North Staffordshire Combined Healthcare NHS Trust

Wards for older people with mental health problems

Quality Report

Harplands Hospital
Hilton Road
Stoke on Trent
ST4 6TH
Tel:(01782) 275025
Website:www.combined.nhs.uk

Date of inspection visit: 14 November 2017
Date of publication: 16/04/2018

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RLY88	Harpland's Hospital	Ward 4	ST4 6TH

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare NHS Trust . Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS 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

Contents

Summary of findings

Overall summary

We found:

- There was no evidence to support the claims made that staff left patients at risk from falls or neglect of their personal care needs.
- Patients were all appropriately dressed and had access to the aids they required to reduce their risk of falling. All patients had shoes, slippers or non-slip socks on their feet.
- Staff were attentive to patent's needs and supported patients in maintaining their dignity.
- Patients were involved in activities in groups or as individuals. The activity workers had designed a programme of activities that would engage and stimulate the patients on the ward.
- Staff addressed the continence needs of patients discretely and offered support when needed. There was no evidence that staff had left any urgent continence need unattended.
- The use of restraint was at a low level. Staff were trained in a recognised method of restraint which took into account the potential frailties of the older patient. When staff used restraint they recorded detail of the incident and offered support to the patients afterwards.
- The ward was clean and free of any offensive odours. We found all bedrooms to be clean and ready for use.
- All permanent staff were trained in safeguarding adults and knew how to identify and report any suspected abuse. The ward manager had acted responsively to the concerns raised and concluded an initial investigation.

However:

- There was a failure to effectively monitor the nutrition and hydration of patients identified at risk by medical staff, dietician or through use of the Malnutrition Universal Screening Tool. When fluid input was recorded at less than the prescribed target level no actions were taken to support hydration.
- There was no evidence of any individualised assessments of continence needs despite the use of continence aids for the majority of patients on the ward.
- Bowel movements had been recorded for some patients. However, there was no evidence that staff regularly reviewed these records to consider if a patient was constipated. In patients with an established cognitive deficit, constipation may make that confusion worse and become the cause of delirium.

Summary of findings

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

Are services safe?
We found:

- The ward environment was clean and free of any clutter that could cause falls.
- Staff had completed risk assessments and care plans for patients in all care records we examined.
- Staff were trained in the use of restraint and took into account the challenges faced in managing aggression in older adults.
- Staff had received safeguarding training and knew how to report any suspected abuse. All staff had received safeguarding training for adults to the recommended level.
- The ward manager had immediately investigated the concerns raised and reported the same day to service managers on their findings.

However:

- Managers had not been able to maintain staffing to the levels they had originally planned for qualified nursing staff for day shifts on ward in October 2017 (an average of 85% of hours required were filled). To ensure there were sufficient staff, existing nursing staff and other members of the multidisciplinary team filled the gaps through working additional unplanned hours. Staff from other wards were also required to maintain safe staffing.

Are services effective?
We found:

- Staff had completed physical health assessments for all patients whose records we reviewed. Patients had care plans in place that reflected the personal physical healthcare needs the assessments had identified.
- Members of multi-disciplinary team continued to assess patient's physical healthcare throughout their admission.
- Staff on the ward had received specialist training in the care of people with dementia. Managers had introduced a training programme in July 2017 focused on developing the physical health care knowledge and skills of ward staff.
- Managers had made improvements in the standard of record keeping around recording physical observations as part of the National Early Warning Scores assessment and interventions to reduce the risk of pressure ulcers in high-risk patients.

Summary of findings

- There was also improvement in the number of complete care plans to manage falls risks. Staff were aware of the strategies used to reduce falls and the needs of individual patients for support with mobility.

However,

- Staff had not completed continence assessments in the six care notes reviewed although it was part of their core physical health assessment. Despite this staff could report on the individual continence needs of patients but there were no care plans to support these needs.
- Staff had not always recorded the nutritional and fluid intake and needs of patients or recorded their actions when there was a shortfall. Only one set of records from the six reviewed was complete. This had been a concern on our last inspection visit in October 2017 and the trust had previously given assurance that situation had improved.

Are services caring?

We found:

- Staff were caring and considerate in their interactions with patients. They provided patients with help and emotional support at the time they needed it.
- Staff took the time to explain choices to patients and encourage independent decision-making. When communication was not possible, staff were able to reference details of a patient's preferences in the care notes.
- Patients were appropriately dressed in day clothes and staff offered support to maintain a patients dignity if it was challenged.
- We saw staff discretely prompt patients to use the toilet and attend to patients who needed support with their continence.
- The carers we spoke with were positive about the ward and the care staff provided.
- They reported that staff informed and involved families in their relatives care and discharge planning and provided them with support when needed.

Summary of findings

Information about the service

Ward 4 at Harplands Hospital cares for patients with physical and mental illness. It has 19 beds and treats both men and women as part of shared care initiative with the local acute hospital. The ward opened on 11 November 2016 as a nursing assessment facility to support step down winter capacity in the local acute hospital. There was then an agreement that from 1 April 2017 that the ward would begin a transition towards a shared care model which was complete by the 1 June 2017. Originally, commissioned to provide 15 shared care beds at the time of our inspection there were an additional 4 beds in operation to support capacity pressures at the local acute hospital.

The CQC last inspected ward 4 on 2 October 2017 as part of the wards for older people with mental health problems core service alongside wards 6 and 7. That inspection formed part of the next phase 'well led' inspection of North Staffordshire Combined NHS Trust.

In its post inspection feedback the CQC had alerted the trust in of concerns around the monitoring and recording of aspects of physical healthcare. This included staff failing to complete records of physical health using the National Early Warning Signs (NEWS) assessment, the monitoring of nutrition, hydration, and the recording and planning to reduce falls risks. The trust provided assurances that managers would address these issues and monitor compliance through regularly weekly audits.

Our inspection team

The inspection team comprised of one CQC inspection manager and a CQC inspector.

Why we carried out this inspection

We inspected this service in response to concerns raised about the quality of care on the ward by a member of the public. They had reported that staff were neglecting physical healthcare needs around continence, personal hygiene and failing to reduce the risk of falls and pressure ulcers. There was also an allegation of an incident of physical abuse of one patient and more general concerns that staff did not respect the privacy and dignity of patients. They also reported that there was not enough staff on the ward to provide good care.

The CQC received concerns on 10 November 2017 and alerted the local safeguarding authority who approached the trust. The CQC made an unannounced inspection of the ward on the 14 November for assurance that trust had addressed the issues raised.

How we carried out this inspection

To fully investigate the concerns raised about the safety and wellbeing of people who use this services, we asked the following questions:

- Is it safe?
- Is it effective?
- Is it caring?

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients

Summary of findings

- spoke with the ward managers and modern matron for the ward
- spoke with four other staff members; one staff nurse and three nursing assistants
- spoke with six relatives and carers visiting the ward.

We also:

- looked at six treatment records of patients

looked at a range of policies, procedures and other documents relating to the running of the service

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all patients have an individualised assessment of their continence needs. When staff identifies a continence need the patient receives regular support and this is detailed in a care plan.
- The trust must ensure that for all patients identified at risk of dehydration, malnutrition or requires a special diet or regular fluid intake that staff monitor and review inputs daily. There must be a clear plan of action in place if there is a shortfall in input that might affect the patient's wellbeing.

Action the provider SHOULD take to improve

- The trust should continue with their efforts to recruit a substantive staff team to ward 4 to ensure continuity of care and a consistent approach to physical health issues.

North Staffordshire Combined Healthcare NHS Trust

Wards for older people with mental health problems

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 4	Harplands Hospital

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 and clean environment

Maintenance, cleanliness and infection control

- The ward environment was clean and free of any odour of faeces and urine. The corridors on the ward were free of clutter that reduced falls risk and enabled free access to the rails fitted to support patients walking safely.

Safe staffing

Nursing staff

- Managers had calculated the number and grade of nurses and healthcare assistants required on each shift. The nursing director and board regularly reviewed these calculations in line with national guidance. Staff on the ward assessed the care need of patients twice daily to determine the level of staffing required at that time. When more staff than planned were required they asked the temporary staffing team for support in filling the roles required.
- Trust gave the CQC an update on vacancies on the 20 October 2017 reflecting progress in filling vacancies previously reported on ward 4. Managers told us there were three healthcare assistant vacancies and six qualified nursing vacancies. They had completed shortlisting for all the vacant posts and had interviews arranged for early November 2017.
- Managers supported ongoing staff vacancies across older people's wards through temporary staffing and filled with familiar bank / agency staff where possible. To manage longer term gaps, they block booked agency staff to ensure that patients' needs are continually met and they are familiar with the ward routines.
- However, managers had not been able to maintain staffing to the levels they originally planned for qualified nursing staff for day shifts on ward in October 2017 (an average of 85% of hours required were filled). Existing nursing staff filled the gaps through working additional unplanned hours or staff from other wards provided support to maintain safe staffing. During the day shifts, other members of the multi-disciplinary team were available to support the safe care of patients on the ward and supported nursing staff in their duties. Overall this was an improvement on the situation between June to August 2017 when only 76% of qualified nursing staff hours required had been filled. The impact of these shortfalls, as reported by staff, was to leave them feeling more tired and stressed in their work. The trust recognised the burden this placed upon staff and was providing them with additional support to manage workplace stress.
- Managers could also access additional staff from the bank or via an agency to maintain safe staffing when there was sickness, other absences and increased demand for care staff.

Assessing and managing risk to patients and staff

- We looked at six care records of patients and found that each of these contained a detailed up to date risk assessment.
- When staff had identified a patient to be at risk there were care plans in place to support them. Staff increased the level of supervision and support they offered to patients in line with the needs of patients at risk. Staff had completed all observation records in the sample we reviewed.

Use of restrictive interventions

- Staff were trained in the use of a recognised method of restraint and took into account the particular challenges faced in managing aggression in older adults. Staff only used restraint after de-escalation had failed.

Safeguarding

- Staff we interviewed were very clear about how they would recognise and report any suspected abuse. All staff had received safeguarding training for adults to the recommended level. We did not observe any patients with obvious injuries (no observable bruises/injuries to faces/exposed arms). We reviewed recent incidents and found staff had followed all falls and any incidents of aggression with immediate assessment for any injury and medical review sought.

Are services safe?

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

- The ward manager had acted promptly on notice of the concerns raised about care on the ward. They had provided initial feedback and assurance to managers by the end of the day the concerns were received. They had discussed the concerns with the patient involved in the specific claims and reviewed their care notes. They had found no grounds to uphold the complaint about mistreatment.

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

- Staff had completed physical health assessments on admission for all six patients whose records we reviewed. This included a physical health review led by a member of the multi disciplinary team (MDT) and physical health review continued throughout a patient's admission.
- To improve consistency and the regularity of physical health reviews the trust told us that they would strengthen this process and reduce duplication, by combining the individual physical health practitioner reviews and the weekly multi disciplinary team meeting.
- However, there were no continence assessments completed in the six care notes reviewed although it formed part of the core physical health record. Despite this staff reported that 14 out of 16 patients they could report on had a continence aid (full pad or pull up) in place. We found staff had only written down details of continence aids required by individuals in some patient's bedrooms.
- Staff awareness of individual continence needs was by verbal handover. Staff had not recorded continence needs in the written handover documents. Information was available in initial assessments shared by the acute hospital team. The trust had responded to these findings by introducing a standard operational procedure to support staff in the assessment and care planning for continence needs.
- The risks of failing to adequately monitor and support continence in this patient group were significant. A person with dementia suffering constipation or a urinary tract infection would be at high risk of rapidly developing a further degree of confusion (delirium). This would lead to increased risk of harm to themselves or others.

Best practice in treatment and care

- We saw patients engaged in activities with staff members during the afternoon of our visit. Activity workers planned a programme of activities for individuals and groups. They took into consideration personal preferences and abilities of individual patients when designing the activity programme. Working with colleagues on the other two older adult wards the activity workers could offer a broader range of activities making use of resources off the ward.
- We reviewed six care records in detail for assurance that staff adequately monitored physical health problems identified at admission and responded to any changes. On our inspection visit on 2 October 2017, we had raised concerns about inconsistency in care planning and monitoring arounds falls, the National Early Warning Scores and hydration.
- The trust had addressed these concerns directly with staff and introduced a weekly audit to monitor compliance. Managers demonstrated that in the first three weeks of using this new audit compliance had increased in all three areas.
- Staff had recorded and completed the falls screening tool for all six patients. They had completed action plans for three out of five patients. However, during our interviews we found staff to have a good awareness of falls risk. Patients had anti-slip socks in place, in line with falls protection plans and no patients on the ward were barefoot.
- Staff on the ward used the National Early Warning Score (NEWS) to assess the well-being of patients through a set of basic physical observations. When staff observed a measurement (such as pulse rate) outside of the normal range, it registered a score on the scale. Staff summed up scores across all the observations and took the action advised within the scoring sheet to escalate any concerns to nursing, medical or emergency services staff. Staff had completed all NEWS required and had escalated any concerns in line with the appropriate guidance. This was an improvement on our October findings when 17% of NEWS records had been missing or incomplete.
- There was daily monitoring by staff for all three patients at high risk of developing a pressure ulcer. Staff ensured that they regularly moved all patients at risk to relieve pressure. They maintained a record of all changes in position of bed bound and immobile patients. All patients had a recognised pressure risk-screening tool completed.
- Staff had not always effectively recorded the nutritional and fluid intake needs of patients. They had

documented the indications for monitoring food and fluids in care plans but had not included them for reference on to the monitoring sheets or handover reports. The dietician's recommendations about consistency of food and the need for thickened fluids was also not included but recorded on a noticeboard in the kitchen.

- Staff had totalled the inputs at the end of the day in only one set of food and fluid charts out of six. This fell short of the trusts policy requirement that a qualified nurse should review that the patient take at least 1200 mls of fluid per day. On two days out of six only 300 mls was recorded with no actions noted to alert medical staff. Another three recorded intake below 1200mls and no actions noted. Only one day recorded above goal.
- The trust's last internal audit on the 6 November 2017 had reported that the ward had achieved 100% compliance with the trusts standard around keeping records of nutrition and hydration. This had reflected steady improvement since the beginning of October and our first inspection visit when we had raised concerns. Our findings on this visit were that the reported staff had not maintained these improvements.
- Managers had not introduced a system for monitoring continence needs. Staff did not always record when they made checks on individuals or any outcomes other than a positive bowel movement. However, staff members reported regularly asking patients if they needed to use the toilet and we observed them doing so at the beginning and end of the lunchtime meal.
- We shared our concerns with the trust about monitoring of hydration/nutrition and continence care immediately after our visit. They told us that they planned to make further improvements in the forms used to record nutrition and hydration. They also planned to introduce a standard operational procedure to support staff in managing continence needs.

Skilled staff to deliver care

- Staff on the ward had received training in working with people with dementia. The physical healthcare team were responsible for training nursing staff in physical healthcare skills. This team based this training on a competency framework developed by Health Education England. The framework contains sections on monitoring vital signs, pressure ulcer, diabetes care and other areas of concern in physical healthcare. This included continence care needs and the team was rolling this out to staff on the ward at the time of our inspection.

Are services caring?

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

Our findings

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We observed staff being caring and compassionate in their interactions with patients in distress. During a mealtime, we observed staff taking time to offer patients a choice of food and explaining the choices available. When patients required support staff offered it immediately.
- The majority of patients fully dressed in day clothes and staff offered support to any patient whose dignity was at risk. Three out of 17 were dressed in a combination of day clothes and pyjamas. Staff explained that they were waiting for relatives to return clothes from washing. We saw no evidence to support the concern that continence aids were visible and some patients had not had their continence needs attended to promptly.
- Patients said staff treated them well and behaved appropriately towards them. We observed a lunchtime meal service and heard patients thank staff for their time and support.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Regular staff and regular bank staff held detailed knowledge of the preferences and needs of the patients they cared for.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

The involvement of people in the care they receive

Involvement of families and carers

- We spoke with six family carers' visiting the ward on the afternoon of our inspection. All reported being regular visitors to the ward. Four of the six visited their relatives daily. They reported always finding staff available to discuss their relative's progress with them.
- No relatives reported that they felt that staff had failed to meet their relative's personal care needs. One relative commended staff for their patience and tenacity in persuading their attempts to accept help.
- Staff informed and involved families and carers appropriately and provided them with support when needed.
- Staff enabled families and carers to give feedback on the service they received.
- The feedback from of carers interviewed was overwhelmingly positive about the ward and staff. General feedback from carers to the ward was also positive and evidenced in the compliments received by the trust and thank you cards displayed on the ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a failure to fully assess and do all that was reasonably practical to mitigate physical healthcare risks