St Andrew's Healthcare - Mens Service

Quality Report

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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

Overall summary

We did not rate this service.

We found:

- The provider had strengthened the implementation of positive behaviour support (PBS) planning since the last inspection in June 2016.
- Staff we spoke with were knowledgeable about using least restrictive practices for restraint and positive behaviour support planning, a recommended approach to managing patients challenging behaviour.
- Staff were caring and keen to do their best for the patients. They were respectful in their approach.
- Care plans and data supported what staff had told us about the use of restraint as a last resort and only after staff had tried to de-escalate and divert patients who were becoming distressed or agitated.
- Data provided showed a downward trajectory in the use of restraint and in the use of prone restraint.

We also found:

- The electronic system was difficult to navigate to find key documents such as positive behaviour support plans. Staff saved some documents on a shared drive rather than in the electronic system. Staff we spoke with knew where to find the information they required, however, information was not consistently in the same place for each record.
- The behaviour observations sheets used codes for behaviour and it was not always clear which exact behaviour related to which code. This meant staff may not be clear what behaviour was expected in certain situations.
- Some seclusion records were missing and staff could not find them.
- Medical staff raised an issue about completing medical reviews for seclusion at night with only one doctor on duty for the site, and a second doctor available until midnight.

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Background to St Andrew's Healthcare - Mens Service

St Andrew's Healthcare Northampton has been registered with the CQC since 11 April 2011. The services have a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

Northampton is a large site consisting of more than ten buildings, more than 50 wards and has 659 beds.

St Andrew's Healthcare also has services in Nottinghamshire, Birmingham and Essex.

The locations at St Andrew's Healthcare Northampton have been inspected 19 times. The last inspection was in June 2016.

Patients receiving care and treatment at St Andrew's Healthcare follow care pathways. These are women's mental health, men's mental health, autistic spectrum disorder, adolescents, neuropsychiatry and learning disabilities pathways.

The services we visited on this occasion were:

Wards for people with learning disabilities or autism:

This part of the service provides inpatient accommodation for patients with learning disabilities over the age of 18 years. We inspected the following wards:

• Hawkins ward, a 15 bed medium secure service for men with learning disabilities and forensic challenging behaviour.

• Harlestone ward, a 20 bed male low secure ward for people with autistic spectrum disorder.

• Naseby ward, a 15 bed service for men with mild/ borderline learning disabilities.

• Mackaness ward, a 15 bed a male medium secure ward for people with autistic spectrum disorder.

This inspection was a focused inspection looking at the use of restraint in learning disabilities services. We gave the provider a week's notice of our intention to carry out this inspection. We also inspected the learning disabilities and autism wards in women's services and the adolescent services.

Our inspection team

Team leader: Margaret Henderson

The team that inspected the services comprised a CQC inspector, a national professional advisor in learning disabilities and a specialist advisor who is a consultant psychiatrist with learning disabilities experience.

Why we carried out this inspection

We carried out this focused inspection following concerns raised by other organisations nationally about the use of restraint in learning disabilities services.

Summary of this inspection

How we carried out this inspection

We carried out this inspection as a focused inspection looking specifically at the use of restraint in learning disabilities services. It was announced a short time before our inspection to enable the provider to provide up to date information.

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

During the inspection visit, the inspection team:

- visited four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 11 patients who were using the service;
- interviewed the registered manager and managers or acting managers for each of the wards;
- spoke with 19 other staff members; including doctors, nurses and psychologists;
- looked at 12 care and treatment records of patients and
- 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 briefly with 11 patients. Five patients said there were not enough staff and this stopped them being able to go out. Only three of the patients spoke about restraint and seclusion. One said it was ok, the other two said staff had treated them roughly during their restraint and seclusion episodes.

We reviewed the action plan from a carer's event held in June 2016. The main points were that carer's wanted more information and wanted to be involved more, St Andrew's had taken action to improve these.

We were unable to speak to carers. We requested contact details for carers but did not receive any for carers of patients at the mens service.

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?

- There were 20 whole time equivalent staff vacancies across three of the four wards at the time of our visit. 8.6 were nurse vacancies and 11.3 were healthcare assistant vacancies. The establishment whole time equivalent was 96 staff. Nurses accounted for 34 of the posts and 62 posts were for healthcare assistants. At the time of our visit the actual establishment was 76 staff. This was made up of 25 nurses and 51 healthcare assistants. Extra staff were used to cover increased observation and enhanced care. The provider had their own bank (bureau) and they used regular agency, whenever possible, if needed.
- The provider had strengthened the implementation of positive behaviour support (PBS) planning since the last inspection in June 2016.
- Staff we spoke with were knowledgeable about using least restrictive practices for restraint and positive behaviour support planning, a recommended approach to managing patients challenging behaviour. Positive behavioural support plans were readily available in paper form for staff and in easy read format for patients.
- Care plans and data supported what staff had told us about the use of restraint as a last resort and only after staff had tried to de-escalate and divert patients who were becoming distressed or agitated. Staff used prone restraint only when the patient had requested it in their care planning (some patients preferred to be taken to the floor forward instead of backwards), or when the patients had put themselves in that position or if an injection was required. Staff turned the patient onto their side or back as soon as possible and the majority of prone restraints lasted less than three minutes. The training department staff supported and trained staff to use other sites for injecting medication to reduce the need for any prone restraint to give medication.
- Data provided showed a downward trajectory in the use of restraint and in the use of prone restraint.
- Staff mandatory training compliance ranged from 86% to 98%. Managers reported that most staff had received specific training in positive behaviour support planning but were unable to provide data on this. Ninety five per cent of staff had completed training in managing aggression.

However:

Summary of this inspection

- The electronic system was difficult to navigate to find key documents such as PBS plans. Some documents were saved on a shared drive rather than in the electronic system.
- The behaviour observations sheets used codes for identifying particular behaviours but it was not always clear what code related to which behaviours. This meant staff may not be clear what behaviour was expected in certain situations.
- Some seclusion records were missing and staff could not find them. Medical staff raised an issue about not being able to complete medical reviews at night with one doctor on duty for the site, and a second doctor available until midnight.

Are services caring?

• Staff were caring and respectful in their approach to patients and showed understanding of individual needs.

• Patients were involved where possible in their care planning. Care plans and positive behaviour support plans were available in easy read format. Carers were involved in care review meetings where possible. Staff used technology, such as video calling, to help patients keep in contact with relatives who lived some distance away.

• Advocacy services were available.

• Patients were involved with the training of staff to manage aggression.

Detailed findings from this inspection

Wards for people with learning disabilities or autism

Safe	
Caring	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- The seclusion rooms, extra care suites and low stimulation rooms all met required standards of safety, comfort and cleanliness. The seclusion rooms had two-way observation, toilet facilities and a clock. Staff completed cleaning records for the seclusion rooms and undertook environmental risk assessments of the seclusion areas as required. However, we noted that the low stimulation room on Mackaness ward smelt of urine when we visited.
- Staff used personal alarms and radios to summon assistance if required.

Safe staffing

- Mackaness ward reported establishment figures of 11.2 whole time equivalent nurses and 21.2 whole time equivalent health care assistants. There were 4.3 nurse vacancies and 6.1 healthcare assistant vacancies. Hawkins ward reported establishment of 11.2 whole time equivalent nurses and 22.4 healthcare assistants. There were 2.5 nurse vacancies and no healthcare assistant vacancies on this ward. Naseby ward reported establishment of 11.2 whole time equivalent nurses and 18.7 healthcare assistants. There were 1.8 nurse vacancies and 6.6 healthcare assistant vacancies on this ward. There was no data provided for Harlestone ward. Minutes of a monthly assurance board meeting in December 2016 reported 42 registered nurse vacancies across the learning disabilities/autistic spectrum disorder pathway for all the St Andrews sites (male and female wards). Managers estimated 18 of these vacancies were for the Northampton site.
- Managers told us they were running an 'Aspire' programme which is a 'grow your own' nursing programme where they support individuals to become qualified nurses.
- The ward managers could increase staffing numbers to meet increased observation and enhanced care needs of patients. The provider had their own bank (bureau) and they used regular agency, whenever possible, if needed. From 1 November 2016 to 31 January 2017, all four wards had covered 14% of shifts with agency staff. This was in line with agency use across the LD/ASD pathway. Managers told us that agency use was decreasing.
- Nursing staff were present in all patient communal and seclusion areas. There was enough staff to offer individual support and to carry out physical interventions on patients following incidents of restraint.
- There was one psychiatrist on duty overnight with a second psychiatrist working until midnight for the whole site. This meant if there were a high number of patients in seclusion across the site, the psychiatrists found it difficult to complete the required medical reviews in a timely manner. Two psychiatrists we spoke with raised this as an issue.
- Staff mandatory training compliance ranged from 86% to 98%. Managers reported that most staff had received specific training in positive behaviour support planning. Across LD services 70 staff had been trained in PBS since November 2016 and a further 70 planned before the end of 2017.
- Ninety five percent of staff were trained in the prevention and management of aggression and violence. Managers provided training data and staff confirmed they had attended this training. In January 2016, the provider had introduced the management of actual and potential aggression (MAPA) training with 22% of staff on Hawkins, 26% of staff on Naseby and 27% of staff on Mackaness having completed the 5 day course. Staff on Hawkins, Naseby and Mackaness wards had all completed the one day foundation course in MAPA. There were no training figures provided for Harlestone. There was a programme in place to train the remaining staff. Training managers told us they plan to have staff trained by January 2018. However, three staff on one ward said they had been booked in to MAPA training and it had been cancelled. MAPA is nationally recognised and places more emphasis on de-escalation and preventing aggression. Staff we spoke with were knowledgeable about the differences in each training

and told us the person taking the lead in any restraint situation would direct the staff in how to respond. Feedback from staff who had attended the course was positive about the content and delivery of the course.

Assessing and managing risk to patients and staff

- The provider had strengthened the implementation of positive behaviour support (PBS) planning since the last inspection in June 2016.
- Staff we spoke with were knowledgeable about using least restrictive practices for restraint and positive behaviour support planning, a recommended approach to managing patients challenging behaviour. Positive behavioural support plans were readily available in paper form for staff and in easy read format for patients. The plans included a pen portrait, skills, needs and plan for each patient. The assistant psychologist checked all information was inputted onto the system from the behaviour observation forms. The assistant psychologists produced functional analysis reports for staff. Positive behaviour support plans identified triggers to certain behaviours and how staff could help the patient cope with them.
- The provider had commissioned regular audits of the use of positive behaviour plans, the most recent in November 2016. Auditors randomly selected plans and audited them using a nationally recognised tool. The audit identified strengths and areas for improvement. Managers had implemented an action plan to put improvements in place, for example, identifying that staff need to encourage replacement behaviours by ensuring patients have the opportunities to demonstrate 'green' behaviours.
- Managers told us a health care assistant had devised 'calm down' boxes, personalised to individual patients. These boxes contained items chosen by the patient that they had identified would help them to calm down. Staff used these to help patients de-escalate. They had proved to be successful and managers had rolled them out across other wards.
- Staff told us and plans showed that restraint was used as a last resort and staff tried to de-escalate and divert patients who were becoming distressed or agitated. Prone restraint was used only when the patient had requested it in their care planning (some patients prefer to the floor forwards instead of backwards) or in some cases if an injection was required. Staff turned the patient onto their side or back as soon as possible and the majority of prone restraints lasted less than three minutes.
- Staff in the training department were supporting ward staff to use other sites for injections to reduce the need for any prone restraint to give medication. A report provided to us at the time of inspection stated that over a third of staff had completed the reinforce appropriate implode disruptive training (RAID). This training is nationally recognised and teaches staff a philosophy to manage behaviour that challenges and to nurture positive behaviour instead. Across the service 35% had received this training.
- Nurse practitioners had run workshops on Hawkins ward looking at restrictive practice and working through examples with staff.
- The electronic system was difficult to navigate to find key documents such as positive behaviour support reports and plans. Staff saved some documents on a shared drive rather than in the electronic system. Seven out of 12 electronic records viewed had a positive behaviour support plan in place.
- The behaviour observations sheets used codes for identifying specific behaviours, however, it was not always clear which exact behaviour related to which code. This meant staff may not be clear what behaviour to expect in certain situations.
- Data for the period 1 January 2016 to 26 January 2017 showed there had been 412 restraints in this service across three of the four wards. There was no data provided for Harlestone ward. Eighty-seven restraints had been on Naseby ward, 150 had been on Hawkins ward and 175 had been on Mackaness ward. Of the 175 on Mackaness ward, 143 had been held for ten minutes or less, on Hawkins ward 121 of the 150 had been for ten minutes or less and on Naseby ward 78 of the 87 had been for ten minutes or less. St Andrew's Healthcare records all hands on contact with patients as restraint.
- Of the 175 incidents of restraint on Mackaness ward, 74 used the prone position. Staff used prone position on seven occasions to administer medication and on 26 occasions to exit seclusion, with one being patient preference and 31 occasions owing to the patient putting themselves into that position. Forty-nine of the prone restraints on Mackaness ward were for less than three minutes and 19 were for less than ten minutes. Of the 150 incidents of restraint on Hawkins ward, 98 used

the prone position. Staff used prone position on 21 occasions to administer medication, on 22 occasions to exit seclusion, and on 31 occasions owing to the patients putting themselves into that position. Sixty-one of the prone restraints on Hawkins ward were for less than three minutes and 34 were for less than ten minutes. Of the 87 incidents of restraint on Naseby ward, 27 used the prone position. Staff used prone position on 14 occasions to exit seclusion and on ten owing to the patient putting themselves into that position. Twenty-two of the prone restraints on Naseby ward were for less than three minutes and four were for less than ten minutes. Staff told us the majority were actually for less than a minute but the system did not capture this amount of time as the data provided could only record less than three minutes as the minimum time.

- Staff injuries occurred on 47 occasions during restraint on Mackaness ward. Of these 25 were caused during the restraint, and 21 caused by patient aggression. On Hawkins ward, there were 40 staff injuries, 21 during the restraint, 18 caused by patient aggression and one manual handling injury. On Naseby ward, there were eight staff injuries, two during the restraint and six caused by patient aggression.
- Managers reported that debriefs for staff following incidents of restraint were not formalised or routinely recorded.
- Data for the period 1 January 2016 to 26 January 2017, showed there were 328 episodes of seclusion on three of the four wards. 128 on Mackaness ward, 126 on Hawkins ward and 74 on Naseby ward, with 285 lasting over one hour and 40 minutes. There was no data provided for Harlestone ward.
- On Naseby ward there were 40 records of seclusion in the seclusion register from 1 November 2016 to 7 February 2017. Nine of these records did not have an incident reporting number and not all of them had the patients NHS number. On Harlestone ward there were no records of seclusion in the seclusion register from June 2014 to August 2016, though from August 2016 to 7 February 2017 there were six seclusions recorded.
- Five out of 12 records we viewed had a restraint and seclusion plan in place. These plans included risks, triggers, early warning signs and preferred de-escalation methods. They also detailed the patients' preferences if staff had to use restraint or seclusion. All plans emphasised that restrictive interventions should be the last resort.
- There were four patients in long term segregation at the time of our inspection. Two patients were on Naseby ward and two were on Hawkins ward. All were in long term segregation due to risks they posed to others. One patient had been in long term segregation for 486 days, another 139 days, another 33 days and another 30 days. The patient in long term segregation for 486 days had been originally admitted for a short assessment period. Staff on the ward reported that they had not been able to find a suitable long term placement for him. They all had long-term segregation plans in place. These covered levels of staff support, physical and mental health needs, social needs, access to fresh air and leave, access to family, reasons for the segregation and plans for reintegration.
- Doctors told us they monitored the use of low stimulation rooms in ward rounds and if staff prevented the patient from leaving the low stimulation room, they would reclassify it as seclusion.
- Naseby ward was part of a pilot to introduce "safewards" to the organisation. Safewards enable staff to identify ways of reducing the use of restrictive interventions. There are 18 wards in total taking part in the pilot. Early data has evidenced a 17% reduction in the use of seclusion and an 8% reduction in the use of rapid tranquilisation. The provider has updated policies to reflect latest national guidance and the Mental Health Act code of practice.

Track record on safety

- We looked at incidents related to restraint. There was an incident reported in November 2016 when a patient reported a member of staff physically abused them during restraint. Managers investigated the incident and took appropriate action. A management plan was put in place to support the patient.

Reporting incidents and learning from when things go wrong

- The provider had updated the incident reporting system to enable clearer analysis on restrictive interventions. This included detailing the reason for the use of prone

restraint. Staff reported episodes of restraint as an incident on the electronic system. The ward manager and senior managers received a trigger alerting them to the incident report and they would then review it.

- The provider had a policy of recording all hands on contact with patients as restraint. This could include guiding someone by the arm to the low stimulation room. The provider was not able to provide a breakdown of the number of these low level restraints.
- Staff discussed restraint incidents and seclusion at multidisciplinary meetings (ward reviews). The ward managers received a monthly dashboard report, containing information about the incidents of restraints and seclusion.
- The provider had a restrictive practice monitoring group that met monthly to review incidents of restraint and seclusion, and used closed circuit television to review individual incidents when needed. At this meeting senior managers identified 'hot spots' and targeted those wards to address any issues.
- The training leads for managing aggression and for positive behaviour support planning attended the wards when requested to help staff learn from incidents and review the use of restraint. This included how to do things differently if appropriate. The provider gave us a copy of the visit tracker to show visits by the training leads for December 2016 and January 2017.

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- Staff were caring and respectful in their approach to patients and showed an understanding of individual need. They spoke about patients in a respectful manner.

Staff sought patient views when putting restraint plans together in order that they could protect their dignity during restraints. These plans also included the support patients wanted following any incident of restraint.

The involvement of people in the care they receive

- Patients were involved in their care planning unless they declined. Care plans evidenced that patient preferences had been included and were individualised. Care plans were available in easy read format.
- Carers were involved in care review meetings where possible. Staff used technology, such as video calling, to help patients keep in contact with relatives who lived some distance away.
- Advocacy services were available to patients if requested. Information on advocacy services was displayed in communal areas. Patients could contact advocacy services directly or staff on the wards would refer patients to advocacy.
- The organisation employed two ex-patients who were involved in training staff in managing aggression. This meant that the training focused on the experience of the patient and provided staff with a better understanding of restraint from the patients' perspective.
- Some patients had advance decisions in place for how they wanted staff to restrain them if that was needed.
- Patients in the service could access an online feedback webpage and receive a response from the provider. There had been comments made by some patients in this service and action taken by the provider in response. This included one comment by a patient who said that staff were supportive and nice but he couldn't use video calling to contact his mum as she didn't have a computer. The provider responded by advising he could use the phone.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure seclusion records are easily available and kept up to date.
- The provider should consider reviewing the behaviour observation paperwork to make it clearer and simpler.
- The provider should continue to review the electronic system to ensure information is saved consistently and easy to access.
- The provider should ensure duty doctors can carry out reviews within the required timeframes at night.