Tees, Esk and Wear Valleys NHS Foundation Trust

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

Inspection report

West Park Hospital
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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

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

Inadequate 

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services. The inspection was prompted by an incident that had a serious impact on a person using the service. This indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks.

We inspected five wards from the acute wards for adults of working age and psychiatric intensive care unit services. The service provides treatment for people who are acutely unwell and whose mental health problems cannot be treated and supported safely or effectively at home. The trust provides the service across 14 wards. During this focussed inspection we inspected the following five wards to include at least one ward from each locality:

- Bransdale ward – 14 bed female acute admission ward at Roseberry Park
- Stockdale ward – 18 bed male acute admission ward at Roseberry Park
- Elm ward – 20 bed female acute admission ward at West Park Hospital
- Danby ward – 13 bed male acute admission ward at Cross Lane Hospital
- Overdale ward – 18 bed female acute admission ward at Roseberry Park

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

This was a focussed inspection looking at the safe and well led key questions. We did not rate key questions at this inspection. However, due to enforcement action taken in safe and well led these key questions have been limited to inadequate.

Our rating of services went down. We rated them as inadequate because:

- We issued a warning notice under Section 29A of the Health and Social Care Act in relation to this service. This limited the rating of this service to inadequate.
- The systems the trust had in place were not robust enough to comprehensively assess and mitigate patient risk on the wards.
- There was a lack of understanding from staff regarding the risk assessment process and what was expected of them when updating documentation. The harm minimisation policy the trust had in place did not provide a structured framework or sufficient guidance to assist staff in carrying out risk assessments for patients effectively.
- There were gaps in information and discrepancies in patient risk documentation across the five wards we visited. Scoring of patient risk did not always reflect the narrative in the patient risk profile and the documented handover of patient risk between staff was inconsistent or information was omitted.
- Staff were not aware of what the trusts' 'Observation and Engagement' policy stipulated regarding night-time checks of patients. None of the wards we visited were following the trusts' own policy in planning and documenting patient observations during the night.

Our findings

- The mechanisms the trust had in place to monitor, audit and ensure oversight of the patient risk assessment process were not effective and were not sufficient to identify areas for improvement.
- The trust did not have an effective procedure and process in place to review and learn from serious incidents.

How we carried out the inspection

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

During the inspection, the team:

- Visited three wards at Roseberry Park, one ward at Cross Lane Hospital and one ward at West Park hospital.
- Spoke to 23 members of staff including clinical managers, a consultant, qualified nurses and health care assistants.
- Attended four multi-disciplinary handover meetings.
- Spoke with two patients.
- Reviewed 16 patient care records.

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

We spoke to two patients during our inspection who told us they felt safe at the service and did not have any complaints about their care.

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

- We issued a warning notice under Section 29A of the Health and Social Care Act in relation to this service. This limited the rating in this key question to inadequate.
- Staff had not regularly updated thorough environmental risk assessments of all ward areas and removed or reduced all risks identified. The environmental risk assessment on Danby ward was due to be reviewed in August 2020, the review did not take place until December 2020. At the time of our inspection the risk assessment had not been authorised by the trusts' quality assurance group. The environmental risk assessment was therefore still unavailable for staff on the ward to refer to, in relation to reducing or mitigating any recent environmental risks.
- Staff did not assess and manage risks to patients well or use a tool that was robust enough to assess patient risk effectively. We looked at 16 care records and risk assessments had not been updated with recent incidents or identified risk on nine of these care records.
- There were three different meetings in place with separate functions where patient risk was discussed between the multi-disciplinary team and nursing team. However, we found that the information in handovers and risk documentation did not match for 11 of the 16 patients we reviewed.

Our findings

- Patient intervention plans were not always being updated following a change in risk or change in prescribed level of observation. We found evidence of this across three wards, on four occasions.
- Staff were unaware of the need for a specific night-time intervention plan. We reviewed 16 patient care records during our visit and the recording of night-time observation plans was either omitted or inconsistent across all wards.
- Observation sheets for two patients on enhanced observations due to risk, did not specify the level of prescribed observations for the patient, or the identified risk. This meant that we were not assured all staff had access to information that was essential to keeping patients safe.
- The wards did not have a good track record on safety. The service did not manage patient safety incidents well. We found that risks relating to a recent serious incident did not appear on the environmental risk section of handover meetings and did not form part of a discussion in multi-disciplinary meetings. The trusts' audit processes did not ensure that risks identified from patient risk assessment and recent incidents were included in handover documentation.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- We issued a warning notice under Section 29A of the Health and Social Care Act in relation to this service. This limited the rating in this key question to inadequate.
- Our findings from the safe key question demonstrated that governance processes did not operate effectively, and that risk was not managed well. The trusts' audit process did not ensure that the documentation staff used for assessing and mitigating patient risk included up to date and consistent information.
- The trust governance systems failed to ensure that staff understood and complied with the trust 'Observation and Engagement' policy to maintain patient safety. The observation and engagement audit that was in place at the time of our inspection did not ensure that hourly checks were being completed for patients on general observations, or that night-time observation plans were in place for patients.
- Staff had not received training or guidance to allow them to effectively assess, mitigate and document patient risk. Staff told us that separately from the harm minimisation training they completed as part of the trust induction programme, they had not received any further training or guidance specific to the completion of risk assessments. Staff had not received training following the implementation of the trusts' in-house risk assessment tool.
- Leaders had failed to ensure that staff knew what was expected of them when assessing and documenting patient risk. This was evident when reviewing the care records as the completion and level of detail in risk assessments was inconsistent across all wards and patients.
- Ward teams did not have easy access to the information they needed to provide safe and effective care. The trust had failed to take sufficient action to ensure their systems and processes supported staff to keep patients safe.
- Lessons learned were not shared effectively with the service to ensure patient safety and drive improvement. All the staff we spoke to were unable to describe any specific communication they had received from leaders to alert them to areas of risk following a recent serious incident. We asked 19 members of staff to give an example of shared learning following this recent incident, although some staff were aware of the incident, not all staff could describe any changes to practice as a result of learning from the incident.

Our findings

Areas for improvement

We found areas for improvement including breaches of legal requirements that the trust must put right.

Action the trust MUST take is necessary to comply with its legal obligations.

Action the trust MUST take to improve:

- The trust must ensure they have systems and processes in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.
- The trust must ensure that all staff receive the appropriate training to carry out patient risk assessments appropriately and consistently.
- The trust must ensure that staff understand and comply with the trust 'Observation and Engagement' policy required to maintain patient safety.
- The trust must ensure that they have an effective procedure and process in place to review and learn from serious incidents.
- The trust must ensure that clear processes are in place to audit and identify areas of improvement required in risk management practice and documentation.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, and one other CQC inspector. The inspection team was overseen by Brian Cranna, Head of Hospital Inspection.

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 17 HSCA (RA) Regulations 2014 Good governance

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