St Mary's Hospital

Quality Report

St Mary's Hospital
Floyd Drive
Warrington
Cheshire
WA2 8DB
Tel:01925 423300
Website: http://www.elysiumhealthcare.co.uk

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Inadequate

Overall summary

We continued to rate St Mary's Hospital as requires improvement because at the last inspection we rated four key questions as requires improvement (effective, caring, responsive and well led) and one key question (safe) as inadequate. We did not review the ratings on this inspection.

Following the inspection in March 2019, we issued a warning notice. This was issued under Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was an unannounced focused inspection relating to issues identified at a previous inspection in March 2019. We also looked at the safeguarding arrangements due to recent intelligence about how the hospital handled safeguarding incidents

On this inspection we found

- The provider had made significant changes and had met the requirements of the warning notice.
- Staff reviewed and recorded patient blood results for patients on clozapine and lithium.
- Staff had developed systems to record blood results and checks on patients on high dose antipsychotics.
- Managers had also put improved systems in place to notify us of safeguarding incidents.
- Managers had improved their oversight of safeguarding incidents and were supported to meet their responsibilities by a safeguarding lead social worker.
- More recent local safeguarding investigations showed more robust investigation, action and oversight.

However:

- There were still some minor shortfalls in medicines management including staff not completing proper

Summary of findings

individualised reviews of clozapine and lithium specific care plans, managers needing to improve the audit trails when blood results were awaiting review and clinicians needing to rationalise the necessity for several blood tests, where possible.

- Managers recognised that local safeguarding incident investigations needed to consider wider root cause analysis approaches and look at organisational and systemic factors as part of their local investigations.

Summary of findings

Contents

Requires improvement

St Mary's Hospital

Services we looked at

- Wards for people with learning disabilities or autism and
- Services for people with acquired brain injury

Summary of this inspection

Background to St Mary's Hospital

St Mary's Hospital is based in Warrington and provides specialist services for people with acquired brain injury, autistic spectrum conditions or both. It is part of the Elysium Healthcare group, which also has other mental health and learning disability hospitals across England.

St Mary's Hospital is a 67-bed hospital which has five wards:

- Cavendish ward, a 17-bed locked rehabilitation ward for men with an acquired brain injury, serving as a step down from low secure services.
- Adams ward, a 12-bed medium secure ward for men with an acquired brain injury with an additional four bed unit attached for people who are also hearing impaired.
- Dalston ward, an 18-bed low secure ward for men with an acquired brain injury.
- Leo ward, a 12-bed locked ward for men with autistic spectrum disorder. Patients on the unit have a primary diagnosis of an autistic spectrum disorder often accompanied by co-morbid conditions and/or a history of challenging behaviour.
- Hopkins ward, a four bed locked ward for women with autistic spectrum disorder. Patients on the unit have a primary diagnosis of an autistic spectrum disorder often accompanied by co-morbid conditions and/or a history of challenging behaviour. Leo and Hopkins wards were next to each other and worked together under the same ward manager and staff group.

There is a registered manager, accountable officer and nominated individual for this location.

The service is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 and
- Treatment of disease disorder and injury.

NHS England and regional specialist commissioners fund the care of patients in the medium and low secure wards. The local clinical commissioning groups funds patients admitted to the non-secure services. St Mary's Hospital accepts referrals from across the United Kingdom and from Ireland.

This is the second time we have inspected the St Mary's Hospital since it has been managed and overseen by the Elysium Healthcare group in August 2018. We inspected in March 2019 and we rated four key questions as requires improvement (effective, caring, responsive and well led) and one key question (safe) as inadequate. We issued a warning notice in relation to regulation 12 - safe care and treatment relating to the management of medicines. We told St Mary's Hospital that they must improve in this area by 10 May 2019. At the last inspection we also issued a number of requirement notices, but we did not review these on this inspection.

On this inspection, we checked whether the improvements had been made to the most serious concerns relating to the management of medicines. On this inspection, we found that the provider had taken sufficient action to address the issues we raised in the warning notice.

We have reported on all the wards at St Mary's Hospital together within this report. The report includes both the wards for patients with acquired brain injury together with the wards for people with autism, due to the relatively low number of beds on the wards for patients with autism.

Our inspection team

The team that inspected the service comprised a CQC inspector, a CQC inspection manager, and a CQC pharmacist inspector.

Summary of this inspection

Why we carried out this inspection

We carried out a focused inspection to check whether improvements had been made to the most serious concerns we identified during our last inspection about the management of medicines when we issued a warning notice to the provider in March 2019. We therefore checked whether the service had made the improvements and was now compliant with regulations relating to the management of medicines under Regulation 12 (safe care and treatment).

We also looked at the safeguarding arrangements as we received recent information of concern about how the hospital was looking into safeguarding incidents and we knew that managers had not told us recently about some safeguarding incidents.

How we carried out this inspection

On this inspection, we assessed whether the service had made improvements in response to the most serious concerns we identified during our last inspection and also looked at recent concerns raised with us. We inspected elements of the following key questions:

• Is it safe?

This inspection was unannounced, which means that the provider did not know we were coming.

Before the inspection visit, we reviewed information that we had gathered about the location and requested additional information from the provider.

During the inspection visit, the inspection team:

- spoke with the service director and one manager for one ward
- spoke with five other staff members from different disciplines including nursing and healthcare assistant staff, the consultant psychiatrist and the social worker with lead responsibility for safeguarding
- looked at seven patients' care and treatment records
- looked at seven medicine charts including looking at the monitoring of patients' physical health and checking that patients on high dose antipsychotic medication were monitored appropriately
- looked at four local safeguarding incident investigations
- looked at a range of policies, procedures and other records relating to the running of the service.

What people who use the service say

We did not speak to patients on this inspection as we were looking at systems and records to see if managers had made improvements.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

Our rating of safe stayed the same and remained inadequate. This was because this was a focused inspection and we only looked at the most serious concerns from the last inspection and recent concerns raised with us. We did not look at the whole 'safe' key question and the hospital had other ongoing regulatory breaches about patient safety that we did not look at on this inspection, so the rating remained the same.

We carried out a focused inspection to check whether improvements had been made since our last inspection in March 2019.

We found that:

- The provider had taken action to address concerns regarding medicines management and there was improved monitoring in place when patients received treatment that required blood monitoring.
- Staff reviewed and recorded patient blood results when this was an important part of patients receiving treatment safely.
- Staff had also improved systems in place to monitor when patients were on high dose antipsychotic medication.
- The provider had taken sufficient action to address the issues we raised in the warning notice, which we issued in March 2019 following our last inspection.
- Managers had also put improved systems in place to notify us of safeguarding incidents.
- The hospital employed a safeguarding lead social worker.
- Managers had improved their oversight of safeguarding incidents.
- More recent local safeguarding investigations showed more robust investigation, action and oversight.

However, on this inspection we found that:

- There were still some minor shortfalls in medicines management including staff not completing proper individualised review of clozapine and lithium specific care plans, managers needing to improve the audit trails when blood results are awaiting review and clinicians needing to rationalise the necessity for several blood tests, where possible.

Summary of this inspection

- Where safeguarding incidents had been considered locally, managers recognised that they tended to focus on personnel factors when looking at the incidents instead of wider root cause analysis to consider organisational and systemic factors as part of their local investigations.

Requires improvement

Services for people with acquired brain injury

Safe

Inadequate

Are services for people with acquired brain injury safe?

Inadequate

Safeguarding

Staff had received training in safeguarding that was appropriate for their role. Training in safeguarding adults and safeguarding children was mandatory and required staff to attend initial and regular refresher training. Across the hospital, 85% of staff were up-to-date with their safeguarding adults training. This was an improvement since the last inspection in March 2019. The training included informing staff of their statutory responsibilities and the importance of speaking up as well as containing a relevant focus on the work of ward staff to make it meaningful for staff working at the hospital. Staff were informed of the zero tolerance policy of speaking negatively to patients.

Staff were supported to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them. Staff were supported to make a safeguarding referral and who to inform if they had concerns. The hospital had recruited a social worker who had lead responsibility around safeguarding. They were re-establishing contact with the local authority safeguarding team and checked that appropriate and timely action was taken to protect vulnerable adults. Managers we spoke with had a good understanding of safeguarding procedures and what to do when faced with a safeguarding concern.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to adult services or the police should take place. When the staff in the hospital were in doubt, managers would speak to local authority staff for guidance on whether a referral was necessary.

We reviewed four recent incident safeguarding investigations. We saw that there was evidence to show that within investigations staff acted promptly to raise safeguarding incidents and speak out. Each incident was considered and investigated by a senior member of clinical staff. However, where safeguarding incidents concerned allegations against staff, we saw that managers focused on personnel factors when looking at the incident instead of wider root cause analysis to consider organisational and systemic factors as part of their local investigations. Managers recognised the need to improve their investigations to be more robust; investigation staff had attended recent root cause analysis training to support this objective as well. Together with oversight by the safeguarding lead and improved contact with the local authority safeguarding team, managers were confident that investigations were now more robust. In one case, there was a delay in reporting a substantiated safeguarding matter to the disclosure and barring service but managers again had learnt from this and put improved systems in place.

Managers had improved their systems to ensure that CQC were properly notified of safeguarding incidents. The hospital had informed the local authority of a small number of significant safeguarding incidents including alleged verbal or physical abuse between patients by staff. However, managers had not also notified us of four of these cases. Managers recognised that they should have notified us and accepted that their systems were not effective. Senior staff had received additional training on their responsibilities including the requirement to notify us of key incidents including safeguarding. The lead social worker reviewed safeguarding incidents and liaised with the local authority, where appropriate. Managers discussed safeguarding incidents at each morning meeting which included improved flagging systems to ensure we were notified.

Requires improvement

Services for people with acquired brain injury

We saw that the safeguarding lead and the hospital director were well sighted on recent individual incidents. A range of performance indicators were monitored through a computerised dashboard which provided information for incidents on each ward including numbers, types and categories of incidents, the timeliness of recording incidents, analysis of the days and times when most incidents occurred, the types of injuries sustained and interventions used, where appropriate. Managers therefore had very detailed safety incident data for each ward. This could be accessed centrally by managers at the hospital and senior managers in the Elysium Healthcare group. Managers met weekly to ensure there were appropriate reviews of the dashboards and incidents at the hospital. Managers were also routinely reviewing closed circuit television footage captured in communal areas during an arbitrary selection of three incidents each week to further assure themselves that patients were being cared for with dignity and respect and safeguarded from abuse. Managers were working with other agencies on a recent safeguarding allegation, which was still being investigated at the time of our inspection.

Medicines management

In March 2019, we found that there no effective system in place for the necessary clinical monitoring of patients prescribed clozapine and lithium who required regular blood tests as an essential part of their ongoing treatment for mental disorder. Therefore, care and treatment was not always provided in a safe way for patients. This was because staff were not assessing risks relating to the proper and safe management of medicines which was a breach of regulation. We issued a warning notice to the provider telling them they needed to improve the management of medicines by 10 May 2019.

Following the last inspection, the hospital had recruited a healthcare support worker to help oversee that all necessary physical health checks, including blood tests were properly requested, acted upon and recorded. The hospital also introduced a blood monitoring form following the feedback on our inspection.

On this inspection we checked whether improvements had been made. We reviewed seven medicines charts and patient records in detail and found staff kept accurate records of the treatment patients received.

Staff reviewed the effects of each patient's medication on their physical health according to national guidance. We reviewed physical health monitoring for patients who were prescribed antipsychotic medicines. A physical health assessment was completed when patients were admitted. Staff kept records of investigations and physical observations in patients' medical notes. In general, we found monitoring had been completed in accordance with national guidance and the hospital policy. Where patients were prescribed high dose antipsychotic treatment, we found there was an improved system to oversee that appropriate monitoring had been undertaken and recorded in accordance with guidance. Patients on high dose antipsychotics were now identified on a whiteboard and there was a corresponding folder containing the physical health checks that each relevant patient had received to monitor that prescribing above recommended levels remained safe for each patient and they were not experiencing significant adverse effects.

The systems in place for managing medicines had improved and now minimised risks and kept patients safe. Some patients were prescribed medicine, such as lithium or clozapine treatment, that required regular monitoring of their blood to ensure that ongoing treatment for their mental disorder was safe. We saw monitoring had improved and had been completed at the appropriate intervals. In addition, at the time of the inspection, there was an improved recording system to provide assurances to managers and prescribing clinicians that these essential blood results were requested or followed up in a timely manner.

This was because on inspection, we found appropriate arrangements were in place for the required routine clozapine and lithium blood monitoring to enable them to be safely administered:

- There was a service level agreement with a local GP service who undertook physical health checks. The systems had improved so that when bloods were taken staff could routinely record, chase up or act when bloods were requested or received for each patient that required blood monitoring. There were routine weekly checks about blood results to ensure any results were back within the hospital and scanned into patients records.

- Where the results were required, the system had improved to ensure these occurred. Managers had told staff that written diary entries that bloods were required for patients must not be crossed out.
- Since May 2019, the hospital had not received any alert or a prohibited notification email from the Clozaril patient monitoring service stating that clozapine treatment had to stop because a valid blood result for relevant patients had not been received.
- Staff checked when patients were admitted whether they were on lithium or clozapine and when they last had received a routine blood test.
- Clinical staff now signed that they had received and reviewed blood tests. Clinicians we spoke with told us that the systems to record and review blood test results and checking them against safe parameters was now effective and helped support them to keep patients safe.
- The proposed regularity of blood retesting through specific clozapine or lithium care plans recorded in relevant patients' current care plans to guide and remind staff.
- The provider was changing and improving their pharmacy support contract and it was planned that pharmacy staff would also review prescription charts, provide support to ward rounds and check that necessary blood tests were taken and recorded.

This meant that there were improved systems in place for the necessary clinical monitoring of patients who required regular blood tests as an essential part of their ongoing treatment for mental disorder such as clozapine and lithium. The hospital had therefore acted to address the most serious concerns raised following our previous inspection in March 2019. Managers had met the requirements of the warning notice.

However, while care plans were in place for patients prescribed lithium or clozapine and had been regularly reviewed, the reviews of the care plans did not clearly detail whether individual monitoring requirements had been met in line with the proposed regularity stated in the care plan.

There was sometimes a short delay in blood results received into the hospital being put on to the patients' records because they were not uploaded and added until the results were reviewed and signed by the appropriate clinician. As a result, although the required tests had been completed, there was sometimes an incomplete audit trail about where particular blood or other results were when they were being reviewed. For example, there was no record of the required electrocardiogram (which measures patients' heart's rhythm and electrical activity) being completed for one patient in the patient's electronic notes. However, the electrocardiogram trace had been seen by the hospital doctor and had been sent to the GP for review. Staff were not able to fully articulate the procedure for ensuing the results of blood tests and electrocardiograms were promptly reviewed and logged onto the hospital system.

In addition, staff sometimes requested blood testing without reference to other required or recently received blood tests so some patients had several blood tests within relatively close proximity without rationalising the requests into fewer blood tests looking at more or all required factors.

The hospital had carried out an audit of high-dose anti-psychotic prescribing in April 2019. This identified a small number of patients on high-dose anti-psychotics. The audit benchmarked against the National Institute for Health and Care Excellence guidelines. The audit noted good practice but highlighted some minor areas of improvement such as ensuring the legal certificate authorising high dose anti-psychotics was properly reviewed when there was a new responsible clinician. There were also a number of recommendations which supported improved practice including regular auditing and an improved monitoring form.

The hospital had a clear policy for physical health monitoring. The hospital 'dashboard' showed that 90% of patients had been assessed using the Lester tool. The Lester tool assessed the cardiometabolic health of patients with mental ill health enabling staff to deliver safe and effective care to improve the physical health of patients. One element of physical health monitoring - the QRISK score - was not yet fully embedded. QRISK was an assessment tool to consider patient's risk of developing a heart attack or stroke over the next 10 years but was only recorded for 8% of patients. Managers had introduced a physical health group to support and monitor implementation of the physical health monitoring policy, with the first meeting due later in August 2019; managers hoped this would lead to improvements in all aspects of physical health monitoring including improved uptake of QRISK.