Oxleas NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RPGAR	Oaktree Lodge	Oaktree Lodge	SE18 3RZ

This report describes our judgement of the quality of care provided within this core service by Oxleas 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 Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas NHS Foundation Trust.

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

Summary of findings

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

As this was a focussed inspection of one ward, we did not change the ratings of this core service.

Our findings from this inspection were:

- At the April 2018 inspection, we found that staff did not follow the trust's policy and national best practice guidance regarding 'do not resuscitate' decisions for patients. Staff did not record that they reviewed these decisions, completed capacity assessments for patients, or involved Independent Mental Capacity Advocates (IMCA) in the decision. At this inspection, staff had reviewed 'do not resuscitate' decisions and completed capacity assessments for patients. IMCAs had also been involved in the decisions. However, one patients' capacity assessment was not sufficiently detailed, and for one patient the IMCA was involved after the decision had been reviewed and confirmed.
- At this inspection we found that an informal patient who did not think they were unwell was recorded as consenting to take medicines. There was no record that they had a capacity assessment regarding the decision to take medicines. It was possible that the patient did not provide informed consent.
- At the April 2018 inspection, we found that staff did not always complete risk assessments for patients when they were admitted, and did not always update patient risk assessments when required. On this inspection, staff had reviewed and updated patients' risk assessments. No new patients had been admitted to the ward.
- At the April 2018 inspection, we found that patients' care plans were not always detailed, specific or met patients' needs. Patients' care plans did not always include patients' preferences and did not show that patients had been involved in developing them. When the visiting GPs assessed and recommended treatment for patients' physical health problems, they did not always record this in the patients' care and treatment records. At this inspection, patients' care plans were detailed, specific and addressed all the patients' needs. Patients' involvement and preferences were reflected in their care plans. Visiting GPs recorded their assessments and treatment recommendations in patients' care and treatment records.
- At the inspection in April 2018, we found that staff were preoccupied with routine and tasks, and spent more time talking with each other than with patients. Staff communication with patients was not always therapeutic. There were few activities for patients to undertake, and patients were largely unoccupied. The outcome of a safeguarding investigation into the standard of care provided to a patient had not led to more widespread learning. At this inspection, staff spent most of their time with patients. There were a range of purposeful activities for patients, patients were smiling, and staff supported them with activities. Staff treated patients with dignity and respect. The additional input from senior managers had supported staff to become more self-aware and more focused on improving care for patients.
- At the April 2018 inspection, the ward leadership team did not effectively monitor and improve good standards of care and treatment for all patients. At this inspection, the additional support of senior managers had provided clear leadership to the staff team, supporting staff to implement changes and addressing issues with team dynamics. The ward was introducing an improved system of quality and performance monitoring to ensure that standards of care and treatment were monitored and improved.

Summary of findings

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

Are services safe?

As this was a focused inspection we did not change the rating for safe.

Our findings from this inspection were:

- At the April 2018 inspection, we found that patients did not always have a risk assessment completed when they were admitted to the ward. Staff did not review and update patient risk assessments when required. On this inspection, no new patients had been admitted to the ward. Staff reviewed and updated patients' risk assessments.
- At the April 2018 inspection, we found that the visiting GPs did not record their assessments or recommended treatment in patients' electronic care and treatment records. This meant there was no record of patients' physical health assessments or treatment recommendations. At this inspection, GPs recorded this information in patients' electronic care and treatment records.
- At the April 2018 inspection, we found that a safeguarding investigation and the outcome regarding a patient's care had not led to wider learning. The patient's care had improved, but the care of other patients on the ward had not been reviewed to identify if they were also affected. At this inspection, we found that senior managers had supported staff to become more self-aware of their attitudes and behaviours. This had resulted in better staff communication, a clearer focus on patient-centred care and increased staff motivation to improve care for all patients.

Are services effective?

As this was a focussed inspection we did not change the rating for effective.

Our findings from this inspection were:

- During the April 2018 inspection, we found that patients' care plans varied in quality, with some care plans not specific, detailed or meeting all of the patients' needs. At this inspection, patients' care plans were specific and detailed and identified all of the patients' needs and how patients could be supported.
- At the previous inspection in April 2018, we found that there was a lack of activities for patients. As patient leave was allocated on a rotational basis, some patients did not have leave from the ward for more than a week. At this inspection,

we found that the number and range of activities had increased significantly. The activity programme included a range of meaningful activities and social activities, including activities recommended by best practice guidance.

- At the inspection in April 2018, we found that a patient with low bodyweight had not been referred to a dietitian. At this inspection, we found that patients' food preferences were recorded and that they had been referred to the dietitian when required.
- At the April 2018 inspection, we found that the trust policy and national best practice guidance was not followed regarding 'do not resuscitate' decisions for patients. There was no record that staff reviewed these decisions, that patients had a capacity assessment, or that Independent Mental Capacity Advocates (IMCA) were involved in the decision. At this inspection, staff reviewed 'do not resuscitate' decisions and completed capacity assessments. IMCAs had also been involved in the decisions. However, staff had not completed a capacity assessment in sufficient detail for one patient, and the IMCA had not been in the decision for another patient until after the decision had been reviewed and confirmed.
- At this inspection, we found that an informal patient who did not think they were unwell was recorded as consenting to take medicines. Staff had not completed a recorded assessment regarding the patient's capacity to decide whether to take the medicines. It was possible that the patient did not provide informed consent.
- Following the inspection in April 2018, the consultant psychiatrist and GPs had started weekly meetings. This led to improved communication and a formal agreement of how they would work together to provide treatment to patients.

Are services caring?

As this was a focused inspection we did not change the rating for caring.

Our findings from this inspection were:

- During the inspection in April 2018, we found that most staff interactions with patients were brief. Patients had little to occupy them and staff spent more time talking with each other than with patients. We also observed a staff member speaking with a patient in a non-therapeutic manner. Staff left patients alone and appeared preoccupied with routine and tasks. At this

Summary of findings

inspection, we observed staff spending most of their time with patients. Staff supported patients with activities, and patients were engaged, smiling, and appeared happier. Staff treated patients with respect and dignity.

- At the inspection in April 2018, patients' care plans showed that some patients had limited involvement in developing their care plans. Staff wrote patients' care plans with limited information regarding patients' preferences or offering them choices. Instead, they focused on the tasks staff needed to do. At this inspection, patients' care plans showed that staff had involved patients in their development. Staff clearly included patients' preferences and their views of their needs and care in the planning.

Are services well-led?

As this was a focused inspection we did not change the rating for well-led.

Our findings from this inspection were:

- At the inspection in April 2018, we found that the leadership team on the ward did not monitor and maintain good standards of care and treatment for all patients. At this inspection, we found that the trust had provided additional management support to ward leaders and the nursing team. Senior managers spent significant amounts of time on the ward supporting staff, providing clear and visible leadership, involving staff with changes, and addressing cultural, professional and motivational issues amongst the staff team.
- At the April 2018 inspection, we found that the systems used to monitor and improve safety and quality had not been effective in identifying areas of poor care on the ward.

  During this inspection, we found the trust had made changes to the system to monitor and improve standards of quality and safety on the ward. There were new systems in place to monitor the quality of patients' care records, to address staff training needs, and to improve how staff collected and used carer and family feedback. The service had increased the frequency of its performance meetings.
- The trust was developing an older people's care forum to share good practice and develop and improve standards of care and treatment for all older adults receiving support from the trust.

Summary of findings

Information about the service

Oaktree Lodge is a 17 bed ward providing continuing care to older adults with mental health problems. The ward provides care and treatment to male and female patients, and most patients also have physical health problems. There were 10 patients on the ward and two further patients in a general hospital at the time of the inspection.

CQC inspected all of the trust's wards for older adults with mental health problems in April 2016. At that time, the core service was rated as good for being safe, effective, caring, responsive and well-led. The overall rating was good.

We undertook an unannounced inspection of Oaktree Lodge on 9 April 2018. This followed the outcome of a safeguarding investigation. Following that inspection, we served a Warning Notice on the trust, requiring them to make significant improvements. During that inspection, we found breaches of the following regulations:

Health and Social Care Act (Regulated Activities) Regulations 2014

Regulation 9 – Person-centred care

Regulation 10 – Dignity and respect

Regulation 12 – Safe care and treatment

Regulation 17 – Good governance

Following the inspection on 9 April 2018, we told the trust to make the following improvements:

- The provider must ensure that patients are involved in their care to the maximum extent possible. This must include decisions regarding future treatment.
- The provider must ensure that risk assessments of patients are undertaken following admission to the ward and are reviewed regularly. Action must be taken to minimise potential risks.
- The provider must ensure that patients are treated with dignity and respect and that staff interact appropriately with patients.
- The provider must ensure that patients can undertake activities, which promote their autonomy and independence.
- The provider must ensure an effective system is in place to assess, monitor and improve the quality and safety of care provided to patients.

We also recommended that the trust take the following action:

The provider should ensure that patients' care and treatment records include details of assessment and treatment by other healthcare professionals, such as GPs.

Our inspection team

The team was comprised of: two CQC inspectors and a CQC assistant inspector.

Why we carried out this inspection

This unannounced inspection took place following our inspection on 9 April 2018. At the inspection on 9 April 2018, we found a number of breaches of regulations. We served a Warning Notice on the trust, requiring them to make significant improvements. This inspection was to check that those improvements had been made.

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

As this was a focused inspection, we inspected some areas of safe, effective, caring and well-led.

Before the inspection visit, we reviewed information that we held about this service.

During the inspection visit, the inspection team:

- visited the ward and observed how staff cared for patients
- spoke with five patients who were using the service
- spoke with the service manager for older adults mental health services in Greenwich
- spoke with seven other staff members; including nurses, healthcare assistants, an occupational therapist, a physiotherapist, a matron and a student nurse
- looked at four care and treatment records of patients
- observed a shift handover by nursing staff

What people who use the provider's services say

Overall, patients said that staff were nice to them. One patient said that staff picked on them. However, they then identified individual staff members who they thought were nice.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff support patients to make decisions about their care. This includes ensuring that patients have the relevant information when deciding if they wish to consent to treatment and have timely access to an independent mental capacity advocate.

Oxleas NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Oaktree Lodge	Oaktree Lodge

Mental Capacity Act and Deprivation of Liberty Safeguards

At the inspection in April 2018, we found that staff did not review decisions regarding not resuscitating individual patients or record patients' capacity assessments. There was no record that Independent Mental Capacity Advocates (IMCA) supported patients regarding the decision. Staff had not followed the trust policy or national best practice guidance regarding decisions not to resuscitate patients. Staff had completed a patient's care plan that did not account for the decision-specific or fluctuating nature of a person's capacity.

At this inspection, we found that staff completed and documented capacity assessments for all patients with decisions not to resuscitate. Two patients' capacity assessments were specific and detailed. They recorded which parts of the capacity test the patient could or could not meet and why. However, one patient's capacity assessment was not as detailed. The recorded information was basic, and did not explain why the patient could not meet a specific part of the capacity test.

Staff recorded patients' capacity assessments for 'do not resuscitate' decisions on a standard form. They had reviewed the decisions for all patients since the inspection in April 2018. Staff had contacted IMCAs to assess and support patients to try and understand the decisions not to resuscitate them. However, for one patient, the involvement of the IMCA occurred after the decision not to resuscitate the patient had been reviewed and confirmed. This meant that assistance from an IMCA to help the patient understand the decision had not been provided before the decision was confirmed. This was not in accordance with the Mental Capacity Act 2005.

The care plan and medical records of an informal patient indicated that they consistently believed that they were not unwell. However, nursing staff recorded that the patient 'consented' to take medicines. There was no record that a capacity assessment had been undertaken to assess if the patient understood why they were taking medicines. This meant that the patient may have taken medicines without

their consent. The consultant psychiatrist indicated that he had previously had discussions regarding whether it was necessary to detain the patient under the Mental Health Act 1983.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe staffing

Nursing staff

- At the inspection in April 2018, we found that nursing staffing levels consistently met the trust's safe staffing levels for the ward. This was unchanged at this inspection.

Assessing and managing risk to patients and staff

Assessing patient risk

- At the inspection in April 2018, we found that patients did not always have a comprehensive risk assessment when they were admitted to the ward.
- At this inspection, staff reviewed and updated patients' risk assessments. Patients' risk assessments were more detailed, including past and current risks relating to patients' physical health and previous incidents of aggression and violence. No new patients had been admitted to the ward.
- The physiotherapist assessed patients who were at risk of falls. They ensured patients' care plans and risk assessments were up to date regarding the risk of falls. The physiotherapist also developed action plans when patients had fallen. This followed best practice guidance: Falls in older people: assessing risk and prevention (2013), published by the National Institute for Health and Care Excellence (NICE).
- When patients were at risk of developing pressure ulcers, staff completed the Waterlow score. This is a recognised tool for assessing the risk of patients developing pressure ulcers.

Staff access to essential information

- At the inspection in April 2018, we found that there was no record of GP assessments or the treatment they prescribed in patients' care and treatment records. At this inspection, we found that the visiting GPs recorded their assessments and treatment recommendations in patients' electronic care and treatment records.

Reporting incidents and learning from when things go wrong

- At the inspection in April 2018, we found that there had not been widespread learning from the outcome of a safeguarding investigation.
- At this inspection, we found that there had been significant improvements in the safety and quality of care of patients on the ward. Following the inspection in April 2018, senior managers had identified staff attitudes and behaviours, and team dynamics, as contributing to the areas for improvement we identified at the previous inspection. A reflective practice group for staff, increased management support, and clear communication of standards, had supported staff to become more self-aware. This had resulted in better communication amongst the staff team. Staff now communicated better, had a clearer focus on person-centred care, and had an increased focus on improving care for patients.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- During the April 2018 inspection, we found that patients' care plans varied in quality. Some patients' care plans were detailed, specific and met patients' needs, but others did not. Patients' care plans did not always reflect their cognitive problems or physical health needs. They were not always specific, and did not guide staff on how they could support patients most effectively.
- During this inspection we reviewed four patients' care plans. The care plans were detailed and specific and identified all the patients' needs. They also described patients' preferences. For instance, staff had clearly recorded patients' preferences regarding food. Staff had recorded specific and detailed plans to monitor patients' physical he

Best practice in treatment and care

- At the inspection in April 2018, we found that there were very few activities taking place.

  There was a lack of purposeful activities, particularly for patients who had cognitive deterioration. Cognitive deterioration means patients' thinking, memory or concentration is affected. Patients' ability to leave the ward was dependant on how many patients wanted to leave the ward on the same day. This meant that staff rotated the frequency of patients being escorted on leave from the ward. Leave was not always based on patients' needs or wishes and patients might not leave the ward for more than a week.
- During this inspection, staff had developed a new activity programme, and there had been a significant increase in the number of activities on the ward. The activity programme focused on purposeful activity, and included quizzes, baking, painting, sewing and reminiscence activities. Reminiscence activities use historical events to activate people's memories. This type of activity is recommended by NICE for people who have dementia (Supporting people with dementia and their carers on health and social care, 2006). Social group activities in the evenings and weekends included a 'pub night' with non-alcoholic drinks and a movie and popcorn night. Activities were displayed on a board in the ward so that patients could see which activities were planned. All patients could leave the ward at least once per week, and patients went out with staff for lunch, shopping or to a cafe. We observed that patients were more engaged with their surroundings than they were during the inspection in April 2018.
- During the April 2018 inspection, we found that a patient had not been referred to the dietitian for their low body weight. The patient's food likes and dislikes had not been recorded. On this inspection, staff recorded patients' food preferences in their care plans and referred patients to the dietitian when required.
- A physiotherapist assessed patients' physical health needs, providing specialist equipment, and operated a seated exercise group for patients. The physiotherapist also delivered training to nursing staff.

Multi-disciplinary and inter-agency team work

- In addition to the nursing team and consultant psychiatrist, an occupational therapist, activities co-ordinator and physiotherapist spent time on the ward each week assessing and supporting patients. Other specialist staff, such as dietitians, attended the ward when patients had been referred to them.
- Following the inspection in April 2018, the consultant psychiatrist and GPs had started weekly meetings. The arrangements for how the consultant psychiatrist and GPs worked together to meet patients' needs had been formalised. This meant that there was a clearer understanding of different doctors' responsibilities and improved communication.

Good practice in applying the Mental Capacity Act

- At the inspection in April 2018, we found that staff did not review decisions regarding not resuscitating individual patients or record patients' capacity assessments. There was no record that patients had been supported by Independent Mental Capacity Advocates (IMCA) regarding the decision. Staff had not followed the trust policy or national best practice guidance regarding decisions not to resuscitate

patients. A patient's care plan also indicated that staff did not understand that patients' capacity refers to a specific decision, and that a person's capacity can fluctuate.

- At this inspection, staff completed and documented capacity assessments for all of the patients with decisions not to resuscitate. Two patients' capacity assessments were specific and detailed. They recorded which parts of the capacity test the patient could or could not meet and why. However, one patient's capacity assessment was not as detailed. The recorded information was basic, and did not explain why the patient could not meet a specific part of the capacity test.
- Staff recorded patients' capacity assessments for 'do not resuscitate' decisions on a standard form, and they had reviewed all decisions for patients since the inspection in April 2018. Staff had contacted IMCAs to assess and support patients to try and understand the decisions not to resuscitate them. However, for one patient, the involvement of the IMCA occurred after the decision not to resuscitate the patient had been reviewed and confirmed. This meant that assistance from an IMCA to help the patient understand the decision had not been provided before the decision was confirmed. This was not in accordance with the Mental Capacity Act 2005.
- The care plan and medical records of an informal patient indicated that they consistently believed that they were not unwell. However, nursing staff recorded that the patient 'consented' to take medicines. There was no record that a capacity assessment had been undertaken to assess if the patient understood why they were taking medicines. This meant that the patient may have taken medicines without their consent. The consultant psychiatrist indicated that he had previously had discussions regarding whether it was necessary to detain the patient under the Mental Health Act 1983.
- A senior manager in the older adults service had plans to undertake face to face training with nursing staff regarding the Mental Capacity Act 2005.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- During the inspection in April 2018, we found that most staff interactions with patients were brief. Patients sat in communal areas of the ward with little to occupy them, and staff spent more time talking with each other than with patients. We also observed a staff member speaking with a patient in a non-therapeutic way. Patients, and other people we spoke with, told us staff spent little time with patients. Patients were left alone by staff, and staff appeared preoccupied with routine and tasks.
- At the April 2018 inspection, we observed staff spent most of their time with patients. Staff spoke with, and supported, patients in a meaningful way. Staff supported patients with activities, and patients were engaged, smiling, and appeared happier than they did at the April 2018 inspection. Staff treated patients with respect and dignity. Overall, patients said that staff were nice to them. One patient said that staff picked on them, but then described individual staff members they thought were nice.

The involvement of people in the care that they receive

- At the inspection in April 2018, patients' care plans showed that some patients had limited involvement in developing their care plans. Staff wrote all the patients' care plans in a way which recorded what staff needed to do for the patient. There was limited information regarding patients' preferences or offering patients choices in most patients' care plans.
- At this inspection, patients' care plans showed that patients had been involved in their development. Staff clearly recorded patients' preferences and their views regarding their needs and care.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- During the inspection in April 2018, we found that the leadership team on the ward did not monitor and maintain good standards of care and treatment for all patients. They lacked knowledge of some local policies and national guidance.
- At this inspection, we found that the trust had provided additional management support to the ward leaders and the nursing team. This involved senior staff being on the ward for significant periods of time during the week. Staff were involved in changes, and a quality improvement initiative had commenced where staff could make suggestions for improvement. The additional management presence on the ward provided clear and visible leadership to the staff team regarding standards of care.
- Senior leaders had identified cultural, professional and motivational issues amongst the staff group. They had worked to improve communication and cohesiveness amongst staff groups on the ward. Whilst this was a work in progress, staff had developed increased awareness, and found the additional senior management presence on the ward helpful and supportive.
- The ward manager had obtained another post, and the permanent ward manager post for Oaktree Lodge had been advertised. In the interim, an acting ward manager was in post, supported by a senior manager and the matron.

Good governance

- At the April 2018 inspection, we found that the systems used to monitor and improve safety and quality had not been effective in identifying areas of poor care on the ward.
- At this inspection, the trust had improved the system to monitor and improve standards of quality and safety on the ward. Staff reviewed patients' risk assessments and care plans in supervision. Following an analysis of staff training needs, management had developed an ongoing training programme to ensure staff were aware of best practice. The service planned to increase the frequency of performance meetings, and there was an increased focus on learning from feedback from carers and family members. The clinical leads from all professions, such as psychology and occupational therapy, had been involved with working with the staff team.
- The trust was developing an older peoples' care forum, which was due to have its first meeting shortly after the inspection. The purpose of this forum was to share good practice and develop and improve standards of care and treatment for all older adults receiving a service in the trust.