Camden and Islington NHS Foundation Trust

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

St Pancras Hospital
London
NW1 0PE
Tel: 02033173500
www.candi.nhs.uk

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Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

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

Summary of this service

We did not rate acute wards for adults of working age and psychiatric intensive care units at this inspection as we only visited one of the trust's eleven wards. We visited Ruby Ward, a women's psychiatric intensive care unit (PICU), due to concerns we received from staff and members of the public. These concerns related to staffing, management of restraint, patient violence and aggression, culture and leadership of the ward.

This was a focused inspection of safe, effective and well-led.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent on the ward to prevent cross infection. Two CQC inspectors visited the ward unannounced on 13 August 2020 during the night shift to complete essential checks. Whilst on site we wore the appropriate personal protective equipment and followed local infection control procedures. The remainder of our inspection activity was conducted off the ward. We conducted staff interviews over the telephone on 18 and 20 August 2020. We reviewed patient care records on-site, but off the ward, on 25 August 2020.

We found:

- The service had already made improvements in relation to the concerns. In May 2020, senior leaders had developed a service improvement plan for the ward, which clearly identified what action needed to be taken to improve the safety of the ward. This plan was reviewed weekly by senior leaders and staff members from the ward. The action plan was still in progress and leaders needed to ensure recent changes made were embedded.
- The members of staff we spoke with felt the ward had improved, although they said that it had been a challenging time on the ward due to staffing pressures and the admissions of very acutely unwell patients. Staff told us there had been many positive changes since the service improvement plan started, particularly around the safety and culture of the ward. Staff told us they now felt listened to by management.
- The trust had improved the senior leadership on the ward. The matron provided excellent day-to-day clinical and operational leadership to staff on the ward. All staff we spoke with said the matron was very supportive and had made a positive impact on the ward. Prior to the service improvement plan in May 2020, the ward had been without adequate clinical leadership, as the ward manager was shielding due to the Covid-19 pandemic. There had been no extra leadership support for the ward and staff said they did not feel supported by management during this time. The trust needed to ensure that when the matron stepped back at the end of September 2020, that there continued to be effective and visible leadership on the ward, and that initiatives to improve team working and morale were sustained.
- Staff had improved how they assessed and managed risks to patients and themselves. The service had recently introduced safety huddles to ensure staff felt safe on the ward and discussed what extra support patients may need to feel safe. The ward had also introduced positive behaviour support plans to help understand and manage challenging behaviours. The trust's reducing restrictive practice lead also supported staff on the ward with de-escalating and managing challenging behaviour, including delivering training in seclusion and restrictive practice.

However:

- The ward had faced challenges with its staffing during the Covid-19 pandemic, with staff being re-deployed elsewhere in the trust, staff off work shielding and natural staff turnover. Although the ward had enough nursing and care staff to keep patients safe and met minimum staffing levels, there was a high use of bank staff. This had put extra pressure on

Summary of findings

permanent staff members who told us they felt burnt out due to high numbers of bank staff on shift who did not know the ward or patients well and were not restraint trained so unable to assist in restraint practices. However, since the service improvement plan had been initiated, staffing on the ward had improved, and most vacancies had been filled. The trust was negotiating with NHS professionals (NHSP), which provided the wards temporary members of staff, to include restraint training as core training for all regular NHSP staff. The psychiatric emergency team available on site to respond to inpatient incidents contained all PMVA trained staff, ensuring incidents requiring restraint could be safely managed.

- Managers had not always made sure staff were supported with regular supervision. The trust told us this was due to staffing challenges during the Covid-19 pandemic. However, this was improving and all staff we spoke with on the inspection said they had recently received supervision.

During this focused inspection, the inspection team:

- spoke with one patient (we offered to speak with all five patients on the ward, however most were too unwell to engage with us)

- interviewed 17 members of staff, including clinical support workers, registered nurses, consultant psychiatrist, reducing restrictive practice lead, the practice development lead and the matron.

- interviewed the two advocates for the ward

- looked at 5 care records

- looked at other documents relating to the running of the ward, including the service improvement plan, incident records, minutes of team meetings.

Is the service safe?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

Staff had improved how they assessed and managed risks to patients and themselves. The service had introduced safety huddles and positive behaviour support plans, which helped staff better understand and manage patients. The trust's reducing restrictive practice lead provided support to staff in de-escalating and managing challenging behaviour. They had also delivered training to staff in seclusion and restrictive practice.

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff reported patient on patient assaults as safeguarding events and put immediate safeguarding plans in place to safely manage patients.

The service managed patient safety incidents well. Staff recognised incidents, such as restraint and patient assaults, and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

Although the ward had enough nursing and care staff to keep patients safe, the ward used a high number of bank staff to manage the staffing challenges during the Covid-19 pandemic. Permanent staff told us they felt burnt out as they had to take on extra work that the bank staff were unable to do. Not all bank NHS professionals (NHSP) staff were trained in restraint and permanent staff told us they found it difficult as bank staff were often unable to assist in restraint practices if required on the ward. The trust was in negotiation with NHS professionals (NHSP) to include restraint training as core training for all regular NHSP staff.

Summary of findings

Is the service effective?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

The service had improved patients' access to physical healthcare. The trust's practice development lead had recently introduced specific physical health care training to staff, which staff told us they found helpful. The practice development lead attended the ward's weekly service improvement plan meetings to review progress with improving patients' physical health needs.

However:

Between May 2020 and July 2020, 41% of staff received clinical supervision to support them with carrying out their duties. This low compliance rate was due to staffing shortages during the Covid-19 pandemic. However, staff told us during the inspection that they had recently received clinical supervision and felt more supported since the service improvement plan had been initiated.

Is the service caring?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

Is the service responsive?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

Is the service well-led?

We did not rate wards for adults of working age and psychiatric intensive care units at this inspection.

The ward had made good overall improvements in response to our concerns. Senior leaders had implemented a service improvement plan in May 2020, which clearly identified the concerns on the ward and how these would be addressed. This plan continued to be reviewed on an on-going basis until all action had been completed. All staff we spoke with said there had been improvements to the safety and culture of the ward since the plan was put in place.

The ward now had excellent leadership. The matron for the ward was providing exclusive day to day clinical and operational management to the ward. All staff we spoke with were overwhelmingly positive about the matron's impact on the ward and felt supported by them.

The culture of the ward had improved. Since the service improvement plan was put in place and the matron joined the ward, staff felt more supported and listened to than they did previously. Staff appreciated being invited to the weekly service improvement plan meetings and felt their voice being heard by senior managers. They felt able to raise concerns without fear of retribution.

Staff said that although the ward had been challenging due to staffing challenges and the high acuity of patients they still enjoyed their job and enjoyed caring for patients.

Senior leaders had worked hard to improve the morale of the ward. Managers increased business meetings and introduced safety huddles to improve team working and enabling staff to feedback. The medical doctor had completed a quality improvement project looking at how to improve morale on the ward, and subsequently introduced an initiative called gem of the week, where staff were praised for their work.

Summary of findings

However:

Although the matron was providing excellent leadership to the ward, the trust needed to ensure that when the matron stepped back to matron duties at the end of September 2020, that a suitable ward manager provided leadership to the ward.

Detailed findings from this inspection

Is the service safe?

Safe staffing

Nursing staff

During the Covid-19 pandemic, the ward faced challenges with its staffing. Some staff were re-deployed elsewhere in the trust, some staff were shielding, including the ward manager, and there was a natural turnover of staff. Although, the service had enough nursing and support staff to keep patients safe, there was a high usage of bank staff. Permanent staff members told us that this led to them feeling burnt out and stressed as they had to take on more work that the bank staff were not able to do.

Senior managers knew about the ward's staffing issues and had included staffing in the ward's service improvement plan. The ward had an active recruitment process and had been proactive in advertising and employing staff. At the time of the inspection, the ward had improved its staffing and had reduced its vacancy rates. There were four band 5 registered nurse vacancies, which had been recruited into and were due to start in September 2020.

In the last 3 months, the service had used 24 full-time agency and bank registered nurses to cover vacancies, sickness and absence. The ward had a higher level of sickness and absence due to the Covid-19 pandemic, which was reflected across all the services in the trust.

Managers supported staff who needed time off for ill health. The staff sickness rate in the last three months was 9%. The staff turnover rate in the last three months was 4%.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

The consultant psychiatrist had recently developed an out of hours psychiatric intensive care unit (PICU) clerking protocol and prescribing guideline designed to address the need to support junior medical staff out of hours when making decisions about unwell patients in a PICU setting.

Mandatory training

Staff had received and were up to date with appropriate mandatory training.

Overall, staff on this ward had undertaken 88% of the various elements, of training that the trust had set as mandatory.

Bank registered nurses who were employed to work on the ward via the NHSP booking system were not always trained in restraint handling. This meant that some bank registered nurses were unable to carry out physical interventions if required on the ward. Staff told us that they felt unsafe when bank registered nurses without this training worked on the wards. This was highlighted to senior managers who were aware of this and told us that the trust was in discussion with NHSP about introducing restraint training to regular bank staff. In the interim, the senior site coordinators ensured skills mix across all services include adequate levels of prevention and management of violence and aggression (PMVA) trained staff. The psychiatric emergency team available on site to respond to inpatient incidents contain all PMVA trained staff ensuring incidents requiring restraint can be safely managed.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed five care records during the inspection.

Staff completed a risk assessment of every patient on admission, using a recognised tool and reviewed this regularly, including after any incident.

Detailed findings from this inspection

Risks to patients were assessed, monitored, updated regularly and managed on a day-to-day basis. Individual risks were discussed in multidisciplinary meetings, individual reviews, handovers and daily safety huddles.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Individual risks and changing risks were discussed in multidisciplinary meetings, individual reviews, handovers and safety huddles.

In the months leading to the inspection and during the inspection, the ward had admitted several acutely unwell patients who displayed with high levels of violence and aggression. There had been several occasions where these patients had assaulted staff and other patients. Staff reported that this had been a challenging environment for them to work in. Where patients presented with a risk of violence and aggression to others, staff appropriately managed patient risk. This included increasing patient's observation levels. Where there had been a patient on patient assault, staff managed these incidents appropriately, raising them as incidents and safeguardings and putting appropriate safeguards in place.

All 17 staff that we interviewed confirmed that they had not witnessed any poor care or treatment by staff towards patients.

The ward had recently introduced safety huddles. These happened at the start of each shift as a way of identifying and managing patient risk. The huddles were attended by representatives from different staff disciplines. Staff shared information that could impact on patient safety and agreed ways of mitigating risks. Staff told us that they thought these huddles had been a positive introduction on the ward to manage risk of the women on the ward.

The ward had recently introduced positive behaviour support plans for patients. Positive behaviour support plans are created to help staff understand and manage challenging behaviours and support strategies never use punishment as a way for dealing with behaviours that challenge. We reviewed a positive behaviour support plan for one patient. It included a concise one-page document summarising strategies to support this patient, which would be useful for bank/agency or staff unfamiliar with the patient and informed them how to safely and positively engage with the patient.

Staff recognised that the ward environment was constrained by the lack of available space. This issue was identified on the service improvement plan and managers, including the restrictive practice lead, were assessing the environment (with patent and staff input) to see how they could improve it.

Use of restrictive interventions

Between January and May 2020, there were 30 episodes of restraint on the ward. In the three months leading to the inspection, there had been a few very unwell patients who accounted for most of the restraint episodes. Most of these patients had since been discharged to a more secure service or had made a recovery and were now in the community.

Before the inspection, we had received intelligence of poor restrictive restraint practices on the ward. During the inspection, the trust had adequately responded to these concerns.

The trust's reducing restrictive practice lead provided regular support to the staff on the ward. They visited the ward to support staff and to provide coaching pre/post and during restrictive practice interventions They reviewed incidents and restraints on the ward and advised staff in the development of patients' management plans. The reducing restrictive practice lead had introduced training to staff around restrictive practice, blanket rules and seclusion. There were further sessions planned for after the inspection.

We saw evidence of staff using verbal de-escalation techniques before using physical restraint practices. Staff told us that the safety huddles had been a useful tool to plan for restraint and to ensure that it was carried out safely.

The ward's training compliance for PMVA restraint training was 95%.

Detailed findings from this inspection

Before the inspection, we had received intelligence that staff were not always recording restraints as incidents in line with trust policy. During this inspection, we found that this was not the case.

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We reviewed four incidences of rapid tranquilisation, which demonstrated that staff had completed the necessary physical health observations to ensure patient safety.

The matron had recently introduced a rapid tranquilisation physical health monitoring booklet for staff to document that vital signs had been recorded regularly. We saw evidence that this was being used appropriately.

The ward did not have a seclusion room. During our inspection, two patients who were very acutely unwell were being nursed on an episode of open-door seclusion in their bedroom. This meant that if the patient became a risk to self and/or others on the ward, staff would re-direct them to their bedroom. On most occasions, their bedroom door was unlocked and the patient was able to come out into the communal area if they wished. However, on some occasions, following a multi-disciplinary meeting, their bedroom door would be locked if their behaviour was deemed too risky to manage. Irrespective of the door being unlocked or locked, the trust's seclusion policy was activated. We saw evidence that these patients had regular nursing and medical reviews as per the trust policy. The seclusion episodes were regularly reviewed and often terminated to ensure least restrictive practice. Records included the patients' views around episodes being reinstated and terminated, which demonstrated good practice. Managers had made referrals for these patients to be transferred to an appropriate PICU bed with seclusion facilities to better meet their needs.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and that when appropriate. For example, where there had been a patient on patient assault, staff reported this as a safeguarding and put immediate plans in place to manage both patients' safety.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. For example, we saw staff reporting episodes of seclusion, restraint, patient on staff violence and a patient damaging ward property.

We saw evidence that staff debriefed patients following an incident. This ensured that patients felt supported.

Is the service effective?

Best practice in treatment and care

Before the inspection, we had received intelligence that patients received poor physical health care. During our inspection, we did not find any evidence to support this. Staff told us they had received the necessary training to support patients with their physical health care. At the start of July 2020, the trust's practice development nurse started providing physical health training to staff on the ward, which staff said they found useful. This included training on electrocardiograms (ECG), blood pressure, national early warning score (NEWS2) recording and infection control. The practice development nurse had begun work improving the ward's clinic room. They also attended the weekly service improvement plan meetings to review how physical health was being addressed on the ward.

Skilled staff to deliver care

Not all staff had received regular clinical supervision in the months leading to the inspection. The percentage of staff that received regular clinical supervision in the last three months was 41%. In May 2020 it was 41%, in June 2020 it was 20% and in July 2020 it was 63%. The reason for the low figure was due to staffing shortages during the Covid-19 pandemic. Staff during the inspection told us they had recently received supervision. Clinical supervision is important to ensure staff feel support to carry out their duties.

Detailed findings from this inspection

Is the service well-led?

Leadership

The trust had improved the leadership of the ward following the implementation of the service improvement plan.

Throughout most of the Covid-19 pandemic (between March 2020 and May 2020), the ward had no physical presence of a ward manager as they were shielding. In May 2020, the ward's matron stepped in to provide day-to-day clinical and operational leadership to staff on the ward. The staff team were overwhelmingly positive about the matron's support on the ward and felt they had initiated positive changes.

At the time of the inspection, the trust was recruiting a new manager for the ward. The matron planned to provide exclusive leadership to Ruby Ward until the end of September 2020. They would then return to their usual modern matron duties overseeing Ruby Ward and Dunkley Ward. Previously, the matron provided support to four wards, which had now reduced to two wards. They said this would make a positive difference as they could provide more focused support to the wards, especially Ruby Ward, which would still likely need enhanced senior support to ensure improvements are embedded.

Leaders had a good understanding of the service they managed. The head of nursing and clinical director had close oversight of the ward as they attended the weekly meeting to review the ward's service improvement plan.

Staff told us that the matron was very visible on the ward and approachable for patients and staff. Some staff told us that the ward manager was not very visible or approachable.

Managers identified that band six registered nurses needed support with their leadership skills. There was a band six registered nurse development programme starting in September 2020 to support them with their leadership skills.

Vision and strategy

Culture

Before the inspection, we had received intelligence that morale was low on the ward. Leaders were aware of this and had put measures in place to try and improve morale.

Staff told us that morale had recently improved, but it was still a work in progress as longer standing staff members built working relationships with new staff members. A medical doctor on the ward had recently completed a quality improvement project to improve staff morale on Ruby Ward. There was a focus on staff emotional wellbeing and respect. The project introduced an initiative called gem of the week, where staff members were nominated and praised for positive pieces of work. The project found an increase in morale since gem of the week was launched.

Staff told us that even though it could be challenging on the ward due to the patient acuity, they still enjoyed their job and enjoyed caring for the women on the ward.

In response to the Covid-19 pandemic, senior leaders at the trust had changed the function of the ward to be a general ward rather than a PICU. Some staff told us that they had found the ward's function changing at very short notice difficult. They told us they did not feel safe when these changes happened at short notice.

Staff told us they now felt supported following incidents when they had been assaulted by patients. Managers encouraged them to take recovery time away from work and they made phone calls to check on their wellbeing. Staff said previously this had not always been the case, and they felt pressured to return to work.

Staff felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Most staff we spoke with were not aware of the trust's Freedom to Speak up Guardian. However, the Freedom to Speak up Guardian had planned to attend the ward's business meeting the following week to explain their role to staff.

Managers had increased the frequency of business team meetings and introduced safety huddles to get feedback from staff, to improve team building and team working. Staff were particularly positive about the introduction of the safety huddles.

Governance

The head of nursing, the clinical director and the ward's senior team had developed a service improvement plan for the ward. Senior leaders and ward staff members attended weekly meetings to review the service improvement plan and to ensure they were on track to complete actions set. The plan identified areas that needed support to improve the ward, such as the ward environment, staffing, restrictive practice and leadership on the ward.

All staff we spoke with were aware of the trust's service improvement plan and felt there had been positive changes on the ward since it.

Management of risk, issues and performance

Staff maintained and had access to the service improvement plan that contained the risks for the ward. This included the ward environment, staffing, use of restrictive practices, and lack of senior leadership on the ward.

Staff concerns matched those on the service improvement plan.

Engagement

Staff on the ward told us they were invited to the weekly meetings to discuss the service improvement plan. Staff told us they felt listened to.

Patients had opportunities to feedback on the service they received through weekly community meetings, which were recorded. Staff asked patients questions such as what could be improved on the ward and if they felt safe on the ward.

The trust's clinical psychologist had recently carried out some work interviewing staff and patients on the ward to obtain their experience of being on the ward and if they felt safe.

Areas for improvement

Action the provider SHOULD take to improve:

The trust should continue to work on recruitment, retention and development of staff to ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on each shift.

The trust should continue to ensure there is effective leadership on the ward and that leaders are visible and approachable for patients and staff.

The trust should ensure that all staff receive regular one-to-one clinical supervision to support them with carrying out their duties.

Our inspection team

The inspection team consisted of a CQC inspector and CQC inspection manager.