of action the staff should take to protect patients. Action included increased observations by staff, ensuring staff visually checked bedroom doors, and ensuring rooms such as kitchens and storage rooms were locked when not in use.

The ligature folders included pictures of areas to highlight the risk. All staff were aware of where the wards' ligature cutters were located with wards having at least two sets, one in the staff office and one in the clinic room. Staff completed training and competencies in the use of ligature cutters as part of their induction.

Our findings

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were given personal alarms at the start of each shift. Patients' bedrooms and communal rooms such as lounges and activity rooms had nurse call points installed. Staff were able to describe how the nurse call system was tested. Patients told us that staff usually responded quickly when they pressed the call button.

All wards displayed staff pictures and details of daily staffing levels. Notice boards contained all the information patients were likely to need, such as details of advocacy services, how to complain, ward activities, menus, and patients' rights. Patients could access outdoor space on the wards.

As recommended in the previous inspection report in June 2021, the trust had refurbished the wards at the Ladywell Unit to make them as safe and comfortable as possible until the unit is relocated. They had also installed netting and barriers to the exterior of the building to protect patients as far as possible from the risk of falling from a height.

Maintenance, cleanliness and infection control

Ward areas were generally clean, well maintained, well-furnished and fit for purpose. Staff followed infection control policy, including handwashing.

Patients told us that the wards were generally kept clean, and any issues they raised were addressed. We observed that most ward areas were kept visibly clean and tidy. However there was an offensive odour in one of the shared bathrooms, and a cluttered examination room on Virginia Woolf ward, and there were crumbs on the carpet in the lounge on Leo ward. We reported these issues to staff at the time of the inspection, who undertook to address them.

Staff and patients on the 4 wards we visited told us that any faults or repairs were identified and addressed quickly. On Virginia Woolf ward staff were awaiting the repair of the health promotion screen which had been broken recently, they noted that new furnishings had been provided recently and the ward now had air conditioning.

The wards had standard operating procedures for hygiene, cleanliness and infection control. Staff followed infection control principles including the use of personal protective equipment.

Seclusion room

The previous seclusion room on ES1 Ward had been decommissioned following a serious incident, and an alternative seclusion room was now in place. Unlike the previous room, it did not yet have a monitoring system in place to monitor vital signs whilst patients were asleep, although there were plans to relocate this equipment. The room had CCTV to monitor patients. It was a much larger and more comfortable area than provided in the previous room, and included safe bedding, toilet and washing facilities, a clock for patients to see, and two-way communication system. Patients using the seclusion room were able to access a 'calm down' box equipped with sensory aids, blue tooth music, and a folder with information about staff members to facilitate developing better relationships.

Clinic room and equipment

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

Staff had access to emergency equipment. If medicines were required out of hours, staff could access these medicines via an on-call pharmacist. Staff checked, maintained, and cleaned equipment. Emergency equipment was checked daily. Staff attached stickers to equipment showing when it had last been cleaned. We found some gaps in recording of when equipment was cleaned on Leo ward, and an error in the recording of controlled drugs administered on 2 dates, and reported these issues to staff who undertook to address them.

Our findings

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment regularly. Staff recorded checks of emergency equipment bags each week and ensured that calibration was up to date. Physical health examinations, such as electrocardiogram monitoring were carried out in treatment rooms. There were appropriate arrangements in place for disposal of clinical waste.

Safe staffing

There had been a significant improvement in the recruitment of nursing and medical staff, who knew the patients. However, there were some gaps in basic training to keep people safe from avoidable harm.

Nursing staff

At the previous inspection in June 2021, we recommended that the trust should continue to address the high number of nursing vacancies on some wards through active recruitment and retention strategies, and improve monitoring of the impact of staffing shortages on patients agreed escorted leave. We found that significant work had been undertaken to improve the permanent staffing on the wards at the time of the inspection. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. On each ward staff prioritised patients' leave to ensure that this could be taken.

Most wards had reducing vacancy rates. The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff generally described the wards as being safely staffed, with the exception of some staff on ES1 ward who were concerned about the level of acuity on the ward.

Bank and agency staff were familiar with the service and knew the patients they were supporting. Patients across the wards said they knew most staff on the wards. Staffing numbers were displayed on each ward in their communal areas. Managers made sure all bank staff had a full induction and understood the service before starting their shift. Staff stated they were supported by senior staff when shifts were short staffed due to unforeseen circumstances.

Managers accurately calculated and reviewed the number and grade of nurses for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Processes were in place for staff on shifts, particularly night shifts, to escalate when they were short staffed or needed additional staff due to patient acuity or increased observation levels. Staff said this worked well and made it easier to obtain support when needed. The service had enough staff on each shift to carry out any physical interventions safely. Staff on all the wards could call for assistance from colleagues on adjacent wards if extra staff were needed to carry out physical interventions.

We looked at staffing data for the 8 wards from August – October 2023. The highest vacancies were in Gresham 1 ward with 38% vacancies in August, and 30% vacancies in September and October 2023. The next highest vacancies were Clare ward at 26% in August, Jim Birley Unit with 23% in September, and John Dickson and Virginia Woolf Wards at 18% in October 2023. The lowest vacancy rates were in ES1 ward, which was overstaffed by 0.4% in August, and with vacancies of 3% in September and 0.8% in October 2023. The trust confirmed that there were recruited staff due to start in vacant positions on the wards, and that other positions had been advertised.

In August 2023, the highest turnover rates were on Leo Ward at 35%, Gresham1 ward at 22%, and Clare ward at 21%. In September 2023 the highest turnover rates were highest on Leo ward at 26%, then Gresham 1 ward at 19%, and Clare ward at 15%. In October 2023 the highest turnover rates were again on Leo ward at 27%, followed by Gresham 1 ward at 19%, and Clare ward at 14%. The lowest turnovers throughout this period were on ES1 with 0% in August and September and 2.9% in October 2023.

Our findings

The highest sickness absence rates were on Gresham 1 ward at 14% in August 2023, on Virginia Woolf ward at 14% in September, and on Jim Birley Unit at 12% in October 2023. The lowest sickness absence rates were on Clare ward at 2% in August and September, and Leo ward at 0.4% in October 2023. Staff on some wards including Virginia Woolf Ward and ES1 noted that there had been some long-term staff sickness due to the stress of the role, and this had also contributed to turnover. Staff described being assaulted frequently in their role, including having items thrown at them, being spat on, kicked and punched. However, they described good team support. Some staff told us that they thought the loss of the activity coordinator role on their wards had impacted on people's unsettled behaviour on the wards.

On ES1 staff noted that they often had to carry out 4-6 hours of one-to-one observations, swapping after every hour. Some staff felt that needed to have one more CSW position on day shifts. However, they also noted that staffing had recently been increased by one staff member on each shift. Staff told us that it could get busy at lunchtimes, with staff administering medicines, and serving in the kitchen, leaving only 2 staff members for patients who were not on enhanced observations.

Staff shared key information to keep patients safe when handing over their care to others. Handover meetings that we attended included relevant information about each patient and plans to meet their needs.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. All wards had a consultant and duty doctor cover. Patients said they were able to see the consultant and doctor when needed. Staff reported there was always sufficient medical cover. However, on ES1 ward there was no permanent consultant psychiatrist cover at the time of the inspection.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Staff told us they would call an ambulance if a patient needed urgent medical attention.

Mandatory training

At the previous inspection in June 2021 we found that the insufficient members of the staff team on each ward had current training in the use of physical restraint and disengagement, immediate life support and basic life support to provide lifesaving care and prevent harm to staff and patients in an emergency. At the current inspection we found an improvement in staff training in these areas.

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

The trust set a target of 85% compliance with mandatory training. We generally found high compliance with staff mandatory training on each ward, with the highest compliance overall on Virginia Woolf at 94%, and the lowest on Leo ward at 84%. However, we found some low levels of training in Basic Life Support, at 50% on Jim Birley ward, and 75% on Leo ward. We also found low levels of training in Immediate Life Support on Leo ward at 56%, Gresham 1 ward at 58%, and Virginia Woolf Ward at 69%. It was difficult to ascertain the precise situation with staff compliance with training in the use of physical restraint and disengagement, as some staff had completed previous training provided, whilst others were undertaking new training in the Seni Lewis Training Programme (SLTP). At the time of the inspection, only

Our findings

50% of staff had completed SLTP team skills training on Leo and Ruskin wards, and 67% had completed this training on John Dickson ward. Training for the multidisciplinary team in SLTP was at 0% on Virginia Woolf Ward, 40% on Jim Birley ward, and 50% on Clare, John Dickson, Ruskin and Gresham 1 wards. On each ward the remaining staff had been booked in to attend the required training.

There were also gaps in training in the National Early Warning Score (for monitoring patients' physical health) with training at 57% on Gresham 1 ward, and fire warden training with training at 50% on Jim Birley ward, 57% on Clare ward and 62.5% on ES1, Virginia Woolf ward and Ruskin ward. The trust was aware of these shortfalls and had plans in place to improve training completion. They had systems in place to ensure that there was a trained staff member with immediate life support training on each shift.

Permanent staff completed at least 2 weeks induction training at the trust, with specific ward inductions including information about the service, patients, ethos, health and safety awareness including ligature risks. Bank staff have a 1-day induction covering the ward layout, observation levels and competencies, searches, ligature risks and emergency equipment. Staff signed to say they have completed this. Each ward had a competency tracker to ensure that all staff were up to date. Competencies included engagement and observations, seclusion, nutrition, the Mental Health Act, medicines and medical devices.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves following best practice in anticipating, de-escalating and managing challenging behaviour, but patient records did not always reflect this. 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.

Assessment of patient risk

We reviewed 24 care records across the wards. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after incidents. When patients arrived at the ward, a doctor and nurse completed an initial risk assessment. A more comprehensive risk assessment was completed within 24 hours of admission. Risk assessments were recorded on a standard form in the electronic patient record. This form included the patient's risk history, potential risks, and support approaches to reduce the likelihood of incidents occurring.

Information was detailed and showed a level of patient involvement in detailing triggers. We found a small number of risk assessments that were not fully up to date on 3 of the 4 wards visited, Leo, Virginia Woolf and ES1 wards. Risk assessments were reviewed at ward rounds, but this was not always updated on the risk assessment tool. We found some gaps of around 2 months for reviews on the risk records on Virginia Woolf ward and Leo ward. In one case on ES1 ward we found that concerns were raised by the safeguarding lead with regard to an incomplete risk screen. Risk assessments were not always reviewed after incidents, including rapid tranquilisation being administered on ES1.

We did not find care plans in place for all risks identified, for example on Virginia Woolf ward there was no neglect care plan in place for a patient assessed as at high risk of neglect. On ES1 there was a missing wound care plan for a patient, and the wound had not been reviewed despite a doctor recording that the wound should be reviewed after 48 hours. On ES1 one patient had unexplained bruises despite having been on one-to-one observations throughout. On Leo ward patients' risk assessment had not been updated after incidents of aggression, falls, and going absent without leave.

The format of risk assessments made it difficult to locate the most up to date information, with subsequent information often being recording in patients' progress notes. This was particularly difficult for staff members who were not familiar with the wards, such as bank or agency staff.

Our findings

However, by attending handover meetings and speaking with staff it was clear that staff were knowledgeable about patients' current needs and risks. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, deescalating, and managing challenging behaviour. On Ruskin ward we found a high standard of risk assessment recording, updated after all risk events, and with good evidence of patient involvement in managing their own risks.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks. However, we found that care plans for patients, did not always include triggers and protective factors, and were not in place to address all risks identified at risk assessment. We were also concerned about the high level of acuity and frequency of incidents on ES1 ward. On ES1 a patient identified as at risk of self-harm did not have a care plan to address this. On Leo ward, records for 2 patients who were absent without leave at the time of the inspection did not have details of actions taken to support them, including welfare checks carried out and contact with relatives, although these actions had been completed.

Patients confirmed they were involved in their risk management plans. Staff shared key information to keep patients safe when handing over their care to others. Shift changes, handovers and multidisciplinary meetings included all the necessary key information to keep patients safe. Staff in multidisciplinary team meetings discussed individual patient's needs and demonstrated an understanding of each patient. Staff on the wards met each day to discuss any changes to patients risks and to assign risk management activities to each member of staff. In addition to regular handover meetings between shifts, staff attended safety huddle meetings and Daily Clinical Care Meetings (DCCM). DCCM meetings on ES1 ward included the whole multidisciplinary team to discuss patient care and management including use of sensory interventions, psychology, and psychotherapy groups and external facilitators including a massage therapist and music company. On Leo ward staff also held a daily end of shift reflection.

Staff identified and responded to any changes in risks to, or posed by, patients. At the previous inspection in June 2021, we recommended that staff continue to carry out physical observations of patients with specific physical health needs and that these be recorded consistently. We found a significant improvement in recording of physical health observations at the current inspection including input from occupational therapists and physiotherapists, deep vein thrombosis and pressure area assessments.

Staff monitored physical health risks through frequent observations. Staff monitored the physical health of patients regularly using the observation chart for the National Early Warning Scores. Staff knew where the emergency grab bag was kept. Staff could observe patients in all areas and observed patients in line with the trusts policies and procedures. Staff checked all patients at least once during every hour. When patients presented a heightened level of risk, this was increased to four times within one hour or continuous observations. The trust policy stated that intermittent level observations should be undertaken at unpredictable times so that patients are unaware of when the observation would take place. We found that staff were generally aware of the need to vary times of observations, and senior staff were auditing observation records to ensure this was the case. On one ward an HIV positive patient did not have a care plan detailing their treatment and support needs whilst a patient on the ward.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. We saw some good examples of staff interventions to support patients deescalating potentially tense or violent situations. This included the use of 'soft words,' a sensory room, activities and support groups.

At multi-disciplinary team meetings patients' needs were considered in a holistic way, looking at family contact, effects of medicines, personal hygiene, engagement, sleep, significant events, patients' understanding of their rights, food and fluid intake, drug and alcohol support, housing, and employment issues.

Our findings

On each shift a duty section nurse led the response team to provide support in the event of any incidents. They also attended each ward to check on staffing levels, and any other issues that might impact on patient safety. Ward managers were able to monitor performance in patient records using a dashboard which displayed compliance with such areas as risk assessments, care plans, and physical health checks.

In response to our concerns about the level of acuity on ES1 ward, the trust advised us of steps they had taken to support the team. These included holding safety huddles twice a day, with a plan to increase these to 3 times daily, including a senior presence. There were also regular leadership walkarounds and regular support provided from the Crisis Intervention Support Service, and a plan to provide further trauma-informed care training for staff.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme. Staff told us that they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We observed skilled de-escalation techniques being used by staff on wards we visited. Ward staff participated in the trust's restrictive interventions reduction programme including use of the safety huddles, monitoring of low-level incidents, and the Dynamic Appraisal of Situational Aggression (DASA) tool. The trust was aiming to eliminate prone restraint of patients, by training relevant staff to administer rapid tranquilisation in the deltoid muscle (in the arm). Staff followed NICE guidance when using rapid tranquilisation, ensuring that appropriate physical health monitoring took place afterwards. The trust monitored staff practices in carrying out physical health checks on patients after they receive rapid tranquilisation in line with trust policy and maintained records of patient restraints, and any attempts at observing physical health as appropriate. Staff understood the Mental Capacity Act definition of restraint and worked within it and followed NICE guidance when using rapid tranquilisation. We found a rapid tranquilisation agreement in place for one patient, with guidelines on how to deescalate, when to use restraint, including individual preferences on how to carry this out for this particular patient.

We found that staff did not often use seclusion on patients across the wards. The only ward we inspected with a seclusion facility was ES1 ward, and records confirmed that this was rarely used. When a patient was placed in seclusion, staff kept records and followed best practice guidelines. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was placed in long-term segregation. We looked at the records for the last patient kept in seclusion on the ward, and they were generally appropriate with clear records of all reviews carried out. However, there were some gaps in recording the exact time and reason seclusion began, and how a particular hazard was addressed for the patient.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it, although there were some gaps in senior staff training.

Staff received training on how to recognise and report abuse, appropriate for their role. There was very high compliance with staff training in safeguarding adults and children at levels 1 and 2. However, there were some gaps in training for more senior staff with no staff trained in safeguarding adults at level 3 on Clare ward (of 1 eligible staff member) 40% of relevant staff trained in this area on Leo ward (of 5 eligible staff) and 50% trained in this are on Gresham 1 ward (of 4 eligible staff). On Clare ward 1 of 2 eligible staff had completed training in safeguarding children at level 3.

Our findings

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers took part in serious case reviews and made changes based on the outcomes. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff took a holistic approach and included reflection on the patient's views and understanding in discussing safeguarding concerns.

However, we were concerned at the high frequency of incidents on ES1 ward, with patients frequently displaying aggressive behaviour to each other, and 2 patients telling us that they did not always feel safe on the ward.

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 including bank staff could access them easily. Records relating to patients' care and treatment were stored on an electronic patient record. Staff recorded hourly observations on paper. These were stored in the nurses' office and uploaded to the electronic records. Staff were able to access paper and electronic records quickly. When patients transferred to a new team, there were no delays in staff accessing their records. The electronic records could be accessed by anyone working within the trust. Records were stored securely. Staff needed to enter a personal identification name, a password and an identity card in order to access the electronic patient record.

On Virginia Woolf ward staff reported that two of the computer terminals were out of order, and that this was causing delays in their recording of patient information.

Track record on safety

This inspection was carried out to review whether learning had been put in place on 8 wards on which a serious incident had occurred resulting in a patient death, between August 2020 and October 2022. In all 8 instances, staff completed a report of the circumstances surrounding the incident within 72 hours and referred the matters for a more comprehensive investigation.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, some incident investigations could take a considerable time to be completed, prior to learning being rolled out across the trust. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff recognised incidents and reported them appropriately. Staff recorded incidents on an electronic incident record, and raised concerns and reported near misses, incidents and serious incidents in line with trust policy.

Our findings

Service improvements were applied as a result of learning from serious incidents. Wards applied identified recommendations and generally completed actions in a timely manner. However, we found a small number of actions that had not been completed as planned.

There was evidence that changes had been made as a result of serious incident investigations. Recommendations and actions from 8 serious incidents, were reviewed on the 4 wards visited and in conversation with the other 4 ward managers as part of this inspection. General themes, such as observations, communication, handover and recording of information were also reviewed. Each directorate within the trust collated and tracked serious incident action plans, recommendations, and actions once a serious incident investigation report was completed. They liaised with lead nurses and senior staff at each service to oversee progress. Actions were then delegated to staff at service and ward level.

Wards applied identified recommendations and completed actions in a timely manner, generally meeting action plan timeframes. On all wards the observation, ligature risk mitigation and patient search processes had improved by applying recommendations and actions identified from serious incidents.

Across the wards all staff had completed their observation competency assessments, ligature training competencies and patient search competencies. Patient care records showed an improvement in recording observation levels so that staff could quickly confirm patients' observation levels and any changes in those levels. Accurate completion of observation records, and conducting intermittent observations at non-standard (unpredictable times) was a particular issue the trust identified from serious incidents. Managers and senior staff now audited observation records daily to address errors in observation entries and to ensure individual staff members were not placed on observation duty for excessive lengths of time. However, they did not record that they had undertaken these checks.

Other improvements across the wards as a result of serious incident investigations included a simpler system for booking additional staff when needed to support increased patient observations, and patient acuity, or staff shortages across the wards. This enabled staff to access additional staff and support quickly from service managers.

Managers debriefed and supported staff after any serious incident. Senior staff investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust worked closely with family members and offered family members the option to be involved in the service improvement and development processes.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff and patients met to discuss the feedback and look at improvements to patient care in team and community meetings. Most staff we spoke with were well informed about recent incidents, including staff who were not working in the service at the time of the incidents. Learning from incidents was part of each ward's business meeting, and blue-light bulletins sent to all staff also provided important safety information to all relevant staff. Staff understood the duty of candour, the need to be open and transparent and give patients and families a full explanation if things went wrong. Managers debriefed and supported staff after any serious incident with a dedicated trust team providing support to wards involved and reflective practice sessions on the wards providing a a space for staff to discuss their thoughts following incidents. However, some staff on Leo and ES1 ward said that the trust could improve support for staff coming back to work after being on leave after an incident.

Ward based scenario training has been developed as a result of learning from serious incidents, to help staff refresh and practise the skills and competencies gained through annual mandatory resuscitation training. Emergency scenarios included a range of medical, psychiatric and environmental situations, such as patients experiencing a cardiac arrest, or patients tying a ligature. The scenario training aimed to test local knowledge (such as how to raise the alarm, or where

to find the suction machine) and provide an opportunity to open a fully equipped emergency bag, manipulate and apply devices such as oxygen masks, defibrillation and oxygen cylinders. There was also an emphasis on the team approach, communication, and team leadership, predicting and preparing. At the time of the inspection, scenario training had taken place on Virginia Woolf and Ruskin wards in April 2023, Jim Birley Unit and Clare ward in June 2023, and twice on John Dickson ward in April 2023. There had not yet been any scenario training on Gresham 1 ward (booked for December) or ES1 ward.

Learning from incidents on Clare and Virginia Woolf wards at the Ladywell unit led to actions to upgrade all accessible windows within the unit, and improve access to alarms, and access for emergency vehicles visiting the site. All relevant windows on each ward in the unit had been changed, with the wards having to move to another temporary ward whilst this was undertaken. The alarm system had been integrated into the Ladywell response alarm. All wards have both wall alarms and mobile handsets for activating the alarm. Work had also begun to integrate internal emergency phone calls with the alarms completed on Virginia Woolf ward, and to be rolled out on Clare ward by February 2024. In the interim period the use of radio sets for internal response calls was a temporary mitigation put in place. In conjunction with the NHS trust responsible for the Ladywell site, access had been arranged so that emergency vehicles could access the unit without passing through a ticket barrier. Staff also had a protocol to go to the building entrance and guide emergency crew to where any incident was taking place. The area outside the unit had also been cleared to enable easier access to all parts of the building, with netting and barriers installed to protect patients as far as possible from the risk of falling from a height. However, although this was an action following the serious incident on Clare ward, information about the home treatment team had not yet been included in the welcome pack for new patients.

On Leo ward staff told us that they had introduced a robust environmental checklist, which included checking that all screws were flush, and they now used mobile phone chargers with short cables only to prevent ligature risks. However, staff were not confident about their learning from incidents, particularly students, some of whom had been on the ward for more than a year. Although managers noted that staff had support from supervision, one to one counselling, and occupational health, staff members told us that they did not get enough support (other than time off) after the most recent serious incident.

On Jim Birley Unit staff were clear about learning from ligature incidents on other wards, and noted increased support for patients with drug and alcohol issues. As a result of the incident on this ward, staff across all wards had completed Naloxone training, and there were systems in place to arranged one to one support for patients at risk, even if they tested negative for drugs.

On Gresham 1 ward, although the full investigation report was not yet available at the time of the inspection, improvements had been made in substance misuse training, monitoring staff observations including respirations observed, and a focus on more interactions from staff on one-to-one observations.

On John Dickson Ward staff had refreshed training about the trust's End of Life policy, including responsibilities for breaking news. Although there was an action plan for the matron to present a session for staff on Communication with Family members, this had not yet been carried out.

On Ruskin ward staff were very aware of learning from the most recent serious incident, and others within the directorate. The named security staff member on each shifts checked for plastic bags, and ensured that these did not go past the nurses stations. There was a list of contraband items on the ward door, and although all staff had access to search training they had requested bespoke search training for the ward. Contraband items were discussed with patients on admission, and they were reminded and visitors were made aware of the restrictions. They had introduced a carer day every week to discuss patients' care and treatment.

Our findings

On ES1, as a result of the most recent serious incident the seclusion room had been decommissioned and relocated to a better equipped area. Managers were auditing seclusion records to ensure that these were completed appropriately, including a seclusion care plan, and up to date risk assessments. Staff had refresher training in raising a medical emergency, using ligature cutters and ensured adequate supplies of anti-ligature clothing.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff were generally positive about the senior leadership of the trust. Leaders in the service could describe how staff were working to provide safe, high-quality care and were striving for excellence. They were aware of the key risks and challenges and were open in sharing them.

We spoke with the deputy chief nurse responsible for ensuring that learning from serious incidents was embedded across the trust. The trust had started utilising the Patient Safety Incident Response Framework (PSIRF) investigatory approaches prior to the current inspection, and these were now becoming embedded within the directorates. Directorates had initiated their own actions as a result of learning from incidents. For example, the Southwark directorate was implementing regular training sessions for Southwark inpatient wards to improve risk assessment and care planning using anonymised real-life cases. They had also implemented regular mini audits of Southwark acute ward notes to ensure events during observations are accurately captured and risk assessments and care plans were updated with routine feedback of these audits at clinical governance meetings.

Clear processes were in place across all directorates following a serious incident. Immediately after the incident a fact finder report was completed, followed by a serious incident review. On the day of the event senior management had a debrief with staff, patients and relatives and discussed immediate measures that needed to be put in place. The critical incident staff support team provided a reflection session for staff. The incident was discussed in business meetings, and clinical governance meetings and circulated by email and other means, including verbally at staff handover meetings and in staff supervision. Where relevant a Blue Light bulletin was issued across the trust to make staff aware of serious risks. For serious incidents resulting in deaths, mortality reviews were conducted, medical colleagues' reviews were taking place, and for particularly serious incidents NHS England and the local integrated care board safeguarding leads conducted or commissioned an independent investigation. However, other than through Blue Light bulletins, we found that staff we spoke with were only aware of incidents that had taken place in their own directorate, and rarely in other directorates.

The trust had a restrictive practice workstream, a project running for 2 years reviewing incidents, to look at ways of reducing restrictions on patients.

The trust believed that the PSIRF would lead to more rapid and higher quality investigation of serious incidents, with recruitment to a total of 4 central investigators, 3 patient safety specialists, a family liaison officer, and team manager. As part of the Patient and Carer Race Equality Framework , a dashboard was being developed to monitor incidents of restraint and ethnicity. There were plans for 'After action reviews' following single incidents, and 'Multidisciplinary

reviews' where multiple patients were involved. 'Lunch and learn' sessions were being arranged to share information with staff, and the trust was working with a neighbouring trust to compare and learn from their PSIRF journey. It had been agreed that the trust quality improvement team would be assisting in compiling and implementing action plans from Learning From Patient Safety Events.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Following a six-month programme of listening and engagement events, the trust launched its strategy 'Aiming High; Changing Lives' in 2021, identifying five strategic ambitions to reflect the complex and dynamic environment in which the trust operated. These were to deliver outstanding mental health care, be a partner in prevention, be a catalyst for change, build a culture of trust together and become effective and sustainable.

Staff spoke of supportive team cultures on their individual wards, and most patients said staff were caring, kind and polite and listened to what they had to say.

Culture

There was a strong organisational commitment and effective action towards improving the service quality and learning from incidents.

Staff described an open culture where learning was encouraged, and people were supported to be open and share their views. They felt respected by their line managers and peers and there was a safe space to discuss learning from serious incidents and care and treatment problems. However, several staff members on Virginia Woolf, Leo and ES1 wards described a high number of incidents occurring on their wards, leading to them being physically assaulted on a regular basis. They described being spat on, bit, kicked, punched, sustaining black eyes, and even concussion. Some described good support from managers, and others said they had not received support, a debrief or reflective practice session. All felt that they needed more support to manage this level of violence, and particularly on returning to work after leave following an incident. On ES1 staff morale was quite low, due to high acuity on the wards, changes in ward manager, and lack of a permanent consultation psychiatrist. Staff described concerns about some inappropriate admissions of forensic patients.

Virginia Woolf staff had been awarded the trust 'Caring and kindness' award in the annual staff awards 2023, nominated by patients and carers.

On Leo ward a cultural appropriate support advocacy service ran the weekly community meeting, providing training, and then attending community meetings to check learning had been embedded.

Governance

Governance processes operated effectively at team level and performance and risk were managed well. The trust had plans in place to address improvements needed in investigating serious incidents more promptly and sharing knowledge of learning from incidents across the trust.

Our findings from the other key question demonstrated that most governance processes operated effectively to monitor and apply learning from serious incidents.

Over 2 years since 2 of the serious incidents we looked at, the full root cause analysis investigation reports were not yet available. Although delays can take place for a number of reasons, including police investigations, and court

proceedings, the trust were aware that they needed to improve processes so that actions could be put in place to prevent reoccurrences. Under the new Patient Safety Incident Response Framework (PSIRF) being implemented, there were plans to speed up the process of investigations and improve their quality. So far there had been 2 waves of staff training in the new ways of working under PSIRF.

The trust monitored most serious incident action plans to ensure the standards of care continually improved and patient safety was not compromised. Directorate leads, lead nurses and matrons then monitored local level recommendations and improvements. However, a small number of actions from serious incident investigations had not been met within timescales set. These included staff training on protocols for breaking news to relatives, changes to the welcome brochure for new patients and carers, and regular implementation of scenario training on all wards. There were also some gaps in staff knowledge of learning from incidents which had taken place in other directorates.

Staff were clear about their roles and responsibilities in relation to patient safety. Ward teams were aware of their performance. Managers and staff knew the issues they were facing and where they were missing targets and were working to make improvements and mitigate risks.

Wards had regular monthly meetings including staff from all disciplines (from doctors to housekeeping). On Virginia Woolf ward staff had introduced quality meetings to look at ways of improving practice in particular areas. Duty senior nurse (DSN) meetings were held every week for each location, the DSNs carried out checks on each shift of staffing on the wards, appropriate immediate life support cover and response trained staff, observations, and patient leave.

A wide range of new audits and checks had been introduced since the previous inspection, including audits of observations, searching and smoking cessation. Senior staff attended the wards regularly ensuring good practice such as staff using the correct patient observation forms, risk assessments were updated, and leave taken. They sent a report to each ward identifying any gaps or areas for improvement approximately twice monthly.

Management of risk, issues and performance

There was an improvement in risk management across the wards, with learning put in place from serious incidents. However, there was some inconsistency in the quality of risk assessments and plans.

Each ward had a risk register and lead nurses and ward managers were aware of the key risk areas on their wards. The risks were discussed at team meetings, and at handovers and in safety huddles. Risks recorded included concerns with staffing, the environment, training compliance, and levels of acuity on the wards, alongside actions taken to mitigate each risk. Most staff were well informed about incidents. Effective systems were in place to monitor action plans and apply actions and recommendations to improve patient care after serious incidents.

We found that some improvements were needed in the recording of risk assessments and care plans on Virginia Woolf, ES1, and Leo wards. We also raised concerns in response to some staff and patients feeling unsafe on ES1 ward. ES1 is the only female PICU in the Trust. The trust advised that in order to support the team to manage violence and aggression they had put in place staff safety huddles twice daily (with a view to increasing these to 3 times daily). Daily Clinical Care Meeting (DCCM) included the whole MDT attend to discuss patient care and management with use of sensory interventions when appropriate. The ward was also undertaking a ‘referred out’ pilot quality improvement project to expedite movement of patients stepped down to acute care. The team liaised with the trust reducing restrictive practices lead for support during high acuity and times of increased assaults, and there was a regular leadership walk around to ensure close engagement with staff and patients. There were plans for further training for staff in individual trauma therapy, a new beauty room had been opened to create more activity options for patients and encourage therapeutic engagement with staff and external facilitators.

Our findings

Information management

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

The trust had systems to collect data from the service. The trust provided dashboards for ward managers which had accurate information on care planning and incidents.

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, staff on Virginia Woolf ward told us that 2 of their computers were out of order at the time of the inspection, impacting on their ability to input information promptly. Managers had access to information on their team's performance collected through clinical audits. This included information on completion of patient risk assessments, care plans, physical health care and medicines administration.

Learning, continuous improvement and innovation

There was a strong commitment to improve and learn lessons from serious incidents. Most staff were familiar with the process and methodology of quality improvement. On Gresham 1 ward staff and patients noted that mealtimes could be very stressful, and they were trialling a new system with the menu being provided in advance, and a card system for the order in which patients go in rather than queuing.

On Ruskin Ward staff gave the example of learning from a mealtime incident, noting that having all patients in the same room can escalate behaviour. They had arranged for all staff members to be present during mealtimes and had not had any incidents at mealtimes since making this change. There was also a quality improvement initiative to improve carer involvement. This involved setting up a carers' surgery on a weekly basis, with all of the multidisciplinary staff involved, including doctors and pharmacists.

On ES1 staff were undertaking a 'referred out' pilot quality improvement project to expedite discharge of patients who have been stepped down to acute care and support reduction in ward acuity.

On Virginia Woolf Ward staff had a project to better facilitate section 17 leave, this included questionnaires for staff and patients, looking at timing issues, and having a morning meeting to plan all leave.

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:

- The trust must ensure that sufficient members of the staff team on each ward have current training in basic and immediate life support, the National Early Warning Score, Safeguarding level 3, Seni Lewis and fire warden training to provide lifesaving care and prevent harm to staff and patients in an emergency. (Regulation 12(2)(c))
- The trust must ensure that patient's risk assessments and risk management plans on all wards are consistently clear and cover all areas identified as a significant risk, including triggers and protective factors. (Regulation 12(2)(a)(b))

Action the trust Should take to improve:

- The trust should continue to address the high number of nursing vacancies on some wards through active recruitment and retention strategies.
- The trust should further work to improve the timeliness of completing serious incident reviews, ensuring all identified actions are completed, and that staff from all directorates are aware of learning from serious incidents across the trust.
- The trust should continue to monitor the level of acuity on ES1 ward and the impact of this on staff and patient's morale.
- The trust should consider how to minimise the impact of withdrawing the activity coordinator role on Southwark wards on patients.
- The trust should consider improving support for staff coming back to work after being on leave after an incident.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspectors, and 2 specialist advisor nurses with experience of working in acute and PICU wards for adults of working age.

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