

Leeds and York Partnership NHS Foundation Trust Acute wards for adults of working age and psychiatric intensive care units

Quality Report

Bootham Park Hospital
Bootham
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RGDX4	Bootham Park Hospital	Ward 1 and Ward 2	YO30 7BY

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of this inspection

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Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We inspected the service as part of an unannounced inspection and found the following concerns:

- We conducted a tour of wards 1 and 2 and found significant concerns. We found there was a serious long-standing problem with a leaking toilet on ward 2. This had leaked into the bedroom below on ward 1. The smell from the leak was pervasive throughout ward.
- Several ligature points were noted throughout both wards.
- In the ward 1 kitchen, which was open to patients, the sink water temperature was 51 degrees centigrade, which presented a scalding risk.
- On the last day of our inspection, we noted a crack in the ceiling on the main corridor of the hospital. This was identified to a member of the senior management team. Part of the ceiling subsequently fell down.
- Staffing levels on wards 1 and 2 were not at full establishment. This meant people were at risk of care that was unsafe.

Are services effective?

We did not look at the effective domain during this inspection.

Are services caring?

We did not look at the caring domain during this inspection.

Are services responsive to people's needs?

We did not look at the responsive domain during this inspection.

Are services well-led?

We did not look at the well-led domain during this inspection.

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust had two acute admission wards and psychiatric intensive care units at Bootham Park Hospital, one for females and one for males.

At the last inspection on 30 September and 1 October 2014, there was a compliance action issued for the safety and suitability of premises.

Our inspection team

The team on the first day of inspection comprised:

- four CQC inspectors.

The team on the second day of inspection comprised:

- six CQC inspectors
- one specialist advisor.

Why we carried out this inspection

We inspected this core service as a result of being notified of delays in the implementation of an action plan submitted by Leeds and York Partnership NHS Foundation Trust after an inspection at Bootham Park Hospital in September 2014. The trust during and subsequent to the September 2014 inspection provided documents that outlined their concerns about the premises and the length of time it was taking to complete

the agreed works. To find a solution the trust had raised this with the relevant parties, including Vale of York commissioning group and NHS property services who were responsible for the building and the plan of work.

We were concerned for the safety of people who used the service and the staff team working at the hospital. The trust closed the hospital to patients on 30 September 2015.

How we carried out this inspection

This was an unannounced inspection.

During this inspection we looked at the following key question:

- is it safe?

Before the inspection visit, we reviewed information we held about the service, including statutory notifications sent to us by the trust. A notification is information about important events that the trust is required to send to us.

During the inspection visit, the inspection team:

- visited wards 1 and 2 and looked at the quality of the ward environment
- spoke with the managers
- spoke with four other staff members.

We also:

- looked at five treatment records of patients
- carried out a specific check of the maintenance of the ward.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure the safety of people who use the service and staff working at the service by completing routine and essential maintenance in a timely fashion.
- The trust must carry out regular checks of both hot and cold water temperatures.
- The trust must ensure staffing numbers are at agreed establishment levels and are sufficient to keep people safe.
- The trust must take action to mitigate ligature risks and keep people safe from harm.
- The trust must take action to ensure that infection control measures are implemented, particularly with regard to the toilet leak from ward 2.
- The trust must implement measures to ensure staff have a clear line of sight across all patient-accessible areas of both wards. This will ensure that safe observations of patients can take place.

Leeds and York Partnership NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)

Name of CQC registered location

Ward 1 and Ward 2

Bootham Park Hospital

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

The trust was found non-compliant with Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 on Wards 1 and 2 at Bootham Park Hospital in December 2013. During our inspection in September and October 2014, we found the trust was still non-compliant with Regulation 15 safety and suitability of premises. As a result, the trust sent us an action plan laying out how they intended to ensure the premises were safe.

Before our inspection, the trust contacted the CQC to tell us they were unable to complete the works required to make the wards safe within the timescales they had given.

We conducted a tour of wards 1 and 2 and found there was a serious long-standing problem with a leaking toilet on ward 2. This had leaked into the bedroom below on ward 1. We looked at the bedroom below and saw there was damage to the ceiling and wall as result of the foul water and urine from the leak. This had caused a noxious smell and a risk of infection, which had resulted in the closure of the bedroom and en suite bathroom. The smell from the leak was pervasive throughout ward 1. We found the toilet where the leak had occurred on ward 2 was still in use and, therefore, contributing to the on-going problem.

There were still several ligature points, which included tilting windows and taps in the kitchen. The ward managers told us there were ligature risks in all bedrooms. Staff said they had taken actions to mitigate these risks by using observation levels that related to the individual risk of the patient occupying the room. On ward 2, the ward manager told us that in order to try to reduce the risk of patients harming themselves by tying ligatures, the staff carried out a risk assessment of the ward weekly. This was done in the form of a ward 'walk round,' which always involved another member of the staff team. This was to ensure staff were aware of the risks and a 'security nurse' was identified on each shift. Handover documentation we reviewed showed that risks were discussed at every handover.

In the ward kitchen, which was open and accessible to patients, the sink water temperature measured at 51 degrees centigrade, which presented a scalding risk. There

was also a tea boiler in the kitchen with a water temperature in excess of 90 degrees centigrade, which presented a serious scalding risk. We identified ligature points in the form of handles and electric flexes.

Staff reported general foul smells occurring on a regular basis from the drainage systems around the wards and within the hospital. Despite regular works being carried out to try to resolve issues, the problems remained.

Lines of sight on both wards were compromised, which meant patients could not be observed safely. We had serious concerns on ward 1 due to the layout of the ward, where there were several areas that staff could not observe patients safely. This meant staff could not assure themselves that patients were safe in all areas of the ward.

On the last day of our inspection, we noted a crack in the ceiling on the main corridor of the hospital. This was identified to a member of the senior management team. Part of the ceiling subsequently fell down. The debris was cleared away but the area had not been cordoned off, which meant people were still at risk of harm if more of the ceiling had collapsed before the remedial works were done.

Safe staffing

Staffing levels were not always in accordance with the provider's establishment levels for each of the wards.

Ward 1

At the time of our inspection, there was one vacancy for a band 2 member of staff. There were also two members of staff on long-term sickness absence. The ward manager told us it was not always possible to get cover for these posts. Staff were on occasions transferred from other areas of the hospital to cover but again this was not always possible. Whilst this impacted on staff supervisions and nurse-led activities, staff told us it did not impact on the safety of people. We were told staff would stay over their designated hours to ensure assessments were carried out. Staff said the ward was on some occasions running on their goodwill and they felt undervalued and taken for granted.

The ward manager said there was no flexibility in the staffing system that would enable continuity of cover during times of staff sickness. However, even with a full

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

complement, staff did not think there were sufficient numbers to manage people who required one-to-one observations. At the time of our inspection, there was one person on one-to-one observations.

Ward 2

At the time of our inspection, there were vacancies for one band 2 and four band 3 staff members. The ward manager told us where they were unable to fill shifts reduced staffing impacted on patient experience, which included cancelled activities. Staff were not always able to have supervision and it was difficult for the ward manager to carry out their

duties as often they had to step in and carry out nursing duties. There were no male qualified staff, which again meant the manager had to regularly step in where a male nurse was required.

Track record on safety

We were told about a recent incident that had resulted in a patient climbing out of a window and onto the roof. The patient was returned safely to the ward after police intervention.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

We did not look at the effective domain during this inspection.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

We did not look at the caring domain during this inspection.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

We did not look at the responsive domain during this inspection.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

We did not look at the well-led domain during this inspection.

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

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (2)(d)

The trust did not take appropriate steps to ensure wards were safe to use for their intended purpose and were used in a safe way.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (2)(h)

The trust did not assess the risk of infection and prevent and control the spread of infection

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Regulation 18(1)

The trust did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to make sure they could meet people's care and treatment needs.