St Andrew's Healthcare Essex service

Quality Report

Pound Lane
North Benfleet
Essex
SS12 9JP
Tel: 01268 723800
Website: www.stah.org/

Date of inspection visit: 10, 17 and 20 February 2020
Date of publication: 19/05/2020

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

Overall summary

St Andrew's Essex provides care for both men and women with a personality disorder and/or mental health issues in a low secure and locked environment.

We carried out this inspection in response to concerning information received through our monitoring processes.

We did not rate this service on this inspection. We found the following areas the provider needs to improve:

- Patients were at risk of avoidable harm. Staff did not always assess and manage patient risks. Multidisciplinary teams were not always reviewing patient observation levels following risk incidents. Staff did not record all risks on one patient's risk log. Staff did not always report incidents appropriately. We reviewed an incident where a patient had tied a ligature which was reported inappropriately.
- The service did not have enough registered nursing and support staff to keep patients safe. Managers had not filled a third of registered nurse shifts and 15% of support staff shifts. Shift leads allocated staff to multiple roles, which impacted on staff's ability to keep patients safe. Both staff and patients told us they didn't feel safe.
- Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others. Staff were not completing intermittent observation records in line with the provider's policy and procedures.
- Staff did not always follow the Mental Health Act Code of Practice in relation to seclusion. Staff did not record the levels of observation accurately for a patient who was secluded for a long time. Staff had not completed the section on informing family, carers or advocacy about the seclusion and had not completed the seclusion room checklist prior to seclusion commencing.
- Staff did not always treat patients with dignity and respect. We were concerned by some of the language used by staff in patient records. Staff recorded information that was judgemental and not a factual account. For example, following an incident involving a staff member being racially abused, it was recorded in the progress notes that the staff told the patient to 'behave yourself' and staff recorded that they told another patient to "stop playing up". In addition, in

Summary of findings

response to an incident of self harm staff recorded in notes that they had told a patient "you're an adult, deal with it". The provider took appropriate action to deal with this incident.

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The provider's governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations and allocation of staff tasks. Managers did not have sufficient oversight of key elements of the service that related to patient safety.
- Managers did not always make notifications to the Care Quality Commission when safeguarding incidents occurred. We reviewed a random sample of six safeguarding incidents, involving physical abuse between patients and managers had failed to notify any to CQC.

However:

- Staff and patients told us they had been offered support and debriefs following a recent serious incident.
- Staff reported that learning from incidents was shared through 'red top alerts'. Managers displayed hard copies in the ward offices.

Summary of findings

Contents

St Andrew's Healthcare Essex

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Wards for older people with mental health problems;

Summary of this inspection

Background to St Andrew's Healthcare Essex service

St Andrew's Healthcare Essex location registered with the CQC on 11 April 2011.

St Andrew's Healthcare also have locations in Northampton, Birmingham and Nottinghamshire.

St Andrew's Essex provides care for both men and women with a personality disorder and/or mental health issues in a low secure and locked environment.

St Andrew's Healthcare Essex location has been inspected six times.

St Andrew's Healthcare Essex location is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act

The location has a nominated individual and a registered manager.

We inspected the Essex location to follow up on concerning information received through our monitoring processes.

The following services were visited on this inspection:

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

We inspected the following wards:

• Audley ward is a male ward with 13 beds.

• Frinton ward is a female ward with 12 beds.

Forensic/inpatient secure:

We inspected the following wards:

• Danbury ward is a low secure male ward with 16 beds.

• Hadleigh ward is a low secure male ward with 16 beds.

• Colne ward is a low secure female ward with 16 beds.

Wards for older people with mental health problems:

We inspected the following ward:

• Maldon ward is a male ward with 6 beds.

All patients receiving treatment at this location were detained under the Mental Health Act (1983).

This location was last inspected in September 2017. This was a scheduled, comprehensive inspection. The service was rated good overall, with safe rated as requires improvement and effective, responsive, caring and well led rated good. A requirement notice was issued for breaches of the following regulation:

Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safe care and treatment.

We told the provider it must make improvements to reduce the number of incidents of restraint and seclusion across the hospital.

Our inspection team

The team that inspected the service comprised two CQC inspection managers and three CQC inspectors. On our second visit we were joined by two colleagues from Essex local authority safeguarding team.

Why we carried out this inspection

We undertook this inspection to follow up on concerning information received through our monitoring of St Andrew's Healthcare Essex location.

Summary of this inspection

How we carried out this inspection

We have reported in three of the five key questions; safe, caring and well led across all core services. As this was a focused inspection, we looked at specific key lines of enquiry in line with concerning information received and therefore we have only reported on these.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all six wards at the hospital
- spoke with 11 patients who were using the service
- interviewed the registered manager for the service and two ward managers
- spoke with ten other staff members; including nurses and healthcare assistants
- looked at four care and treatment records of patients
- reviewed 15 incident records

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 11 patients. Nine patients were unhappy about different aspects of the service. Three patients described incidents where they had been verbally or physically abused by staff. Other feedback included that wards were short staffed which resulted in leave and activities being cancelled, staff not completing intermittent observations, patients not feeling safe, and complaints not being taken seriously or responded to.

However, two patients told us regular staff were kind, compassionate and listened to them and one patient told us that staff were good at de-escalation.

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?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Patients were at risk of avoidable harm. Staff did not always assess and manage patient risks. Multidisciplinary teams were not always reviewing patient observation levels following risk incidents. Staff did not record all risks on one patient's risk log. Staff did not always report incidents appropriately. We reviewed an incident where a patient had tied a ligature which staff had not reported appropriately.
- The service did not have enough nursing and support staff to keep patients safe. Managers had not filled all registered nurse and support staff shifts. Staff were allocated to multiple roles, which impacted on their ability to keep patients safe.
- Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others. Staff were not completing intermittent observation records in line with the provider's policy and procedures on 629 out of 3,364 occasions.
- Staff did not always follow the Mental Health Act Code of Practice in relation to seclusion. Staff did not record the levels of observation accurately for a patient who was secluded for a long time. We reviewed the records of a patient on Colne ward, who staff secluded for 19 days (425 hours). Staff observation entries recorded no risk issues for 422 hours of the seclusion. Staff had not completed the section on informing family, carers or advocacy about the seclusion and had not completed the seclusion room checklist prior to seclusion commencing.
- The provider did not manage safeguarding concerns effectively. The local authority safeguarding team reported 22 open safeguarding cases for the Essex location, dating back to May 2019. The safeguarding team requested information from the provider to help investigate, however they had not received the required information. There was a discrepancy between the local authority's open cases (22) and the provider's open cases (10). The provider had not notified CQC about nine of the safeguarding cases on the local authority's list. We reviewed a further six safeguarding incidents on the provider's incident database, which involved physical abuse between patients. Managers had not reported these incidents to the local authority or to CQC.

Summary of this inspection

However:

- Staff and patients told us they had been offered support and debriefs following a recent serious incident.
- Staff reported that learning from incidents was shared via 'red top alerts'. Managers displayed hard copies in the ward offices.

Are services caring?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Staff did not always treat patients with dignity and respect. We were concerned by some of the language used by staff in patient records. Staff recorded information that was judgemental and not a factual account. For example, following an incident involving a staff member being racially abused, it was recorded in the progress notes that the staff told the patient to 'behave yourself' and staff recorded that they told another patient to "stop playing up". In addition, in response to an incident of self harm staff recorded in notes that they had told a patient "you're an adult, deal with it". The provider took appropriate action to deal with this incident.

Are services well-led?

We did not rate this key question.

We found the following areas the provider needs to improve:

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The provider's governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations and allocation of staff tasks. There was no evidence that the provider undertook regular and effective audits of these issues.
- Managers did not have sufficient oversight of key elements of the service that related to patient safety. We found issues with the quality and timeliness of incident reports. Managers did not ensure shift tasks and patient observations were allocated in line with policy. Managers had not ensured the service provided suitable numbers of staff to meet patients' needs.
- Managers did not always make notifications to the Care Quality Commission when safeguarding incidents occurred. We reviewed a random sample of six safeguarding incidents, involving physical abuse between patients and managers had failed to notify any to CQC.

Summary of this inspection

- Managers did not always engage with external agencies. We were provided with examples of managers being obstructive towards the police, local authority safeguarding teams and advocacy staff.

Forensic inpatient or secure wards

Safe	
Caring	
Well-led	

Are forensic inpatient or secure wards safe?

Safe staffing

The service did not have enough registered nursing and support staff to keep patients safe.

We reviewed 12 shift planners on Colne ward between 29 January 2020 and 10 February 2020. The planned numbers were three registered nurse and five support staff in the day and two registered nurses and four support staff at night. Managers had not filled 33% of registered nurse day shifts and 15% of support staff shifts. Shift leads had not allocated staff to key safety roles on five of the planners.

During our visit on 17 February 2020, Colne ward had two registered nurse staff and five support staff staff on duty to support 14 patients. The planned numbers were three registered nurse and seven support staff. Three support staff staff were allocated to enhanced and intermittent patient observations and one was allocated to a safety check role.

We reviewed eight shift planners on Frinton ward between 06 and 10 February 2020. The planned numbers were two registered nurse and seven support staff during the day and two registered nurse and five support staff at night. Managers had not filled 13% of registered nurse shifts and 11% of support staff shifts.

We reviewed nine shift planners between 01 and 10 February 2020 on Audley ward. The planned staffing numbers were two registered nurse and five support staff during the day and two registered nurse and four support staff at night. Managers had not filled 11% of registered nurse shifts and 20% of support staff shifts.

We reviewed 13 shift planners on Maldon ward between 04 and 10 February 2020. The planned numbers were one registered nurse and three support staff during the day and one registered nurse and two support staff at night. Managers had not filled 8% of registered nurse shifts and 33% of support staff shifts.

We reviewed records for a patient on Colne ward who complained of shoulder pain from 7 January 2020 and was complaining of being in pain until taken for medical treatment on 15 January 2020. Staff had recorded that "there was no available staff to take her". Staff did not submit a notification to CQC for this incident.

Patients on Hadleigh ward told us that on the night of 16 February the ward was staffed with one registered nurse and one support staff. The planned numbers were one registered nurse and four support staff.

Nine out of 13 staff we spoke to told us staffing levels were unsafe across the site, seven reported that patients were unable to take leave.

Assessing and managing risk to patients and staff

Staff did not always assess and manage patient risks. We reviewed records of a multidisciplinary meeting in relation to a patient who staff assessed as high risk of self harm and had been tying ligatures. The patient had been handed risk items by another patient that they were using to tie ligatures. The actions from the meeting did not address this and the patient tied another ligature later that day. Staff had recorded six self harming incidents for this patient between 26 January 2020 and 3 February 2020. We reviewed the risks and significant incidents log for these dates and staff had not logged any of the incidents.

The services intermittent observation records did not provide an accurate record of times staff completed observations. We found the 15 minute and five minute intermittent observation recording sheets were pre-populated with times. We raised this with managers on the first day of the inspection. On our visit the following week we saw the provider had implemented new sheets, without prepopulated times.

Forensic inpatient or secure wards

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others.

Staff were not completing intermittent observation records in line with the provider's policy and procedures.

We reviewed intermittent observation records for four patients on Colne ward. We reviewed records for 15 days for one patient on 15 minute observations, and 70 records for thirteen days for three patients on five minute observations. We found discrepancies in the 15 minute observation records in relation to the location of the patient during times reported on incident records and the location recorded on the observation sheets. We found three examples of this. In the five minute observation records staff had not recorded observations on 342 occasions out of a possible 2,500. Staff had not completed details of risk and rationale on 58 out of 70 records.

We reviewed intermittent observation records for two patients on Audley ward. We reviewed four days of records for one patient on five minute observations. Staff had not recorded observations on 267 occasions out of a possible 576. We reviewed records for one day for one patient on 15 minute observations. Staff had not recorded observations on 20 occasions out of a possible 288.

Staff did not always keep patients safe from harm whilst on enhanced and intermittent observations. We reviewed information relating to an incident resulting in a patient death. We identified issues relating to ways in which staff managed patient risk in the days prior to the incident and how staff managed the incident on the day. This included how staff completed observations and how staff mitigated risk to the patient. Staff had prescribed 15 minute observations for this patient. There was no evidence that staff had considered increasing the level of observations for this patient. Records reviewed for the day of the serious incident indicated the patient was left unobserved for 40 minutes.

Shift leads were allocating staff to key safety roles and patient observations at the same time. Staff reported it was not possible to complete their allocated tasks safely in this situation.

On Frinton ward, shift leads had allocated staff to patient observations and safety roles on six of the eight planners reviewed. On Audley ward, shift leads had allocated staff to patient observations and safety roles on seven of the nine planners reviewed. On Maldon ward, shift leads had allocated staff to patient observations and safety roles on four of the 13 planners reviewed.

Staff did not always follow the Mental Health Act Code of Practice in relation to seclusion. Staff did not record the levels of observation accurately for a patient who was secluded for a long time. We reviewed the records of a patient on Colne ward, who staff secluded for 19 days. This amounted to a total of 425 hours in seclusion. Staff observation entries recorded no risk issues for 422 hours of the seclusion. Staff recorded no risk issues for a continuous ten days and then for a further six days. Staff had not completed the section on informing family, carers or advocacy about the seclusion and had not completed the seclusion room checklist prior to seclusion commencing.

We reviewed the provider's incident database and staff reported 911 incidents of restraint between April 2018 and 16 February 2020, 152 restraints were to prevent self harm and 571 to prevent violence and aggression.

Safeguarding

The local authority safeguarding team reported 22 open safeguarding cases for the Essex location, dating back to May 2019. The safeguarding team requested information from the provider to help investigate, however they had not received the required information. There was a discrepancy between the local authority's open cases (22) and the provider's open cases (10). The provider had not notified CQC about nine of the safeguarding cases on the local authority's list. We reviewed six safeguarding incidents on the provider's incident database, which involved physical abuse between patients. Managers had not reported these incidents to the local authority or to CQC.

Track record on safety

The provider had reported a serious incident that resulted in a patient death in February 2020.

Reporting incidents and learning from when things go wrong

We reviewed a random sample of 15 incidents between 08 June 2019 and 06 February 2020.

Forensic inpatient or secure wards

Staff did not always report incidents appropriately. We reviewed an incident where a patient had tied a ligature which was reported as a physical health incident instead of a self harm incident.

Staff reported that learning from incidents was shared through 'red top alerts'. Managers displayed hard copies in the ward offices. We viewed two recent red top alerts relating to a recent serious incident that had occurred on Colne ward, reminding staff to follow the enhanced observation procedure.

Are forensic inpatient or secure wards caring?

Staff did not always treat patients with dignity and respect. We were concerned by some of the language in patient records. Staff recorded information that was judgemental and not a factual account. For example, following an incident on Hadleigh ward involving a staff member being racially abused, it was recorded in the progress notes that the staff told the patient to 'behave yourself' . Another example included an incident record for Hadleigh ward and staff recorded that they had told the patient to "behave yourself" and also said "you won't do anything to me so stop showing off".

Staff on Colne ward had recorded "a patient as "playing up".

One patient told us they had asked for staff support following an incident of self harm and were told "You're an adult, deal with it". The provider took appropriate action following this incident.

Are forensic inpatient or secure wards well-led?

Leadership

The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The provider's governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations and allocation of staff tasks. There was no evidence that the provider undertook regular and effective audits of these issues.

Managers did not always engage with external agencies. We were provided with examples of managers being obstructive towards the police, local authority safeguarding teams and advocacy staff. Following the inspection CQC facilitated a meeting to improve relations with the local authority safeguarding team.

Culture

Managers did not ensure staff at this location were aware of issues identified in CQC inspection reports for other St Andrews Healthcare locations.

We reviewed six emails that the chief executive officer had sent to all staff between January 2018 and October 2019. These related to CQC inspections of other St Andrew's Healthcare locations and included feedback about parts of the services which needed improvement.

We asked eight staff, including ward mangers and the registered manager if they were aware of CQC actions that had been taken in relation to findings at other St Andrew's locations, none of the staff could describe this and how the actions may be relevant to their service.

We were not assured that managers were ensuring learning took place across locations to improve practice.

Staff spoke positively about local leadership but felt disconnected from the main Northampton site and reported feeling isolated.

Governance

Managers did not have sufficient oversight of key elements of the service that related to patient safety.

We found issues with the quality and timeliness of incident reports. This had not been addressed despite requiring sign off by managers.

There were discrepancies across the service in how wards allocated shift tasks and managers did not ensure adherence to the services policies relating to patient observations. Managers had not ensured the service provided suitable numbers of staff to meet patients' needs.

Managers did not always make notifications to the Care Quality Commission when safeguarding incidents occurred. We reviewed a random sample of six safeguarding incidents, involving physical abuse between patients and managers had failed to notify any to CQC.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff treat patients with dignity and respect. (Regulation 10 (1))
- The provider must ensure that observations are undertaken in line with the provider's engagement and observation policy and protocol. (Regulation 12 (1) (2) (a) (b) (c)).
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff to meet patients' needs. (Regulation 12 (1) (2) (c))
- The provider must ensure they report safeguarding concerns to the local authority. (Regulation 12 (1) (2) (i))
- The provider must ensure staff follow the Mental Health Act Code of Practice in relation to use of seclusion. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure that they notify the Care Quality Commission of all notifiable incidents and safeguarding concerns. (Regulation 18 (2) (e))

Action the provider SHOULD take to improve

- The provider should ensure staff record incidents appropriately.
- The provider should ensure learning is shared across all locations.
- The provider should ensure they work effectively with external agencies.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents • Managers did not always make notifications to the Care Quality Commission when safeguarding incidents occurred. We reviewed a random sample of six safeguarding incidents, involving physical abuse between patients and managers had failed to notify any to CQC. This was a breach of regulation 18

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 • The service did not have enough nursing and support staff to keep patients safe. Managers had not filled all registered nurse and support staff shifts. This was a breach of regulation 18

This section is primarily information for the provider

Enforcement actions

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 10 HSCA (RA) Regulations 2014 Dignity and respect • We were concerned by some of the language in patient records. Staff recorded information that was judgemental and not a factual account. For example, following an incident on Hadleigh ward involving a staff member being racially abused, it was recorded in the progress notes that the staff told the patient to 'behave yourself' . Another exampleincluded an incident record for Hadleigh ward and staff recorded that they had told the patient to "behave yourself" and also said "you won't do anything to me so stop showing off". • Staff on Colne ward had recorded a patient as "playing up". • One patient told us they had asked for staff support following an incident of self harm and were told "You're an adult, deal with it". This was a breach of regulation 10

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 • Patients were at risk of avoidable harm. The service did not always manage patient safety incidents well. • Staff did not always act to prevent or reduce risks to patients and staff. Staff did not always keep patients safe from harm whilst on enhanced observations.

This section is primarily information for the provider

Enforcement actions

- Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others.
- Shift leads were allocating staff to key safety roles and patient observations at the same time which meant that there was a risk that staff would be required to respond to an incident or other event leaving patients' unobserved.
- Staff did not always follow the Mental Health Act Code of Practice in relation to seclusion. Staff did not record the levels of observation accurately for a patient who was secluded for a long time. We reviewed the records of a patient on Colne ward, who staff secluded for 19 days (425 hours). Staff observation entries recorded no risk issues for 422 hours of the seclusion. Staff had not completed the section on informing family, carers or advocacy about the seclusion and had not completed the seclusion room checklist prior to seclusion commencing.

This was a breach of regulation 12

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 • The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The provider's governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations and allocation of staff tasks. There was no evidence that the provider undertook regular and effective audits of these issues. • Managers did not have sufficient oversight of key elements of the service that related to patient safety. We found issues with the quality and timeliness of incident reports. Managers did not ensure shift tasks

This section is primarily information for the provider

Enforcement actions

and patient observations were allocated in line with policy. Managers had not ensured the service provided suitable numbers of staff to meet patients' needs.

This was a breach of regulation 17