Barnet, Enfield and Haringey Mental Health NHS Trust

RRP

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRP47	Magnolia Unit	Magnolia Unit	EN2 0JB

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

Summary of findings

Ratings

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	

Summary of findings

Contents

Summary of findings

Overall summary

We carried out a focused inspection of this service in response to a complaint the CQC received reporting that the service was not providing good quality care to patients. The complaint raised concerns regarding the monitoring and recording of patients' nutrition and hydration intake, patients not receiving their medicines on time and some staff not being caring. At the time of the inspection, the complaint was still under investigation by the trust. We did not rate the service following the inspection.

During the inspection, we followed up on each area of concern raised and found the following;

- The ward had a high nursing staff vacancy rate, which had impacted on the quality of patient care. Some patients reported that they had to wait long periods of time for the bedside call bells to be answered. We found occasions when agency and bank staff worked 50 hours or more in one week, which increased the risk of errors in patient care.
- Patients did not always have care plans in place that reflected their needs. Care plans did not consistently demonstrate that families and carers were involved and some care plans did not reflect individual risks.
- Whilst medicines were mostly managed well on the ward, some medicines were not correctly labelled once opened. Medicines storage systems did not comply with the trust medicines management policy and British standards institution guidance.
- The ward did not have an effective system in place to ensure that those patients identified as needing extra support with eating and drinking received help during mealtimes. During the inspection, we observed that there were not sufficient staff available to support patients. Food and fluid charts were not always completed.
- A complaint that had raised concerns about the service had been managed effectively. The ward manager had ensured that all staff were aware of the complaint and the areas for improvement.

At the time of the inspection, we told the ward management team the negative feedback we had received from patients on the day of the inspection. Following the inspection, the ward manager put an immediate action plan in place that addressed most of the concerns identified in this report.

Summary of findings

Background to the service

Magnolia Unit is a 33 bedded inpatient unit that provides short-term inpatient care at St Michaels primary care centre in Enfield. At the time of the inspection, there were 32 patients on the ward. The ward has 28 rehabilitation beds and five beds for assessment for admission.

The purpose of the unit is to prevent acute hospital admissions, where possible, by rehabilitating patients in the community. The unit is also designed to be a 'step down' service from acute hospital. This is for patients who are well enough to be discharged from hospital but require further support before they are discharged back to residential care or their own homes. The service provides access to nurses, doctors, occupational therapy, and physiotherapy. Specialist nursing services from the community also attend to see patients. The service accepts patients who are aged 18 years and over and registered with a GP in the London Borough of Enfield.

Our inspection team

The team was comprised of two CQC inspectors, 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 a member of the public that the service was delivering poor care and treatment to patients. As part of our inspection, we checked to ensure the service was providing a good level of care and the service was making improvements where needed.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

This was a focussed inspection; we only looked at some areas of Safe, Effective, Caring, and Responsive.

Before the inspection visit, we reviewed information that we held about the service including the last inspection report from 2015.

What people who use the provider say

During the inspection, patients and carers gave a mixed response to their care and treatment on the ward. Some patients reported that there was not enough staff and they waited a long time for bedside call bells to be

answered. Two patients gave examples of staff members who were not caring. Other patients reported that they felt safe on the ward and were happy with their care. Patients did not always feel that they or their families or carers were involved in care planning.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- The provider must ensure that there is a robust recruitment plan in place to fill the nursing vacancies and ensure that staff are not working excessive hours to cover staffing gaps.
- The provider must ensure that patients' individual needs are appropriately addressed in care plans and involve families and carers where possible.
- The provider must ensure that there is a robust and effective system in place for managing mealtimes and patients who require support with eating and drinking. This includes ensuring that food and fluid intake is appropriately monitored and recorded.

Action the service SHOULD take to improve

- The provider should ensure that opened medicines are managed safely and medicine storage is in accordance with trust policy and national guidance.
- The provider should ensure that patients do not wait long periods of time for their bedside call bells to be answered.

Barnet, Enfield and Haringey Mental Health NHS Trust

Community health services for adults

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

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

- The ward had a high nursing staff vacancy rate, which had impacted on the quality of patient care. Agency and bank staff, at times, worked excessive hours. During the inspection, we observed that, during lunchtime, there were not enough staff to support patients with eating and drinking. Some patients reported that they had to wait long periods of time for the bedside call bells to be answered.
- Staff did not ensure that patients had care plans in place that were consistent in quality and reflected the patients' needs.
- Medicines were not always labelled correctly once opened and medicines storage systems did not comply with the trust medicines management policy and British standards institution guidance.
- Staff had access to emergency equipment and emergency medicines.
- Staff had completed most mandatory training sessions.

Medicines

- Whilst medicines were mostly well managed, some medicines were not always correctly labelled once opened. At the time of the inspection, we found liquids and creams that had been opened and did not display the dates when opened and the expiry date. Liquids and creams have a reduced expiry once opened. This increased the risk of patients receiving a medicine or cream that was no longer effective.
- The medicine storage systems in the clinic room did not ensure medicines were being 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 carried out a monthly medicines audit based on national guidance. From September

2017 to March 2018, compliance was consistently 100%. However, the audit did not include a prompt for the auditor to check the compliance of medicine storage cabinets. During the inspection, we found, on two separate occasions, that staff had not locked the medicine cupboard. This increased the risk of medicines being mishandled. After our inspection, the ward put an action plan in place to ensure the areas of concern were addressed.

Environment 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.
- At the time of the inspection, we found the ward stocked a small batch of non-safety needles. Health and safety guidance recommends safety needles are used in order to reduce needle stick injuries. The ward pharmacist immediately addressed this issue and removed the non-safety needles.
- Staff routinely monitored the clinical room temperature and fridge temperatures. Temperatures were appropriately recorded and were within the recommended range.

Quality of records

- Patients' care plans were not consistent in quality and did not always reflect the specific needs of the patient. Out of the five records we checked, we found one care plan that demonstrated good practice. The record included a 'reach out to me' care plan for a patient diagnosed with a cognitive impairment. The care plan demonstrated good family involvement. However, the other four care plans were not of good quality. Two care plans did not reflect the needs of the patient. For example, one patient was prescribed a specific medicine that had associated risks. However, the care plan did not describe the risks and how the patient would be supported. Another patient was assessed as needing a catheter. However, there was no specific care plan in place for the use of a catheter.

Cleanliness, infection control and hygiene

- At the time of the inspection, the ward environment was clean and tidy.

Mandatory training

- The mandatory training record mostly demonstrated that staff had completed the required mandatory training sessions and the remaining staff were booked on to training courses in the near future.

Staffing levels and caseload

- The ward had a high nursing staff vacancy rate and employed bank and agency nurses to cover the staffing shortages. In April 2018, the vacancy rate was 21.7%. The trust vacancy target rate was under 10%. The ward had a high turnover rate of 17.7% and a high sickness rate of 7.6%. Staffing data showed that in January 2018, December 2017 and November 2017 some shifts had not been covered each month. In December 2017, 15.5% of shifts for registered nurses had not been filled.
- Shift rotas demonstrated that, on occasions, agency and bank staff were working excessive hours in order to cover staffing shortages. We reviewed shift rotas for February and March 2018 and found five examples of agency and bank nurses and HCAs working excessive hours. In a seven-day period, five members of staff had worked more than 50 hours. In one case, one member of staff had worked 77 hours within one week. These excessive hours presented as a risk and did not follow recommended nursing guidance on safe working hours. Staffing shortages had been exacerbated by a sickness outbreak earlier in 2018. The ward manager confirmed that once the sickness outbreak was over, staff were able to reduce their hours.
- During the inspection, some patients reported that they had waited a long time for their bedside call bells to be answered. One patient reported that they had waited a long time to be assisted with the toilet, which had resulted in them soiling themselves. The ward manager told us that there had been recruitment challenges and the trust was working to fill the posts. The ward had an action plan in place to address the staffing shortages which included participating in trust recruitment events.
- The ward had regular input from a community GP. The GP attended the ward for 20 hours per week, Monday to Friday. Out of these hours, the ward used a service called 'Barn Doc'. This was an out of hours community GP service.

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.

Summary

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

- The ward did not manage mealtimes effectively or ensure that patients' nutrition and hydration needs were monitored and appropriately recorded. The ward lacked sufficient staff to ensure that patients were supported with eating and drinking.
- Staff received regular supervision. The ward manager kept a supervision completion log, which was updated regularly.

Nutrition and hydration

- The ward did not manage mealtimes effectively. The ward lacked sufficient staffing to support individual patients at mealtimes and the system in place to identify patients in need of support was not robust. Patients who required extra support and monitoring during meal times were meant to be provided with a red tray so that staff members could easily identify who required help. We observed at lunchtime and found that it was not possible to identify the patients who required support without regularly referring to the 'patient at a glance' board in the nursing office, because the 'red tray' system was not being used effectively. There was no indication at patients' individual bedsides that extra support was needed, so patients' food was not presented on a red tray. We observed that the four patients identified as being on 'red tray' were not being actively supported and encouraged to eat and drink. We observed one patient attempting to feed themselves whilst waiting for a member of staff for support. We observed staff telling eachother that there was not enough staff to support everyone. The lack of robust systems and sufficient staffing to support mealtimes meant that staff could not be assured that patients were eating and drinking. The ward put an action plan in place to address the concerns raised relating to the management of patients' nutrition and hydration needs.
- Food and fluid charts were not always maintained. Out of the five records we checked, two charts were not adequately completed. The lack of recording of food and fluids increased the risk of patients being malnourished or dehydrated, as staff could not be assured that patients were eating and drinking regularly.

Competent staff

- Records showed that, on average, 84% of staff received supervision. Records showed when staff had missed a supervision session due to being off sick or on leave. We spoke with six members of staff who told us that they received regular supervision and found the process helpful. The ward planned to provide regular agency and bank staff with supervision from April 2018.

Are services caring?

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

Summary

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

- Patients had mixed views about staff on the ward and the care and treatment they received. Some patients reported occasions where staff had not been respectful and caring. Patients reported they waited long periods of time for bedside call bells to be answered.

Compassionate care

- Whilst patients had access to bedside call bells, patients told us that they waited long periods of time for them to be answered. During the inspection, we observed one call bell sounding for seven minutes. However, staff were observed to be extremely busy. Out of five patients we spoke with, three patients reported that they regularly waited a long time for the call bell to be answered. At the end of the inspection, our concerns were fed back to the ward management team. Following the inspection, the ward manager spoke with individual patients to explore their concerns and an action plan was developed to ensure there would be an improvement in response times.
- Patients we spoke with had a mixed view of the ward and staff team. Two out of five patients reported that they felt safe and happy on the ward. Three patients raised concerns about some members of staff and how they treated patients. Some patients said that staff did not always treat patients respectfully. At the end of the inspection, our concerns were fed back to the ward management team to be followed up. Following the inspection, the ward manager investigated the concerns with each patient and found that the concerns raised did not require any further action.

Are services responsive to people's needs?

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

Summary

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

- Some care plans lacked family and carer involvement.
- A complaint that had raised concerns about the service had been effectively managed. We found that the ward manager had ensured that all staff were aware of the complaint and the areas for improvement.
- Staff ensured that they closely monitored and recorded patients' physical health and weight.

Planning and delivering services which meet people's needs

- The ward ensured that patients' physical health and weight were regularly monitored and recorded. We reviewed five patient records and found in all cases physical health was being managed appropriately.
- During the inspection, two patients told us that they had not been involved in discussions about their care plan and one patient reported that their family had not been involved in writing the care plan. We also saw that other patients' care plans did not confirm whether family involvement had been offered.

Learning from complaints and concerns

- The ward had managed the serious complaint the CQC had received about the ward not providing good quality care effectively. We found that the ward had managed the complaint appropriately and put action plans in place to address the concerns raised. The ward manager ensured that staff discussed complaints and the outcomes in the clinical governance meetings and in-house training sessions. Staff told us that the monthly team meetings were an opportunity to discuss feedback and learning. Senior managers in the trust carried out a responsive visit to the ward to review everyday practice on receipt of the complaint. Following the visit, the ward put an action plan in place to address the areas for improvement. The action plan was being monitored at a local level and at the trust 'deep dive' meetings.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients did not always receive care plans that supported their needs. Care plans were not always personalised or involve families and carers. This was breach of regulation 9(1)(a)(b)(c)(2)(3)(a)(b).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The ward did not have an effective system in place to manage mealtimes. There were not sufficient staff available to support patients eating and drinking. Food and fluid charts were not always maintained. This was a breach of regulation 14(2)(4)(a)(d).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The ward had a high nursing vacancy rate, agency, and bank staff at times worked excessive hours to cover the staffing shortages. This was a breach of regulation 18(1).