North East London NHS Foundation Trust

# Acute wards for adults of working age and psychiatric intensive care units

## Quality Report

**Sunflowers Court**
Goodmayes Hospital, 157 Barley Lane, Goodmayes,
Ilford, IG3 8XJ
Tel: 08446001200.
Website: www.nelft.nhs.uk

Date of inspection visit: 21 October 2015
Date of publication: 26/01/2016

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RATY1 | Sunflowers Court | Ogura ward<br>Titian ward | IG3 8XJ |

This report describes our judgement of the quality of care provided within this core service by North East London 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 North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London 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 carried out our previous inspection of acute wards for adults of working age and psychiatric intensive care units at Sunflowers Court in December 2014. This was completed under our previous inspection regime. Consequently, we did not rate the service.

This focused inspection, carried out on 20 October 2015, checked whether North East London NHS Foundation Trust had made improvements in relation to those areas where the service was previously non-compliant with health and social care regulations.

We will rate acute wards for adults of working age and psychiatric intensive care units at our next comprehensive inspection of North East London NHS Foundation Trust.

This inspection found:

- Staff prescribed and managed anti-psychotic and sedative medicines safely. Staff followed trust procedures to ensure they protected patients from the risk of over-sedation.
- Staff carried out appropriate checks on the physical health of patients.
- Staff knew how to access emergency equipment, such as ligature equipment, in an emergency.
- Staff had developed individual plans to manage risks to the health and safety of each patient.
- Staff treated patients with kindness and respect. Staff involved patients and their relatives appropriately in planning and reviewing their care and treatment.
- Activities were available to patients on Titian and Ogura wards.
- Patients on both wards were able to access information about how to complain and advocates visited the wards.

However:

- Staff did not always explain in the notes of community meetings how they would address the complaints and concerns patients had raised.
- Whilst staff appropriately observed patients assessed as being at risk, we identified a number of ligature points on Titian ward. The trust had not completed a risk assessment to identify all the ligature points on the ward and the trust did not have an action plan or schedule of works that explained how the trust would address these risks. Staff had not appropriately assessed or managed potential ligature risks associated with the use of plastic bin bags in communal areas of the ward.
- Patients could not always keep their possessions secure because on Titian ward there was a blanket ban on patients having the key to the locker in their bedroom. Senior managers informed us during the inspection that they would immediately rectify this and patients would receive a key to their locker unless this posed a risk to health and safety.

# Summary of findings

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

### Are services safe?

- Staff prescribed and managed anti-psychotic and sedative medicines safely. Staff followed trust procedures to ensure they protected patients from the risk of over-sedation.
- Staff carried out appropriate checks on the physical health of patients.
- Staff knew how to access emergency equipment, such as ligature equipment, in an emergency.
- Staff had developed individual plans to manage the risks to the health and safety of each patient.
- Whilst staff appropriately observed patients assessed as being at risk, a number of ligature points were identified on Titian ward. The trust had not completed a risk assessment to identify all the ligature points on the ward and the trust did not have an action plan or schedule of works that explained how the trust would address potential ligature risks. Staff had not recognised or managed potential ligature risks associated with the use of plastic bin bags in communal areas of the ward.

### Are services effective?

We did not inspect the service in relation to this question during this focused inspection. We will report on this question and provide a rating after the next comprehensive inspection of the service.

### Are services caring?

This focused inspection found:

- Staff treated patients with kindness and respect.
- Staff involved patients and their relatives appropriately in planning and reviewing their care and treatment.

### Are services responsive to people's needs?

- Patients could not always keep their possessions secure because on Titian ward there was a blanket ban on patients having the key to the locker in their bedroom. Senior managers informed us during the inspection that they would immediately rectify this and they would give patients a key to their locker unless this posed a risk to health and safety.
- Patients on Titian and Ogura wards told us there were activities available to them.

# Summary of findings

- Patients on both wards were able to access information about how to complain and advocates visited the wards. However, staff did not always explain in the notes of community meetings how they would address the complaints and concerns patients had raised.

**Are services well-led?**

We did not inspect the service in relation to this question during this focused inspection. We will report on this question and provide a rating after the next comprehensive inspection of the service.

# Summary of findings

## Information about the service

**At this focused inspection, we visited an acute ward and the psychiatric intensive care unit (PICU).**

Ogura ward is an acute mental health unit for up to 20 adult male patients. The service cares for men suffering from acute mental health problems, who are in crisis and who cannot be cared for at home due to the level of risk they present to themselves or others.

Titian ward is a psychiatric intensive care unit (PICU) for up to 15 adult male patients.Patients on Titian ward present a high risk to themselves and/or others, or are at risk of absconsion and it is believed the risk cannot be safely managed in an acute environment.

The multi-disciplinary teams on both wards include a medical team, consultant psychiatrist, nurses, psychologists and occupational therapists.

## Our inspection team

The team that inspected Ogura and Titian wards consisted of five people: two CQC inspectors, an inspection manager, a nurse specialist advisor, a pharmacy inspector and an expert by experience. The expert by experience is a person who has developed expertise in relation to health services by using them.

## Why we carried out this inspection

At our previous inspection of acute wards for adults of working age and psychiatric intensive care units at Sunflowers Court in December 2014, we found the service was not compliant with all the required health and social care regulations. We identified that regulations were not being met because:

- Staff had not always planned how to manage risks to patients' health and safety.
- On Titian ward, staff had not always followed trust guidance in relation to the management of patient prescriptions for sedative and anti-psychotic medicines. Patients were consequently at risk of being over-sedated and of not receiving the appropriate checks of physical health.
- Staff had not always taken patients' views and experiences into account when planning their care and treatment. They did not always give patients appropriate information in relation to their care.
- There was a lack of opportunities and support for people in relation to activities and promoting their autonomy.

We asked North East London NHS Foundation Trust to make improvements. We carried out this focused inspection on 20 October 2015 to check whether the trust had taken effective action to ensure the service complied with the required standards.

## How we carried out this inspection

This inspection was focused on checking whether the service was meeting the required standards in relation to:

- How staff managed risks to patients.
- The management of medicines on Titian ward.
- Patient involvement in planning their care and treatment.
- Patient access to activities.

# Summary of findings

Before the inspection visit, we reviewed information that we held about the service. During the inspection visit, the inspection team:

- Visited Ogura and Titian ward.
- Read four patient records on Ogura ward and three patient records on Titian ward.
- Spoke with seven patients on Ogura ward and three patients on Titian ward.
- Check how staff managed medicines and read 12 prescription records on Titian ward
- Spoke with the manager for each ward.
- Spoke with seven other staff members, including doctors, nurses and a pharmacist.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure that risks to patients from ligature anchor points are identified and assessed and appropriate works to address them scheduled.
- The trust must ensure that appropriate steps are taken to address the potential ligature risks posed by the use of plastic bin bags in communal areas of the wards.

### Action the provider SHOULD take to improve

- The trust should ensure that the minutes of community meetings explain how staff will address the complaints and concerns raised by patients.
- The trust should ensure staff support patients to make advance directives about their care and treatment

North East London NHS Foundation Trust

# Acute wards for adults of working age and psychiatric intensive care units

**Detailed findings**

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Ogura ward | Sunflowers Court |
| Titian ward | Sunflowers Court |

# 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

- On Titian ward, patient bedrooms were clean and well-maintained. The trust had taken action to minimise risks to patients by reducing ligature points in the bedrooms. For example, there were pull-down curtain rails, anti-ligature taps and shower heads. However, each en suite (and all the communal toilets) had toilet roll holders, paper tower holders and soap dispensers that all potentially provided ligature points, as did the actual en-suite door itself, as it had standard hinges.
- The deputy manager told us that the matron had carried out a recent ligature audit on Titian ward, but no written information on the outcome of this audit was available at the time of the inspection. The trust had no formal record of ligature points and no action plan in relation to how and when risks would be addressed.
- The ward manager explained the measures which were in place on Titian wards to mitigate identified ligature risks – for example, the communal bathroom (which had standard taps which were a ligature point) was kept locked and access was risk assessed. They told us the multi-disciplinary team supported patients at risk of self-harm by means of a care plan that included one to one observation by staff. Staff nursed patients at higher risk of self-harm in bedrooms closer to the nursing office. In addition, staff carried out hourly observations of all parts of the ward.
- Plastic bin bags were being used in three waste bins on communal areas of Titian ward. A recent serious incident had occurred within Sunflowers Court that had involved the use of a plastic bag. Staff on Titian ward were not able to identify where plastic bin bags were used on the ward, or the potential ligature risk they posed. We raised this with the Director of Nursing during our visit for immediate follow up; they advised that a policy and procedure regarding plastic bags was in development and that staff had been issued with interim guidance.
- At our previous inspection in December 2014, we found that patients were at risk because some staff did not know the location of ligature cutters to use in an emergency. The trust told us that, since our previous inspection, staff have received additional training and supervision in relation to accessing emergency equipment.
- At this inspection, we found that patients were now safe in relation to this issue. We spoke with five staff on Ogura ward and four staff on Titian ward. They were all able to show us the location of the ligature cutters**.**
- Staff had kept records that confirmed they had checked emergency equipment each day. This reduced risks by ensuring this equipment was readily accessible and well-maintained.

### Assessing and managing risk to patients and staff

- At our previous inspection, in December 2014, we found that staff had identified and reviewed the risks to each patient but had not developed management plans to ensure that these risks were minimised.
- Following that inspection, the trust management team told us they had taken action to improve the management of risks to patients. At this inspection, ward managers told us care records were now checked during supervision sessions and there were weekly audits of care records to ensure that every patient has an up to date, comprehensive risk management plan.
- At this inspection, we confirmed that the multi-disciplinary team had made arrangements to manage risks to people. Staff told us they reviewed the current risks to each patient during nursing handovers (three times each day) and management handovers (with the ward doctors once each day).
- We read three care records on Titian ward and four care records on Ogura ward. Staff had made appropriate plans to manage individual risks to patients. For example, in the case of a patient on Ogura ward, the multi-disciplinary team had amended the arrangements for a patient's home leave in the light of an incident that had occurred. In another instance, the clinical team on Titian ward had ensured that a patient who was at risk

of self-harm was asked about their anxieties in daily one to one sessions. The staff team had then made plans to vary the way they observed and supported the patient in accordance with their mood.

- Staff were undertaking audits each week to check whether risk assessments and management plans were up to date. We noted that these audits did not identify good practice or areas for further development. This meant their use as a tool for continuous improvement were limited. Senior managers told us they were in the process of introducing new audit systems with a focus on the quality and accuracy of record keeping.
- In December 2014, patients were at risk on Titian ward because staff were not following trust guidance on safely managing antipsychotic and sedative medicines. During that inspection, we observed that some patients on Titian ward were asleep or appeared drowsy during the day. Staff had prescribed high dose antipsychotic medicines and regular doses of sedating benzodiazepines to some patients. However, staff had not recorded the rationale for this in the patient notes. In addition, staff had not effectively put into practice trust procedures to identify and alert the responsible clinical team to this group of patients. Consequently, patients on high dose antipsychotic medicines were at risk of not receiving the appropriate follow up and healthcare. This meant their physical health was at risk.
- At this inspection, we found that the trust had taken effective action to ensure staff safely managed antipsychotic and sedative medicines. Staff told us they were aware of trust guidance on this issue. They told us that since the last inspection, a pharmacist and psychiatrist had reviewed each patient's prescription and made the necessary changes to comply with trust procedures.
- We checked the prescription charts and care records related to medicines for all 12 patients on Titian Ward. The action taken by the trust had led to an overall reduction in the use of sedating medicines. We observed that patients were not sleepy and were able to participate in activities and talk with staff.
- We saw evidence in patient records of detailed daily input by the ward pharmacist. They had promptly identified any patient who was prescribed high dose antipsychotics and ensured a monitoring form was kept with the patient's prescription charts. This form detailed the arrangements staff should make to ensure they monitored the patient's physical health in line with trust guidance. Care records confirmed staff had arranged for patients to have the appropriate health checks. If the patient had declined a health check, staff had documented this and further attempts had been made to encourage the patient to have the check.
- Staff had recorded their rationale when they prescribed a patient regular doses of sedative benzodiazepines. Additionally, medical staff had made a clear plan, documented in the patient's notes, to decrease the dose and frequency of these medicines. This showed clinicians were taking action to ensure they managed sedative medicines safely.

# 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

We did not inspect the service in relation to this question during this focused inspection. We will report on this question and provide a rating after the next comprehensive inspection of the service.

# 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

- At our previous inspection of the service in December 2014, we observed that staff did not always provide patients with appropriate and respectful support. For example, on Titian ward we observed that staff did not initiate conversations with patients and only responded when a patient made a direct request for support.
- At this inspection, we found staff treated people with kindness and respect. We spoke with seven patients on Ogura ward and three patients on Titian ward. Patients reported that staff were responsive and helpful. We spoke with seven staff across both wards. They knew how to treat patients with dignity and respect. For example, a nurse on Titian ward explained to us how they were aware of their body language and tone of voice when talking with patients and aimed to ensure that patients felt they had received a positive response from them.
- During the course of the inspection, we observed responsive, discreet and respectful interactions between patients and staff that met patients' practical and emotional needs.

The involvement of people in the care that they receive

- At our December 2014 inspection, we found staff had not taken p
- During this inspection, we found staff had involved patients in planning their care and treatment on both wards. Three patients on Titian ward and seven patients on Ogura ward told us staff had discussed their care and treatment with them. They said staff had developed a care plan with their involvement and that they had received a copy of it.
- The three care records we checked on Titian ward and the four records we checked on Ogura ward included evidence that staff had discussed care and treatment with patients. For example, staff had made a daily record of each patient's progress that included information about how staff had engaged with them and the patient's views of their care and treatment.
- Patients told us staff listened to their views. For example, a patient told us staff had responded to their concerns about the side effects of a medicine.
- The care records we viewed showed that with the patient's agreement, their relatives were involved in planning and reviewing the patient's care and treatment. For example, care records showed the family member of a patient on Ogura ward had been involved in meetings with the multi-disciplinary team to discuss the patient's treatment and discharge plan.
- We noted that care records did not include any advance directives from patients in relation to their wishes about their care and treatment. A senior manager told us that, although the trust had a policy on advance directives, there had not been an associated implementation plan to promote their use. Staff had not been trained to promote the use of advance directives and consequently, patients seldom used them.

# Are services responsive to people's needs?

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

## Our findings

### The facilities promote recovery, comfort, dignity and confidentiality

- At our previous inspection, patients told us they did not have somewhere secure to store their possessions. At this inspection, we found that patients had a safe for valuables in their bedroom. However, patients on Titian ward were not able to use their safe because of a blanket ban on the use of small keys on the ward. We raised this with senior managers during the inspection. The managers told us they would immediately rectify this by arranging for staff to assess the risks for each patient in relation to them having their own key. They said they would then ensure patients had a key to their safe as appropriate.
- At our previous inspection, patients reported they were bored and there was a lack of available activities. At this inspection, patients on Titian ward told us they could play table tennis or basketball. Some patients told us they went to art therapy sessions and a newspaper group. Patients on Ogura ward told us they played pool and watched the television. Patients on both wards told us there were less organised activities at weekends but they were able to play board games and watch films.
- During the inspection, we observed patients engaged in meaningful activities with staff including table tennis, one to one sessions and reading newspapers. Occupational therapy staff told us about a range of activities that were available on Titian ward including a social cooking group each week..

### Meeting the needs of all people who use the service

- At our previous inspection, we found a lack of readily accessible information on display in the wards for patients. For example, in relation to how people could make a complaint or contact external services, such as advocacy and the Care Quality Commission.
- At this inspection, we noted there were no notice boards on Titian ward. Staff told us the noticeboards had been recently damaged.Therefore, there was no information displayed about how to make a complaint. Information about the advocacy service was displayed in the nursing office window. During the inspection visit, advocacy staff visited the ward and spoke to patients individually.
- We read notes of recent community meetings. They showed staff used the meetings to inform patients about the advocacy service which patients could use to assist them to make a complaint. Staff also explained to patients how they could get more information about their treatment.
- The minutes recorded issues patients raised as complaints or compliments. It was not clear from these notes that staff advised patients of the trust formal complaints procedure when they raised concerns about their care and treatment at these meetings.
- The 15 October 2015 notes of the Ogura ward community meeting stated that a patient made a request in relation to food. There was no explanation about what staff would do in response.

# 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

**We did not inspect the service in relation to this question during this focused inspection. We will report on this question and provide a rating after the next comprehensive inspection of the service.**

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br>The trust had not ensured that risks to patients from ligature anchor points were identified and assessed and appropriate works to address them scheduled. The trust had not ensured that appropriate steps were taken to address the potential ligature risks posed by the use of plastic bin bags in communal areas of the ward.<br><br>**This was a breach of regulation 15(1).** |