

Oxleas NHS Foundation Trust

Mental health crisis services and health-based places of safety

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)
RPGAE	Oxleas House	Pre-Admission Suite	SE18 4QH

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.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We undertook a focused inspection of the trust's Pre-Admission Suite (PAS) looking only at responsive key question. The inspection was undertaken following information of concern we received about the length of time patients stayed in the PAS and complaints from patients and relatives. As this was a focused inspection of the PAS, we did not change the rating for this core service.

Following this inspection, we issued a letter of intent to the provider informing it that we proposed to impose conditions on the provider's registration in accordance with section 31 of the Health and Social Care Act 2008 because of the serious concerns we had about the length of time patients were staying in the PAS, the inadequate facilities provided to patients for lengths of stay beyond 12 hours, and the overly restrictive environment. We asked the trust to take immediate action to address the issues. The provider responded quickly describing the actions it was taking to minimise risks to patients in the service. The trust informed us it had decided to close the PAS as it failed to meet essential standards of quality and safety in respect of length of stay; patient privacy, dignity and comfort; and access to and from the unit for informal patients. The PAS closed on 27 August 2019. Following the closure of the PAS we told the trust we would take no further action in response to the serious concerns we had identified at the time of the inspection.

Our findings from this inspection were:

- Patients were staying in the Pre-Admission Suite (PAS) for too long. The unit was intended for short stays of under 12 hours, but patients routinely stayed for longer. Between 1 January 2019 – 15 July 2019 151 patients had stayed in the PAS for longer than 12 hours. Sixty-four of these patients had stayed for over 24 hours. Of these, 11 patients had stayed between 2-3 days and 12 patients had waited for 3-8 days. This placed patients at risk of psychological harm. The physical environment and facilities did not meet the needs of people waiting for long periods.
- Patients privacy, dignity and comfort was compromised. The room only contained upright, non-reclining and armless chairs that were not suitable for spending long periods of time on. There were difficulties in accessing meals, snacks and drinks. No bedding was provided, there was a lack of private space and limited access to shower facilities outside the unit. There was no separation of male and female patients and no safe places to store possessions. This compromised patients' dignity, privacy, comfort and recovery.
- The PAS was a potentially overly restrictive environment for patients. The PAS waiting area had restricted access via an entrance door with a key code. Patients could not leave the PAS without permission and when they did leave, staff accompanied them. Patients were not admitted to hospital, not legally detained and had consented to wait in the PAS for admission. Some patients were not happy about the restrictions placed on them, for example not being able to go outside when they wanted to. One person became agitated when he was not allowed to go outside immediately as there was no member of staff available to accompany him at that time.

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 inspect safe.

Are services effective?

As this was a focused inspection we did not inspect effective.

Are services caring?

As this was a focused inspection we did not inspect caring.

Are services responsive to people's needs?

We did not review the rating for responsive as we did not inspect all of this key question and inspected only a small part of the overall core service.

Our findings in respect of responsive were:

- Patients were staying in the Pre-Admission Suite (PAS) for too long. The unit was intended for short stays of under 12 hours, but patients routinely stayed for longer. Between 1 January 2019 – 15 July 2019 151 patients had stayed in the PAS for longer than 12 hours. Sixty-four of these patients had stayed for over 24 hours. Of these, 11 patients had stayed between 2-3 days and 12 patients had waited for 3-8 days. This placed patients at risk of psychological harm. The physical environment and facilities did not meet the needs of people waiting for long periods.
- Patients privacy, dignity and comfort was compromised. The room only contained upright, non-reclining and armless chairs that were not suitable for spending long periods of time on. There were difficulties in accessing meals, snacks and drinks. No bedding was provided, there was a lack of private space and limited access to shower facilities outside the unit. There was no separation of male and female patients and no safe places to store possessions. This compromised patients' dignity, privacy, comfort and recovery.
- The PAS was a potentially overly restrictive environment for patients. The PAS waiting area had restricted access via an entrance door with a key code. Patients could not leave the PAS without permission and when they did leave, staff accompanied them. Patients were not admitted to hospital, not legally detained and had consented to wait in the PAS for admission. Some patients were not happy about the restrictions placed on them, for example not being able to go

Summary of findings

outside when they wanted to. One person became agitated when he was not allowed to go outside immediately as there was no member of staff available to accompany him at that time.

Are services well-led?

As this was a focused inspection we did not inspect well led.

Summary of findings

Information about the service

The Pre-Admission Suite (PAS) is a waiting area for patients who have been assessed as requiring an inpatient admission but are not subject to the Mental Health Act. Patients stay in a waiting area whilst staff try to find a bed on a ward for them. The PAS is located in Oxleas House.

Patients come to the PAS mainly from the emergency department in the acute hospital trust in the building

next door after the psychiatric liaison team have assessed them as needing an informal admission to an inpatient mental health bed. The aim is that patients will wait in the PAS for no longer than 12 hours.

The Greenwich home treatment team manager oversees the running of the PAS. The PAS can accommodate a maximum of four patients waiting for admission. The PAS is staffed by one registered nurse and two non-registered nurses. When the PAS does not have any patients admitted, staff are re-deployed to work in other parts of the trust within Oxleas House.

Our inspection team

The team that inspected the service comprised one CQC inspector, an inspection manager and one specialist advisor with experience of working in mental health crisis services.

Why we carried out this inspection

This was an unannounced focused inspection, due to the concerns we received about this service from complaints and from information provided by the trust regarding lengths of stay.

How we carried out this inspection

To fully understand the experience of people who use services, we usually 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?

However, as this was a focused inspection, we inspected only the responsive key question to follow up the concerning information we had received.

Before the inspection visit, we reviewed information that we held about this service, including information provided by the trust.

During the inspection visit, the inspection team:

- visited the suite, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with three patients who were waiting in the service;
- spoke with the unit manager and a senior manager;
- spoke with three other staff members;
- looked at four care and treatment records of patients; and

Summary of findings

- looked at the operational policy for the unit and other documents relating to the running of the service

What people who use the provider's services say

We spoke to three patients admitted to the Pre-Admission Suite (PAS). All three patients said staff were nice to them. Patients said if they needed anything staff would facilitate this. For example, getting a drink from the separate kitchenette. We observed staff interacting with patients in a thoughtful and respectful way.

However, patients were bored and said there was nothing much to do to keep them occupied apart from watching

the television. Some patients were not happy about the restrictions placed on them, for example not being able to go outside when they wanted to. One person became agitated when he was not allowed to go outside immediately as there was no member of staff available to accompany him at that time.

Oxleas NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Name of service (e.g. ward/unit/team)

Name of CQC registered location

Pre-Admission Suite

OXLEAS House

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

As this was a focused inspection we did not inspect safe on this occasion.

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

As this was a focused inspection we did not inspect effective on this occasion.

Are services caring?

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

Our findings

As this was a focused inspection we did not inspect caring on this occasion.

Are services responsive to people's needs?

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

Our findings

Access and discharge

Most people using the Pre-admission suite (PAS) came via the emergency department of the neighbouring acute hospital trust. Patients were assessed by the psychiatric liaison team and had agreed to an informal admission to a mental health bed. Due to pressures on the acute care pathway a bed was not always identified for the patient immediately. Patients consenting to an informal admission were asked to wait in the PAS until an acute mental health bed became available. Since May 2019, patients were waiting for increasing lengths of time as there were no or limited beds available in the trust or in the independent sector. The trust aimed to keep patients in the PAS for less than 12 hours. Any patient stays of longer than 12 hours were recorded as a breach on the trust's incident reporting system.

Patients were waiting in the PAS for excessively long periods of time. Before the inspection, we requested data from the trust regarding the length of time people were waiting in the PAS. The trust told us that between 1 January 2019 and 15 July 2019 151 patients had waited in the PAS for longer than 12 hours. There were 38 12-hour breaches in May 2019, 45 in June 2019 and 17 in the first two weeks of July 2019. Of the 151 patients who stayed longer than 12 hours, 64 went on to stay over 24 hours. Between 1 March 2019 and 15 July 2019 11 patients waited in the PAS between two and three days. A further 12 patients waited in the PAS for between three and eight days.

During the inspection, we reviewed the records for four patients who had been in the PAS for longer periods of time. We chose these records as we wanted to understand more about the care and treatment the patients received during their time in the PAS. The patients were on the PAS for 41 hours, 21 hours, 50 hours and seven days.

The facilities promote recovery, comfort, dignity and confidentiality

The PAS did not provide an environment that was sufficiently comfortable for patients who were waiting a number of hours. The PAS did not provide an environment that was sufficiently comfortable for patients who were waiting for long periods. Staff supported a maximum of four patients at any time in the PAS. The room contained eight chairs. The chairs were upright, vinyl covered, and

without arms. They did not recline. They were suitable for sitting on but not for sleeping or lying down. There were three patients in the PAS at the time of our visit. Each patient had two chairs pushed together. Some were attempting to lie down although the space available was not enough to do this comfortably.

Staff provided patients with blankets, but said it was against the trust operational policy to provide pillows. They reported this had led to complaints from patients who had stayed overnight and been denied a pillow. We saw patients folding a blanket to make a pillow to rest their head.

The PAS did not have suitable facilities for personal hygiene. The PAS had one toilet and wash basin but no shower facilities. Patients who wanted a shower could use the shower in the health-based place of safety (HBPoS) next door if this was not in use. The HBPoS was in use at the time of our visit, so the shower was not available. Staff said they could take a patient onto an inpatient ward for a shower, if needed, but would need to accompany them. Not all staff we spoke with were aware of this, although a poster in the staff office stated this was possible. Staff provided patients with toiletries and towels could be obtained from the inpatient wards in the same building.

The food and drink provided to the patients in the PAS was very limited. Hot and cold drinks were kept in a locked room and could not be accessed freely by patients as they waited. Due to the long length of time some patients were waiting in the PAS the trust had arranged for patients to obtain hot meals from an inpatient ward in the same building. The ward ordered four extra meals, and these were brought to the PAS at midday and in the evening. Patients could not eat their hot meals at a dining table, they ate their hot meals at their seats.

Staff did not provide patients with any extra activities to occupy themselves whilst they waited. The PAS had one wall mounted television that was difficult for all the patients sitting in the room to see. In addition, only one book was present in the PAS, staff said they had more books, but these had gone missing. This meant patients had no activities to keep them busy or occupied whilst they waited.

There was no door to the PAS waiting area. The waiting area was open onto a corridor that was used by patients and staff including those attending a clozapine clinic in the

Are services responsive to people's needs?

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

clinic room at the end of the corridor. Any patient attending the clozapine clinic would walk past the waiting room to reach the clinic. Similarly, home treatment team staff saw patients in the interview rooms opposite the waiting room. This compromised the privacy and dignity of patients in the PAS.

Both male and female patients were accommodated together in the PAS and shared the one toilet available. At the time of the inspection there were two male patients and one female patient waiting. There was no private space or means of separating patients of different genders.

Patients had access to a garden area leading directly off the waiting area that they could access at all times.

During the inspection, the safety alarm from the inpatient wards kept sounding in the PAS. The alarm was loud and intrusive. This was uncomfortable for patients.

Meeting the needs of all people who use the service

Staff did not always support patients to maintain contact with their families and friends. Patients could have visitors in the PAS but there was limited space as there were only a total of eight chairs. A manager reported it was easier to accommodate visitors if the weather was good enough to use the attached garden. However, at times staff had to restrict the number of visitors to the PAS when it was too crowded.

The environment was overly restrictive for patients who were not admitted to hospital, not detained and consenting to wait for admission. Patients were not free to leave and enter the PAS as it was locked and needed a code for key pad access. Patients could go outside the PAS but had to be accompanied at all times by staff. In addition, if a patient wanted to go home, the doctor would be called to assess them first. All patients were on intermittent observations (every 15 minutes). Staff said this was standard policy and was not based on an individual risk assessment. The information leaflet provided for patients using the PAS stated that patients would be asked to consent to a search of their person and belongings on arrival at the suite. The Mental Health Act Code of Practice states that unless a patient is detained under the Act or is subject to a deprivation of liberty authorisation or Court of Protection order under the Mental Capacity Act, providers and their staff must be careful to ensure that the use of restrictive interventions does not impose restrictions which could amount to a deprivation of liberty. Examples of this include informal patients being prevented from leaving a hospital. The environment was highly restrictive, and their individual needs were not being considered. This put patients at risk of being unlawfully deprived of their liberty.

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

As this was a focused inspection we did not inspect well-led on this occasion.