Southern Health NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Our findings

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

Good 

We carried out this unannounced, focused inspection because we received information about the safety and quality of the service. The concerns were specifically about Elmleigh, which is one of the acute mental health hospitals in the trust. The concerns were about a lack of therapeutic intervention from staff and activities for patients, incidents not always being reported, observations of patients not being therapeutic or engaging, patients being unable to take regular leave from hospital due to staffing levels, issues with medication administration and a poor culture amongst the staff team at all levels.

We inspected both wards at Elmleigh, in Havant. Red bay and Blue bay are acute wards for adults of working age. Red bay is a female-only 17-bedded ward and Blue bay is a male-only 17-bedded ward.

We inspected the service on 21 April 2021 due to the concerns raised above. However, during the inspection we had significant concerns about the lack of robust the monitoring of patient's physical health care. We therefore returned on 26 April 2021 to look more closely at this specific issue.

On 29 April 2021, following this inspection, we sent the trust a letter of intent under section 31 of the Health and Social Care Act 2008 identifying our serious concerns about the safety of patients on Blue and Red bay wards and requested the trust submit information to explain how they would make immediate improvement. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. A letter of intent sets out our intention to take urgent action if the provider does not assure us that it will make the required improvements urgently.

On 4 May 2021 the trust sent us a detailed action plan which provided assurance on what had been done immediately to improve care and treatment on the ward. We therefore did not take any further enforcement action but will continue to monitor the action plan closely to ensure the trust makes the improvements within the timeframe it has set out.

Following the inspection, the trust also voluntarily capped admissions by reducing the bed numbers on each ward by three.

We did not rate this service at this inspection because we did not look at all of the key questions or all of the key aspects of the key questions. The previous rating of good remains. It should be noted that this rating related to all of the acute mental health services at Southern Health and not just Elmleigh.

At Elmleigh we found:

- There was not enough staff with the right skills and knowledge to ensure that patients had high quality care and treatment. The ward did not have a full multi-disciplinary team and were missing input from key disciplines such as clinical psychology and occupational therapy. There was only one locum consultant psychiatrist covering both wards. There was a high number of agency staff deployed who did not always know the patients' needs and risks. Nursing and healthcare staff were stretched, busy and did not have the time to regularly complete incident forms, therapeutically engage with patients or arrange activities. Staffing was not increased when the acuity on the ward increased, for example when additional patients required extra observations to monitor their risk.

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- Staff did not always assess or monitor all risks to patients, including mental health and physical health. We found that the physical health needs of eight patients with known conditions and risks had not been adequately assessed or monitored. Staff did not always assess risk prior to patients taking approved leave from hospital as they did not complete a mental state assessment. When completing observations of patients, staff were not considering a patient's risk or therapeutically engaging with patients. Staff recorded basic details such as 'appears asleep', 'in bed space' or 'in ward area'.
- Patients did not always receive a range of care and treatment interventions suitable for an acute mental health ward for adults of working age that was consistent with national guidance on best practice. Meaningful activities on both wards were lacking. The wards had been without therapy and activity staff for some time and nursing and healthcare assistant staff were not proactive in providing activities on the ward.
- The ward team did not include and did not have access to the full range of specialists required to meet the needs of patients on the wards. The trust had not ensured that all staff had access to training to enable them to have a range of skills needed to provide high quality care. Staff did not receive regular formal clinical or management supervision. Agency staff and new starters did not always receive a full induction to the ward.
- Staff at all levels did not feel supported by the trust. Staff did not feel listened to and felt their concerns were not taken seriously. Staff told us they were stretched, stressed, burnt-out and that they were too busy and constantly "fire-fighting". Morale across both wards was low.
- The trust did not have robust governance arrangements in place to ensure managers had adequate oversight of areas of risk and improvement such as meaningful activities and psychological interventions, physical health monitoring and reporting of incidents.

However:

- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- The trust had recently recruited to the occupational therapy, psychology and activity co-ordinator vacancies.

How we carried out the inspection

During the inspection visit, the inspection team:

- interviewed the deputy director of nursing for mental health
- interviewed two ward managers
- spoke with 13 members of staff, including four nurses, five health care assistants, one occupational therapy technician, one consultant psychiatrist, one ward clerk, and one human resources assistant.
- spoke with seven patients
- reviewed all 34 patient care and treatment records
- reviewed all 34 patient prescription charts and physical health monitoring forms
- reviewed a sample of observation records
- reviewed a sample of incident reports
- attended a multi-disciplinary team meeting and

Our findings

- completed an observation of the communal areas of both wards.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Patients told us that staff were nice, caring, treated them with dignity and respect but were always busy. Leave was often cancelled, or time was reduced due to staff shortages. Patients said they would like to do activities but there currently weren't any. Patients said although there are always staff around, they are not always able to interact with them and they spend most of the day in their bedrooms.

Is the service safe?

Good  

This was a focused inspection, so we did not rate this key question during this inspection. The good rating relates to the rating awarded at the previous inspection and relates to all of the acute mental health services at Southern Health and not just Elmleigh.

At Elmleigh we found that:

- There was not enough staff with the right skills and knowledge to ensure that patients had high quality, safe care and treatment. Patient's risks were not assessed by the multi-disciplinary team as the team were missing input from key disciplines such as clinical psychology and occupational therapy. There was only one locum consultant psychiatrist covering both wards. There was a high number of agency staff deployed who did not always know the patients' needs and risks. When staff were completing observations of patients they were not doing so therapeutically and ensuring they considered patients risks, in line with the trusts policy. Staffing was not increased when the acuity on the ward increased, for example when additional patients required extra observations to monitor their risk. Some shifts only had one qualified nurse on duty.
- Staff did not always assess or manage patient's physical health risks well. We found three patients with diabetes who had not received weekly blood glucose monitoring and did not have their physical needs included in their care plans or risk assessments. A patient with a falls risk had not had their risk of falls assessed. Information about a patient with epilepsy was not recorded on the physical health monitoring screen. Three patients required wound care, which had not been care planned. One patient's wound had become infected. Staff were using National Early Warning Score 2 (NEWS2) physical health monitoring forms but not responding to the escalation scores. This meant that potential physical health risks were not being addressed in good time.
- Staff did not always have time to complete a mental state examination of patients before they were signed out for section 17 leave (permission to leave the hospital escorted or unescorted for an approved length of time). Although patient risks were discussed in handover meetings, patient's mental state may have deteriorated during the shift and therefore may be at increased risk to themselves or others whilst on leave.
- Staff told us they were unable to regularly complete incident forms, due to being so busy. This meant that learning from incidents could not always happen as not all incidents were recorded.

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- Medicine charts were not always clear. We found several charts that had prescribing changes that were not clearly shown. For example, we saw a chart with the same medication written twice which could have led to staff accidently giving a patient a double dose of medicines. We also saw charts where a 'stopped medicine' had not been clearly crossed out. We also found that the controlled drugs book on Blue bay had errors in stock recording.

However:

- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme and as a result there had only been one incident of seclusion in the past six months.

Is the service effective?

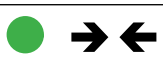
Good 

This was a focused inspection, so we did not rate this key question during this inspection. The good rating relates to the rating awarded at the previous inspection and relates to all of the acute mental health services at Southern Health and not just Elmleigh.

At Elmleigh we found that:

- The ward team did not include and did not have access to the full range of specialists required to meet the needs of patients on the wards such as psychologists, occupational therapies, and activity co-ordinators. The trust had not ensured that staff had access to training to enable them to have a range of skills needed to provide high quality care.
- Patients did not always receive a range of care and treatment interventions consistent with national guidance on best practice, such as having access to meaningful activities seven days a week or psychological interventions including cognitive behavioural therapy or dialectical behavioural therapy.
- Staff did not receive regular formal clinical or management supervision. Agency staff and new starters did not always receive a full induction to the ward.

Is the service caring?

Good 

We did not have any concerns which related to this key question and did not inspect against it. The good rating relates to the rating awarded at the previous inspection.

Is the service responsive?

Good 

Our findings

We did not have any concerns which related to this key question and did not inspect against it. The good rating relates to the rating awarded at the previous inspection.

Is the service well-led?

Good 

This was a focused inspection, so we did not rate this key question during this inspection. The good rating relates to the rating awarded at the previous inspection and relates to all of the acute mental health services at Southern Health and not just Elmleigh.

At Elmleigh we found that:

- Staff at all levels did not feel supported by the trust. Staff did not feel listened to and felt their concerns were not taken seriously. Staff told us they were stretched, stressed, burnt-out, that they were too busy and constantly "fire-fighting". Morale across both wards was low.
- The ward had not had a full multidisciplinary team since September 2020. The trust had recently recruited to the occupational therapy, psychology and activity co-ordinator vacancies but there had been a significant gap in the multidisciplinary team. This impacted the quality of care that patients were receiving from staff an increase in incidents and meant that patients did not receive holistic, recovery-focused care and treatment.
- The trust did not have robust governance arrangements in place to ensure managers had adequate oversight of areas of risk and improvement such as meaningful activities and psychological interventions, physical health monitoring and reporting of incidents.
- A service user feedback audit, which gathered feedback from patients across the trust between April and September 2020, recognised that when wards postponed group activities patients were bored and this led to an increase in self-harming incidents. The audit also stated that activities were arranged after hearing this feedback, but we found this was not the case at Elmleigh.

Our findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all patients have their physical health needs assessed, and where physical health needs are identified they must ensure there is a clear plan of care, that patients get the care they need, and this is regularly monitored. (Regulation 12)
- The trust must ensure that all patients have their mental state assessed prior to taking leave from hospital and that this is documented. (Regulation 12)
- The trust must ensure that all incidents are reported. (Regulation 12)
- The trust must ensure that its medicines management procedures are robust, and that documentation is accurate. (Regulation 12)
- The trust must ensure that all patients have access to meaningful activities and psychological interventions as recommended by national guidance on best practice. (Regulation 9)
- The trust must ensure that all staff, including agency staff, receive a comprehensive induction and regular supervision. (Regulation 18)
- The trust must ensure that staff at all levels are encouraged to raise concerns, have their concerns listened to and are supported to do their role. (Regulation 17)
- The trust must ensure that there are robust governance arrangements in place to identify and respond to risks and make improvements. (Regulation 17)

Action the provider SHOULD take to improve

- The trust should ensure that staff concerns are listened to, taken seriously and that wellbeing is considered. The trust should ensure that there is action taken to prevent 'burn-out'.

Our inspection team

The team that inspected the service comprised one deputy chief inspector, two inspection managers, two CQC inspectors, and one specialist advisor. The specialist advisor was a nurse with a professional background in acute mental health wards.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance