St Matthews Unit

Quality Report

29-31 St Matthews Parade
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Date of inspection visit: 30 to 31 August 2016
Date of publication: 17/05/2017

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

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

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

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

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

Overall summary

We carried out an unannounced inspection of St. Matthews Unit on 30 and 31 August 2016 due to concerns that were raised with the Care Quality Commission. During the inspection we found that:

- The provider placed mental health patients and care home patients together across both wards with no separation.
- Staff did not always update risk assessment's following incidents. Staff recorded some incidents on the risk summary but did not update care plans when risks had changed.
- Staff were not following safe management processes on the storage, disposal and dispensing of medication.
- The managers did not ensure that staff had received the necessary training to ensure that carry out their role effectively.
- Care plans were not individualised, holistic, or recovery focused. Care plans for specific needs were not routinely followed, reviewed, or updated.
- Individual sessions with patients to discuss care and treatment were not taking place.
- Access to psychological therapies was minimal.
- Staff did not ensure that all areas of the ward were clean, well maintained, and safe for patents use.
- Information governance systems were not robust and learning from investigations or incidents was inconsistent.

Summary of findings

- The managers did not ensure that staff received mandatory training.
- The managers did not ensure that regular supervision was taking place in accordance to policy.
- The managers allocated two qualified nurses to each shift across both wards for up to 58 patients. There was no evidence of nurses spending one to one time with patients.

Summary of findings

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Summary of this inspection

Background to St Matthews Unit

St. Matthews Unit was a 58 bedded hospital that provided rehabilitation services to people who have needs related to their mental health and who were either detained under the Mental Health Act 1983, were subject to a Deprivation of Liberty authorisation, or were voluntarily staying at the hospital.

The unit was over two wards. Downstairs, Hazel ward had 23 bedrooms and upstairs, Birch ward had 31 bedrooms; including six double bedrooms across the two wards. At the time of inspection, the unit had 27 patients residing on Hazel ward and 31 patients residing on Birch ward.

Both wards were mixed gender. The provider reported that Hazel ward functioned as a hospital and Birch ward as a care home.

At the time of inspection the unit was registered to provide

- treatment of disease, disorder or injury
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- accommodation for persons who require nursing or personal care

At the time of inspection, there was a registered manager in place.

St Matthews Unit had been registered with the CQC since 1 October 2010. Prior to this inspection, the Care Quality Commission had inspected the service four times since its registration. We had last inspected the service in March 2016 where we found that people who were assessed as needing personal or nursing care in a residential care home were cared for on the same floors as those who were detained under the Mental Health Act. CQC had therefore assessed this service against the standards, which are relevant to an independent rehabilitation hospital. We did this because of the distribution of patients detained under the Mental Health Act across both floors. The higher care standards must apply in order to ensure the safety of this vulnerable group of patients.

Since this inspection, the provider moved all detained patients from the location and applied to remove the regulated activity assessment or medical treatment for persons detained under the Mental Health Act 1983. This variation of registration has since been granted and the service has ceased to be a hospital.

Our inspection team

The inspection Manager was Tracy Newton.

The team leader for this inspection was Deborah Holder, CQC Inspector, mental health hospitals.

The team that inspected the service consisted of two inspection managers, four CQC inspectors, and a Mental Health Act reviewer.

Why we carried out this inspection

We carried out an unannounced focused inspection of St Matthews Unit on 30-31 August 2016 due to concerns raised to the CQC.

The concerns included:

- restrictive practices including restraints and manual handling
- standards of care plans and risks assessments
- compliance with mandatory training
- supervision standards.

Summary of this inspection

How we carried out this inspection

This inspection was a focused inspection and asked the following questions of the service:

- Is it safe?
- Is it effective?
- Is it well-led?

CQC inspectors did not review every aspect of safe, effective, and well led. The inspection focused on questions relating to the concerns raised. As a focused inspection, we did not rate this service.

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the premises and looked at the quality of the environment
- observed staff providing support to patients in communal areas
- observed interactions between staff and patients
- spoke with three patients that used the service
- spoke with the registered manager, the ward manager and seven staff that worked at St. Matthews Unit
- spoke with two carers
- looked at 13 care and treatment records
- looked at five medication charts
- observed a medicines administration round
- looked at 14 personnel files and reviewed training 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 six patients that were receiving care and treatment at the unit.

One patient reported they were not aware of their rights as a voluntary patient and reported restrictive practices. They reported that voluntary patients were not always able to leave the ward when they wanted to.

Patients we spoke with told us they did not like living on a mixed gender ward and disliked living with individuals of the opposite sex. Some patients were looking forward to moving to a new ward.

Some patients were not aware of their treatment plans, goals, and discharge plans. One patient stated staff had told them that they would never achieve discharge.

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 have not rated this service. We found that:

- Individuals with different needs and risks were mixed with no separation; the wards did not comply with Department of Health guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice.
- The layout of the building did not allow staff to observe all parts of the wards. There were multiple blind spots without mitigation in place.
- Resuscitation equipment was not located on either ward and there was no emergency medicine including anaphylaxis kits (used to treat severe allergic reaction)available for staff to use when administering depot injections.
- Staff did not following policy for the storing, disposing and dispensing of medication.
- Bathrooms, shower rooms, and toilets were dirty and some were in need of repair.
- Doors were propped open with furniture and fire extinguishers. Some of these were fire doors and should remain closed. High-risk areas such as cleaning and maintenance cupboards and the hairdressers were unlocked.
- Patient's records did not always contain up to date and detailed risk assessment; individual risk management logs did not reflect recent risk behaviours.
- The provider reported some but not all incidents.
- The provider did not have a robust process for recording, investigating and learning from incidents.

Are services effective?

We have not rated this service. We found that:

- Care plans were not individualised, holistic, or recovery focused. Care plans for specific needs were not routinely followed, reviewed, or updated.
- There were no care plans in place for informal patients with capacity to help them understand their rights.
- Individual sessions with patients to discuss care and treatment were not taking place.
- Not all identified nutritional and hydration needs were monitored in accordance with care plans.
- Access to psychological therapies was minimal.
- Staff were not receiving regular supervision.

However

Summary of this inspection

- Care records were stored in a locked nursing office.
- Medication charts and medication prescribing followed National Institute for Health and Care Excellence guidelines.
- An induction programme was in place for staff.

Are services well-led?

We have not rated this service. We found that:

- Information governance systems were not robust.
- The process for recording, investigation or learning from incidences was not robust or consistently applied.
- Managers did not ensure that all staff received mandatory training.
- Managers did not ensure that regular supervision was taking place in accordance with the providers own policy.
- The managers allocated two qualified nurses to each shift across both wards for up to 58 patients. There was no evidence that one to one sessions with patients' were taking place.

However:

- Some staff told us that they enjoyed working on the wards.

Detailed findings from this inspection

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Well-led	

Summary of findings

Are long stay/rehabilitation mental health wards for working-age adults safe?

Safe and clean environment

- The provider reported patient's bedrooms were divided into different areas of the building to provide separation of mental health and care home patients. We observed that these areas were not managed, as doors were propped open, which allowed patients to walk freely through areas of the building that should have been separated.
- The layout of the unit meant that there were blind spots that were not observed by staff at all times. Mirrors had been fitted to mitigate the risk. However, they had not been fitted in all areas.
- We found ligature points across the unit and in the garden. We found doors to storage cupboards and rooms left unlocked that had risk items and ligature points within them.
- The wards were mixed sex and did not comply with the Department of Health guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice. There was no separation between male and female bedrooms. Toilets and bathrooms were unisex. We observed both males and females use the same toilet and a female patient tried to gain access to a toilet that was occupied by a male patient.
- The unit had two clinic rooms, one on each floor. Resuscitation equipment was not located in either clinic room. An emergency grab bag was stored in the reception area. However, there was no oxygen cylinder, and the suction machine was broken. A second machine was located but had not been safety tested and staff did not know how to use it. No emergency medicines were available for staff to use when administering depot injections in accordance with Resuscitation Council guidelines. There was no evidence to show that staff

regularly checked the emergency bag. There was no anaphylaxis kits (used to treat severe allergic reaction)available for emergency treatment of anaphylactic reactions.

- The provider had two blood pressure monitoring machines neither had been calibrated. Blood pressure cuffs were available but visibly dirty.
- Hazel ward clinic was clean but the sink was slow to drain, medication was stored in the fridge where required. We found two boxes of medication that were wet and other medication was frozen to the back of the fridge. There were gaps in the daily clinic room and fridge temperature checks. We found a prescribed meal substitute shake made up in the fridge for use throughout the day, which was not in line with medication policy.
- Birch ward clinic was visibly dirty, the sink and floor was dirty, and there was medication (tablets) on the floor. We saw a tablet crusher that was visibly dirty. Staff did not record daily room and fridge temperature consistently, so they could not ensure that medication was kept within the recommended storage temperature. Staff had not labelled all medication with an opened by date. There was an item of jewellery stored in the controlled drugs cupboard. No soap was available for hand washing and concentrated green detergent was used to wash hands and medicine pots.
- Medication consent forms (T2 and T3) were not attached to medication charts. There service used medication profiles for some patients but not for others. One chart did not have a patient photo attached. Not all entries on medicine charts were clear.
- Staff did not follow best practice for disposal of sharps and medication. The sharps bin contained tablets. A full sharps bin had no date of assembly or closure. The drug disposal bin was not secure.
- The clinic room fridge was broken. There was no sign on the fridge to indicate that it was broken and should not be used. There was a large oxygen cylinder in the clinic but no trolley to assist with moving the cylinder. Staff had not locked away or stored medication securely in the clinic room. We found four different medications on the worktop.
- On Hazel ward, we found two bathrooms that were visibly dirty. One had no toilet paper and the door was hard to open. The waste bin contained soiled items and patient's medication was on the bathroom side. One shower room contained a broken shower chair and had a broken ceiling panel with exposed wires. In one toilet, there were plastic ties for clinical waste bags. Cleaning records were missing or out of date.
- The door to the internal garden was propped open and there was a strong smell of cigarette smoke. Patients were smoking in a section of the garden designated for no smoking. There were numerous patients in the garden with no staff observation.
- Patients could access the main kitchen, as the door was unlocked. There were items in the kitchen that could present as risk to patients.
- On Birch ward, we found several bedroom and corridor doors propped open with furniture and fire extinguishers. Some of these were fire door and should remain closed.
- Toilets and bathrooms were dirty; two toilets had no toilet roll or paper hand towels. We found razors in the clinical waste bin in another bathroom. Cleaning records were missing or out of date.
- Staff had left the hairdresser's room unlocked. The room contained scissors and razors and was cluttered with unnecessary items. The hairdryer had an electrical safety test sticker dated May 2013.There was a long cord for the velux window that was a ligature risk.
- We found one cleaning cupboard unlocked, making it accessible to patients. This cupboard contained glue, several screwdrivers, ant powder, a knife, plastic ties, and numerous cleaning products. Prescribed medication belonging to a discharged patient was located within this room.

Safe staffing

- The staffing establishment for St. Matthews Unit was two qualified nurses and 22 healthcare assistants across the two wards during the day, reducing to two qualified nurses and 14 healthcare assistants for night shifts.
- We found discrepancies between staffing rota's and numbers of staff on duty during our inspection; there were eight staff members on duty that were not included in the rota. The manager reported that this was a result of introducing a new electronic system. Rotas between January and August 2016 showed that regular bank staff were used to compliment permanent staff to ensure adequate staffing.
- In August 2016 there was eight night shifts covered by agency staff. Between April and June 2016, there were three qualified nurse shifts left unfilled.

- There was no evidence is care records of staff spending regular one to one time with patients.
- There were two qualified nurses across the two wards; therefore, it was difficult for a qualified nurse to be present in communal areas of the ward at all times.
- Overall, compliance with mandatory training was 64%. Compliance to Mental Health Act training and Mental Capacity Act training was significantly lower at 34%. Overall, 45% of staff had completed first aid training. However, only 2% of these staff had received an update or refresher since 2014.
- We saw no evidence of staff training in the Human Rights Act 1998 as recommended by National Institute for Health and Care Excellence for any setting where restrictive interventions are used.
- We looked at 14 staff personnel files; one staff had no references and one staff reference was dated 10 months after they commenced employment with St. Matthews. Two staff had historical references that were not current at the time of recruitment and one reference contained no information but was signed and dated. One member of staff had commenced employment without any references received. One member of staff had no application form or CV.

Assessing and managing risk to patients and staff

- The provider reported that no restraint had taken place between March and August 2016. We observed three occasions during our visit where patients movements were redirected by staff. The provider confirmed that they do not record this intervention and did not recognise it as restrictive practice.
- The provider's policy did not reflect the up to date National Institute for Health and Care Excellence guidelines on violence and aggression: short-term management in mental health, health and community settings; they did not have a reducing restrictive intervention reduction programme in place.
- We reviewed 13 care records. All care records had a risk assessment in place. However, review and updating following incidents was not routine practice. Individual risk management logs did not reflect recent risk behaviours. There was little evidence of patient involvement in risk assessment and refusal to participate in risk assessments was not recorded.
- There was no evidence of ongoing assessment of mental state and impact on risk in case notes.
- There were no care plans or contracts in place for informal patients. One patient, who was informal, reported that they are not always able to leave at will, as staff would not always provide an escort. Staff confirmed that on one occasion an informal patient was encouraged to return to the ward for their own safety. Staff did not demonstrate understanding of the rights of an informal patient.
- The provider had systems in place to manage safeguarding incidents. The provider had reported some but not all safeguarding concerns to the safeguarding team and CQC. There were two incidents where safeguarding process had not been considered and concerns had been dealt with under the complaint process; both incidences related to concerns around poor care and treatment from staff.
- Overall, 66% of staff had completed safeguarding training.
- Staff were not following the provider's medication policy. Consent forms and current medication forms were not kept together so staff were unable to check patients consent for medication. We found prescribed medication in unlocked and public areas of the ward. Oxygen was kept in one patient's room for their personal use. However, this room was unlocked and the door was propped open.

Track record on safety

- The provider reported no serious incidents between March and August 2016.
- There was no robust process in place to document, monitor, and review serious incidents. The provider used an accident and incident log, which contained limited information and did not detail investigation following reported concerns; for example attempted and actual absence of patients without leave (AWOL).

Reporting incidents and learning from when things go wrong

- The provider reported some but not all incidents to the QCQ and safeguarding team. Staff had reported two safeguarding incidents to the manager. The manager had not followed safeguarding processes.
- The manager confirmed that staff would benefit from developing their understanding of what to report and when to send notifications to CQC.
- The manager reported they would discuss incidents during staff supervision and handovers. We were not

provided with evidence to support this. The provider had a serious incidents requiring investigation (SIRI) policy. Some incidents were recorded on an incident log however, this process was not robust. The log did not reflect all incidents and there was no evidence of robust investigation or lessons learnt.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- We reviewed 13 care records. Overall, 12 records had gaps in documentation and lacked evidence of regular reviews taking place, care plans were not individualised, holistic, or recovery focused. There was a lack of patient involvement in care plans and refusal to participate was not recorded. There was no evidence that patients had been given a copy of their care plans.
- Where assessments had identified the need for specific care plans such as speech and language, dietary requirements or personal hygiene, these care plans were not consistently in place. For those with care plans in place, we found no evidence they were implemented by staff.
- Staff were not regularly reviewing or updating care plans to support ongoing monitoring of physical health issues; two falls assessments had not been updated following falls. One 'Do Not Attempt CPR' care plan had not been reviewed for eight months.
- There were discrepancies within two care records regarding the level of support patients required for mobility. One care plan contained conflicting information for a patient's capacity regarding their personal hygiene.
- Staff were not recording daily case note entries to determine if Section 17 leave had taken place, or if it had been offered or declined. There was no evidence to support that individual sessions with patients to discuss care and treatment were taking place. There were gaps in daily entries in some case records.
- There were no care plans in place for informal patients with capacity, to help them understand their rights.
- Staff stored patient files in a locked nursing office.

Best practice in treatment and care

- The GP and not the responsible clinician prescribed all medication, including psychiatric medication, apart from Clozaril.
- We looked at five medication charts. Medication prescribing followed National Institute for Health and Care Excellence guidance.
- Access to psychological therapies was minimal. The unit did not have its own dedicated psychologist and there was no evidence of active psychological input in some patients care records.
- Physical healthcare needs were met the local GP practice via appointment at the surgery.
- Staff were not monitoring all identified nutritional and hydration needs according to care plans.
- Monthly nutrition screening was not taking place for all patients where it was required and staff were not recording patient's weight regularly.

Skilled staff to deliver care

- The multidisciplinary team consisted of nurses, doctors, health care workers, an occupational therapist, and administrators. The unit had occupational therapy assistants to support the activities programme, some of these assistants also worked as care support staff.
- The provider had a supervision policy in place, which recommended monthly supervision as a minimum requirement. Staff were not receiving regular supervision. Overall, 7% of qualified nurses and 26% health care workers had received supervision between January and August 2016.
- We looked at 12 supervision files. Overall, 91% had discrepancies within the recording and documentation of when supervision had occurred.
- The manager reported regular team meetings and discussions were taking place however, we saw no evidence to support this.
- The provider's prevention and management of aggression and violence policy stated all clinical staff who worked in 'at risk' situations would be trained in control and restraint. The policy also stated all staff should be trained in breakaway technique. Overall 31% of staff had completed control and restraint training with 12% in date for annual refresher.

Adherence to the MHA and the MHA Code of Practice

- Overall, 34% of staff had received training in the Mental Health Act. Therefore, staff were not sufficiently trained to work with patients there were caring for.

Long stay/rehabilitation mental health wards for working age adults

- Consent forms and current mediation forms were not kept together so staff were unable to check patients consent for medication.
- At the time of inspection, 15 patients were detained under the Mental Health Act.
- There was a lack of documentation to confirm if rights under the Mental Health Act were routinely explained upon and after admission.

Good practice in applying the MCA

- Overall, 34% of staff had received training in the Mental Capacity Act. Therefore, staff were not sufficiently trained to work with patients there were caring for.
- Overall, 31 patients were subject to a Deprivation of Liberty Authorisation or were waiting assessment.
- Mental capacity assessments were in place however, there was no evidence of thorough assessments or best interest decisions by the clinical team. We saw no evidence of patients being involved or supported to make decisions. There was no involvement of family or Independent Mental Capacity Advocates in best interest decision-making processes.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good governance

- Information governance systems were not robust, information was not always in good order and accessible. There was no risk register specific to the unit. Some incidents were recorded on an incident log. However, the log did not reflect all incidents and there was no evidence of robust investigation or lessons learnt. The manager confirmed that incidents are recorded in different places.
- The manager did not ensure that all staff had received mandatory training.
- The manager did not ensure that regular supervision was taking place in accordance to policy. Overall, 7% of qualified nurses and 26% of health care assistances had received supervision between January and August 2016. We looked at 12 supervision files; 91% had discrepancies within the recording and documentation of when supervision had occurred.
- The manager allocated two qualified nurses to each shift for up to 58 patients.
- Some staff told us that they enjoyed working on the unit.
- The unit did not participate in any accreditation schemes.