Kent and Medway NHS and Social Care Partnership Trust

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

Inspection report

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Date of inspection visit: 8 and 9 December 2020
Date of publication: 12/02/2021

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services responsive to people's needs?	**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

Kent and Medway NHS and Social Care Partnership Trust (KMPT) provides assessment and treatment for adults of working age in 10 acute wards and one psychiatric intensive care ward based in three hospital sites across the trust. We undertook a focused inspection at Littlebrook Hospital based in Dartford which has four inpatient wards:

- Willowsuite – 12-bedded male psychiatric intensive care ward
- Amberwood – 17-bedded mixed ward
- Cherrywood – 17-bedded mixed ward
- Pinewood – 16-bedded male ward.

During this inspection, we visited three wards: Willowsuite, Amberwood ward and Cherrywood ward. We could not visit Pinewood ward as we were informed there was a Covid-19 outbreak on the ward. We were able to speak to staff remotely and gather feedback from patients.

On this inspection, we found some areas that the service needed to improve:

- The trust did not always ensure that the premises were well-maintained. On all four wards there were long standing maintenance issues. For example, three of four wards had damaged walls and doors which had been reported for several weeks and were yet to be resolved.
- Patients and staff told us there they found the quality of the food could be better and that there was a lack of choice for patients with dietary, cultural and religious needs. They told us that patients often had to order takeaways to meet their dietary needs. In addition, some patient's dietary needs were not assessed and monitored.
- Staff were not always completing their mandatory training in line with the trusts' target. Although the trust reported that face-to-face training had to be rescheduled due to Covid-19, records showed the service did not always meet the trust's target for the e-learning modules.
- Although most care and treatment records we reviewed were clearly written and of good quality, we did however see in some records, gaps in recording in areas which included missing risks summaries, missing observation levels and missing patient histories.
- Patients and staff reported that some of the restrictions in place were impacting on patient's wellbeing. For example, patients on Willowsuite were not allowed to have their mobile phones and it was not always clear the rationale behind this.
- It was not always clear how patients' informal complaints, feedback and concerns were documented and actioned. Staff were not always aware that changes in practice may be as a result of actions or learning from patient complaints or feedback and we could not determine the level of staff involvement in the decisions.

However;

- Staff completed and regularly updated risk assessments of all ward areas, and they removed or reduced any risks identified. Ward areas were clean.

Our findings

- Staff managed patients that exhibited behaviours that challenged well. They followed best practice in anticipating, de-escalating and managing challenging behaviours.
- Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service worked to ensure the facilities promoted comfort, dignity and privacy.
- Local leaders had the skills, knowledge and experience to perform their roles, they were visible in the service and approachable for staff. Staff felt respected, supported and valued.
- Staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities.

Background to inspection

Kent and Medway NHS and Social Care Partnership trust's acute wards for adults of working age and psychiatric intensive care units were last inspected as part of a comprehensive inspection in October 2018, where it was rated requires improvement overall. It was rated requires improvement for the key questions, are services safe, effective and well-led, and good for the key questions are services caring and responsive

We undertook this inspection to follow up on concerns raised by the Mental Health Act reviewer visit to Littlebrook hospital in September 2020. The concerns were that patients were being secluded in bedrooms and staff recorded these poorly plus the environment was in a poor state of repair. We were also aware of a number of complaints about the service from patients and carers.

We inspected the key lines of enquiry relating to safe responsive and well-led. As we inspected only one of three hospital sites, the current rating for acute wards for adults and psychiatric intensive care units remains unchanged.

During our inspection visit, we saw that the service had made improvements to address some of the concerns raised following the Mental Health Act reviewer visit. However, we did find several areas of concern which are detailed in this report.

The service 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 trust has a nominated individual.

How we carried out this inspection

You can find 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

The team that inspected the teams comprised two CQC inspectors, one inspection manager, head of hospital inspection, two specialist advisors, one mental health act reviewer and an expert by experience.

Before the inspection visit, we reviewed information we held about this provider as well as feedback and concerns from patients, carers and other stakeholders.

Our findings

During the inspection, we carried out a tour of the environment, reviewed 29 patients' care and treatment records, including the long-term segregation records for patient's subject to these restrictions, reviewed meeting minutes, spoke with staff including the Head of service, matrons, ward managers, deputy ward managers, staff nurses and support workers. We reviewed complaints, incidents and policies.

Is the service safe?

Inspected but not rated

- The trust did not always ensure that the premises were well-maintained. Three of the four wards had damaged walls and doors which had been reported for several weeks were awaiting repairs. The TV in the patient area on Willowsuite had been broken for several weeks and had not yet been replaced. The walls of the seclusion room on Willowsuite were not robust enough to prevent easy damage by patients. One bedroom on Willowsuite and one bedroom on Pinewood had to be decommissioned because of damage to the doors which meant the wards now had less beds which has impacted on admissions. The fire exit door on Amberwood had broken glass which had been boarded with plywood for several months.
- Patients and staff told us that maintenance was an issue and that response times for repairs could be slow. Staff told us repairs and replacement of equipment usually took a long time, and this was documented in the risk register and staff were concerned some of these could pose potential risk to patients. The trust informed us that there was a business case to rectify the doors on Willowsuite, however we were concerned about the length of time it took to resolve maintenance issues.
- Staff did not always keep up-to-date with their mandatory training in line with trust's target. Although the trust reported that face-to-face training had to be rescheduled due to Covid-19, some staff had not completed their e-learning modules. For example, the trust's target for the three yearly clinical risk assessment and management foundation course was not met on three of four wards.
- Although most care and treatment records we reviewed were clearly written and of good quality, we did however see in some records gaps in recording in areas which included missing risks summaries, missing observation levels and patient histories. Some medication charts had errors and were in poor condition.
- We saw two concerns relating to patient records following rapid tranquilisation, and the recording of risk and progress notes for a patient on long term segregation. We informed the provider at the time of inspection and they told us that they would be addressing this by offering staff more training around record keeping, and they would be taking steps to ensure records were thorough and complete.

However;

- Staff completed and regularly updated risk assessments of all ward areas, and they removed or reduced any risks identified. They knew about any potential ligature anchor points and mitigated the risks to keep patients' safe. Staff had alarms in case of an emergency, and patients had easy access to nurse call systems.
- Ward areas were clean and well furnished. Staff made sure cleaning records were up-to-date. They followed the trust's infection control policy including for handwashing and use of personal protective equipment.

Our findings

- Staff managed patients that were a risk to themselves, staff and peers well. They followed best practice in anticipating, de-escalating and managing challenging behaviours. Staff risk assessed all patients thoroughly and regularly updated their risk assessments. On Willowsuite, there was a multi-disciplinary team (MDT) that met daily to discuss patients' risks. Staff could describe how they would safely manage a patient that was violent or aggressive. Staff told us they used restraint and seclusion only after attempts at de-escalation failed.
- The seclusion room at Littlebrook was unavailable to patients on the ward as it was being used as an extra care area for one patient. The majority of seclusion and long-term segregation records we reviewed had clear rationale for the seclusion and followed the trust policy for documentation and review.
- In all bar one occasion, the documents we reviewed showed that staff were following the trust's protocol for the use of rapid tranquilisation. Staff carried out observations for patients who were given injectable rapid tranquilisation and reported this on the incident management system. Staff told us there was no blanket use of rapid tranquilisation, and that patients were only prescribed rapid tranquilisation by the responsible clinician when required.
- The service had enough nursing and support staff to keep patients safe. The service reported low vacancy rates across all four wards. The service had successfully recruited to posts for band 5 nurses on Amberwood, Pinewood and Cherrywood wards. Staff told us and records showed that the wards had the right number of staff and skills mix on most shifts. Managers were able to cover shifts at short notice, and the service reported low use of agency staff.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Managers took part in serious case reviews and made changes based on the outcomes. The service had made 26 safeguarding referrals in the last three months, and most were related to patient on patient physical assault.
- Staff knew how to report and what to report as an incident. The service had a comprehensive incident reporting system and incidents were regularly reviewed by managers. Staff and patients were debriefed by managers following an incident and they were given appropriate support as required. Managers thoroughly investigated incidents and shared learning outcomes with the teams. The trust had a service for staff to raise concerns called 'Green Button' and they can also do this via their locality freedom to speak up ambassadors.

Is the service responsive?

Inspected but not rated

- Patients and staff told us they found the quality of the food could be better and that there was a lack of choice for patients with dietary, cultural and religious needs. There were limited options for patients as the menu contained only two choices for every meal time. The items on the menu rotated every three weeks and there was no listing of foods for patients requiring a special diet. Patients had made complaints about the lack of choice, taste and quality of the food and staff at all levels told us the food was an issue. Staff had on occasions ordered tinned soup from dry supplies to supplement patients' diet and some patients regularly ordered takeaways in order to meet their dietary, religious and cultural needs.
- We saw in patient records that dietary needs were not always assessed such as nutritional requirements for patients who were lactose intolerant. Patients had informed staff they were lactose intolerant, they were still provided meals containing dairy. Staff told us they would normally contact the kitchen if the patient required a special diet, it was not clear how this happened.

Our findings

- Patients reported that some of the restrictions the service had implemented were impacting on their wellbeing. Patients on Willowsuite were not allowed to have their mobile phones and it was not always clear the rationale behind this. Visitors had not been allowed on Willowsuite since March 2020, and some patients reported this was challenging for them. Although managers reported this was due to reducing the spread of Covid-19, patients could meet with their visitors in the visitor's rooms on other wards.
- It was not always clear how patients' informal complaints, feedback and concerns were documented and actioned. Staff we spoke to were unaware of any changes in practice which had been made as a result of actions or learning from patient informal complaints or feedback, or what role they played in addressing these. Although staff told us patients could give feedback and raise concerns during community meetings, these meetings did not always happen on all wards. Meeting minutes we reviewed did not always show actions taken to address concerns raised. The 'you said, we did' board on Amberwood did not show any correlation between what patients said and what staff did.

However;

- Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to. Managers monitored the number of delayed discharges. There were 29 delayed discharges across Pinewood, Cherrywood and Amberwood wards in the last three months. The trust reported that the reasons for the delays were due to the impact of Covid-19 pandemic on social care and housing. The trusts executive's weekly huddle focused on reducing delayed transfers by reviewing barriers to discharges and worked towards removing them. Staff involved patients and carers during discharges.
- Staff made sure patients could access information on treatment, local service, their rights and how to complain. Patients had access to advocacy when required. Patients were reminded of their legal rights and staff assisted patients to access other legal services such as a solicitor. Staff told us the advocates had reduced the number of ward visits due to Covid-19 but were easily accessible by phone. Information for informal patients on 'right to leave' were clearly displayed on the wards.
- The service treated formal complaints seriously, investigated them and learned lessons from the results and shared these with the whole team and wider service. There was information on the ward for patients and carers in how to raise complaints and we saw that there were processes for the teams to review complaints and consider the outcomes. The service had received 13 compliments in the last three months, including one thanking staff for their kindness and support.
- The service worked to ensure the facilities promoted dignity and privacy. The service supported and made adjustments for patients and staff with mobility issues. The wards had quiet areas and rooms where patients could meet with visitors in private. All wards had outside space that patients could access easily. Patients personal possessions were stored safely in a secured room, and they could easily access them. The wards had a ward phone and patients could make phone calls in private.
- Staff provided patients with fruits and drinks throughout the day. Patients could make their own hot drinks and snacks and were not dependent on staff.

Is the service well-led?

Inspected but not rated

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

Our findings

- Staff felt there was a strong team working and mutual support between staff within wards and across the service. They felt respected, supported and valued. Staff were positive and proud about working for the trust and their teams and described the culture as good, open and honest. Staff were confident they could raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Teams worked well together and where there were difficulties managers dealt with them appropriately.
- There was a clear framework of what must be discussed at a ward, team or directorate level. Formal complaints, safeguarding, incidents and learning from incidents were standing agenda on ward governance meetings. Staff had implemented recommendations from reviews of deaths, incidents, formal complaints and safeguarding alerts at the service level. Staff undertook or participated in local clinical audits. Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Staff made notifications to external bodies as needed. Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients
- Staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities. Staff on Cherrywood ward and Willowsuite were piloting a new patient risk assessment tool to predict, manage and reduce their risk of violence and aggression.

1. Managers received feedback from patients, carers and staff and used it to make improvements. Patients and carers were involved in decision-making on how to improve the service.

However:

- It was not clear how managers were addressing the issue around staff not always ensuring records were thoroughly completed. Although the bi-monthly clinical quality checks had identified this as an issue, managers had not provided any actions or recommendations to address this. We fed this back to the service following our inspection, and managers informed us they would carry out more training for staff to ensure records were thorough and complete.

Our findings

Areas for improvement

Action the trust **MUST** take to improve:

The trust MUST take action to ensure that patients nutritional needs are assessed and provide food to meet their dietary needs, including cultural and religious needs (Regulation 14)

The trust MUST take action to remedy all outstanding maintenance issues, and ensure the facilities and equipment are well-maintained and fit for purpose (Regulation 15)

Actions the provider **SHOULD** take to improve:

The service should consider reviewing ward restrictions, including use of mobile phones on individual basis and also ensure consistency for how patients would meet with their visitors.

The trust should consider a robust mechanism of capturing informal complaints, feedback and concerns raised by patients and how they would address them.

The service should take steps to address the mandatory training compliance to ensure trust's targets are met.

The service should ensure patient records are thorough and complete, and there is coordination between patient records on different systems.

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 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment