Barking, Havering and Redbridge University Hospitals NHS Trust

King George Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Medical care (including older people's care)

King George Hospital

Detailed findings

Services we looked at
Medical care (including older people's care);

Detailed findings

Contents

Our inspection team

Our inspection team consisted of one inspection manager, five inspectors and two specialist advisors. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection for London.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

We carried out a focussed, responsive inspection of Medical care (including older people's care) at King George's Hospital. This inspection was in response to a specific incident which occurred on Holly Ward, which we were made aware of.

The incident was sufficiently serious to give rise to concerns regarding the care of patients with dementia, mental health (MH) issues and learning disability (LD) and in particular those exhibiting challenging behaviour.

Our inspection focussed on the care and welfare of particularly vulnerable patients.

Summary of findings

Following our inspection, we were assured that the incident was not indicative of a culture of poor care for such patients or systemic failings. We determined that it was an isolated incident. There were systems in place within the medical care core service to meet the needs of patients with dementia, MH issues and LD.

The trust acted in a timely manner to deal with the incident as soon as they were made aware of it. The incident is being dealt with by the trust and the relevant regulatory bodies. We have requested regular updates from the trust regarding this incident. We will continue to monitor the delivery of care to patients with dementia, MH issues and LD as well as the wider patient community through ongoing engagement with the trust.

Medical care (including older people's care)

Are medical care services safe?

Mandatory training

All staff completed Safeguarding Level 1, 2 and 3 (dependent on their roles and responsibilities), as part of their mandatory training. This was repeated 3 yearly. Within this training there was an LD component and a requirement to complete the MCA and DOLS e learning module for Level 2 and above.

Nurses and healthcare assistants (HCAs) were also required to complete a 30-minute face-to-face training session on dementia care. All staff completed Tier 1 and Tier 2 dementia training; this was delivered as e-learning. At the time of our inspection, the service was introducing Tier 3 dementia training for senior sisters and charge nurses.

The target for the year end safeguarding mandatory training set by the clinical commissioning group was 90% whilst the trust's own target was set at 95%, both of these were achieved by year end (April 2019).

To ensure that training was effective, the leads for safeguarding, LD and dementia care carried out regular "5x5" audits. These involved the leads visiting the wards and asking the staff on duty five questions about dementia care, safeguarding or LD care. The leads described the results of the audits as being positive. They said that the audits were useful in identifying gaps in staff understanding which could then be fed back into training development. These surveys were included as a work stream within the trust's Safeguarding Annual Workplan 2018/19.

In August 2018, the service provided additional LD, Mental Capacity Act (MCA) and DoLS training to all medical staff within the service. The clinical leads described this training as well received. This view was reflected by medical staff on the wards.

At the time of our inspection, the service was developing a training module in respect of caring for patients with mental health issues. The Trust had defined the initial target audience for the training as clinical site, Band 7s and above in the emergency department and four key staff within the safeguarding adult team. This was being developed by the local NHS mental health trust.

Safeguarding

The service had met the trust's target of 95% compliance in safeguarding. Staff had a clear understanding of their responsibilities to safeguard patients from harm. Staff were able to explain when they would make a safeguarding referral and the process for doing so.

The named nurse safeguarding adults for the hospital told us that they had recently introduced a "think family" audit schedule, which fed into the trust's annual safeguarding audit schedule. This audit had yet to take place.

There was a trust-wide risk register. This was regularly reviewed by the safeguarding team and discussed at the trust's monthly operational group meetings. The number one risk on the risk register related to ensuring knowledge and best practice in adherence to the Mental Capacity Act.

There were regular safeguarding bulletins which were shared with staff electronically with updates from the safeguarding ream. In addition, there were regular opportunities for staff to "drop in" and meet the safeguarding team.

The named nurse safeguarding adults told us that they attended external safeguarding boards, which had significantly improved the working relationship with one of the local boroughs and allowed the team to ensure all referrals were followed up.

The safeguarding team told us they were supported by a critical friend; a professional external to the hospital with extensive safeguarding knowledge and experience who gave challenge in respect of the trust's safeguarding policies and procedures. Following the inspection, we were told that the safeguarding team were supported by the designated safeguarding managers from the CCG, and safeguarding supervision is provided.

The Annual Safeguarding Adults Report (2017/2018) showed that the Safeguarding Team had developed a three-year Safeguarding Strategy (2018-2020) to replace the previous individual strategies for children and adult safeguarding. The strategy aimed to strengthen the trust's "Think Family" approach and the collaborative working with our community colleagues.

The strategy was developed collaboratively with internal and external stakeholders including representatives from

the trust's Divisions, colleagues from the tri-Borough Safeguarding Children and Adult Boards and Barking, Havering and Redbridge Clinical Commissioning Group. Clinical areas were visited by members of the safeguarding team to capture the views of patients/ visitors about the proposed strategy. The strategy was aligned to the key safeguarding priorities identified at national and local level

The Safeguarding Adult Team comprised of:

- Director of Nursing, Safeguarding & Harm Free Care
- Named Nurse for Safeguarding Adults
- Named Doctor for Safeguarding Adults
- Lead Nurse Learning Disabilities
- Safeguarding Adults Advisor, Mental Capacity Act and Deprivation of Liberty Safeguards
- Emergency Department Safeguarding Advisor (2 WTE)
- Safeguarding Adults Advisor
- Safeguarding Adults Secretary

In addition, there was a trust-wide safeguarding advisor for harmful practices who supported the safeguarding team and reported the named midwife for safeguarding.

The Safeguarding Strategic & Assurance Group met quarterly and was chaired by the trust's Chief Nurse who is the executive lead for safeguarding. The remit of the group is to obtain assurance that robust systems and processes are in place to safeguard children and adults and to ensure the trust meets the statutory and legislative requirements of safeguarding children and adults. In February 2018 a Patient Partner joined the group whose role is to represent the voice of the service-user and contribute to driving forward the safeguarding agenda.

Nurse staffing

During our inspection, the wards were well staffed, with only Holly ward having one less health care assistant (HCA) than its planned staffing number. Senior staff described ensuring staffing levels as a challenge but said that they were able to ensure a full complement of staff, although this involved the use of bank and agency staff, and occasionally matrons, being counted in the numbers.

Staff told us that there was an assessment protocol in place to be completed for all patients over 65, patients with LD, MH or dementia co-morbidities and those demonstrating signs of delirium. This protocol was based on a dependency ranking system of one to four, with patients rated as four requiring one-to-one care.

Following the inspection, we were told that the trust did not rate patients' dependency from one to four. We were told that all patients over 65 and/or those who presented as confused were given an Abbreviated Mental Test Score (AMTS). This was on admission as part of the 7 day patient assessment booklet.

In addition, we were told following the inspection that the trust had a Dementia and Delirium care plan which prompted staff to assess patients and plan care appropriately. It had a specific 24 hour re-assessment for the delirium component so that the patient was reassessed within a 24 hour period.

Staffing was assessed as per the Trust Safe Staffing Policy. The Trust also had guidelines for "cohorting bays" to prevent falls.

The matron for elderly care told us that where patients were assessed as "four" there was a multidisciplinary team meeting to determine the specific care requirements. They told us that she had no trouble in accessing agency mental health nurses (RMNs) or HCAs to provide one to one care. Staff confirmed that this was the case. They said that where patients were wandering within a ward, security would be assigned to follow them at a distance to ensure their safety. We observed this on Gentian ward.

Following our inspection, we requested information regarding training received by security to intervene with confused patients. This information was not provided. Having wandering patients followed by untrained security staff was not best practice and did not foster a caring atmosphere.

We were provided with the trust's policy on challenging behaviour which was appropriate and up to date. Staff were aware of the policy and how to access it.

The service had 1.2 full time equivalent practice development nurses for care of the elderly.

Records

Medical care (including older people's care)

We reviewed 12 patient records for patients with additional needs arising from LD, dementia or mental health issues. The records included appropriate additional care plans for these patients.

Incidents

There were processes in place for escalating concerns and raising incidents. Staff were aware of these processes and were able to demonstrate how they would raise an incident. We had sight of the process by which incidents were escalated and investigated. Senior staff told us that where staff had an informal concern or a suggestion for improvement they could raise this at the morning safety huddles held daily on the wards. Some staff confirmed that they had done so. Staff told us they felt confident in doing so.

Senior staff told us that they fed back to staff who reported incidents, as well as sharing learning across the directorate and across the trust where appropriate.

There was a weekly patient safety summit which all staff were welcome to attend at which key incidents within the service were discussed and learning from incidents which had occurred elsewhere in the trust was shared.

In addition, staff told us that incidents which occurred on the wards were discussed as they arose.

The divisional senior leadership team told us that they had been working to promote the reporting of incidents with staff, in part through increasing their visibility on the wards. In addition, they said that by being on the wards they could recognise those members of staff in need of additional support prior to an incident occurring and ask the practice development nurses (PDN)s to support them.

Are medical care services effective?

Multidisciplinary working

During our inspection, we observed effective MDT working between nursing, medical and allied health professional (AHP) staff. We observed a ward round during which all the MDT staff involved were confident to share their opinion and their opinion was listened to.

Nursing staff described a positive working relationship with the psychiatric liaison team, who were employed by the local mental health trust. They said the psychiatric liaison team were supportive and gave appropriate, practical advice on caring for patients. Some nurses told us that although the psychiatric liaison team were supportive, due to the high demand on the service, they were not always able to attend patients in person, meaning that patients did not always receive psychiatric assessment or support in a timely manner. They said, however, that in those circumstances the team were able to provide useful telephone advice.

Senior staff told us that for the past year there had been joint governance meetings between the trust and the local mental health trust in respect of cross-service issues. We had sight of minutes of the group which evidenced that incidents relating to the care of patients with mental health issues were discussed. Senior staff said that the group was positive, with representatives of both trusts sharing the challenges they faced in supporting each other. For example, at one of the meetings, the psychiatric liaison team asked that, prior to making a referral to the team regarding patients showing symptoms of delirium, the medical team eliminate the possibility that the delirium is a result of a medical condition such as a urine infection. Senior staff told us that this message had been cascaded to staff. Nursing staff on the wards were aware of this.

The trust had worked with a number of external stakeholders and agencies including the local mental health trust to develop its dementia strategy. It had adopted the "Remember the me in dementia" strapline from the Blackpool Teaching Hospital's dementia strategy, with their permission.

There was both a LD and a dementia team within the trust who were available to offer advice, training and support to staff caring for patients with LD or dementia. In addition, there were safeguarding and learning disability and dementia champions. Ward staff were aware of the teams and the link nurses and of how to contact them.

The trust's LD team worked in partnership with local LD partnership boards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We checked the records of 12 patients who had Deprivation of Liberty Safeguards (DoLS) in place. All of the patients had fully documented mental capacity assessments in their notes. Of the 12 DoLS forms we

checked all were in date and contained relevant information. 11 were fully completed, one of the DoLS forms, however, was missing a date for when it was completed.

Staff had a clear understanding consent, MCA and DoLS. We saw evidence of nursing staff having reported incidents through the electronic system where DoLS documentation had not been completed.

Since our last inspection in June 2018, the trust had amended the mental capacity assessment tool to make it more user friendly. Senior staff also told us that they had provided additional training to medical staff in respect of mental capacity assessments and DoLS. In particular, they had introduced a training programme which included actual scenarios being acted out, in order to support staff in transforming technical knowledge into practice.

There were three advocacy services (one from each of the local boroughs) who worked within the trust and supported patients who lacked capacity to consent to care. We saw evidence of the use of advocates in patients' notes.

Are medical care services caring?

Compassionate care

We observed numerous positive interactions between staff and patients with dementia, LD and MH issues. For example, we observed a staff member introduce herself to a patient with dementia before conversing with a patient about a topic that was of interest to them whilst taking the patient's observations. We observed a physiotherapist encouraging a patient with dementia whose walking ability was being observed. They asked the patient where they would like to walk to in order to add purpose to the exercise.

One patient with dementia told us that staff were "very kind" and "took the time to talk". Staff spoke about patients with care and compassion and told us that patient wellbeing was their primary focus.

We spoke with a patient's relative who described a high level of care.

Understanding and involvement of patients and those close to them

The trust's Tier 1 and Tier 2 dementia training, which formed part of the mandatory training for all nursing and medical staff had been accredited by the Alzheimer's Society as giving those who completed it "Dementia Friend" status. A dementia friend is someone who learns more about what it's like to live with dementia and then turns that understanding into action. There were 5,727 Dementia Friends working across the trust.

The care of the elderly wards made use of Reminiscence Interactive Therapy Activities (RITA) screens. RITA screens are interactive touch screen systems that allow patients to enjoy relaxation music, watch archive BBC news footage, view old photographs and listen to famous speeches, to help spark memories and start conversations on the wards. RITA screens can be personalised with bespoke images and content in order to create a 'life story' collage, which is of particular help to patients with dementia and helps those caring for them to better understand the patient and their needs.

Are medical care services responsive?

Meeting people's individual needs

Staff demonstrated knowledge and understanding of caring for patients with LD, MH and dementia. We observed staff following best practice when caring for patients with dementia, for example the use of the butterfly scheme and red trays.

Staff told us that they were supported to care for patients with additional needs arising from dementia, LD and mental health issues. There was a LD and a dementia team within the trust who were available to offer advice, training and support to staff caring for patients with LD or dementia. Staff told us these teams were highly supportive. On Fern and Gentian Wards there were notice boards with instructions on when and how to contact these teams, on Holly ward the contact details were in a book in the medical office.

Families of patients with dementia completed the Royal College of Nursing's "This is Me" document, which set out patient's individual care preferences and needs. There were completed "This is Me" documents in 11 of the 12 records we checked.

Patients with LD had LD passports, which they brought with them and were stored in their notes for the duration of their attendance at hospital. This allowed staff to understand the individual needs of the patient.

There was a dedicated dementia nursing team within the trust who provided advice, support and training for staff caring for patients with dementia. In addition, on each of the wards there was a dementia link nurse. The Director of Nursing for Safeguarding and Harm free Care within the trust told us that the trust planned to introduce specific contracts for dementia link nurses, meaning that conflicting priorities could not take them away from their dementia work and training.

There was an LD working group which met monthly. The working group included the trust's LD team, multidisciplinary staff from relevant areas and a number of service users. The service users had assisted the LD team in drafting its policies relating to the care of patients with LD into easy read formats. In addition, the group had supported other services within the trust to amend their practice to make their services more LD friendly. For example, they had helped develop a system for the blood testing service where patients with LD or patients suffering from anxiety could book ahead. This had increased attendance by such patients at the blood testing service. Similarly, in the outpatient departments, LD patients were able to take pagers which would buzz when their appointment was due rather than having to wait in waiting rooms which they may find distressing.

In 2019, the Director of Nursing for Safeguarding and Harm free Care organised the Dementia Conference., where patients, staff and families learned about and shared experiences of caring for people with dementia with both internal and external speakers. The conference was attended by approximately 120 staff and the team had had requests for a second conference.

Learning from complaints and concerns

The service took immediate action in relation to the incident which led to this inspection as well as setting up a longer-term investigation into the incident. All complaints relating to the care of patients with LD or dementia were sent for review to the lead nurses for those areas.

Staff were able to describe learning arising from complaints and concerns.

Are medical care services well-led?

Leadership

There was a strong governance structure in the medical care core service. This meant that senior staff had clear oversight of issues and risks within the service. There were appropriate structures and processes in place to ensure that senior staff were made aware of incidents in a timely manner and that they were dealt with appropriately before the learning was cascaded to staff throughout the service.

There were lead nurses for MH, LD, dementia and safeguarding. The leads for these areas had the appropriate levels of expertise and experience to carry out their roles. The leads for these areas told us that they were listened to by senior staff and were invited to provide their input on strategic decisions which were likely to impact on patients from those groups.

Culture

There was a positive culture within the service. Staff told us that they enjoyed working for the service and felt supported to provide care to all patients. They spoke highly of both local and senior managers and described them as supportive.

Senior staff told us that they encouraged staff to raise concerns and treated incidents as learning opportunities. This was reflected by staff. Senior nursing staff told us that they endeavoured to visit the wards and undertake "hands on care" alongside staff. They said that this helped them to understand the challenges faced by staff and also to remain approachable. Staff described the senior leadership team as approachable.

The week before our inspection, Holly ward, on which the incident leading to the inspection took place, had been returned to the matron for elderly care's management. Prior to this, the ward had been part of trial to introduce a minimal medical intervention unit. As such, there was a slight difference on the culture of Holly ward, in respect of ways of working. We raised this with senior staff who recognised this and said they were working to integrate Holly ward back into the service.