St Andrew's Healthcare

St Andrew's Healthcare - Mens Service

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Insufficient evidence to rate
Are services caring?	Insufficient evidence to rate
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced focused inspection was triggered by the receipt of information which gave us concerns about the safety and quality of services on two wards at the hospital. CQC received this information of concern between July and September 2022. Our last inspection of this service was in June 2022.

The concerns received included the following:

- safe staffing levels and how incidents were safely managed
- physical healthcare and care of the deteriorating patient
- one incident of poor medicine management
- use of restrictive practices.

Our rating of this location stayed the same. We rated it as requires improvement because:

We found:

- On Heygate ward, the night shift lacked leadership to support staff to make decisions on how to minimise restrictive practice and maintain effective relational security.
- On Heygate ward, there was a delay in prescribing medication to one patient. Referrals to the physical healthcare team for out of hours admission were not always robust.
- On Heygate ward, night staff implemented a blanket restriction without clear rationale.
- Despite remedial action taken by the provider there was a strong smell of drains from the toilets in the therapy corridor of Malcom Arnold House, leading to Heygate ward.
- We found 4 incidents of staff sleeping on duty on Fairbairn ward.

However:

- Both wards showed that while nursing shifts had not started with the planned number of staff, managers filled gaps with known bank staff to bring staffing levels up to safe numbers. Staff told us that in the previous few months staffing levels had improved. The provider had improved pay and conditions for staff and had measures in place to address both recruitment and retention of staff. We found the staffing issue had improved at our last inspection of these services in June 2022, and there was evidence of slow but continued improvement since our last inspection.
- All staff we spoke with knew how to report incidents and record them in the electronic system. We reviewed incident records against safeguarding referrals and daily care notes which confirmed this judgement. Managers shared lessons learned from incidents within teams to prevent future occurrence of the same incident.
- Compliance with safeguarding training was 100% on Fairbairn ward and 80% on Heygate ward. All staff we spoke with understood what constituted a safeguarding concern.
- Staffing levels meant enhanced observations had been carried out safely.
- Staff managed the routine physical healthcare of patients well and managed physical healthcare incidents well.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	We were not able to go onto this ward as on the day of inspection the ward was in isolation due to a COVID-19 outbreak. We did however carry out a desk top review of 2 serious incident notifications and a whistle blowing report received by CQC, away from the ward setting. Prior to this inspection we received 2 notifications of staff sleeping on duty, 1 allegation of inappropriate touch and 1 incident of inappropriate force during a restraint. We also received intelligence from a key stakeholder that staffing numbers were low and safety of the ward was compromised. In order to review the circumstances around all concerns we reviewed staffing numbers, and we reviewed how staff documented and knew about how to manage patient risk. Our rating of this location stayed the same. We rated it as requires improvement because: • We found 4 incidents of staff sleeping on duty on Fairbairn ward. Two incidents had been reported to CQC and 2 other incidents were recorded in the electronic incident records. • Actual numbers of staff against the planned establishment were not always met at the start of a shift. However vacant shifts were filled with bank and agency staff which brought staffing levels up to safe numbers. The provider had improved pay and conditions for staff to increase numbers and started to put measures in place to address both recruitment and retention of staff. We found the staffing issue had improved at our last inspection of these services in June 2022, and there was evidence of slow but continued improvement since our last inspection. • All staff we spoke with knew how to report incidents and record them in the electronic system. We reviewed incident records against safeguarding referrals and daily care notes

Summary of findings

which confirmed this judgement. Managers shared lessons learned from incidents within teams to prevent future occurrence of the same incident.
- All staff had completed safeguarding adults' level 3 training on Fairbairn ward.

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

Requires Improvement

Prior to this inspection we received 4 concerns about incidents that had occurred on Heygate ward. We received 2 patient concerns about quality of care. One was in relation to a patient who told us their leave was cancelled without good reason, and a second was that staff used seclusion inappropriately. We received 1 safeguarding notification in relation to use of force from staff on a patient and 1 serious incident notification in relation to omission of a medication for diabetes. In order to review the circumstances around all concerns we reviewed staffing numbers, how staff were trained to provide safe care, and we reviewed the safeguarding practices. We also reviewed how staff documented and knew about how to manage patient risk.
Our rating of this location stayed the same. We rated it as requires improvement because:

- The night shift on Heygate ward lacked strong leadership to support staff to make decisions on how to minimise restrictive practice and maintain effective relational security. Dynamics between staff and patients were strained as staff did not always feel confident to manage the aggression of patients and to manage ward rules effectively.
- As a result of a decision made by night staff, we found a blanket restriction in place on Heygate ward. Hot drinks were not readily available to patients. There were no care plans or risk assessments that documented reasons for this restriction.
- In one incident, communication between ward staff and the physical healthcare team did not occur in a timely way to manage an out of hours admission.
- One concern had been reported to us around a delay in prescribing medication following the admission of a patient. We found evidence to

Summary of findings

support the concern. The medicines error was identified but not until 10 days after admission. However, the provider had investigated the omission and had put plans in place to prevent a reoccurrence of the incident.

- There was a strong smell of drains from the toilets in the therapy corridor of Malcom Arnold House. Although remedial action was in place the smell remained at the time of our inspection.

However:

- The ward was staffed with the right numbers of staff to keep patients safe. The start of some shifts did not always meet the planned numbers, but gaps were filled during the shift with bank staff which brought staffing levels up to safe numbers. Staffing had improved since our last inspection of these services in June 2022, and there was evidence of slow but continued improvement in the time since our last inspection.
- Staff managed incidents safely. Staffing numbers did not have an impact on the ability to manage incidents. All staff we spoke with on Heygate ward knew how to report incidents and record them in the electronic system. We reviewed 2 whistleblowing reports and 1 serious incident made to us and found incident records, safeguarding records, and daily care notes supported this. Lessons learned from incidents were shared within teams to prevent future occurrence of the same incident.
- Staff managed safeguarding incidents well. We reviewed 1 safeguarding concern and 2 complaints reported to us and found staff had reported, recorded, escalated, and investigated all incidents in line with policy. We saw evidence of the providers investigation reports, response letters and a duty of candour letter. Compliance with safeguarding adults level 3 training on Heygate ward was 80%. All staff we spoke with understood what constituted a safeguarding concern.

Summary of findings

- Staff managed the routine physical healthcare of patients well. Patients had full physical healthcare checks on admission and at regular intervals thereafter.

Summary of findings

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Summary of this inspection

Background to St Andrew's Healthcare - Mens Service

St Andrew's Healthcare – Men's Service registered with CQC since 11 April 2011. The service did not have a registered manager in post at the time of the inspection but does have a nominated individual as required, and a controlled drugs accountable officer. At the time of the inspection, the provider had applied to change its registration with CQC to one location instead of multiple registrations across one site. A new application for a registered manager was in progress at the time of the inspection.

At this inspection, we visited one ward in the following core services:

- Acute wards for adults of working age and psychiatric intensive care units: Heygate ward – a psychiatric intensive care unit with 10 beds for males.

We had planned to visit the following core service, but due to a COVID-19 outbreak, this ward was in isolation at the time of our inspection. Therefore, we carried out a remote review of data and the incidents that had been reported to us.

- Forensic inpatient or secure wards: Fairbairn ward, a 17-bed medium secure ward for adult males who are deaf.

CQC have inspected this location 12 times. The most recent comprehensive inspection of this location was in June 2022. The overall rating for the location was Requires Improvement. We rated Safe as requires improvement, Effective, Caring, and Responsive as good and well-led as requires improvement. Forensic inpatient or secure services, the overall rating was requires improvement, with safe, effective and well led rated as requires improvement and caring and responsive as good. Acute wards for adults of working age and psychiatric intensive care units was rated requires improvement overall. Safe and well led were rated requires improvement with effective, caring and responsive as good.

What people who use the service say

Acute ward for adults of working age and psychiatric intensive care units:

We spoke with five patients on Heygate ward.

Three patients told us they felt safe on the ward. While another patient told us they did not feel safe because "co patients were all at different levels of wellness and could be unpredictable in their behaviours". He said that one night during an incident "staff put me in the seclusion room and grabbed me. I have a broken right hip and it affects the way I walk so I am not feeling safe about my hip. He also said he put in a complaint about this and how staff did not know about his physical health concerns and asked to go to a different hospital as being here isn't helping my care".

A fifth patient told us that while he felt safe "things often kicked off at night-time when some patients became rude and pushed the boundaries. This results in staff becoming cross and taking people into seclusion". He told us that one evening he witnessed "an unreasonable restraint when a co patient had been shadow punching a wall. He felt this was not justified and it's the staff who play games and 'enjoy' themselves, they break the rules, and they joke about me, indirectly".

Summary of this inspection

Three patients said they thought there were enough staff who got on well with patients, however one patient felt "staff had too much paperwork to do and this meant they could not spend time with them". Another patient told us "he could see some improvements in staffing and felt staff were more available for help". Two patients told us that "staff at night-time were not always as friendly as those in the daytime and they just seemed to do their own thing".

Three patients told us they had been involved in discussions about their care and treatment plans and all three patients felt staff were considerate and treated them well.

Three patients confirmed they had all had regular physical health check-ups and staff did blood pressure and temperature check every day.

Forensic inpatient or medium secure wards:

Following a COVID-19 outbreak and subsequent isolation of the ward on the day of our inspection, we did not go onto Fairbairn ward or speak with any patients on that ward. However, we did have feedback from one patient who had raised a complaint prior to our inspection:

The patient reported that while he felt safe on the ward, he had noticed staff had been sleeping during their observations of him. He also reported this had not been the first time this had happened.

How we carried out this inspection

The inspection team visited two wards between 18 October and 20 October 2022. During the inspection we:

- observed how staff cared for patients;
- reviewed the medicine management of one patient on Heygate ward;
- reviewed two complaints on Heygate ward and two complaints on Fairbairn ward;
- reviewed four safeguarding notifications, one on Heygate ward, two on Fairbairn ward.
- reviewed the physical health care of one patient on Fairbairn ward, and one on Heygate ward;
- spoke with 5 patients who were using the services;
- spoke with 14 staff including nurses, healthcare support workers, psychologist, pharmacist, social worker, safeguarding lead, and physical healthcare lead;
- reviewed seven patient care records;
- reviewed 13 patients' medicines charts and physical observation records,
- observed one patient and staff interaction on Heygate ward;
- reviewed documents remotely;
- reviewed a range of policies, procedures and other documents relating to the running of the services.

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.

Areas for improvement

Action the service 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.

Summary of this inspection

Action the service MUST take to improve:

Acute ward for adults of working age and psychiatric intensive care units:

- The provider must ensure that all medicines prescribed to patients on admission are clearly and correctly recorded and prescribed. (Regulation 12(2)(g))
- The provider must ensure that the smell from drains and toilets in the therapy corridor of Malcom Arnold House is permanently resolved as soon as possible. Regulation 15(1)(2)
- The provider must ensure that the blanket restriction found on Heygate ward around patients' free access to hot drinks is properly managed. (Regulation 13(4)(a))
- The provider must ensure that staff are compliant with mandatory training and compliance with basic life support training improves. (Regulation 18(1)(2))
- The provider must ensure that all incidents of restraint are documented to include least restrictive approaches including de-escalation. (Regulation 17 (1)(2))
- The provider must ensure they strengthen night-time leadership on Heygate. (Regulation 17(2)(b))
- The provider must ensure they improve communication processes between staff and the physical healthcare team to cover out of hours admissions, and referrals following serious physical health incidents. (Regulation 17(2)(a))

Forensic inpatient or secure wards:

- The provider must ensure staff safely observe patients when completing enhanced observations. (Regulation 12 (1)(2))

Action the service SHOULD take to improve:

Acute ward for adults of working age and psychiatric intensive care units:

- The provider should continue to deliver the recruitment and retention plan which has commenced.
- The provider should improve night-time leadership to reduce restrictive practice and improve compassionate and supportive care to patients.

Forensic inpatient or secure wards:

- The provider should continue to deliver the recruitment and retention plan which has commenced.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Not inspected	Not inspected	Not inspected	Insufficient evidence to rate	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Insufficient evidence to rate	Insufficient evidence to rate	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Insufficient evidence to rate	Insufficient evidence to rate	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

Safe	Requires Improvement
Well-led	Insufficient evidence to rate

Are Forensic inpatient or secure wards safe?

Requires Improvement

Our rating of this location stayed the same. We rated it as requires improvement because:

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Prior to this inspection we received 4 safeguarding notifications detailing 2 incidents of staff sleeping on enhanced observations, 1 allegation of inappropriate touch and 1 incident of inappropriate force during a restraint. We also received intelligence from a key stakeholder that staffing numbers were low and safety of the ward was compromised. We had concerns that these incidents were connected to staffing numbers and whether staff could keep patients safe.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. We noted a high use of agency staff on this ward. Out of 124 shifts for the period, 57 agency staff had been used on 40 shifts. Managers had previously acknowledged the high use of agency staff in this service but confirmed they always requested familiar agency staff and ensured they had undertaken full induction to the service and orientation to the ward.

A review of staffing rosters for the period 19 August 2022 to 19 October 2022, showed that while the service had enough nursing and support staff on each shift to maintain safe staffing levels, many shifts, 102 out of 124 shifts, included bank and agency staff. Bank staff were usually internal staff who knew the wards and the patients and managers always requested staff familiar with the service. The data showed that for the period 19 August 2002 to 19 October 2022, seven shifts had not met the requirement of 2 registered nurses per shift, though all shifts had at least 1 registered nurse and managers made up the shortfall with 1 additional healthcare assistant on 3 of the shifts and 2 additional healthcare assistants on the other 4 shifts. Staff we spoke with on other wards told us that on such occasions the ward manager also supported the shift when required.

The system in place which we reported on at our last inspection continued to run effectively, so that bleep holders were alerted to gaps in shifts and were able to flexibly and easily move staff within services to fill gaps.

Requires Improvement

Forensic inpatient or secure wards

The provider explained how they had improved pay and conditions for staff and had started putting measures in place to address the longer issues of recruitment and retention. We found that conditions and morale around staffing had improved since our last inspection of these services in June 2022, and there was evidence of slow but continued improvement in the weeks since June 2022. We felt the provider should ensure that the system implemented at our last inspection continue to improve the staffing picture and flexibility of workforce in these nationally challenging times.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. There were 4 incidents of staff sleeping on duty.

Assessment of patient risk

Prior to this inspection we received 4 safeguarding notifications detailing 2 incidents of staff sleeping on enhanced observations, 1 allegation of inappropriate touch and 1 incident of inappropriate force during a restraint. We were concerned that staff did not effectively manage risks to patients well.

We reviewed 4 patients risk assessments and management plans. The records showed that staff completed risk assessments for each patient on admission, using a recognised staffing tool short term assessment of risk and treatability (START) and reviewed this regularly, including after any incident. Staff also completed more specific risk management plans. Staff also completed specific risks assessment as required, for example, the historical risk-20 (HCR–20), which is a 20-item structured clinical guide for the assessment of violence risk.

Management of patient risk

We reviewed 4 patient records and documentation included in the records showed that staff had recorded the known risks to each patient and acted to prevent or reduce risks.

Ongoing reviews recorded by staff showed that staff identified and responded to any changes in risks to, or posed by, patients.

Prior to this inspection, we were aware of 2 incidents of staff sleeping on duty on Fairbairn ward. During a review of documentation, we found a further 2 incidents of staff sleeping on enhanced observations. The incidents had occurred while staff were carrying out enhanced patient observations. Three of the 4 incidents had occurred in the evening and one in the daytime, no harm was experienced by patients as a result of these incidents. We found no evidence to suggest that staff found sleeping on duty had been working excessively long hours on the ward to fill vacant shifts. We have reported on this in the well led section of this part of the report.

Our review of the incident records, the patients daily care notes, safeguarding concerns, and investigation reports showed that the provider was aware of the incidents had fully investigated and taken appropriate disciplinary action.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Requires Improvement

Forensic inpatient or secure wards

Prior to this inspection we received 4 safeguarding notifications which included 2 incidents of staff sleeping on enhanced observations, 1 allegation of inappropriate touch and 1 incident of inappropriate force during a restraint. Therefore, at this inspection, we reviewed whether staff managed safeguarding practices effectively in this service.

All staff in the service had been trained in safeguarding adults level 3 and 96% for children safeguarding level 2. All staff knew how to recognise and report abuse and how to raise a safeguarding. A social work team had oversight and facilitated all child visits where needed. Prior to the inspection we had received 4 safeguarding notifications about incidents that had taken place on the ward. All incidents had been documented well, and the referrals made to local authority safeguarding were thorough and appropriate.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service reported, recorded and investigated patient safety incidents well, following regulation and provider policy.

Prior to this inspection we received 4 safeguarding notifications which included 2 incidents of staff sleeping on enhanced observations, 1 allegation of inappropriate touch and 1 incident of inappropriate force during a restraint. We had concerns that these incidents were connected to staffing numbers and whether staff could keep patients safe.

We reviewed 2 incidents of staff sleeping on duty on Fairbairn ward, known to us prior to the inspection. Whilst reviewing records we found 2 further incidents of staff sleeping on duty. The provider was aware of all four incidents and they were correctly recorded in the electronic incident record. The reasons why 2 incidents were reported to CQC and 2 were not was that 2 incidents occurred on the same day by the same staff member giving cause for a safeguarding concern, the third one was part of a patients complaint to CQC, and the fourth one was categorised as a low level no harm incident.

Our review of records in connection to the 4 incidents of staff sleeping, the daily care notes, safeguarding and investigation reports demonstrated that managers had fully reported and investigated the incidents, taken appropriate and timely disciplinary action and identified lessons learned.

We reviewed the safeguarding incident notified to us as a result of a complaint made by a patient of inappropriate touch during a restraint. We reviewed the incident record, the statements made by staff during the provider's investigation and the local authority investigation. The local authority closed the investigation with no evidence to uphold the complaint. The provider's investigation was thorough and did not uphold the complaint. The provider took appropriate action to safeguard the patient by offering opportunities for the patients to talk about the incident, and staff who were alleged to have been involved did not work in the service whilst the investigation was ongoing. The investigation showed that the family of the patient were involved throughout the investigation process.

We reviewed the safeguarding incident notified to us as a result of a complaint made by a patient of a forceful restraint incident. We reviewed the investigation completed by the provider, and reviewed daily care notes, records of staff interviews and the incident record. We found that staff had raised the allegation immediately following the incident, the

team discussed the allegation made by the patient in their morning meeting and the manager commenced an investigation. Daily care records showed staff had made attempts to de-escalate the patient in the first instance and managed the attempted aggression as per care plan. The patient made a request to enter seclusion to calm down. The provider had completed a thorough investigation report, and the allegation was not upheld.

Are Forensic inpatient or secure wards well-led?

Insufficient evidence to rate

We did not re-rate this key question at this inspection because we did not have sufficient evidence from all key lines of enquiry to do so. The previous rating of requires improvement remains the same.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers investigated incidents when complaints were made that staff had slept on duty and took action to manage the performance and competence of staff who carried out enhanced observations. The provider had ensured staff did not carry out enhanced observations for excessive amounts of time with the same patient. We reviewed observation sheets for Fairbairn ward where reports of staff sleeping on duty was noted. The sheets showed that staff were rotated for observational duties. We did not see any one staff member doing more than 1 hour of observation with a single patient and no more than 2 hours of consecutive observations. This included general observations. The provider had responded to previous inspection reports where this issue had been highlighted and carry out regular checks and audits on enhanced support observations. The audits include the length of time staff spend with each patient and if harm occurred during the period of observation and whether this was attributed to staff competence to carry out observations. Results of audits were reviewed by senior managers and action taken where necessary if staff performance falls below the required standard.

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

Requires Improvement

Safe	Requires Improvement
Effective	Insufficient evidence to rate
Caring	Insufficient evidence to rate
Well-led	Requires Improvement

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

Requires Improvement

Our rating of this key question stayed the same. We rated it as requires improvement because:

Safe and clean environment

A toilet block that had been out of order for over a year did not have clear signage to the nearest working toilet.

Maintenance, cleanliness and infection control

Concerns about the environment had not been reported to us prior to the inspection and was not planned to be a focus of this inspection. However, we noticed a strong smell of drains in the corridor which led to Heygate ward. Staff advised us the smell was coming from the drains in the accessible and unisex toilets in the therapy corridor, and that the toilets had been out of order for over a year. There was no signage to advise staff, patients, or visitors that the toilets were out of order or where the nearest alternative facilities could be found. Post inspection the provider evidenced that the toilets were in working order since September 2022 with remedial action taken to manage the smell from the drains on a daily basis. The provider explained that the smell was due to pipework under the building which the provider was aware of and had taken weekly action to manage the smell. However, the smell remained at the time of our inspection despite action taken by the provider to eliminate the smell."

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Prior to this inspection we received 4 concerns about incidents that had occurred on Heygate ward. Two patient concerns about quality of care, 1 safeguarding notification and 1 serious incident notification. We had concerns that these incidents were connected to staffing numbers and whether staff could keep patients safe.

The service had enough nursing and support staff to keep patients safe.

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

Requires Improvement

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.

The service had an establishment of eight registered nurses and 16 healthcare assistants. The service had two registered nurse vacancies and two health care assistant vacancies. Staff establishment for this ward was 2.00 whole time equivalent (wte) registered nurses and 5.0wte healthcare assistants in the daytime and 2.00wte registered nurses and 3.0wte healthcare assistants in the evening.

On some occasions, the actual numbers of staff against the planned establishment were not always met at the start of a shift. Gaps in shifts were usually filled with known bank staff which brought staffing levels up to safe numbers. For example, on the morning of our inspection, there was 1 gap in qualified staff and 3 gaps in healthcare assistant staff. However, within 1 hour of the start of the shift, the gaps had been filled by regular bank staff. The nurse in charge, escalated the gaps to the on-site co-ordinator and they worked to fill the gaps in the shifts.

The data showed that for the period 19 August 2022 to 19 October 2022 eleven shifts had not met the requirement of two registered nurses per shift. Though all shifts had at least one registered nurse, on seven of these occasions the nurse shortfall was made up with an additional 2.0wte healthcare assistants, on two occasions the shortfall was made up with one additional healthcare assistants, and on two occasions, both of which were evening shifts, it appears that the shifts ran with just one registered nurse and 3.0wte healthcare assistants.

Staff told us that in the previous few months staffing levels had improved slightly. Two patients we spoke with confirmed they had seen improvements in staffing numbers during the previous few weeks. The provider explained how they had improved pay and conditions for staff and had started putting measures in place to address the longer issues of recruitment and retention. We found that conditions and morale around staffing had improved since our last inspection of these services in June 2022, and there was evidence of slow but continued improvement since our last inspection. The provider should ensure that the system implemented at our last inspection continue to improve the staffing picture and flexibility of workforce in these nationally challenging times.

Heygate ward used two qualified agency staff, known to patients, usually for night duty. Any other staff came from the internal bank of staff who were familiar with the ward.

Some patients told us they didn't know some temporary staff well. The length of time a patient stayed on the ward was short, because the purpose of the ward was to stabilise a patient's mental health before transferring to a suitable alternate placement or back home. This meant, that there were times when patients only encountered some temporary staff once in their stay on the ward.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We observed a bank staff member, who was obviously known to other staff and who had come onto the ward after the nurse's morning handover, receiving a full handover from the nurse in charge for that shift.

Patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled and if they were then staff discussed the reasons why with patients and rearranged the leave or activity.

The service had enough staff on each shift to carry out any physical interventions safely. The service also had access to a designated physical healthcare team.

Staff shared key information to keep patients safe when handing over their care between shifts, or when staff came onto the ward after morning handover.

Mandatory training

Prior to this inspection we received 4 concerns about incidents that had occurred on Heygate ward. Two patient concerns about quality of care, 1 safeguarding notification and 1 serious incident notification. We had concerns that these incidents were connected to staffing numbers and whether staff had been suitably trained to keep patients safe.

We reviewed the training figures related to the focus of this inspection. Specifically, basic life support, immediate life support, safety Intervention training (previously MAPPA) and safeguarding adults' level 3.

Training compliance on Heygate ward for the above courses was basic life support 67%, immediate life support 80%, safety intervention training 83%. Managers were able to show us that the reason for a shortfall on basic life support training was due to a recently cancelled course due to trainer illness, and two staff who were on long term sick leave and had gone out of date. Where staff were not up to date with their training such as basic life support, they booked themselves onto courses.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves effectively. We found a blanket restriction in place on Heygate ward.

Assessment of patient risk

Prior to this inspection we received 4 concerns about incidents that had occurred on Heygate ward. Two patient concerns about quality of care, one safeguarding notification and one serious incident notification. We had concerns that these incidents were connected to how staff assessed risk.

Staff completed risk assessments for each patient on admission, using a START risk assessment tool. The multidisciplinary team were all involved in completing patient risk assessments and risk management plans, so they could consider all aspects of care and treatment.

The 4 care records we reviewed as part of our focussed inspection showed that these patients all had up-to-date risk assessments and management plans. There was evidence that staff always discussed risk as part of ward round and staff discussed specific risks with each patient and their family when patients gave permission to do this.

Management of patient risk

Prior to this inspection we received 4 concerns about incidents that had occurred on Heygate ward. Two whistleblowing reports about quality of care, 1 safeguarding notification and 1 serious incident notification. Therefore, we reviewed whether staff managed risks effectively. Staff we spoke with knew about the risks to each patient and acted to prevent or reduce risks. Staff had easy access to patient's positive behaviour support plans in the nursing office. We observed two nurse handovers, and both included all the information staff required for the shift. Six staff we spoke with confirmed this always happened on this ward. Staff could observe patients in all areas of the ward.

Staff we spoke with knew of the providers search policy and told us how they followed this procedure when they needed to search patients or their bedrooms to keep them safe from harm. The ward displayed a list of contraband items so patients knew what they could have on the ward.

We found a blanket restriction in place on Heygate ward. Hot drinks were not readily available to patients, this meant patients needed to ask staff for a hot drink. We saw the drinks station did not have flasks of hot water available. A staff member and one patient told us that night staff had moved the drinks flasks into the office to prevent patients having too much coffee and sugar before bedtime. However, there were no care plans or risk assessments that documented reasons for this restriction and no evidence that staff had reviewed the restriction since the decision.

We reviewed 1 patient concern that was raised to us prior to inspection. This was in relation to a patient who told us that staff had cancelled their leave with no reason. We spoke with the patient who told us they felt they had been treated unfairly, and not listened to. We reviewed all clinical documents in relation to this incident, including ward round notes and care plans and leave documentation. We found evidence to support the team had made a decision based on clinical risk as the patient had displayed risk behaviours in the community putting them self and others at risk. We saw that staff managed the risk well and the decision by staff to suspend leave showed full discussion and rationale for doing so.

Use of restrictive interventions

Night staff did not always use the least restrictive options to manage the safety of the ward. We found 1 incident where seclusion was used instead of de-escalation as a first resort.

Prior to this inspection we received 1 whistleblowing concern about an incident that had occurred on Heygate ward in relation to the use of restraint and seclusion. One patient told us they had been taken to seclusion by staff instead of staff using de-escalation in the first instance.

We spoke with the patient who told us about a time when they felt night staff did not use de-escalation in the first instance when they became agitated or upset and a second patient told us they had witnessed this incident. Two other patients we spoke with said staff on night duty had used restraint in a heavy-handed way and one of these patients told us he had made a complaint about this. Three patients told us that the attitude of night staff was different to those on day shift.

We reviewed 3 incidents, 2 complaints and a notification that involved restraint. We looked at the daily care notes, the electronic incident records, investigation reports, safeguarding reports, and the restraint policy. Staff had recorded all incidents in detail and the investigation into the patient who had made a complaint about the use of seclusion when de-escalation failed showed this was not upheld. However, having compared the specific incident of restraint reported to us against the daily care notes for the relevant incident time, we found there was very little reporting of what de-escalation had actually taken place before the restraint.

Eighty-three per cent of staff on this ward had completed safety Intervention training (previously MAPPA). Which included de-escalation strategies. We spoke with five staff and six patients on this ward about de-escalation, restraint, and seclusion. Staff knew their roles and how to use restraint and seclusion appropriately.

One staff member told us that some patients were more challenging at night-time and some night staff sometimes found this challenging. We reviewed incident data for the period 19 August 2022 to 19 October 2022 and found the number of incidents at night was only slightly less than daytime but would have been managed with less staff than on days. There were 56 incidents reported on night shift compared to 62 for day shift.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Prior to this inspection, we received 1 safeguarding notification of an allegation of staff on patient retaliation. We reviewed this incident and 2 additional safeguarding concerns on Heygate ward. We looked at the incident record, the safeguarding referral, the investigation reports, and the actions taken by the provider because of the investigation. We saw that managers had followed provider policy and procedure and reported to the weekly safeguarding meeting. The incident reported to us was not upheld.

Staff received training on how to recognise and report abuse, appropriate for their role in line with national guidance. On Heygate ward, compliance with safeguarding training for children, young peple and adults, level 2 was 100% and level 3 safeguarding children young people and adults was 80%. The online element of training for level 3 was 100% compliance. The level of training provided met national guidance on safeguarding children, young people and adults as there was a mandatory requirement for all registered staff to complete Level 3 training. All other practitioners that had regular contact with patients, their families or carers, received level 2 training.

Staff knew how to respond to patients' complaints about care, and where necessary how to safeguard patients from abuse or neglect. Staff took the right steps to raise safeguarding reports to the local authority as required and managers investigated incidents thoroughly taking action when needed.

Medicines management

One episode of insulin management was not well managed. Managers picked up the medicines error, but not until 10 days after admission. However, the incident was investigated, and lessons learned were identified.

Prior to this inspection we received 1 notification of a serious incident in relation to medicines management. We found evidence to support the concern; the incident had occurred.

We reviewed the medication error notification. Staff had omitted to prescribe and administer the long acting insulin for 10 days following admission. The pharmacy service had visited the ward, completed their medication reviews of the new admission, noted previous insulin usage and documented this in the patients progress notes. Routine practice would be for the pharmacist to advise the medical team of this new information to enable a prescription of the relevant medication to be made. Due to a personal emergency the pharmacist had to leave the ward and the actions required to follow through with the prescribing of the medication was not communicated to the covering pharmacy team, or the responsible clinician covering for the substantive responsible clinician. Staff on the ward did not pick up the error until the substantive responsible clinician arrived back from annual leave 9 days later.

The provider had investigated the incident thoroughly and had identified lessons learned. We reviewed the investigation report which included referral documentation, admission report, daily care notes, medicine charts, nursing notes and pharmacy notes and spoke to the patient involved.

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

Requires Improvement

The investigation identified the referral information provided by the previous placement had omitted to include long term insulin medicine. It also identified the medicine chart had not been sufficiently updated and followed up on admission. Communication between the ward and pharmacy services was not effective at the time of this admission. The investigation had highlighted several missed opportunities which resulted in a delay to the correct diabetic medication being prescribed.

The provider had taken all necessary steps to investigate and take action to respond to this incident. Duty of candour was offered to the patient and an apology given, for missed opportunities in care. No harm came to the patient as a result of the medication omission.

Track record on safety

Reporting incidents and learning from when things go wrong

The service had a good track record on safety. The service reported, recorded, and investigated patient safety incidents well, following regulation and provider policy.

Prior to this inspection we received 4 concerns about incidents that had occurred on Heygate ward. Two whistleblowing reports about quality of care, 1 safeguarding notification and 1 serious incident notification. We had concerns that these incidents were connected to staffing numbers and whether staff could keep patients safe.

All staff we spoke with knew how to report incidents and record them in the electronic system. A review of 3 incident notifications and a further 4 incidents picked at random from the provider electronic records supported our judgement. We tracked incidents against the involved patients daily care notes, safeguarding referrals and speaking with staff and patients.

We saw how incidents were categorised against provider policy, and how managers had investigated serious incidents and written up those findings in investigation reports. Identifying lessons learned.

Staff understood the duty of candour. We saw evidence of two duty of candour letters to patients and their families. The letters were open and transparent and gave patients and families a full explanation when things went wrong and offered an apology.

Managers debriefed and supported staff after any serious incident. Staff and patients we spoke with confirmed this. Two patients we spoke with confirmed staff had spoken with them and supported them after serious incidents.

Staff met to discuss the feedback and look at improvements to patient care. Managers shared lessons learned from incidents within teams to prevent future occurrence of the same incident. Managers met at weekly clinical governance meetings to discuss themes and investigation outcomes and shared the lessons learned with managers across the site and with staff at handovers, team meetings and through internal email.

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

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

Requires Improvement

Insufficient evidence to rate

We did not re-rate this key question at this focused inspection and the current rating of good remains.

We did not rate this key question as there was insufficient evidence to do so.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission.

Prior to this inspection we received 1 notification of a serious incident in relation to the management of medication. This was reported in the medicines section of the report. At this inspection, we reviewed records of 3 other patients with physical healthcare conditions to ensure this was not a reoccurring theme.

We did not find evidence to support our concern that staff did not effectively manage the physical healthcare of patients.

Staff managed the routine physical healthcare of patients well. Patients daily care records, physical observation records, and verbal reports from staff and patients confirmed our judgement.

We saw that all patients had physical healthcare checks on admission. Staff and the responsible clinician in the receiving team carried out these checks and following referral the physical healthcare team carried up more in-depth checks. However, we found 1 episode where a patient had not received a check up by the physical healthcare team until some days after admission. This was due to ward staff admitting the patient urgently during the evening and not making a referral to the physical healthcare team at the same time. The physical healthcare team worked 8.00am to 8.00pm Monday to Friday and limited cover of 2 physical healthcare staff 8.00am to 8.00pm at weekends, in addition to an on call doctor 24 hours per day. When staff admitted patients to the ward outside of these hours the communication processes in place were not sufficiently robust to ensure that there were no delays in referring new admissions to the physical healthcare team.

Nursing staff completed routine daily checks, and specific health checks and body mapping after any incident of potential harm or injury thereafter.

Staff developed individual care plans which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

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

Insufficient evidence to rate

We did not re-rate this key question at this focused inspection and the current rating of good remains.

We did not rate this key question as there was insufficient evidence to do so.

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

Requires Improvement

Kindness, privacy, dignity, respect, compassion and support

Most staff treated patients with compassion and kindness, respected patients' privacy and dignity, understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients told us some staff on night duty were not always compassionate and supportive.

Two patients told us they felt that some night staff did not always use de-escalation in the first instance when they became agitated or upset and initiated the use of seclusion. Three patients told us that the attitude of night staff was different to those on day shift.

One staff member told us that some patients were more challenging at night-time and some night staff sometimes found this challenging.

Three patients we spoke with told us night staff behaved differently to daytime staff. We spoke with a patient who contacted us prior to the inspection to inform us about a seclusion that had taken place before de-escalation had been used. They told us they had "agreed to walk to seclusion with night staff". We also spoke with a second patient who told us he had witnessed this. A third patient told us "things often kicked off at night-time when some patients became rude and pushed the boundaries. Too much rudeness from patients is difficult for them (staff). This results in staff becoming cross and taking people into seclusion". We reviewed 3 incidents reports, patients daily care notes and staff training records and staff rosters for night-time shifts. One incident relating to a restraint suggested that night staff did not always use de-escalation techniques and engagement strategies as a first resort with the patients involved.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

Our rating of this key question stayed the same. We rated it as requires improvement because:

Leadership

Most leaders had the skills, knowledge and experience to perform their roles, and had a good understanding of the services they managed, were visible in the service and approachable for patients and staff. We found that there was lack of oversight by senior leaders to ensure decisions taken by the team offered high quality care to patients, and that leaders could offer closer support and role modelling for night staff.

We found the therapeutic relationships on Heygate ward between night staff and patients was difficult and some staff did not always manage relational security well. Dynamics between patients and between some staff and some patients caused tension on the ward. Some night staff made decisions about how to safely manage the rules and boundaries on the ward that were not always explained to patients. Some night staff took decisions to manage patient behaviour, such as control of the environment (blanket restriction), a week prior to our inspection and use of seclusion, rather than de-escalation, without oversight from senior, more experienced staff. These decisions were not subsequently reviewed by the next shift or the ward team. As a result, patients became frustrated with the decisions made, and this resulted in tension between night staff and patients. Patients told us they didn't always trust all night staff.

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

Requires Improvement

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. However, on nights, staff did not always make decisions that resulted in high quality care.

We saw evidence that culture workshops and training had taken place across the organisation as a response to our inspection of July 2021. The Heygate clinical model was adapted to be used in training. This training included the philosophy, motivational interviews, boundaries, behaviour principles such as compassion focus, therapeutic approaches, managing change and enhanced support.

Staff told us they felt able to raise concerns. A system was in place where staff could raise concerns, through the St Andrews 'safe call' system. We heard that this service now had a freedom to speak up guardian, this is someone who can provide an alternative route to speak to the ward manager or other supervisors. Their role was independent and impartial and available for all staff to use.

The service shared key messages which helped to prevent a closed culture. (closed cultures are when there is poor culture that can lead to harm, where patients may be at risk of potential, deliberate or unintentional harm including human rights breaches such as abuse) from happening. The service did this through several learning interventions, which started with induction of new staff, through to refresher training. However, night staff had not been supported by senior leaders to ensure decisions they made to manage relational security between staff and patients delivered high quality care. We saw that night staff made decisions that impacted on patient care, and a positive experience for patients, for example the decision to use seclusion instead of de-escalation as a first resort and removing access to hot drinks from patients. This meant patients developed a lack of trust of staff and told us decisions were made without consultation.

The ward had a care awards initiative to celebrate success and improve the quality of care across the organisations four core values, accountability, compassion, respect, and excellence. This award was presented monthly to nominated staff across the division.

Governance

Our findings from the other key questions we looked at as part of this inspection demonstrated that most governance processes around safeguarding, incident reporting and staffing, operated effectively at team level and that performance and risk were mostly managed well.

However, the ward did not meet compliance with mandatory training and not all staff had received training in basic life support. Whilst there was a cleaning regime in place to manage the odour from the drains and toilet in the Malcom Arnold House therapy corridor, the provider did not have an effective way to regularly review the situation. The toilet had been decommissioned since December 2021, there was no signage in place to direct people to the nearest toilet, and the provider had taken no further action to address the problem aside from deodorisation.

Systems and processes for ward teams contacting the physical healthcare team were not always effective. When staff admitted patients to the ward outside of office hours the communication processes in place were not sufficiently robust to ensure that there were no delays in referring new admissions to the physical healthcare team. The systems and processes for checking medication of new admissions were not always effective and in particular when key staff were absent.

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

Requires Improvement

A blanket restriction around access to hot drinks, that had been imposed by night staff on Heygate ward, had not been effectively reviewed.

There were no effective systems and processes or audits to ensure incidents of restraint included details of the least restrictive option such as de-escalation used before restraint was implemented

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 17 HSCA (RA) Regulations 2014 Good governance **Acute ward for adults of working age and psychiatric intensive care units:** • The provider must ensure that all incidents of restraint are documented to include least restrictive approaches including de-escalation. • The night shift on Heygate ward lacked strong leadership to support staff to make decisions on how to minimise restrictive practice and maintain effective relational security. Dynamics between staff and patients were strained as staff did not always feel confident to manage the aggression of patients and to manage ward rules effectively. • In one incident, communication between ward staff and the physical healthcare team did not occur in a timely way to manage an out of hours admission, and referrals following serious physical incidents.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Acute ward for adults of working age and psychiatric intensive care units:** • Not all staff were compliant with mandatory training specifically basic life support training.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Acute ward for adults of working age and psychiatric intensive care units** • As a result of a decision made by night staff, we found a blanket restriction in place on Heygate ward. Hot drinks were not readily available to patients. There were no care plans or risk assessments that documented reasons for this restriction.

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 **Acute ward for adults of working age and psychiatric intensive care units:** • One concern had been reported to us around a delay in prescribing medication following their admission. We found evidence to support the concern. The medicines error was identified but not until 10 days after admission. The provider had investigated the omission and had put plans in place to prevent a reoccurrence of the incident. **Forensic inpatient or secure wards:** • We found four incidents of staff sleeping on duty on Fairbairn ward. Staff could not have observed patients safely while sleeping.

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 **Acute ward for adults of working age and psychiatric intensive care units:** • The provider must ensure that the smell from drains and toilets in the therapy corridor of Malcom Arnold House is permanently resolved as soon as possible.