Care Quality Commission

Camden and Islington NHS Foundation Trust

Acute Admission Wards

Quality Report

Tel: 020 3317 3500
Website: www.candi.nhs.uk

Date of inspection visit: 27-30 May 2014
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Highgate Mental Health Centre	TAF72	Amber, Jade, Opal, Sapphire and Topaz wards	N19 5JG
St Pancras Hospital	TAF01	Dunkley, Laffan and Rosewood wards; and The Rivers Crisis House	NW1 0PE

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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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Overall summary

People experienced care that was compassionate, sensitive and kind. We also found that the wards were well-led and that ward managers were visible and accessible to both people using the service and staff.

The services provided helped people to improve their mental health and return to live in the community. Staff on the acute admission wards consistently provided people with information on their rights under the Mental Health Act 1983, or as informal patients, and checked that this was understood. However, staff members' understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) was poor and assessments of capacity lacked detail.

Some people were moved between wards several times during one admission, some of which occurred at night.

Services were not always safe as people were not protected from identified risks. For example, while environmental risk assessments had been completed and individual clinical risk assessments were in place, staff were not able to articulate how they would manage the risks to patients from ligatures. Some people told us that staff were slow to take action to protect them after they had been assaulted by another patient on the ward. In addition, whilst action had been taken to prevent illegal drugs coming on to the wards this was still an ongoing issue.

Summary of findings

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

Are services safe?

People were not protected effectively from risks to their health, welfare and safety. Although individual clinical risk assessments were in place for people using the service, staff were unable to tell us about the measures in place to mitigate and manage the ligature risks that had been identified in October and September 2013.

Some people told us that they felt unsettled and unsafe after they had been assaulted by another patient on the ward. They said that staff were slow to take action to protect them from further assaults. In addition, whilst action had been taken to prevent illegal drugs coming on to the wards this was still an ongoing issue.

Learning from serious incidents was not always shared promptly within and across wards, in a way that enabled change and reduced risks to people using the service and staff.

Are services effective?

The care and treatment that people received led to improved mental health and supported people to return to live in the community. People's needs were also assessed and care was delivered in line with their individual care plans.

Staff received training, supervision and professional development. This enabled them to deliver care which was to a good standard.

However, staff members' understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and their application, was poor.

Are services caring?

Staff were caring. They responded to people in distress in a calm and respectful manner and de-escalated situations effectively. They also took the time to explain people's care and treatment, and to support them.

Services were interested in the people they cared for and staff were committed to providing good quality care.

Are services responsive to people's needs?

Services were not organised in a way that met people's needs effectively. Some people using the service were moved between wards several times during one admission. Of these, some people were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. There were informal agreements, rather than clear guidelines, on

Summary of findings

the management of transfers between wards. This meant that transfers of people between wards were not managed in a planned and co-ordinated way. This had a negative effect on people's care and hospital experience.	
Are services well-led? The trust had a vision and direction that was communicated effectively to staff. The delivery of services was also supported by the trust's governance structures. We found that the wards were well-led and that ward managers were visible and accessible to staff and people who used the service. The trust encouraged the development of the service.	

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.

Summary of findings

The trust had a vision and direction that was communicated effectively to staff. The delivery of services was also supported by the trust's governance structures. We found that the wards were well-led and that ward managers were visible and accessible to staff and people who used the service.

The trust encouraged the development of the service.

Our findings

Highgate Mental Health Centre (five acute admission and treatment wards)

Vision and strategy

The trust's vision and strategies for the service were evident and on display in some wards. Staff on all wards considered they understood the vision and direction of the trust. However, several staff suggested that communication was predominantly one way, from the board to the wards and were not sure whether messages travelled effectively in the opposite direction.

Responsible governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Ward managers had regular contact with their modern matron and divisional manager. On occasions senior trust managers came to the wards. For example, the Director of Nursing attended an incident discussion on Amber Ward and had arranged to spend the day on Opal Ward. However, some ward managers and staff felt that senior managers only visited or contacted the ward when something had gone wrong.

Leadership and culture

We found the wards to be well-led and there was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day-to-day provision of care and treatment to people, were accessible to staff and proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improvements in care. Staff we spoke with on the wards were enthusiastic and engaged with ward developments. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by their line manager.

Engagement

Service user engagement

Care was mostly person-centred. All acute admission wards encouraged the engagement and involvement of people through regular community meetings which people were encouraged to attend. Minutes of community meetings showed that people had raised issues important to them including repairs that were required, and requests for more and different activities. A local service user group visited the acute admission wards and spoke with people about any concerns or issues they had. These issues were then raised with the ward staff who took action to address them.

Staff engagement

We spoke with staff at different levels on all wards we visited. Most staff reported feeling supported by their manager. Many were new to the trust and were positive about their experience during their period of employment.

Staff were aware of the trust's whistleblowing policy and told us they felt able to raise any concerns they had about the care and treatment of people who use the service with senior managers. Some staff gave us examples of when they had spoken out about concerns about the care of people and said this had been received positively as a constructive challenge to ward practice.

Many staff told us that morale in the service had been very low following significant changes in the trust in recent years. However, they also considered that morale was improving and the trust was traveling "in the right direction". Staff were kept up to date about developments in the trust through regular emails.

Performance improvement

Most ward managers told us they had access to ongoing leadership training and development. This covered the theory of management as well as scenarios and techniques which could be used in practice. Most felt supported by their immediate line managers.

Data was collected regularly on performance. Each acute admission ward completed a balance scorecard, which

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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.

recorded their performance against a range of indicators and was reported on every quarter. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance. Managers could compare their performance with that of other wards which provided further incentive for improvement. We saw evidence of improving performance in many areas on all wards.

St Pancras Hospital (three treatment wards and one crisis house)

Vision and strategy

The trust's vision and strategies for the service were evident and staff had a good understanding and knowledge of these. Staff on all wards considered they understood the vision and direction of the trust. However, several staff suggested that communication was predominantly one way, from the board to the wards, and were not sure whether messages travelled effectively in the opposite direction.

Responsible governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Ward managers had regular contact with the modern matron and divisional manager. On occasions senior trust managers visited the wards. However, some ward managers and staff felt that senior managers only visited or contacted the ward when something had gone wrong.

Leadership and culture

We found the wards to be well-led and there was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day to day provision of care and treatment to people and were accessible to staff and proactive in providing support. One ward manager, who had been in post for several months on an interim basis, had made a significant positive impact on the quality of care provided on the ward. People using the service spoke very highly of the ward manager and said how approachable they were.

The culture on the wards was open and encouraged staff to bring forward ideas for improvements in care. Staff we spoke with on the wards were enthusiastic and engaged with ward developments. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by their line manager.

A few staff described the overall culture of the trust as one of blame and criticism but this was not a generally held view expressed by staff.

Engagement

Service user engagement

There was a service user forum for people who used the crisis houses, which was due to meet on the day of our visit. All acute admission wards encouraged the involvement of people through regular community meetings, which people were encouraged to attend. Minutes of community meetings showed that people had raised issues important to them including repairs that were required and requests for more and different activities. A local service user group visited the acute admission wards every month and spoke with people about any concerns or issues they had. These issues were then raised with the ward staff who took action to address them. These meetings had resulted in requests for more information leaflets on the wards, for example, and these had been made available.

Staff engagement

We spoke with staff at different levels on all wards we visited. Most staff reported feeling supported by their manager. Many were new to the trust and were positive about their experience during their period of employment.

Staff were aware of the trust's whistleblowing policy and told us they felt able to raise any concerns they had about the care and treatment of people who use the service with senior managers. Some staff gave us examples of when they had spoken out about concerns about the care of people and said this had been received positively as a constructive challenge to ward practice.

Many staff told us that morale in the service had been very low following significant changes in the trust in recent years but was now improving. Staff were kept up-to-date about developments in the trust through regular emails.

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.

Performance improvement

Most ward managers told us they had access to ongoing leadership training and development. This covered the theory of management as well as scenarios and techniques which could be used in practice. Most felt supported by their immediate line managers.

Data was collected regularly on ward performance. Each acute admission ward completed a balance scorecard, which recorded their performance against a range of indicators and was reported on every quarter. Where performance did not meet the expected standard, action plans were put in place and implemented to improve performance. Managers could compare their performance with that of other wards, which provided further incentive for improvement. We saw evidence of improving performance in many areas on all wards.

We were concerned, however, that learning from serious incidents was not always shared promptly with ward staff or across different wards so that changes could be made that reduced risks and benefitted people using the service and staff. Staff on different wards described a number of serious incidents that had occurred and been investigated by the trust. They described not being informed of lessons learned. Some said they felt unsupported by senior management with one staff describing this as feeling “abandoned by senior management” following a serious incident. Another ward manager had been waiting almost four months for the outcome of an investigation into an incident during which a staff member sustained a serious injury. They had made recommendations for improvements but did not know whether these would be approved or implemented. Some staff on more than one ward told us they did not feel protected from verbal and/or physical abuse on the wards.

Detailed findings

Camden and Islington NHS Foundation Trust

Acute admission wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Amber, Jade, Opal, Sapphire and Topaz wards	Highgate Mental Health Centre
Dunkley, Laffan and Rosewood wards; and The Rivers Crisis House	St Pancras Hospital

Mental Health Act responsibilities

On the whole, the use of the Mental Health Act was good in the acute admission wards. Mental health documentation reviewed was mostly found to be compliant with the Act and the Code of Practice in the records of people detained under the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that capacity assessments usually consisted of a short confirmation of whether or not the person was considered to have capacity. Many of the staff we spoke with had poor knowledge of the relevant legislation and how it applied to their work with people. Staff we spoke with did not know who to contact within the trust for advice on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The trust did not have an MCA or DoLS policy to support staff in applying the legislation appropriately.

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

Summary of findings

People were not protected effectively from risks to their health, welfare and safety. Although individual clinical risk assessments were in place for people using the service, staff were unable to tell us about the measures in place to mitigate and manage the ligature risks that had been identified in October and September 2013.

Some people told us that they felt unsettled and unsafe after they had been assaulted by another patient on the ward. They said that staff were slow to take action to protect them from further assaults. In addition, whilst action had been taken to prevent illegal drugs coming on to the wards this was still an ongoing issue.

Learning from serious incidents was not always shared promptly within and across wards, in a way that enabled change and reduced risks to people using the service and staff.

Our findings

Highgate Mental Health Centre (five acute admission and treatment wards)

Track record on safety

Staff we spoke with on all acute wards knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the clinical governance team for the trust who maintained oversight. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these. Ward managers were confident that their staff teams knew what they needed to report.

Staff and people using the service were provided with support and time to talk about the impact of serious incidents on the ward. This was especially apparent following the deaths of patients on two wards.

Learning from incidents and improving safety standards

Ward managers maintained an overview of all incidents reported on their wards. Incidents were investigated and some managers told us they were made aware of incidents that had occurred on other wards at weekly meetings of ward managers and the modern matron. Staff told us incidents were discussed in team meetings and changes were made to the care of people in response.

We were concerned, however, that learning from serious incidents was not always shared promptly across different wards so that changes could be made that reduced risks and benefitted people. Staff reported receiving little feedback on investigations of incidents or action plans put in place to prevent reoccurrence. There was also little evidence of sharing between wards following incidents. For example, a person on Amber Ward had locked themselves in the bathroom and staff only gained entry after calling the police. Staff on other wards we visited were unaware of this incident and had therefore not considered actions to prevent it happening again. Similarly, staff on a ward where a death had occurred recently were not aware of any particular learning from the incident or any immediate actions taken afterwards to mitigate further risks.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We spoke with people using the service on all the acute wards we visited. The majority of people told us they felt safe. However, a few people had felt unsettled and unsafe after incidents had occurred on the wards. One person described how they had been assaulted by another person using the service and they had felt unsupported by staff when they reported the assault to the police. Another person told us how they had continued to feel unsafe after a person who had assaulted them remained on the same ward for several days before being transferred to another.

Staff had received training in safeguarding vulnerable adults and children and most staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trust's safeguarding policy and could name the safeguarding lead. They knew who to inform if they had safeguarding concerns. Staff provided examples of

Are services safe?

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

safeguarding referrals that had been made. An 'easy' guide to managing safeguarding concerns was on display and available for staff on wards as a reminder of the action to take when concerns arose.

Safeguarding was discussed at ward team meetings and we saw this was a standing item on the agenda for meetings. Safeguarding discussions with staff also took place during supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures.

Assessing and monitoring safety and risk

Safe staffing

High levels of staff vacancies on some wards, such as Opal and Topaz, resulted in a significant use of temporary staff in order to ensure there were sufficient staff deployed on each shift to maintain standards of quality and safety. Managers told us they were able to obtain additional staff when the needs of people changed and more staff were required to ensure their safety. We reviewed the staff rotas for the weeks prior to our inspection and saw that staffing levels were in line with levels and skill mix determined by the trust as safe. The only exception occurred in response to late notice sickness absence where replacement staff could not be found in time.

Temporary staff, who had not worked on a ward before, were given a brief induction to the ward, which included orientation to the layout of the ward. They were provided with written guidance on the local health, safety and security procedure for the ward, which they were expected to read at the start of their shift.

Some ward managers were concerned about high levels of sickness absence which also resulted in the use of more temporary staff to cover the shortfall. Where possible the wards tried to use regular temporary staff that were familiar with the ward, people using the service and routines. Managers told us that the trust was undertaking a large recruitment drive in an attempt to bring in more permanent staff.

Ward managers acknowledged that people using the service could not always take up agreed escorted leave, at the time they wished to, as there were not always enough staff to escort them. Staff tried to organise escorted leave so that as many people as possible were able to go out as agreed. Similarly we found that planned activities for people were sometimes cancelled because of insufficient staff being available to organise them.

Restrictive practices

Staff were sometimes required to use physical interventions with people who use the service. Training records showed that most staff had been trained in the use of restraint. [RJ4] All staff on the acute admission wards that were unable to take part in a restraint had been identified and were in the process of being redeployed to other settings. All incidents involving restraint were recorded.

Staff told us there was a greater emphasis within the trust on the use of de-escalation techniques and as a result the number of times people were restrained had been reduced. Two–thirds of the restraints in the last year were face-down and medication was administered in 77% of the restraints. New guidance published by the Department of Health in April 2014 called 'Positive and Safe' includes new guidance on the use of face down restraint which aims to ensure this is only used as a last resort. Staff told us that they were still using face-down restraint but when their training was refreshed they were being trained to use alternative approaches. Senior staff told us that the guidance on restraint was being revisited. Further work is needed on this to reduce the risk of physical and psychological harm to patients and staff.

The last CQC inspection of the trust's other acute admission wards at St Pancras Hospital in August 2013 found that some rooms, such as lounges for people using the service, were being kept locked without any explanation. During the course of this visit we found that all communal and single-gender lounges at Highgate Centre for Mental Health were kept unlocked and could be accessed by people using the service when they wished. We found no blanket restrictions being imposed on people.

There were notices on all entrance/exits from the ward that informed people who were informally admitted that they could leave the ward.

Risks to individuals

We saw that individual risk assessments had been conducted in respect of patients on the wards. Staff told us that where particular risks were identified, such as a risk to self or to others, and then measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of people by staff were increased. Individual risk assessments we reviewed took account of people's previous history as well as their current mental state. Risk assessments had generally been

updated but we noted examples of where this had not happened following significant events in a person's life. For example, one person's risk assessment had not been updated following an asylum refusal even though this was a known high risk factor for the person. In addition, in a review of records of six people on Amber Ward we did not find evidence of a review of a person's risk assessment being carried out prior to going on leave. This was similar on Topaz Ward where we noted that risk assessments were not routinely conducted prior to people going on leave. This meant that risks to people when they were outside the hospital may have been overlooked.

Written handover information about people was printed twice a day and pinned to the noticeboard in the office for staff to see. Staff told us that handovers included discussion of individual risks to people.

The trust's quarterly balance scorecard for January to March 2014, which measured performance on all wards in the trust, showed that almost all people admitted to an acute admission ward at Highgate Mental Health Centre had a care plan in place that addressed the active risks that had been identified in their current risk assessment. Trust data showed that the majority of patients on the acute admission wards had undergone a full risk assessment within five days of admission, which was the trust's performance target.

Understanding and management of foreseeable risks

Most managers and staff were aware of the main risks to people on the wards as identified in their individual risk assessments.

We saw that assessments had been carried out of ligature risks on all wards in October 2013. On four of the five wards at the Highgate Centre these assessments had failed to record any specific action to be taken to mitigate the risks.

The ligature risk assessments identified many high and medium level ligature risks on all wards. However, on Opal Ward the ligature risk assessment failed to identify the risks of a piece of furniture in a bedroom that was subsequently used by a person using the service to tie a ligature. The same furniture in other wards had been identified as a 'high' risk. Staff were unclear why this had not been identified.

The trust had taken action to address some identified risks such as the changing of some smoke detectors. There were plans in place to conduct a larger programme of works which would address many of the existing ligature risks. These were subject to board approval in July 2014. However, in the intervening period there was a lack of clear guidance in place to help staff minimise or mitigate the risks to people of existing medium and high risk ligatures points in the ward environment.

Staff we spoke with, including temporary staff, were unaware of or unable to articulate how the existing ligature risks in the ward environments were being managed. Staff on Opal Ward told us that they locked the communal bathrooms and toilets, which contained known ligature risks, when they were not in use. But we found that the disabled toilet was kept unlocked even though the ligature risks identified were similar. Staff were not able to explain the different approaches to managing risks in the bathrooms and disabled toilet. There was no record of what or how decisions about ligature risk management in the ward environment had been made.

In addition, any local ward policy or procedure in respect to ligature risk management was not routinely communicated to temporary staff. For example, the local health, safety and security procedure for Opal Ward dated April 2014, which staff told us was provided to temporary staff to read, did not identify ligature points on the ward, explain how they were to be managed or informed staff of the need to lock any particular doors.

Environmental checks of the acute admission wards were carried out every half an hour. These checks helped identify any repairs required or any immediate concerns. On some wards we were told this involved checking bathroom doors were locked, but this was not specifically recorded.

We noted a number of serious incidents had occurred in the trust over recent months which had involved the use of ligature points and resulted in serious harm to people. At the Highgate Mental Health Centre we found evidence of four separate serious incidents in March and May 2014 which involved attempts to self-harm with a ligature.

After the inspection the trust produced a patient safety alert to support ward staff to think about how they would manage the risk of ligature points. This was positive but the impact of this would still need to be evaluated.

Permanent staff knew where ligature cutters were located and told us they knew how to use them. A temporary nurse we spoke with on one ward was not aware of where the

Are services safe?

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ligature cutters were kept and incorrectly thought the emergency team would bring them with them in an emergency. This misunderstanding could cause a potentially life threatening delay in an emergency involving a ligature.

Records showed that environmental safety checks were carried out every half an hour on the wards. This helped identify the need for any repairs and protect people from general risks in the ward environment.

We noted that a large number of audits were conducted on all wards. For example, there were regular audits of infection control and prevention, and staff hand hygiene to ensure that people who use the service and staff were protected against the risks of infection. We saw that the wards were clean and people told us that standards of cleanliness were usually good. The wards were well-maintained and the corridors were clear and clutter free. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. We saw these were not over-filled.

Emergency equipment, including automated external defibrillators and oxygen, was in place and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices were also checked regularly to ensure they were working correctly. Most staff had undertaken training in life support techniques but some staff told us they were not entirely confident in relation to responding to medical emergencies as they had not been involved in any simulation or practice in a ward situation. Where medical emergencies had occurred, however, managers told us they had been managed effectively.

Monthly checks were carried out on management of fire risks, including checks of firefighting equipment, signage and escape routes. This helped protect people from the risk of harm.

Staff told us there was a problem with illegal drugs coming onto the acute admission and treatment wards. This was confirmed by some people using the service. Staff told us that attempts to address the problem included the restriction of access of outside visitors to a courtyard in the unit which was used by people from the wards. There was also a programme of work led by the Trust Local Security Management Specialist. This has included the use of drug sniffer dogs and also support from the local safer Neighbourhood Team. This had been successful to a degree but staff were aware that drugs continued to come onto the wards but they did not know how. The trust had a policy in place in respect of searching premises, patients and/or their property which had last been revised in 2010. The date for reviewing the policy was December 2013 and was therefore overdue. The policy described the search procedure and the use of drug dogs in inpatient settings as a form of drug detection. The policy stated that 'all patients have the right to receive care in a safe environment, free from drug and alcohol use.' Whilst there has been some progress this is still an ongoing issue.

St Pancras Hospital (three treatment wards and one crisis house)

Track record on safety

Staff we spoke with on all acute wards knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the clinical governance team for the trust who maintained oversight. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these. Ward managers were confident that their staff teams knew what they needed to report.

Staff and people using the service were provided with support and time to talk about the impact of serious incidents on the ward.

Learning from incidents and improving safety standards

Ward managers maintained an overview of all incidents reported on their wards. Incidents were investigated and some managers told us they were made aware of incidents that had occurred on other wards at weekly meetings of ward managers and the modern matron. Staff told us incidents were discussed in team meetings and changes were made to the care of people in response.

However, we found that ward managers often waited several months to receive feedback on the outcome of serious incident investigations. For example, following a serious assault on staff by a person on Laffan Ward in January 2014 the ward manager had still not received a report of the incident investigation, four months later. This delay in reporting back to staff on the outcome of investigations meant that lessons learned from incidents

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were not being shared in a timely manner with staff. As a result appropriate strategies and actions to prevent a re-occurrence of such incidents could not be accurately formulated and implemented by staff.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had received training in safeguarding vulnerable adults and children and most knew how to recognise a safeguarding concern. Staff were aware of the trust's safeguarding policy and could name the safeguarding lead. They knew who to inform if they had safeguarding concerns. Staff provided examples of safeguarding referrals that had been made. An 'easy' guide to managing safeguarding concerns was on display and available for staff on wards we visited as a reminder of the action to take when concerns arose.

Safeguarding was discussed at ward and team meetings and we saw this was a standing item on the agenda for meetings. Safeguarding discussions with staff also took place during supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures.

Assessing and monitoring safety and risk

Safe staffing

High levels of staff vacancies on some wards, resulted in a significant use of temporary staff in order to ensure there were sufficient staff deployed on each shift to maintain standards of quality and safety. Managers told us they were able to obtain additional staff when the needs of people changed and more staff were required to ensure their safety. We reviewed the staff rotas for the weeks prior to our inspection and saw that staffing levels were in line with levels and skill mix determined by the trust as safe. The only exception occurred in response to late notice sickness absence where replacement staff could not be found in time.

Temporary staff, who had not worked on a ward before, were given a brief induction to the ward, which included orientation to the layout of the ward. They were provided with written guidance on the local health, safety and security procedure for the ward, which they were expected to read at the start of their shift.

Some ward managers were concerned about high levels of sickness absence which also resulted in the use of more temporary staff to cover the shortfall. Where possible the wards tried to use regular temporary staff that were familiar with the ward, people using the service and routines. For example, two long-term temporary staff were being used on Opal Ward and they were receiving regular supervision from the ward manager in the same way that permanent staff were supervised. Managers told us that the trust was undertaking a large recruitment drive in an attempt to bring in more permanent staff.

Ward managers acknowledged that people using the service could not always take up agreed escorted leave, at the time they wished to, as there were not always enough staff to escort them. Staff tried to organise escorted leave so that as many people as possible were able to go out as agreed. Similarly we found that planned activities for people were sometimes cancelled because of insufficient staff being available to organise them.

Restrictive practices

Staff were sometimes required to use physical interventions with people who use the service. Training records showed that most staff had been trained in the use of restraint. [RJ1] All staff on the acute admission wards that were unable to take part in a restraint had been identified and were in the process of being redeployed to other settings. All incidents involving restraint were recorded.

Staff told us there was a greater emphasis within the trust on the use of de-escalation techniques and as a result the number of times people were restrained had been reduced. Last year two–thirds of the restraints were face-down and medication was administered in 77% of the restraints. New guidance published by the Department of Health in April 2014 called 'Positive and Safe' includes new guidance on the use of face down restraint which aims to ensure it is only used as a last resort. Staff told us that they were still using face-down restraint but when their training was refreshed they were being trained to use alternative approaches. Senior staff told us that the guidance on restraint was being revisited. Further work was needed on this to reduce the risk of physical and psychological harm to patients and staff.

The last CQC inspection of acute admission wards at St Pancras Hospital in August 2013 found that some rooms, such as lounges for people using the service, were being kept locked without any explanation. During the course of

Are services safe?

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

this visit we found that all communal and single-gender lounges were kept unlocked and could be accessed by people using the service when they wished. We found no blanket restrictions being imposed on people.

There were notices on all entrance/exits from the ward that informed people who were informally admitted that they could leave the ward.

Risks to individuals

At the last inspection of St Pancras Hospital in August 2013 we found that individual risk assessments were not always completed for people. At the current inspection we noted that improvements had been made. We saw that individual risk assessments had been conducted in respect of patients on the wards. Staff told us that where particular risks were identified, such as a risk to self or to other people then measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of people's previous history as well as their current mental state.

We reviewed the healthcare records of two people using the service at the Rivers Crisis House. These showed that safety plans had been put in place.

The trust's quarterly balance scorecard for January - March 2014, which measured performance on all wards in the trust, showed that almost all people admitted to Dunkley and Laffan Wards, and 92% of those admitted to Rosewood Ward, had a care plan in place that addressed the active risks that had been identified in their current risk assessment. Trust data also showed that all people using the service on Dunkley, Laffan and Rosewood Wards had undergone a full risk assessment within five days of admission, which was the trust's performance target.

Understanding and management of foreseeable risks

Most managers and staff were aware of the main risks to people on the wards as identified in their individual risk assessments.

We saw that assessments had been carried out of ligature risks on all wards in September and October 2013. The ligature risk assessments identified many high and medium-level ligature risks on all wards. However, we found that the risk assessments on Dunkley, Laffan and Rosewood Wards failed to record any action to be taken to mitigate any of the risks identified.

The trust had taken action to address some of the identified risks such as the changing of some smoke detectors, removal of bath taps and boxing-in of television sets on the wards. There were plans in place to conduct a larger programme of works which would address many of the existing ligature risks. This was due to commence on the wards in June 2014. However, in the intervening period there was a lack of clear guidance in place to help staff minimise or mitigate the risks to people of existing medium and high risk ligatures points in the ward environment.

Most staff we spoke with, including temporary staff, were unaware of or unable to articulate how the existing ligature risks in the ward environments were being managed. Staff told us it was difficult to manage risks on the wards at St Pancras Hospital as the estate was old and the layout, including blind spots, made it particularly difficult to observe all areas of the wards.

On Dunkley Ward we were told that a smoke detector had been recently removed from a bathroom as it was deemed to be a ligature risk. However, there was a portable telephone on a trolley outside the bathroom with a long cord which could have constituted a risk to people.

This had not been identified as a potential risk to people and was not being managed.

We noted a number of serious incidents had occurred in the trust over recent months which had involved the use of ligature points and resulted in serious harm to people. At St Pancras Hospital we found evidence of a serious incident in March 2014 which involved an attempt to self-harm with a ligature resulting in harm to the person.

After the inspection the trust produced a patient safety alert to support ward staff to think about how they would manage the risk of ligature points. This was positive but the impact of this would still need to be evaluated.

Records showed that environmental checks of the acute admission wards were carried out every half an hour. This helped identify the need for any repairs and protected people from general risks in the ward environment. Staff told us there were continual problems with blocked toilets and showers on the wards. They reported that the estates management team responded fairly quickly when emergency repairs were needed but it could be a long wait for less urgent repairs or improvements to the ward environment.

Are services safe?

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

We noted that a large number of audits were conducted on all wards. For example, there were regular audits of infection control and prevention and staff hand hygiene to ensure that people who use the service and staff were protected against the risks of infection. We saw that the wards were clean and people told us that standards of cleanliness were usually good. The wards were well-maintained and the corridors were clear and clutter free. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. We saw these were not over-filled.

On Laffan Ward, where there had been a number of complaints about cleanliness, the interim ward manager had worked with cleaning contractors to bring about an improvement in standards of cleaning. The manager regularly conducted a ward walkaround with the site manager and domestic staff which ensured that a good standard of cleanliness and hygiene was maintained. Rosewood Ward was described by a person as “spotlessly clean.”

Emergency equipment including automated external defibrillators and oxygen was in place and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Staff knew where ligature cutters were located and told us knew how to use them. Medical devices were checked regularly to ensure they were working correctly. Most staff had undertaken recent training in life support techniques. Staff at the Rivers Crisis House had practised dealing with an emergency that required the use of the ligature cutters and had found this very useful. Where medical emergencies had occurred managers told us they had been dealt with effectively.

Monthly checks were carried out on management of fire risks including checks of firefighting equipment, signage and escape routes. This helped protect people from the risk of harm.

Staff told us there was a problem with illegal drugs coming onto the treatment wards. This was confirmed by people using the service. There was also a programme of work led by the Trust Local Security Management Specialist. This has included the use of drug sniffer dogs and also support from the local safer Neighbourhood Team. This had been successful to a degree but staff were aware that drugs continued to come onto the wards but they did not know how. The trust had a policy in place in respect of searching premises, patients and/or their property which had last been revised in 2010. The date for reviewing the policy was December 2013 and was therefore overdue. The policy described the search procedure and the use of drug dogs in inpatient settings as a form of drug detection. The policy stated that ‘all patients have the right to receive care in a safe environment, free from drug and alcohol use.’ Whilst there has been some progress this is still an ongoing issue.

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 of findings

The care and treatment that people received led to improved mental health and supported people to return to live in the community. People's needs were also assessed and care was delivered in line with their individual care plans.

Staff received training, supervision and professional development. This enabled them to deliver care which was to a good standard.

However, staff members' understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and their application, was poor.

Our findings

Highgate Mental Health Centre (five acute admission and treatment wards)

Assessment and delivery of care and treatment

Medicines management

Appropriate arrangements were in place in relation to the management of medicines. We reviewed the medicine administration records of several patients on each ward we visited. Most had been completed appropriately and explained why any particular dose had been omitted. Wards regularly audited medicine records to ensure recording of administration was complete. For example, as part of a 'productive wards' initiative Amber Ward had conducted a daily audit of records in May 2014 in order to identify any potential 'missed doses'. The results showed an improvement in the recording of administration on the ward with no 'missed doses' identified in the last three weeks.

Trust data from January – March 2014 showed that there had been no recording omissions on the medicine administration records of people on four of the five acute admission wards. The only exception was Opal Ward where only 75% of people's medicine administration had been correctly recorded. An action plan had been put in place on the ward to address this shortfall. The evidence showed that the majority of medicines were administered to people as prescribed.

People using the service were provided with information about their medicines. Pharmacist and ward staff discussed changes to people's medicines, and mental health medicines information leaflets were available for people. Most people we spoke with on the wards confirmed they had received information about medicines and knew what they were for. Several people told us the potential side-effects of medicines had been explained while other people were not clear about the side-effects of their medicines. We checked a few medicines stored on the wards and found these were all within the expiry date. Ward staff told us that arrangements for medicine supplies were good. This meant that people had access to medicines when they needed them, without delays.

Our pharmacist inspector checked the management of medicines on Jade Ward in detail. We saw that medicines were stored securely on the ward. Temperature records were kept of the medicines fridge and clinical room in which medicines were stored, providing evidence that medicines were stored appropriately to remain fit for use.

Prescription charts were clear and completed fully, showing that people were receiving their medicines as prescribed. One person had been on leave from the ward for one week, and had received supplies of medicines to take home, to ensure they did not miss essential treatment. One person had been prescribed aqueous cream. There was no record of use on their prescription chart. Staff told us that this was because the person applied the cream themselves. Staff told us that people were supported to apply creams, and occasionally insulin. When we asked to see the trusts self-administration policy, we were told it was out-of-date and in the process of being revised.

We noted that one person had been prescribed a medicine for insomnia on an "as required" basis. However, this had been administered at night 20 times over a 23-day period. The trust had a policy on the use of medicines for insomnia, which stated that these medicines should not be used for longer than 14 days without a clinical review; however staff on the ward at the time of our visit were not aware of this. [JE1]

Comprehensive assessments

People's needs were assessed and care was delivered in line with their individual care plans. Records showed that risks to physical health were identified and managed effectively. Assessments included a review of the person's

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physical health on at least a weekly basis. Where physical health concerns were identified care plans were put in place to ensure the person's needs were met and clinical observations were made more frequently.

Trust data from January to March 2014 showed that almost all people admitted to the acute admission wards had a physical assessment (or their refusal had been documented) during their admission. Sapphire, Amber and Topaz Wards had completed physical assessments for 100% of people. Jade and Opal were slightly lower but above the trust's target of 85%. This showed that good levels of physical health assessments were taking place. The wards had nurse leads for physical health which had helped highlight the importance of the physical health needs of people and raise the profile amongst all staff.

Some wards had performed well in terms of the percentage of people who received a nutritional assessment within 72 hours of admission. We noted that both Amber and Topaz Wards had achieved 100% of completed nutritional assessments. However, the other three wards had failed to reach the trust's target of 80% of people assessed within three days. Less than half of people on Jade Ward had received a nutritional assessment within three days.

In addition, only Topaz Ward had achieved the trust's target of 95% of people using the service receiving a substance misuse assessment within 72 hours of admission. Jade Ward performed particularly poorly with only a quarter of people undergoing a substance misuse assessment with 72 hours.

Ward managers told us that these targets are closely monitored and where the ward had failed to meet a particular target an action plan was put in place to address the shortfall.

Care plans were in place that addressed people's assessed needs. We saw that these were reviewed on a regular basis and updated or discontinued as appropriate. Most people told us they were aware of their individual care plan and many had been involved in developing their care plans. People gave examples of how their individual needs were met. Staff described how a comprehensive management plan had been put in place for one person with particularly complex needs on Amber ward. A clear plan had been shared with all staff which resulted in a consistent approach and led to a reduction in the person's level of distress. We observed staff implementing the plan during our visit. The positive effects of this on the person were evident and this was a marked improvement from their previous review.

Use of the Mental Capacity Act

Some staff told us they had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and had received an email from the trust regarding recent legal decisions in respect of the Mental Capacity Act 2005, to make them aware of the changes.

We saw that capacity assessments were discussed in multidisciplinary team meetings and documented. However, capacity assessments were generally considered in respect of the Mental Health Act 1983 rather than the Mental Capacity Act 2005 and usually consisted of a short confirmation of whether or not the person was considered to have capacity. Many staff we spoke with had not heard of DoLS and did not know how the legislation applied to their work with people. Staff we spoke with did not know who to contact within the trust for advice on the Mental Capacity Act 2005 and DoLS. A senior manager confirmed the trust did not have a Mental Capacity Act or DoLS policy to support staff in applying the legislation appropriately although some flow charts were available to guide staff.

Promoting good health

Wards had a lead nurse for physical health who kept an overview of the physical health needs of people and ensured physical health care plans were kept up to date.

The wards used a system of modified early warning signs (MEWS) to identify physical health concerns. MEWS enabled staff to recognise when a person's physical health was deteriorating or giving cause for concern and so trigger referral to medical staff. Staff had received training in MEWS and we saw that the majority of MEWS scores had been calculated for people using the service, whose clinical observations records we reviewed.

The trust had a target of 45% of people using the service undergoing an initial assessment or review in respect of care planning for smoking cessation. The quarterly balance scorecard for the acute admission wards dated April 2014 showed that the trust did not meet the target in quarter four of 2013/14. However, an increase of nine per cent demonstrated that improvements were made in comparison with previous quarters. Many ward staff were trained in smoking cessation and could prescribe nicotine

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patches to people with the support of the pharmacist. People who use the service confirmed to us that they were offered help to stop smoking although not all were interested in stopping.

Outcomes for people using services

The acute admission wards used a number of measures to monitor the effectiveness of the service provided. A range of audits were conducted on a weekly or monthly basis. We saw examples of audits of planned activities for people, the explanation of people's rights, infection control and prevention measures and physical health checks, on all the wards we visited. Information from completed audits was fed back directly to the staff member responsible during supervision, as well as being reported to the ward and governance teams and used to identify and address changes needed to improve outcomes for people.

The acute admission wards were not externally accredited.

Staff, equipment and facilities

Staff training and development

Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training pertinent to their role including safeguarding children and adults, fire safety, life support techniques and the use of physical interventions. Records showed that most staff were up-to-date with statutory and mandatory training requirements. New staff undertook a period of induction before being included in the staff numbers. Ward managers had access to the electronic staff records (ESR) for their team. This allowed them to maintain oversight of their progress in respect of training completion. The training provided helped ensure staff were able to deliver care to people safely and to an appropriate standard.

Most staff told us they received clinical and managerial supervision every month where they were able to reflect on their practice and incidents that had occurred on the ward. However, some staff told us that this could be cancelled when the acute admission wards were very busy. For example, one nurse told us they had had supervision three times in the last five months and as a newly qualified nurse would have liked more frequent supervision from senior staff.

Staff described receiving support and debriefing following serious incidents. There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. Many staff mentioned good team work as one of the best things about their ward.

Equipment was checked regularly and monitored to ensure it was fit for purpose. Staff knew how to use the equipment provided and their competency was checked. Equipment was cleaned between use and a checklist was used to record weekly checks and cleaning of medical devices such as blood pressure monitors and treatment trolleys. Records we reviewed showed that bedframes and mattresses were also cleaned on a regular basis.

Access to meaningful activities

Weekly activity programmes for people using the service were advertised on all wards. People also had access to occupational therapy. An occupational therapist was assigned to each ward and conducted individual assessments of people's needs. All wards had dedicated part-time activity workers during some week days. Staff told us that there had been full-time activities workers on the acute admission wards in the past but this had recently been reduced. On the days without an activity worker ward staff were allocated to facilitate activity groups. Logs were kept of daily activities provided on the wards and who had participated. Staff told us that planned activities were sometimes cancelled at busy times because of a lack of staff available to run them.

People we spoke with on the wards confirmed that activities were organised on the wards although they did not always take place due to staff shortages. There were mixed views about the activities in terms of whether there were sufficient activities on offer and their quality. A person on Sapphire Ward, for example, said that activities rarely took place with the exception of walks in the local park. Whereas another person told us there was plenty to do in the ward. People were positive about most of the activities that took place. For example, people on Topaz Ward were very complimentary about the art therapy provided.

The trust had a target of 75% of people who use the service being involved in and/or being offered at least four activity sessions every week. Data from the quarterly balance scorecard for the last quarter showed that most wards, apart from Jade Ward, were achieving this. On Jade Ward we noted that only a quarter of people had been involved in or offered four activity sessions every week.

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Several people complained about a lack of activities at the weekend, this was particularly evident on Topaz Ward. At St Pancras Hospital, where the trust's other acute admission wards were located, staffing levels remained constant throughout the week, which enabled staff to organise meaningful activities at the weekend as well as during the week. In contrast, the wards at Highgate Mental Health Centre, although having the same number of beds as most wards at St Pancras Hospital, had reduced numbers of staff working at the weekend. Staff told us this sometimes made it difficult to provide meaningful activities at the weekend. However, some ward managers booked additional bank and/or agency staff at the weekend, despite the additional cost, to make sure that planned activities with people who use the service could still take place.

Multidisciplinary working

Assessments on wards were generally multidisciplinary in approach, with involvement from medical, nursing and specialist teams. There was evidence of effective multidisciplinary team (MDT) working in people's records. People who use the service had access to nursing and medical staff as well as psychologists, occupational therapists and social workers. We saw that care plans included advice and input from different professionals involved in peoples' care. People we spoke with confirmed they were supported by a number of different professionals on the wards.

We observed a MDT meeting and found this was effective in sharing information about people and reviewing their progress. Different professionals worked together effectively to assess and plan people's care and treatment.

Information from the quarterly balance scorecard, used to monitor performance of wards across a range of measures, in April 2014 showed that the majority of discharge letters were sent to people's GPs within one week of their date of discharge. Three wards, Sapphire, Topaz, and Jade, achieved 100% while Opal and Amber Wards achieved 90% or more discharge letters sent to GPs within the target time. This showed that most people's GPs were informed of their discharge from hospital and current medicines in a timely manner.

Mental Health Act (MHA) 1983

Information on the rights of people who were detained was displayed in wards and independent advocacy services were readily available to support people. Staff were aware of the need to explain people's rights to them. The explanation of rights was audited regularly on all wards and ensured that people understood their legal position and rights in respect of the MHA. People we spoke with confirmed that their rights under the MHA had been explained to them. This showed that the trust had completed actions identified after the last inspection.

A person who was not detained under the MHA told us that their rights had been explained and they knew they could leave at any time. We noted, however, the person had recently been transferred from Sapphire Ward. Their health care records from their time on Sapphire stated that unescorted leave was to be granted on condition the person adhered to blood tests and accepted referral to alcohol services. As an informal patient the person should not have been prevented from leaving the ward for any reason and unescorted leave could not legally be subject to 'conditions'.

The use of the MHA was mostly good in the inpatient wards. Mental health documentation reviewed was generally found to be compliant with the Act and the Code of Practice in the detained patients' files we examined. When we reviewed MHA documentation held in the MHA office of the trust, we found that all detention papers were on file and were completed appropriately. This included applications for renewal of detention and hearings (appeals and referrals).

However, we noted that assessments of capacity to consent often consisted of a short confirmation of whether or not the person was considered to have capacity with no further explanation of how capacity was assessed.

St Pancras Hospital (three treatment wards and one crisis house)

Assessment and delivery of care and treatment

Medicines management

Appropriate arrangements were in place in relation to the management of medicines. We reviewed the medicine administration records of several patients on each ward we visited. Most had been completed appropriately and explained why any particular dose had been omitted. Wards regularly audited medicine records to ensure recording of administration was complete. The majority of medicines were administered as prescribed.

People were provided with information about their medicines. Pharmacist and ward staff discussed changes to people's medicines, and mental health medicines

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information leaflets were available for people. Most people we spoke with told us their medicines had been explained to them by staff although some people were not always clear about the possible side-effects of the medicines. Some people on Laffan Ward told us they would like more "easy to understand" written information about the medicines they were prescribed.

Ward staff we spoke with told us that arrangements for medicine supplies were good. This meant that people had access to medicines when they needed them without delays.

Trust data from January – March 2014 showed a variation between wards in terms of recording omissions on the medicine administration records of people using the service. For Laffan and Rosewood Wards 83% of people had no recording omissions on their medication chart. On Dunkley ward, however, only 40% of people had no recording omissions on their medication chart. Ward managers told us that action plans had been put in place on the ward to address shortfalls in performance.

Our pharmacist inspector checked medicines management on Dunkley Ward in detail. We found medicines were stored securely on this ward. Controlled drugs and emergency medicines were stored and managed appropriately, with daily checks taking place. Medicines requiring refrigerated storage were stored appropriately and records showed that they were kept at the correct temperature, to remain fit for use.

Prescription charts were clear and fully completed, providing evidence that people were receiving their medicines as prescribed, when they needed them. We saw that if people were detained under the Mental Health Act 1983, the appropriate legal authorities were in place for medicines to be administered to them. If people were allergic to any medicines, this was recorded on their prescription charts, however we noted that the source of allergy information on most charts was stated as "RiO", the electronic patient record system, instead of the original source of the information, such as the persons GP. One person had been on leave from the ward for three days, and we saw that medicines had been supplied to this person to take away to ensure that they did not miss any essential treatment.

Pharmacists checked the doses of antipsychotic medicines prescribed to ensure that people were not prescribed over the recommended maximum dose. If someone was prescribed above the maximum dose, there was a monitoring form which doctors used to justify the dose prescribed. When people were prescribed medicines to be given when needed, such as medicines for agitation, we saw that people's prescription charts stated the maximum dose to be given in 24 hours, and we saw that this was not exceeded. Therefore medicines were prescribed and administered to people safely.

Comprehensive assessments

People's needs were assessed and care was delivered in line with their individual care plans. Records showed that risks to physical health were identified and managed effectively. Assessments included a review of the person's physical health on at least a weekly basis. Where physical health concerns had been identified care plans were put in place to ensure the person's needs were met and clinical observations were made more frequently. Observation levels and monitoring of physical health were determined according to individual needs. We reviewed several care plans on both wards and these showed that individual plans were in place which addressed people's assessed needs.

Trust data from January to March 2014 showed that almost all people admitted to the acute admission wards had a physical health assessment (or their refusal had been documented) during their admission. Rosewood and Dunkley Wards at St Pancras Hospital had completed physical assessments for 100% of people. Laffan was slightly lower but well above the trust's target of 85%. This showed that good levels of physical health assessments were taking place. The wards had nurse leads for physical health which had helped highlight the importance of the physical health needs of people and encourage staff to complete assessments.

The wards had performed less well in terms of the percentage of people who received a nutritional assessment within 72 hours of admission with Dunkley, Laffan and Rosewood Wards all failing to reach the trust's target of 80% of people assessed within three days. In addition none of these wards had achieved the trust target of 95% of people using the service receiving a substance misuse assessment within 72 hours of admission.

Ward managers told us that where the ward had failed to meet a particular target this was closely monitored by the trust and an action plan was put in place to address the

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shortfall. For example on Laffan Ward, the interim ward manager told us that the new admission checklist had been amended to include a reminder for staff that the substance misuse assessment should be completed.

Staff at the Rivers Crisis House told us there was often insufficient time to assess people in detail before they came to the unit. However, we saw that people had a detailed assessment on admission.

Care plans were in place that addressed people's assessed needs. We saw that these were reviewed on a regular basis and updated or discontinued as appropriate. Most people told us they were aware of their individual care plan and many had been involved in developing their care plans. People gave examples of how their individual needs were met.

We noted at the Rivers Crisis House that crisis, contingency and relapse plans were usually not completed until a person was discharged from the unit. As a result there was a risk that if the person left prior to their agreed discharge there would be no crisis or contingency plan on the electronic records system for the person that could be seen by other professionals involved in their care. There was a risk that important information about the person would be lost.

Use of the Mental Capacity Act

Some staff told us they had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and had received an email from the trust regarding recent legal decisions in respect of the Mental Capacity Act 2005, to make them aware of the changes.

We saw that capacity assessments were discussed in multidisciplinary team meetings and documented. However, capacity assessments were generally considered in respect of the Mental Health Act 1983 rather than the Mental Capacity Act 2005 and usually consisted of a short confirmation of whether or not the person was considered to have capacity. Many staff we spoke with had not heard of DoLS and did not know how the legislation applied to their work with people. Staff we spoke with did not know who to contact within the trust for advice on the Mental Capacity Act 2005 and DoLS. A senior manager confirmed the trust did not have a Mental Capacity Act or DoLS policy to support staff in applying the legislation appropriately although some flow charts were available to guide staff.

Promoting good health

Wards had a lead nurse for physical health who kept an overview of the physical health needs of people and ensured physical health care plans were kept up to date.

The wards used a system of modified early warning signs (MEWS) to identify physical health concerns. MEWS enabled staff to recognise when a person's physical health was deteriorating or giving cause for concern and so trigger referral to medical staff. We saw that the majority of MEWS scores had been calculated for people whose clinical observations records we reviewed.

The trust had a target of 45% of people using the service undergoing an initial assessment or review in respect of care planning for smoking cessation. The quarterly balance scorecard for the acute admission wards dated April 2014 showed that the trust did not meet the target in quarter four of 2013/14. However, an increase of nine per cent demonstrated that improvements were made in comparison with previous quarters. People using the service confirmed to us that they were offered help to stop smoking although not all were interested in stopping.

Outcomes for people using services

The acute admission wards used a number of measures to monitor the effectiveness of the service provided. A range of audits were conducted on a weekly or monthly basis. We saw examples of audits of planned activities for people, the explanation of people's rights, infection control and prevention measures and physical health checks, on all the wards we visited. Information from completed audits was fed back directly to the staff member responsible during supervision, as well as being reported to the ward and governance teams and used to identify and address changes needed to improve outcomes for people.

At the Rivers Crisis House people were asked to complete the seven item Short Warwick-Edinburgh Mental Well-Being Scale on admission and again before they were discharged. The service had been open for less than five months but there were plans to analyse the results of the pre and post-admission assessments in order to measure the impact of the service in terms of measuring improved outcomes for people.

Staff, equipment and facilities

Staff training and development

Staff received appropriate training, supervision and professional development. Staff told us they had

undertaken training relevant to their role including in safeguarding children and adults, fire safety, life support techniques and the use of physical interventions. Records showed that most staff were up to date with statutory and mandatory training requirements. New staff undertook a period of induction before being included in the staffing numbers. Ward managers had access the electronic staff records (ESR) for their team. This allowed them to maintain oversight of their progress in respect of training completion. The training provided helped ensure staff were able to deliver care to people safely and to an appropriate standard.

Staff at the Rivers Crisis House told us they had undergone a detailed induction as a team before the unit opened in January 2014. The induction covered issues and procedures such as safeguarding vulnerable adults and infection control. Staff had received ligature risk training including practical simulations which allowed them to practice the skills they had learned in theory. Staff told us they had found the induction helpful.

Most staff told us they received clinical and managerial supervision every month. However, some staff told us that this could be cancelled when the acute admission wards were very busy.

Staff described receiving support and debriefing following serious incidents. There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. Many staff mentioned good team work as one of the best things about the ward.

Equipment was checked regularly and monitored to ensure it was fit for purpose. Staff knew how to use the equipment provided and their competency was checked. Equipment was cleaned between use and a checklist was used to record weekly checks and cleaning of medical devices such as blood pressure monitors and treatment trolleys. Records we reviewed showed that bedframes and mattresses were also cleaned on a regular basis.

Access to meaningful activities

Weekly activity programmes for people using the service were advertised on all wards. People had access to occupational therapy. An occupational therapist was assigned to each ward and conducted individual assessments of people's needs. All wards had dedicated part-time activity workers during some week days. Staff told us that there had been full-time activities workers on the acute admission wards but this had recently been reduced. On the days without an activity worker ward staff were allocated to facilitate activity groups. Logs were kept of daily activities provided on the wards and who had participated. Staff told us that planned activities were sometimes cancelled because the wards were very busy and there were no staff available to run them. Feedback from people on Laffan Ward about the lack of activities at the weekend had led to the development of a weekend activities programme which was about to start. The ward also compiled activity packs for people to use on an individual basis. On Rosewood Ward a fitness instructor visited the ward once a week in response to a request from women using the service.

The trust had a target of 75% of people who use the service being involved in and/or being offered at least four activity sessions every week. Data from the quarterly balance scorecard for the last quarter showed that most wards were achieving this.

At St Pancras Hospital staffing levels remained constant throughout the week, which enabled staff to organise meaningful activities at the weekend as well as during the week. This ensured that planned activities with people who use the service could take place at the weekend.

The Rivers Crisis House, based on the St Pancras Hospital site, offered people an alternative to hospital admission. People using the six-bedded unit were encouraged to attend groups and activities at the Jules Thorne Recovery Centre which was located nearby. People using the service described a range of planned and meaningful activities taking place at the weekends such as museum and nature reserve visits.

Multidisciplinary working

Assessments on wards were generally multidisciplinary in approach, with involvement from medical, nursing and specialist teams. There was evidence of effective multidisciplinary team (MDT) working in people's records. People who use the service had access to nursing and medical staff as well as psychologists, occupational therapists and social workers. We saw that care plans included advice and input from different professionals involved in people`s care. People we spoke with confirmed they were supported by a number of different professionals on the wards. We observed a thorough discussion of a person's needs in an MDT meeting on Rosewood ward.

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Staff on Laffan Ward told us there were daily 'board' meetings where members of the MDT came together to briefly discuss all people admitted to ward and address any immediate concerns.

Staff described good working relationships with community mental health teams but acknowledged that there could be difficulties getting a care coordinator assigned to a person who did not have one already.

Information from the quarterly balance scorecard, used to monitor performance of wards across a range of measures, in April 2014 showed that the majority of discharge letters were sent to people's GPs within one week of their date of discharge. Dunkley Ward achieved this 100% of the time, while Laffan Ward achieved 90% or more discharge letters sent to GPs within the target time. The only exception was Rosewood Ward which sent discharge letters to people's GPs within one week less than 80% of the time. This was a significant drop compared with previous quarters. Overall, the majority of people's GPs were informed of their discharge from hospital and current medicines in a timely manner.

Mental Health Act (MHA) 1983

Information on the rights of people who were detained was displayed in wards and independent advocacy services were readily available to support people and their use was encouraged. Staff were aware of the need to explain people's rights to them. The explanation of rights was audited regularly on all wards and ensured that people understood their legal position and rights in respect of the MHA. This showed that improvements had been made following the last inspection of St Pancras Hospital in August 2013, after which a compliance action had been made. This means that this compliance action has been removed.

The use of the MHA was mostly good in the inpatient wards. Mental health documentation reviewed was generally found to be compliant with the Act and the Code of Practice in the detained patients' files we examined. When we reviewed MHA documentation held in the MHA office of the trust, we found that all detention papers were on file and were completed appropriately. This included applications for renewal of detention and hearings (appeals and referrals).

In a detailed review of people's records on Rosewood Ward, however, we found that some prescribed medicines had not been appropriately authorised before being administered. Two people in particular appeared to have been unlawfully treated with medicines prescribed to address the side-effects of psychiatric medicines. These were reported to the nurse in charge who immediately reported the errors and confirmed the medicines would not be administered until lawfully authorised.

In addition, we noted that assessments of capacity to consent often consisted of a short confirmation of whether or not the person was considered to have capacity with no further explanation of how capacity was assessed.

The Rivers Crisis House did not provide a service to people detained under the MHA.

Are services caring?

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

Summary of findings

Staff responded to people in distress in a calm and respectful manner and de-escalated situations effectively. They also took the time to explain people's care and treatment, and to support them.

Services were interested in the people they cared for and staff were committed to providing good quality care.

Our findings

Highgate Mental Health Centre (five acute admission and treatment wards)

Kindness, dignity and respect

People's privacy and dignity were respected. People who use the service told us staff treated them with respect, even when restrictions in relation to their care and treatment were in place. We observed staff interacting with people in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner and de-escalated situations by speaking quietly and listening to people who were frustrated and/or angry about having to be detained in hospital. They appeared interested and engaged in providing good quality care to people.

Attempts were made to maintain people's privacy and dignity where possible. For example, there were stickers on people's bedroom doors asking others to 'knock and wait for a response before entering.'

People using the service on all acute admission wards told us they were treated well and supported by staff. Staff were described as "kind" and "caring." People were highly complimentary about staff who were described as "fantastic" and "beyond reproach." Staff were said to "go the extra mile."

People had access to drinks and snacks at any time.

Several people on different wards complained to us that personal items had gone missing from their bedrooms whilst they had been in hospital. Staff explained that people were not given keys to their rooms because these had gone missing over time. They said that people could ask staff to lock their rooms when they were out. However, this was not always a practical option for people or they did not want to bother staff who were already very busy. People said they would have benefitted from a lockable space or cupboard to keep their belongings safe.

Involvement of people using the service

Staff told us that people using the service were involved in developing their own care plans. We saw on some wards that people had made written comments about their care plans. People we spoke with on different wards were generally aware of the content of their care plans although some people said they had only been shown to them in the last few days before our inspection visit. Some people confirmed they had been involved in developing their own care plan. However, none of the seven people we spoke with on Jade Ward said they had seen their care plan. One person's comments were typical when they said "I haven't got a clue about my care plan."

People were encouraged to involve relatives and friends in care planning if they wished. Carers were invited to ward rounds and actively involved in discharge planning where this was relevant.

All acute admission wards held weekly community meetings with people to gather their views about the ward. Minutes of the meetings were kept and on some wards we saw they were displayed for everyone to see what had been discussed.

The views of people using the service were also gathered through the use of surveys. Responses to surveys were fed back to ward staff to enable them to make changes where appropriate.

Emotional support for care and treatment

Staff demonstrated good emotional support to people on the ward at an individual level. We observed staff taking time to explain and support people in a sensitive manner. They responded to the needs of relatives and carers and took time to explain care and treatment and address any concerns. We observed a staff member attempting to reassure a carer about the safety of their relative in the ward following a serious incident.

The wards attempted to use a recovery based approach to working with people. Sapphire Ward, which was the assessment ward, usually admitted people who had not been admitted to hospital before or for a long time. People were supported to return to the community as soon as possible. Staff on all wards spoke of the importance of

Are services caring?

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

providing information to people as a way of promoting self-recovery. On several wards we saw care plans were in place for people that actively encouraged their independence and empowerment.

There was evidence to show that the majority of people using the service were offered a one-to-one meeting with a member of staff every day. Trust data for the period January - April 2014 showed that most on the acute admission wards were offered a one-to-one meeting each day. We noted from people's records, however, that the quality of one-to-one meetings varied between wards. For example, people on Amber Ward confirmed they were given the option of having one-to-one time with staff every day. Whereas people on Jade Ward told us that they frequently did not have one-to-one time with a nurse, although trust performance data suggested this had been happening regularly earlier in the year. One person thought the lack of one-to-one meetings was a result of staff shortages or disinterest. During a review of people's healthcare records on Sapphire Ward we found evidence that most people were offered one-to-one time with staff every day. However, we noted that one person had not been offered daily one-to-one time because they did not speak English.

St Pancras Hospital (three treatment wards and one crisis house)

Kindness, dignity and respect

People's privacy and dignity were respected. People who use the service told us staff treated them with respect, kindness and compassion even when restrictions in relation to their care and treatment were in place. We observed staff interacting with people in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner and de-escalated situations by speaking quietly and listening to people who were frustrated and/or angry about having to be detained in hospital. Staff tried not to be intrusive when observing people and checking on their welfare. This was appropriately balanced against the risk of potential harm coming to people

Attempts were made to maintain people's privacy and dignity where possible. For example, there were stickers on people's bedroom doors asking others to 'knock and wait for a response before entering.'

People on Rosewood Ward told us that staff were accessible and always visible on the ward. As one patient explained, "you hardly find staff in the office". People described receiving "excellent" and "brilliant" care from staff on the ward who were "lovely and kind." A group of seven people we spoke with on Laffan Ward were all positive about the quality of care they received from nursing staff. Staff were described as approachable and friendly and the doctors "listened and cared." Similar views were expressed by people on Dunkley Ward.

People had access to drinks and snacks at any time.

On Rosewood, which was a 12-bedded ward, the living space was relatively small and when incidents occurred it was difficult for other people using the service to remove themselves from the situation. They reported that they sometimes found this distressing. Similarly at the Rivers Crisis House we noted that all six bedrooms led directly off the main living space. As a result people told us that it was sometimes noisy at night when other people using the service were talking in the lounge or when incidents occurred.

Two women on Laffan Ward told us they felt too many male staff were allocated to the female corridor and suggested they could be more respectful when entering people's rooms.

Involvement of people using the service

Staff told us that people using the service were involved in developing their own care plans. We saw on some wards, such as Laffan Ward, that people had expressed their views in the development of care plans. Many people we spoke with on the acute admission wards told us they had been involved in developing their care plans. People were encouraged to involve relatives and friends in care planning if they wished. Carers were invited to ward rounds and actively involved in discharge planning.

All acute admission wards held weekly community meetings with patients to gather their views about the ward. Minutes of the meetings were kept and on some wards we saw they were displayed for everyone to see what had been discussed in the previous meeting. On Laffan Ward the female lounge was being refurbished in order to make it a more comfortable space. This was in direct response to feedback from people using the service.

The views of people using the service were also gathered through the use of surveys. Responses to surveys were fed back to ward staff to enable them to make changes where appropriate.

Are services caring?

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

Emotional support for care and treatment

Staff demonstrated good emotional support to people on the ward at an individual level. We observed staff taking time to explain and support people in a sensitive manner. Staff responded to the needs of relatives and carers and took time to explain care and treatment and address any concerns.

The wards attempted to use a recovery based approach to working with people. At the Rivers Crisis House staff had received training in the recovery model prior to the opening of the service in January 2014. Visiting hours at the crisis house were from 8am to 10pm, which ensured carers, relatives and friends could visit at a time that was convenient for them. People using the service were encouraged to complete a detailed personal recovery plan which included plans for keeping well, managing ups and downs, moving on after a crisis and pursuing ambitions and dreams. There was a good ethos of recovery amongst staff which was communicated to people using the service.

People were supported to return to the community as soon as possible. Staff on all wards spoke of the importance of providing information to people as a way of promoting self-recovery. We saw written information on a range of topics was available to people on all the wards we visited. Service user groups we spoke with prior to the inspection were positive about the role of crisis houses in preventing admission to hospital.

There was evidence to show that the majority of people were offered a one-to-one meeting with a member of staff every day. Trust data for the period January to April 2014 showed that every person using the service on the wards was offered a one-to-one meeting each day with staff. People on Laffan Ward told us they regularly received one-to-one time with staff and were pleased with the quality of interactions that took place. People on Rosewood and Dunkley Wards were also very positive about the one-to-one time they spent with staff and described them as always having time to listen.

Are services responsive to people's needs?

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

Summary of findings

Services were not organised in a way that met people's needs effectively. Some people using the service were moved between wards several times during one admission. Of these, some people were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. There were informal agreements, rather than clear guidelines, on the management of transfers between wards. This meant that transfers of people between wards were not managed in a planned and co-ordinated way. This had a negative effect of people's care and hospital experience.

Our findings

Highgate Mental Health Centre (five acute admission and treatment wards)

Planning and delivering services

Acute beds

The bed manager told us that there were no catchment area wards that people were routinely admitted to. People were admitted to any available acute admission bed in the trust. There were thirty people occupying admission beds in the independent health sector at the time of our visit, many of whom were awaiting transfer to an acute bed within the trust.

Weekly meetings were held with the bed management team to review any people whose discharge from the acute admission wards was delayed. Resources were then deployed to try and facilitate the person's discharge. However, staff told us that many issues of delayed discharge were as a result of a lack of suitable housing options locally. All the wards we visited were full and the majority of people on the wards were detained in hospital under a section of the Mental Health Act 1983.

The pressure on acute beds was such that the flow of people through the hospital was sometimes disjointed leading to frequent ward moves for some people. The trust risk register acknowledged that there was also a risk in treating people outside of the borough in which they lived in terms of the quality of care they received and a risk of increased lengths of stay in hospital. In response to this concern the trust had developed a tracker system to plot the pathway through care of every person using the service. By doing this they hoped to be able to identify blockages and trends in order to be able to escalate them and make improvements in the system and people's experience.

Gender-specific beds

Male and female sleeping areas were separate on all the acute admission wards we visited. Everyone had their own room. Most rooms had an en-suite shower and toilet facilities. A few rooms on each ward did not have en-suite facilities but had access to a separate bathroom and toilet facilities. There were separate female-only lounges on all the wards which provided a safe space for women who preferred a women-only environment.

Psychological therapies

There was some input from a psychologist on all of the wards we visited. Ward staff could make direct referrals of people to the psychologist if this was thought to be appropriate. A few people we spoke with on the acute admissions told us they had seen a psychologist during their admission. On Amber Ward a psychologist had assisted staff to develop a care plan for a person whose behaviour had been challenging to others. This had proved very successful in encouraging more positive behaviour and reduced levels of conflict.

Right care at the right time

Referrals/admission/treatment times/discharges:

Care was delivered in the inpatient service by a multidisciplinary team.

Staff on the acute admission wards told us they frequently needed to work with up to four different community mental health teams which sometimes made liaison with the teams difficult. Care co-ordinators were always invited to Care Programme Approach (CPA) meetings and usually attended. If a person using the service did not have an allocated care co-ordinator there could be delays in getting one assigned.

Care pathway

Sapphire Ward was used as an assessment ward with a proposed length of stay of about two weeks. People were usually discharged back to the community with additional support in place or were assessed as requiring treatment on one of the other acute admission wards. However, on the day of our visit to Sapphire we were told there were eight people on the ward awaiting transfer to the

Are services responsive to people's needs?

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

'treatment' wards. The beds on the ward were all full and as a result the ward could not admit a person requiring assessment. In addition, the ward had become all male, as a result of recent admissions. This meant that any female who may have benefitted from assessment on the ward had to be admitted directly to the 'treatment' wards or to out of area provision. This restricted the choice of women who had not been admitted to hospital before or for a long time.

Staff told us there was a great pressure on beds and as soon as one patient was discharged another was admitted. Staff described how they were unable to keep empty beds for patients who went absent from the ward without being formally granted leave (AWOL). If they returned to the ward they would often find there was no longer a bed for them. Staff on Opal Ward described how two people, who had been absent from the ward, both returned at the same time. Their beds were no longer available on the ward and this resulted in 18 people being on a 16-bedded ward. While staff were trying to locate beds in the trust for the people who had returned there was a serious incident on the ward involving another person. The pressure on beds sometimes had a detrimental effect on the care provided to people.

Several people told us how they had been moved from one ward to another during their admission. This impacted on the continuity of care they received. For example, one person, who had been moved three times during the one admission period, told us "you just start to open up to staff and they move you on again." They said they were frustrated at having to repeat their history to different staff on different wards.

We reviewed the records of 20 people on Jade Ward. Despite being a 16-bedded ward there were four more people included in the ward numbers who were either on leave or absent without leave being granted. Of the 20 records we reviewed we found that eight people had been admitted to only one ward. A further seven people had been moved once or twice between wards and four people had been moved three or four times in the one admission. Staff told us that it was not unusual for people who were not known to staff to be moved onto the ward without a plan of care. An agreement had been reached with the bed manager that nobody was to be transferred without a clearly documented care and treatment plan in place. Staff told us there was no formal policy in place regarding which team should care for the person transferred, although there was an informal agreement that they would be cared for by the original medical team for the first three days.

Similarly on Topaz Ward a review of the healthcare records of 17 people showed that nine people had experienced at least one ward transfer during the current admission episode. Of these one had experienced five transfers and another had been transferred six times. Some people had been transferred into the ward from Sapphire, the assessment ward, and others had been moved from the psychiatric intensive care unit. However, we also found a transfer that had occurred after a bedroom became uninhabitable and another was a result of routine bed management. We spoke with two people who had experienced multiple transfers between wards. One person reported they found it difficult having to get to know different nursing teams. Staff told us that a person's mental state was not always a factor determining who should be transferred in order to manage beds effectively.

Information provided by the trust showed that last year nearly 100 people had been transferred into acute admission wards from other trust wards between 11pm and 7am. Since April, this number had reduced and eight people had moved during these hours. This was disruptive to people's care and likely to be unsettling and interfere with their sleep and rest.

Some people using the service experienced several moves for non-clinical reasons between wards during one admission. Of these some people were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. There were informal agreements rather than a clear protocol on the management of transfers between wards. This meant that transfers of people between wards were not managed in a planned and coordinated, way which had a detrimental effect of people's care and hospital experience.

Equality, diversity and human rights:

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the wards. Local faith representatives visited people on the ward and could be contacted to request a

visit. There was a faith room available to people although staff told us that the faith room was kept locked and inaccessible to people at the weekend. The reason for this was not clear.

Interpreters were available to staff and were used to assist in assessing people's needs and explaining people's rights as well as their care and treatment. Leaflets explaining people's rights under the Mental Health Act 1983 were available in different languages. During our review of people's healthcare records on the wards we noted that interpreters had accompanied people to multidisciplinary meetings when the person did not speak English well. However, staff told us interpreters were not available over the telephone for day-to-day interpreting and to conduct a daily one-to-one meeting between staff and a person using the service.

A choice of meals was available. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to access appropriate meals.

A women's forum, open to all women who used the service, met every month. The forum encouraged women to talk about issues important to them and any concerns they had during their admission, particularly related to their gender.

Learning from concerns and complaints

There was a system in place to learn from complaints. We saw information on how to make a complaint was displayed in the wards. Information on the patient advice and liaison service (PALS) and independent advocacy services was also displayed. People could raise concerns in community meetings and this was usually effective. Staff told us they tried to address people's concerns informally as they arose. We observed staff responding appropriately to concerns raised by relatives and carers of people using the service and negotiating solutions. People told us they knew how to raise concerns and make a complaint. Most people we spoke with told us they felt they would be able to raise a concern should they have one, and believed they would be listened to by staff.

St Pancras Hospital (three treatment wards and one crisis house)

Planning and delivering services

Acute beds

Weekly meetings were held with the bed management team to review any people whose discharge was being delayed. Resources were then deployed to try and facilitate the person's discharge. However, staff told us that many issues of delayed discharge were as a result of a lack of suitable housing options locally. All the wards we visited were full and the majority of people on the wards were detained in hospital under a section of the Mental Health Act 1983.

Staff at the Rivers Crisis House told us they sometimes felt pressure to take inappropriate admissions. As a new service, with a specific model of care, many staff within the trust and outside did not understand the purpose of the service and that it did not admit people who were detained or people prescribed controlled drugs.

The pressure on acute beds was such that the flow of people through the hospital was sometimes disjointed leading to frequent ward moves for some people. The trust risk register acknowledged that there was also a risk in treating people outside of the borough in which they lived in terms of the quality of care they received and a risk of increased lengths of stay in hospital. In response to this concern the trust had developed a tracker system to plot the pathway through care of every person using the service. By doing this they hoped to be able to identify blockages and trends in order to be able to escalate them and make improvements in the system and people's experience.

Gender-specific beds

Male and female sleeping areas were separate on all the acute admission wards we visited. A few rooms on each ward did not have en-suite facilities but had access to a separate gender specific bathroom and toilet facilities. There were separate female-only lounges on all the wards which provided a safe space for women who preferred a women-only environment. Rosewood Ward was an all-female ward and catered for women who preferred, or would benefit from, an all-female environment.

Psychological therapies

There was some input from a psychologist on all of the wards we visited. Ward staff could make direct referrals of people to the psychologist if this was thought to be appropriate.

Right care at the right time

Referrals/admission/treatment times/discharges

Care was delivered in the inpatient service by a multidisciplinary team.

Are services responsive to people's needs?

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

Care coordinators were always invited to Care Programme Approach (CPA) meetings and usually attended. If a person using the service did not have an allocated care coordinator there could be delays in getting one assigned.

At the Rivers Crisis House a leaving plan was developed with people when they were preparing for discharge. The leaving plan focussed on how people would get the support they needed when they were at home. People were referred to other services such as psychology services, recovery and rehabilitation teams and university mental health workers, depending on their needs or circumstances. Leaving plans were shared electronically with people's GPs which ensured they were received in a timely manner.

Care pathway

The Rivers Crisis House offered an alternative to admission to one of the inpatient wards for informal patients. The service had six beds and accepted self-referrals.

Staff told us there was a great pressure on beds and as soon as one patient was discharged another was admitted. Staff described how they were unable to keep empty beds for patients who went absent from the ward without being formally granted leave. If they returned to the ward they would often find there was no longer a bed for them.

Several people also told us how they had been moved from one ward to another during their admission. This impacted on the continuity of care they received. We reviewed a number of people's records on the wards we visited. On Laffan Ward we reviewed the healthcare records of 17 people (16 people admitted to the ward and one who was absent without leave). Of these 17 people six people had been transferred three times during their admission. Seven had been admitted directly to the ward. On Rosewood Ward we noted that of the 12 people admitted to the ward two had been transferred between wards three of four times during their admission.

Information provided by the trust showed that last year nearly 100 people had been transferred into acute admission wards from other trust wards between 11.00pm and 7.00am. Since April this number had reduced and 8 people had moved during these hours. This was disruptive to people's care and likely to be unsettling and interfere with their sleep and rest.

The pressure on acute beds was such that the flow of people through the hospital was sometimes disjointed leading to frequent ward moves for some people. The trust risk register acknowledged that there was also a risk in treating people outside of the borough in which they lived in terms of the quality of care provided and increased length of stay. In response to this concern the trust had developed a tracker system to plot the pathway through care of every person using the service. By doing this they hoped to be able to identify blockages and trends in order to be able to escalate them and make improvements in the system.

Some people using the service experienced several moves for non-clinical reasons between wards during one admission[RJ2] . Of these, some people were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. There were informal agreements rather than a clear protocol on the management of transfers between wards. This meant that transfers of people between wards were not managed in a planned and co-ordinated way. This had a detrimental effect of people's care and hospital experience.

Equality, diversity and human rights

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the wards. Local faith representatives visited people on the ward and could be contacted to request a visit.

Interpreters were available to staff and were used to assist in assessing people's needs and explaining people's rights, as well as their care and treatment. Leaflets explaining people's rights under the Mental Health Act 1983 were available in different languages.

A choice of meals was available. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to access appropriate meals.

Rosewood ward was an all-female ward. Women were often admitted to the ward at their request or because of particular issues that made an all-female environment more conducive to their needs. For example, women whose behaviour may put them at risk in a mixed gender

Are services responsive to people's needs?

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

environment, those with particular cultural needs and women whose individual experiences meant a mixed setting was detrimental to their mental health, could be admitted to the ward if they chose.

At the Rivers Crisis House the manager acknowledged that people who had used the service during the four months it had been open were not reflective of the local community in terms of ethnicity and wanted to explore further how they could encourage referrals from people of south Asian origin and young black men in particular, who were over-represented in other acute mental health settings.

Learning from concerns and complaints

There was a system in place to learn from any complaints made. We saw that information on how to make a complaint was displayed in the wards. Information on the patient advice and liaison service (PALS) and independent advocacy services were also displayed. People could raise concerns in community meetings and this was usually effective. Staff told us they tried to address people's concerns informally as they arose. We observed staff responding appropriately to concerns raised by relatives and carers of people using the service and negotiating solutions. People told us they knew how to raise concerns and make a complaint. Most people we spoke with told us they felt they would be able to raise a concern should they have one and believed they would be listened to by staff.

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.

Summary of findings

The trust had a vision and direction that was communicated effectively to staff. The delivery of services was also supported by the trust's governance structures. We found that the wards were well-led and that ward managers were visible and accessible to staff and people who used the service.

The trust encouraged the development of the service.

Our findings

Highgate Mental Health Centre (five acute admission and treatment wards)

Vision and strategy

The trust's vision and strategies for the service were evident and on display in some wards. Staff on all wards considered they understood the vision and direction of the trust. However, several staff suggested that communication was predominantly one way, from the board to the wards and were not sure whether messages travelled effectively in the opposite direction.

Responsible governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Ward managers had regular contact with their modern matron and divisional manager. On occasions senior trust managers came to the wards. For example, the Director of Nursing attended an incident discussion on Amber Ward and had arranged to spend the day on Opal Ward. However, some ward managers and staff felt that senior managers only visited or contacted the ward when something had gone wrong.

Leadership and culture

We found the wards to be well-led and there was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day-to-day provision of care and treatment to people, were accessible to staff and proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improvements in care. Staff we spoke with on the wards were enthusiastic and engaged with ward developments. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by their line manager.

Engagement

Service user engagement

Care was mostly person-centred. All acute admission wards encouraged the engagement and involvement of people through regular community meetings which people were encouraged to attend. Minutes of community meetings showed that people had raised issues important to them including repairs that were required, and requests for more and different activities. A local service user group visited the acute admission wards and spoke with people about any concerns or issues they had. These issues were then raised with the ward staff who took action to address them.

Staff engagement

We spoke with staff at different levels on all wards we visited. Most staff reported feeling supported by their manager. Many were new to the trust and were positive about their experience during their period of employment.

Staff were aware of the trust's whistleblowing policy and told us they felt able to raise any concerns they had about the care and treatment of people who use the service with senior managers. Some staff gave us examples of when they had spoken out about concerns about the care of people and said this had been received positively as a constructive challenge to ward practice.

Many staff told us that morale in the service had been very low following significant changes in the trust in recent years. However, they also considered that morale was improving and the trust was traveling "in the right direction". Staff were kept up to date about developments in the trust through regular emails.

Performance improvement

Most ward managers told us they had access to ongoing leadership training and development. This covered the theory of management as well as scenarios and techniques which could be used in practice. Most felt supported by their immediate line managers.

Data was collected regularly on performance. Each acute admission ward completed a balance scorecard, which

Are services well-led?

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recorded their performance against a range of indicators and was reported on every quarter. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance. Managers could compare their performance with that of other wards which provided further incentive for improvement. We saw evidence of improving performance in many areas on all wards.

St Pancras Hospital (three treatment wards and one crisis house)

Vision and strategy

The trust's vision and strategies for the service were evident and staff had a good understanding and knowledge of these. Staff on all wards considered they understood the vision and direction of the trust. However, several staff suggested that communication was predominantly one way, from the board to the wards, and were not sure whether messages travelled effectively in the opposite direction.

Responsible governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Ward managers had regular contact with the modern matron and divisional manager. On occasions senior trust managers visited the wards. However, some ward managers and staff felt that senior managers only visited or contacted the ward when something had gone wrong.

Leadership and culture

We found the wards to be well-led and there was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day to day provision of care and treatment to people and were accessible to staff and proactive in providing support. One ward manager, who had been in post for several months on an interim basis, had made a significant positive impact on the quality of care provided on the ward. People using the service spoke very highly of the ward manager and said how approachable they were.

The culture on the wards was open and encouraged staff to bring forward ideas for improvements in care. Staff we spoke with on the wards were enthusiastic and engaged with ward developments. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by their line manager.

A few staff described the overall culture of the trust as one of blame and criticism but this was not a generally held view expressed by staff.

Engagement

Service user engagement

There was a service user forum for people who used the crisis houses, which was due to meet on the day of our visit. All acute admission wards encouraged the involvement of people through regular community meetings, which people were encouraged to attend. Minutes of community meetings showed that people had raised issues important to them including repairs that were required and requests for more and different activities. A local service user group visited the acute admission wards every month and spoke with people about any concerns or issues they had. These issues were then raised with the ward staff who took action to address them. These meetings had resulted in requests for more information leaflets on the wards, for example, and these had been made available.

Staff engagement

We spoke with staff at different levels on all wards we visited. Most staff reported feeling supported by their manager. Many were new to the trust and were positive about their experience during their period of employment.

Staff were aware of the trust's whistleblowing policy and told us they felt able to raise any concerns they had about the care and treatment of people who use the service with senior managers. Some staff gave us examples of when they had spoken out about concerns about the care of people and said this had been received positively as a constructive challenge to ward practice.

Many staff told us that morale in the service had been very low following significant changes in the trust in recent years but was now improving. Staff were kept up-to-date about developments in the trust through regular emails.

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.

Performance improvement

Most ward managers told us they had access to ongoing leadership training and development. This covered the theory of management as well as scenarios and techniques which could be used in practice. Most felt supported by their immediate line managers.

Data was collected regularly on ward performance. Each acute admission ward completed a balance scorecard, which recorded their performance against a range of indicators and was reported on every quarter. Where performance did not meet the expected standard, action plans were put in place and implemented to improve performance. Managers could compare their performance with that of other wards, which provided further incentive for improvement. We saw evidence of improving performance in many areas on all wards.

We were concerned, however, that learning from serious incidents was not always shared promptly with ward staff or across different wards so that changes could be made that reduced risks and benefitted people using the service and staff. Staff on different wards described a number of serious incidents that had occurred and been investigated by the trust. They described not being informed of lessons learned. Some said they felt unsupported by senior management with one staff describing this as feeling “abandoned by senior management” following a serious incident. Another ward manager had been waiting almost four months for the outcome of an investigation into an incident during which a staff member sustained a serious injury. They had made recommendations for improvements but did not know whether these would be approved or implemented. Some staff on more than one ward told us they did not feel protected from verbal and/or physical abuse on the wards.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated activities) Regulations 2010** **Assessing and monitoring the quality of service provision** People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although numerous ligature risks had been identified on all wards staff were not able to articulate how they were being managed or mitigated on a day to day basis. This was a breach of Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated activities) Regulations 2010** **Consent to care and treatment** The trust did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people or where that did not apply for establishing and acting in accordance with people's best interests. Mental capacity assessments lacked explanation of how capacity had been assessed. Many staff had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This was a breach of Regulation 18 (1)(a)(b) (2)

Regulated activity	Regulation

Compliance actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 10 HSCA 2008 (Regulated activities)

Regulations 2010

Assessing and monitoring the quality of service

The trust did not have an effectively operating system to share learning from incidents in order to make changes to peoples care in order to reduce the potential for harm to service users.

This was in breach of Regulation 10(2)(c)