Barnet, Enfield and Haringey Mental Health NHS Trust

# Wards for older people with mental health problems

## Quality Report

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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) |
|---|---|---|---|
| RRP02 | Chase Farm Hospital | Silver Birches | EN2 8JL |

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield & Haringey Mental Health NHS 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 Barnet, Enfield & Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield & Haringey Mental Health NHS Trust.

**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 findings

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# Summary of findings

## Overall summary

We carried out a focused inspection of this service in order to assess whether the service was implementing changes as a result of the unexpected death that occurred on the ward in late 2017. The Care Quality Commission (CQC) also received a complaint in January 2018 that related to the service delivering poor care and treatment. The concerns related to staff not being respectful towards patients and a lack of monitoring and recording of physical health results. At the time of the inspection, the complaint was under investigation by the trust. We did not rate the service following the inspection.

We found the following areas that the provider needs to improve:

- The ward did not have a robust system in place to ensure ward staff had access to patients' individual blood results in a timely manner.
- The service did not always manage medicines safely. Prescribers did not always ensure that they completed medicine charts correctly, medicines that had been opened were not correctly labelled, and stored medicines were not organised. Medicine storage cabinets did not comply with the trust's medication management policy.
- Staff did not always assess patients' individual needs and care plan for this appropriately. This included a lack of assessment and monitoring of continence care and patients' individual pain levels.
- The ward lacked effective medical leadership. The ward had not had a permanent doctor in post since November 2017. The issues we identified during the inspection were a reflection of the need for consistent medical oversight.

However, we found the following areas of good practice:

- Ward staff discussed outcomes from incidents and lessons learned. We found that the ward had begun to implement improvements following the recent serious incident investigation.
- Staff actively encouraged regular hydration and regularly monitored food and fluid intake.
- Additional specialist training was offered to staff to improve their physical health monitoring skills. This included heart monitoring checks (ECG) and national early warning score (NEWS) training. NEWS is a systematic way of recording physical health results to identify improvement or deterioration.
- Staff engaged in activities and conversations with patients. At the time of the inspection, we found that staff treated patients with dignity and respect.

# Summary of findings

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

### Are services safe?

We carried out a focussed inspection of this service and reviewed specific areas of practice. We did not rate the service following our inspection.

We found the following areas that the provider needs to improve:

- The service did not have a reliable system in place to ensure ward staff could access patients' blood results. Staff told us that not all locum doctors could access the system.
- The ward did not always manage medicines safely. Medicines were not organised or stored in appropriate cabinets. Staff did not always follow handwashing procedures prior to the administration of medicines, and medicine administration charts lacked important information.

However, we found the following areas of good practice:

- Staff received feedback from the recent incident investigation. Staff told us they attended in-house training in order to improve practice.
- The ward had put in place an 'admission and post admission checklist'. This was a recommendation and learning from the serious incident that happened in September 2017.

### Are services effective?

We carried out a focussed inspection of this service and reviewed specific areas of practice. We did not rate the service following our inspection.

We found the following areas that the provider needs to improve:

- Patients who had specific needs did not always receive an assessment and a care plan that reflected their needs. Care plans were not always up to date and personalised.
- Staff did not monitor and record patient pain levels. Staff could not be assured that patients who were prescribed pain relief were comfortable or that the pain relief was effective.

However, we found the following areas of good practice:

- Staff actively encouraged patients to stay hydrated. Staff regularly recorded patients' nutrition and fluid intake.
- Staff had completed additional training in order to improve their skills in monitoring patients' physical health.

# Summary of findings

**Are services caring?**

We carried out a focussed inspection of this service and reviewed specific areas of practice. We did not rate the service following our inspection.

We found the following areas of good practice:

- During the inspection, we observed positive and caring interactions between staff and patients.

**Are services well-led?**

We carried out a focussed inspection of this service and reviewed specific areas of practice. We did not rate the service following our inspection.

We found the following areas that the provider needs to improve:

- The ward lacked effective medical leadership and consistent medical input. The ward had not had a permanent doctor in place since November 2017 and relied on locum doctors.

However, we found the following areas of good practice:

- As a result of a recent complaint and serious incident investigation, the ward was making improvements.

# Summary of findings

## Information about the service

## Our inspection team

The team was comprised of one CQC inspector, one CQC inspection manager, a specialist advisor who has clinical experience in working with older adults with mental health problems and a bank pharmacist inspector.

## Why we carried out this inspection

We carried out a focussed, unannounced inspection of this service in response to the Care Quality Commission receiving information from the public that staff were not respectful to patients and a there was lack of monitoring and recording of physical health results. We also followed up on an unexpected death that happened in September 2017. The investigation outcome from this death made recommendations that aspects of patients' physical health monitoring and recording needed to be improved. As part of our inspection, we checked to ensure the service was making improvements and learning was being embedded into everyday practice.

## How we carried out this inspection

This was a focussed inspection; we looked at some areas of Safe, Effective, Caring and Well-Led.

Before the inspection visit, we reviewed information that we held about the service including the last two inspection reports from 2015 and 2017.

During the inspection visit, the inspection team:

- visited the service and observed how staff were caring for patients
- spoke with the ward manager
- spoke with three other staff members; including nurses and healthcare assistants

We also:

- looked at four treatment records of patients
- spoke with one carer of a patient using the service
- carried out a specific check of the medicine management on the ward including a review of eight medicine administration charts of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the provider's services say

During the inspection, we were not able to get feedback from patients on the ward due to patients' cognitive impairments. However, we observed care being delivered and staff engaging patients in activities. One carer told us that they felt staff were kind to patients. However, reported the environment could be improved.

# Summary of findings

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that there are robust systems in place in order for ward staff to access patients' individual blood results without delay.
- The provider must ensure that medicines are prescribed and managed safely. This includes ensuring that frequency of doses are clearly recorded on medicine administration charts, staff follow handwashing procedures prior to medicine administration, medicines that have been opened are correctly labelled and stored medicines are appropriately organised in order to avoid errors.
- The provider must ensure that patients' individual needs are assessed, appropriately care planned and regularly reviewed. This particularly relates to continence and pain management.

### Action the provider SHOULD take to improve

- The provider should complete the recruitment of a permanent consultant and ensure that the ward has effective medical leadership and consistency of care to patients as quickly as possible.
- The provider should ensure that medicine storage cabinets are lockable and follow the correct specification as stated in the provider's medication management policy.

Barnet, Enfield and Haringey Mental Health NHS Trust

# Wards for older people with mental health problems

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Silver Birches | RRP02 |

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

This was a focussed inspection and we did not inspect all areas of practice.

## Mental Capacity Act and Deprivation of Liberty Safeguards

This was a focussed inspection and we did not inspect all areas of practice.

# 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 ward provided single gender accommodation. The ward was divided in to 'blue house' for male patients and 'red house' for female patients.
- The ward planned to create a dementia-friendly environment. The ward team submitted a bid for funding and won £110,000 to change the environment to become a dementia-friendly unit. An external company was working with the ward to create a better space for patients. The estimated completion date for the works was the end of April 2018.

Maintenance, cleanliness and infection control

- At the time of the inspection, we observed ward areas to be clean and tidy.
- Staff did not always wash their hands prior to dispensing medicines. During the inspection, we observed a medicine round and found that staff did not wash their hands prior to and during the medicine round. This increased the risk of spreading infectious diseases. This was not in accordance with infection control principles.

Clinic room and equipment

- Emergency equipment was available on the ward and was easily accessible. A resuscitation bag was available on the ward and was appropriately fitted with a tamper proof seal. Emergency medicines were located within a sealed box in the clinic room.
- The ward manager had additional clinical equipment to carry out physical health checks. The ward manager told us that the ward had recently purchased an ECG machine. This was a recommendation from an incident investigation.
- Staff routinely monitored the clinical room temperature and fridge temperatures. Temperatures were appropriately recorded and were within the recommended range.

### Safe staffing

Nursing staff

- Managers had ensured that most permanent nursing posts had been filled. The ward was expected to have 11.6 whole time equivalent (WTE) registered nurses in post and 17.4 WTE nursing assistants. At the time of the inspection, the ward had nine WTE nurses in place and 14.8 WTE nursing assistants in post. The ward was in the process of recruiting in to the vacant positions. The ward manager told us that the ward was not at full capacity, but they were able to employ extra staff when required. Staff told us that they felt the ward was well staffed.
- A qualified nurse or nursing assistant was present in communal areas at all times. During the inspection, we observed staff interacting with patients and observing them throughout the day.

Medical staff

- Whilst there was adequate medical cover for patients during the day and night, the ward lacked consistent medical cover. This meant that there was a gap in leadership at the ward level. This had an impact on consistency of medical care for patients.

Mandatory training

- Whilst most mandatory training sessions were completed, not all staff had completed life support training. Out of 24 staff who were required to complete basic and intermediate life support training, nine members of staff were not up to date. However, training records demonstrated the outstanding training had been booked.

### Assessing and managing risk to patients and staff

Staff access to essential information

- The ward did not have a robust system in place to ensure that ward staff had timely access to patient blood results. In two out of four records that we looked at, there was a lack of blood result information. In three records, there were no records to demonstrate that additional blood tests had taken place when required. Ward staff told us that there had been recent occasions when locum doctors had been unable to access the

laboratory blood result system. Ward staff relied on doctors who had access to this to copy the results over onto the electronic patient record system. This system was inconsistent and unreliable, increasing the risk that patients would not receive the appropriate treatment. Following the inspection, the trust told us that the current system in place had been reviewed and a local protocol for the management of blood results was being drafted.

Medicines management

- Whilst controlled medicines were appropriately recorded and checked, medicines were not always managed effectively. The medicines trolley was disorganised and opened liquids and creams did not display the dates when opened and the expiry date. Liquids and cream have a reduced expiry once opened. This increased the risk of patients receiving a medicine or cream that was no longer safe to use. Some medicines were stored in individual patient trays and other patients' medicines were mixed with stock medicines. This did not follow national guidance ('Duthie' report, 2005) recommendations on 'safe and secure handling of medicines' and increased the risk of medicines being misused or lost.
- The medicine storage systems in the clinic room did not ensure medicines were being safely stored in line with the trust's medicines management policy and British standards institution guidance. The ward used wooden cupboards instead of recommended metal storage cabinets. The trust's safe and secure handling of medicines audit did not include this requirement; therefore staff had not checked this during audits. The medicine trolley lid was broken and could not be locked. This increased the risk of medicines being mishandled. These issues were raised to the ward manager on the day of inspection so they could be quickly addressed.
- Medicine administration record (MAR) charts were not always appropriately completed. In five out of eight MAR charts that we checked, the frequency guidance for individual doses was not clear. For example, the frequency on the prescription charts stated "BD PRN" which meant twice a day, as and when required. However, there was no clear direction on the advised length of time between doses. In all five MAR charts, the issue related to a medicine called Lorazepam to help calm patients who were agitated. The lack of direction of when to administer further doses of this particular medicine increased the risk of staff administering the medicine at different times of the day.

## Track record on safety

- The CQC was alerted to an unexpected death on the ward in late 2017. This was classed as a serious incident and a routine investigation took place. The investigation report identified areas of learning for the ward that focused on the lack of physical health checks including a heart monitoring check (ECG), blood tests and routine blood pressure and pulse checks. The investigation report did not indicate that the incident was directly related to the care and treatment provided by the service.

## Reporting incidents and learning from when things go wrong

- The ward had started to make improvements in practice following an unexpected death in late 2017. The investigation into the death highlighted areas of practice for the ward to improve, specifically the monitoring of patients' physical health. During our inspection, we saw evidence that practice had started to improve and further specialist training had been planned for staff to complete in April 2018.
- The ward manager ensured that outcomes of incidents were shared with the wider team. The ward had regular clinical governance meetings for all staff members. The December 2017 meeting minutes demonstrated that the ward manager discussed the outcomes of the investigation into the unexpected death and the need to improve physical health monitoring. In the January 2018 meeting, staff reviewed best practice for recording physical health checks. The trust carried out a responsive quality visit to the ward to review clinical practice. The trust concluded the complaint investigation after the inspection had finished.

# 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

### Assessment of needs and planning of care

- Whilst patients had a full mental health assessment prior to entering the service, staff did not ensure that patients' toileting and continence needs were assessed on admission and appropriately care planned. Most patients had been transferred from another older adults' service, which was located close to the ward and were not reassessed for this particular need. In all four care records reviewed, there was no record of each patient's level of need in this area, how this would be supported and a date for review. The lack of assessment and care planning meant that the ward could not be assured that they were meeting patients' needs by reviewing and monitoring patients who came in to the service continent and become incontinent during an admission.
- Staff did not always ensure that care plans were up to date and personalised. Two out of four records we checked were not up to date. One of the care plans was to support the management of the patients' diabetes. However, the care plan was not personalised to the individual patient and was generic in style. During our inspection in September 2017, we found that the quality of diabetes care plans required improvement. The trust had ongoing action plans to improve this area of practice.
- The ward had put in place an 'admission and post admission checklist'. This was a recommendation following the serious incident that happened on the ward in late September 2017. Staff were expected to complete the checklist within six hours of admission and within seven days of discharge. The checklist included administrative tasks and physical health checks.
- Whilst patients' physical health was regularly monitored, the ward did not effectively assess and record patients' levels of pain. In all three records reviewed, the medicine charts indicated that all three patients were prescribed pain relief. However, staff did not assess whether the pain relief was effective or whether the patient was still in pain. Staff did not record pain scores on the national early warning score (NEWS) sheet or using specific pain assessment tools. The lack of assessment and recording meant that staff could not be assured that patients were comfortable or whether pain relief was still required.

### Best practice in treatment and care

- Staff ensured that patients' nutrition and hydration needs were met. Staff understood that patients were to be offered a drink every hour. As a result of the ward receiving a serious complaint that raised concerns around nutrition and hydration, in March 2018 the ward held a 'hydration week' and staff received in-house training. This included staff learning about the needs of patients and participating in related activities. During the inspection, we observed staff proactively encouraging patients to drink and there was an opportunity for patients to join a weekly smoothie making group. We reviewed four patients' individual food and fluid charts and found these were well maintained.

### Skilled staff to deliver care

- Staff were given additional specialist training when there was a clinical need. For example, the investigation into the unexpected death on the ward, identified a need for further training to equip staff to monitor patients' physical health more closely. A plan was in place to make sure all relevant staff had completed in-house heart monitoring training (ECG) by the beginning of April 2018.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- Staff treated patients with dignity and respect. During the inspection, we observed staff positively interacting with patients. Staff actively engaged with patients in activities and treated patients with respect. We observed staff prompting patients to drink fluids throughout the day. A carer told us that staff were kind to patients.

# 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

### Leadership

- The service lacked effective medical leadership. A permanent consultant had not been in post since November 2017 and the nurse consultant who had been assigned to the ward had recently left their post. During the inspection, we found that there was a lack of consistency in the processes to record patient blood results, medicine administration charts were not sufficiently completed and a lack of oversight of some areas of patients' physical health needs. The lack of strong and cohesive medical leadership contributed to these areas of practice that needed further improvements. The assistant director for the service informed us during the inspection that interviews for a permanent doctor were taking place in April 2018.

### Culture

- Staff reported a positive culture on the ward. Staff reported that they felt the job was rewarding and felt that patients were well supported. Staff told us that their colleagues worked well together as a team and were welcoming to new staff.

### Governance

- The ward had begun to implement changes as a result of the recent incident and complaint on the ward. At the time of the inspection, the complaint about the quality of care was still under investigation. However, the trust had put an initial action plan in place to address the issues raised.

### Engagement

- Carers and relatives had opportunities to give feedback about the service. The ward carried out privacy and dignity audits, which involved carers and relatives providing feedback under various care-related headings. For example, respect, person-centred care, dignity and self-esteem. In March 2018, three out of 10 carers responded and gave the service a 100% score.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The system in place for staff to access patient blood results in a timely manner was unsafe and inconsistent.<br>Medicines were not always being managed safely in the service.<br>This was breach of regulation 12(1)(2)(a)(b)(g)(h). |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>Patients did not always receive assessments and care plans that supported their needs. Care plans were not always personalised and regularly reviewed.<br>This was breach of regulation 9(1)(a)(b)(c)(2)(3)(a)(b). |