Good

Oxleas NHS Foundation Trust

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

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)
RPGAD	Green Parks House	Betts Ward Norman Ward Goddington Ward	BR6 8NY
RPGAE	Oxleas House	Avery Ward Maryon Ward Shrewsbury Ward The Tarn	SE18 4QH
RPGAH	Woodlands Unit	Lesney Ward Millbrook Ward	DA14 6LT

Summary of findings

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

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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Overall summary

We re-rated acute wards for working age adults and psychiatric intensive care units as good because:

- Following our inspection in April 2016, we rated the services as good for effective and caring.
- During this most recent inspection, we found that the services had addressed the issues that had caused us to rate safe, responsive and well led as inadequate following the April 2016 inspection.
- The acute wards for adults of working age and psychiatric intensive care units were now meeting Regulations 9, 10 and 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Summary of findings

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

Are services safe?

Good

We re-rated safe as **good** because:

- The service had addressed the issues that had caused us to rate safe as inadequate following the April 2016 inspection.
- In April 2016, we found that the trust had breached same sex accommodation guidelines on multiple occasions. Risk assessments for ligature risks on the wards did not include all areas of the wards. Staff were unaware of all of the environmental risks on the wards. We also found that medicine charts were in poor condition and there was inconsistent recording and reviewing of prescribed medicines. When we visited in February/March 2017 there had been no same sex accommodation breaches for four months. Ligature risk assessments covered all areas of the wards and included photographs of the ligatures. This meant staff could easily identify the ligature risks in each room or area. All of the nursing staff were aware of these risks. Medicine charts were fully completed and clearly recorded prescribed medicines and doses. Since the last inspection, medicine charts had changed and the quality of the charts was better.
- During the current inspection we also found that the trust had started implementing 'safewards' on the acute wards. This is a recognised way of working which reduces incidents of conflict, violence and aggression. Staffing levels on the acute wards had also increased. Three registered nurses and two healthcare assistants worked during the day shifts. The number of incidents involving patients being restrained by staff had significantly decreased. Staff were aware that prone restraint should not be used wherever possible.
- The number of incidents of patient restraint had reduced by a third since the previous inspection.

However:

- We found that when patients were restrained, half of these restraints involved patients being restrained in the prone position, which put them at increased risk of avoidable harm. The number of incidents of restraint overall had decreased significantly since April 2016.
- Patients had to hand in shoelaces and hooded top cords for the first three days of their admission to hospital. This was a blanket practice affecting all patients and was not based on individual risk assessment.

Summary of findings

- Although the review of 'as required' medicines had improved since the inspection in April 2016 we found several medicine administration records where 'as required' medicines that were not being administered had not been reviewed. Similarly a few patients had received medicine to help them sleep for more than three weeks without review of the prescription

Are services effective?

Good

We rated effective as **good** because:

- At the last inspection in April 2016 we rated effective as **good.**
- During this inspection we found that care plans were detailed and specific to the patient, and met the patients' needs. Most patients' care plans showed that patients had been involved in their development. The majority of patients reported that they had been given a copy of their care plan.

Are services caring?

Good

At the last inspection in April 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Patients we spoke with during the current inspection knew what was in their care plans and most had been involved in developing their care plans. Most patients had a copy of their care plan. Overall, patients found staff helpful and some patients were very positive regarding staff.

Are services responsive to people's needs?

Good

We re-rated responsive as **good** because:

- The service had addressed the issues that had caused us to rate responsive as inadequate following the April 2016 inspection.
- In April 2016, we found that most wards had bed occupancy levels above 100%. When patients returned from leave, a bed had to be found for them. The lack of available beds meant patients were having to sleep for the night on other wards. In addition, some patients waited on a ward whilst a bed was found. On occasions, patients slept for the night on sofas. When we visited in February/March 2017, we found significant improvements. Bed occupancy was almost always under 100%. Since the last inspection the trust had contracted for an additional 12 beds in a neighbouring NHS trust. When patients went on overnight leave, their bed remained available for them for the next 24 hours. Patients were no longer required to sleep on sofas or other wards due to a lack of available beds. A pre-admission suite had recently opened at Oxleas House. The

Summary of findings

suite had space for four patients to wait for a bed to be found for them. Staff reported that the additional 12 beds and new bed management system had a major impact. Patients and families were less frustrated, wards were safer, and staff had more time to provide care to patients.

Are services well-led?

Good

W**e** re-rated well-led as **good** because:

- The service had addressed the issues that had caused us to rate well-led as inadequate following the April 2016 inspection.
- In April 2016, we found that local risk registers were not available. During the February/March 2017 inspection, we found local risk registers on all wards. The risks included on the risk registers included staffing levels, blind spots, violence and fire risk. Staff understood what items were on the risk registers, and these were discussed in staff team meetings. Staff understood the actions required to minimise risks on the risk registers.
- The trust board was clearly sighted on the pressures affecting the acute wards and PICU. It was closely monitoring progress with plans for sustainable improvement.

Summary of findings

Information about the service

Green Parks House, Oxleas House and the Woodlands Unit are part of Oxleas NHS Foundation Trust. The wards provide care and support for people aged 18 and over living with mental illness in the London boroughs of Bexley, Bromley and Greenwich. Patients are admitted informally or as detained patients under the Mental Health Act 1983.

We inspected the following wards:.

Green Parks House:

Betts Ward – a 18 bed mixed gender ward

Goddington Ward – a 17 bed mixed gender ward

Norman Ward – a 17 bed mixed gender ward

Oxleas House:

Avery Ward – a 20 bed female ward

Maryon Ward – a 20 bed male ward

Shrewsbury Ward – a 20 bed male ward

The Tarn – a 16 bed male psychiatric intensive care unit

Woodlands Unit:

Lesney Ward – a 20 bed mixed gender ward

Millbrook Ward – a 20 bed mixed gender ward

When the CQC inspected the trust in April 2016, we found that the trust had breached regulations. We issued the trust with three requirement notices for acute wards for adults of working age and psychiatric intensive care units. These related to the following regulations under the 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

Our inspection team

Our inspection team was led by:

Team Leader: Jane Ray, Head of Hospital Inspection (mental health) Care Quality Commission

The team that inspected acute wards for adults of working age and the psychiatric intensive care units consisted of three inspectors and two specialist advisors, who were senior nurses with experience of working in mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether Oxleas NHS Foundation Trust had made improvements to their acute wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection of the trust in April 2016.

When we last inspected the trust in April 2016, we rated acute wards for adults of working age and psychiatric intensive care units as inadequate overall.

We rated the core service as inadequate for safe, responsive and well-led, and good for effective and caring.

Following the April 2016 inspection, we told the trust it must make the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- The trust must take action to reduce the number of same sex accommodation breaches.
- The trust must ensure that effective bed management systems are in place to avoid patients having to sleep on sofas and in lounges.
- The trust must ensure that medication cards are accurate and reflect any risks in relation to prescribed medication.

Summary of findings

- The trust must ensure that ligature assessments are carried out for all ward areas.
- The trust must ensure that all care plans are person centred and that patients receive a copy of this where applicable.
- The trust must take action to address and develop local risk registers to include actions and timescales implemented to manage the risk identified.

These related to the following regulations under the 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

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?

Before the inspection, we reviewed information that we held about acute wards for adults of working age and psychiatric intensive care units. We also requested information from the Trust and other organisations. This information suggested that the rating of good for caring made following our April 2016 inspection was still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as inadequate for safe, responsive and well led. We also checked that the rating of good for effective was still valid regarding patients' care planning. We also made a recommendation at the last inspection which was followed up at this inspection. We gave the trust one week notice of the inspection.

During the inspection visit, the inspection team:

- visited all nine acute wards and a psychiatric intensive care unit at the three hospital sites and looked at the quality of the ward environment
- spoke with 28 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 30 other staff members including doctors, nurses, modern matrons, healthcare assistants, an administrator and an estates and facilities manager
- interviewed the director with responsibility for these services
- attended two teleconference bed management meetings
- looked at 27 treatment records of patients
- looked at 62 patient medicine administration records
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Patients told us they felt safe on the wards. They knew what was in their care plans and most patients had been involved in developing them. Most patients had a copy of their care plan. Overall, patients found staff helpful and some patients were very positive regarding staff.

Summary of findings

Good practice

- Ligature risk assessments on the wards included photographs of the ligature points. This meant staff could easily identify the ligature risks in each room or area.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that a review takes place of the need to remove shoelaces and hooded top cords from all patients admitted to acute wards.
- The trust should ensure that all nursing staff on the wards receive the updated restraint training as soon as practicable, with a view to reducing the number and proportion of patient restraints in the prone position.
- The trust should ensure that all 'as required' medicines prescribed for patients are reviewed regularly.

Oxleas 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
Betts Ward Goddington Ward Norman Ward	Green Parks House
Avery Ward Maryon Ward Shrewsbury Ward The Tarn	Oxleas House
Lesney Ward Millbrook Ward	Woodlands Unit

Good

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

- During our April 2016 inspection, we found that ligature risk assessments did not include communal areas on wards. Not all staff recognised or understood the ligature risks on their ward. During the current inspection, every ward had a thorough and detailed ligature risk assessment. These risk assessments included each ligature risk in every room or area of the ward. Photographs were included in the ligature risk assessments. This meant staff could easily identify the ligature risks in each room or area. All of the nursing staff knew the ligature points on the ward they worked. Bank and agency staff were shown the ligature risk assessments when they began working on a ward. Ligature points were discussed regularly in staff team meetings and staff reported increased awareness of ligature points. Some rooms on wards, such as bathrooms and lounges were locked. Patients could only access them with staff supervision. This was as a result of the assessed risks in those rooms.
- Each ward had a number of high observation bedrooms. These bedrooms were near the nurses office. Ligature risks in these rooms had been removed or covered. For example, at Woodlands Unit each ward had two high observation rooms. Removal of ligature risks had included changing the bedroom windows. The other windows in the wards were also going to be replaced, but priority had been given to the high observation rooms. At Green Parks House, bedroom door handles had been changed. Windows in the high observation rooms had also been replaced.
- During the inspection in April 2016, we found there had been breaches of same sex accommodation guidance. In the six months prior to that inspection there had been 117 breaches of same sex accommodation on acute wards. Most of these breaches were at Oxleas House. The trust had not followed the Mental Health Act code of practice or department of health guidelines. At the current inspection we found that Avery, Maryon and Shrewsbury wards had changed to become single gender wards. Avery was a female only ward and Maryon and Shrewsbury wards were for men. None of the wards in the trust had any same sex accommodation breaches in the four months before this inspection. The trust senior management had clearly indicated to staff that same sex accommodation breaches were not to happen. The duty senior nurses at each site, and nurses on the wards, understood this. The patients we spoke with told us they felt safe, including female patients on mixed gender wards.
- All of the wards had blind spots where staff could not easily see what was happening. Convex mirrors were due to be installed on the wards. This would mean that staff would have all round visibility including blind spots. This would increase the safety of patients and staff on the wards. The mirrors were due to be installed at Woodlands Unit immediately following the inspection. Mirrors were also due to be installed at Green Parks House and Oxleas House.

Safe staffing

- Since our last inspection, staffing levels on the wards had increased. On the acute wards there were now five staff during the day, three of whom were registered nurses. At night there were two registered nurses and one health care assistant. This meant the wards were safer, and more effective, high quality care could be provided to patients. The staffing on the Tarn had remained the same since the previous inspection. However, the number of beds on the Tarn had increased from 14 beds to 16 beds. The recommended number of beds for psychiatric intensive care units is a maximum of 14 beds (National minimum standards for psychiatric intensive care units, NAPICU, 2014). A plan to increase staffing levels on the Tarn and was due to be reviewed after the inspection.

Assessing and managing risk to patients and staff

- During the inspection in April 2016, there had been 230 incidents of restraint of patients in the six months prior to that inspection. On this inspection there had been 69 incidents of restraint on the wards in the previous three months. Fifty per cent of these restraints involved patients being restrained in the prone position at some stage.

Good

Are services safe?

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

- The Tarn recorded the highest number of restraints (21) and the highest number of prone restraints (13). Of the nine restraints on Maryon ward, seven involved the prone position. On Lesney ward five of the twelve restraints involved the prone position. Of the 69 restraints overall, 27 involved rapid tranquilisation. All but two of these involved rapid tranquilisation by injection.
- The number of incidents of restraint had reduced significantly since the previous inspection. However, the proportion of restraints which involved prone restraint had increased. Best practice guidance from the National Institute of Health and Care Excellence (NICE) advises prone restraint should be avoided wherever possible.
- The trust had started implementing 'safewards' on the acute wards. This is a recognised way of working which reduces incidents of conflict, violence and aggression. The trust had also made a 'sign up to safety' pledge to reduce the number of prone restraints. In addition, work had been undertaken with the organisation providing restraint training. This led to patients no longer needing to be in the prone position when injectable rapid tranquilisation was admninistered. However, not all staff had undertaken this training at the time of the inspection.
- During the inspection in April 2016, some staff were not aware that prone restraint should be avoided wherever possible. During this inspection all nursing staff, except one, identified that prone restraint should be avoided if possible. All of the staff spoke of using verbal de-escalation and only restraining a patient as a last resort.
- During the current inspection staff told us that patients admitted to the acute wards were required to hand in certain items. Patients had to hand in shoelaces and the cords from hooded tops. These would be handed back to patients after the first three days of admission, where appropriate. This was a blanket practice affecting all patients. This practice was to reduce the risk of patients using shoelaces or cords to harm themselves. However, many of the patients on the acute wards were not assessed as a risk to themselves. This practice did not reflect individual patient risk assessments and was not person-centred.
- During the inspection in April 2016, we found that the medicine administration record charts were of a poor quality and in poor condition. There was often unclear dose information and it was unclear who had made changes to the prescriptions. There was not always an admission date, status, the name of the consultant was sometimes missing. During the current inspection we reviewed 62 patients' medicine administration charts on six wards. Medicine charts were fully completed and clearly recorded prescribed medicines and doses. Since the last inspection, the charts had changed and the quality was better. All patients' medicine charts were in good condition and prescriptions were legible.
- During the April 2016 inspection, we found that patients PRN (as required) medicines were not always reviewed regularly. Eight patients had PRN hypnotics for more than seven nights without a medical review. During the current inspection we found the prescribing and review of PRN medicines had improved. However, five patients medicine charts had PRN medicines which had been prescribed more than three weeks earlier. The patients had not required these medicines but they remained on the patients medicine charts. Three patients had received PRN hypnotics for more than seven nights and had not had a medical review.
- The staff personal alarm system at the Woodlands Unit did not always operate safely and effectively. Although this was highlighted on the risk register it was a longstanding issue.

Reporting incidents and learning from when things go wrong

- At the last inspection we reported that four Goddington Ward patients had died within a period of six months. The coroner investigated each of these deaths, and the cause of death of one patient was suicide. We also reported a further death just after the inspection by a patient on leave from Betts ward. This death is currently being investigated by the coroner. Since that time the trust had commissioned an external panel to review the investigation reports of the deaths of the patients from Goddington ward. The panel produced a report which highlighted a number of areas for improvement. These included more effective multi-disciplinary working, stronger leadership and improved care plans.

Good

Are services safe?

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

- The trust had acted on the findings and incorporated them into a quality improvement plan for all of the acute wards. The ward manager and consultant on Goddington ward had changed and the new management team had a positive impact.

Are services effective?

Good

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

- Following the previous inspection, we issued a requirement notice and told the provider to ensure that patients' care plans were person-centred. We also said that patients should have a copy of their care plan.
- We reviewed the care plans of 27 patients during the inspection. Overall, care plans were detailed and specific to the patient and met the patients' needs. Most patients' care plans showed that patients had been involved in their development. Some patients had made amendments to their care plans. However, four patients care plans did not demonstrate that patients had been involved in their care plan. The majority of patients reported that they had been given a copy of their care plan. However, this was not recorded on the patients' electronic records.

Good

Are services caring?

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

Our findings

At the last inspection in April 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

- Patients we spoke with at the current inspection knew what was in their care plans and most patients had been involved in developing their care plans. Most patients had a copy of their care plan. Overall, patients found staff helpful and some patients were very positive regarding staff.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- During the last inspection in April 2016, we found that most wards had bed occupancy levels above 100%. This meant that when patients were on leave, their bed was used for a new patient to be admitted. When patients returned from leave, a bed then had to be found for them. The lack of available beds meant patients were having to sleep for the night on other wards. This affected the continuity of care. In addition, some patients waited on a ward whilst a bed was found. On occasions, patients slept for the night on sofas.
- Since the last inspection the trust had contracted for an additional 12 beds in a neighbouring NHS trust. Plans were in place to re-open an empty ward as an acute ward. When patients went on overnight leave, their bed remained available for them for the next 24 hours. Patients were no longer required to sleep on sofas or other wards due to a lack of available beds. A pre-admission suite had recently opened at Oxleas House. The suite had space for four informal patients to wait for a bed to be found for them.
- In the four months before the current inspection, bed occupancy for the acute wards was under 100%. Maryon and Shrewsbury wards had 100% bed occupancy, but only for the month before the inspection. Otherwise bed occupancy ranged from 88% to 99% on the wards. At 5pm each day, a bed management meeting identified all of the available acute beds within the Trust. In the month before the inspection, there was an average of five acute beds available per day. On three days there had been only one bed available at 5pm. However, on 17 days there had been five or more beds available at 5pm. On 22 days at least one ward had more than one available bed. A ward at Oxleas House had two empty beds available on the day we visited. Two beds were also available on a ward at Green Parks House when we visited.
- During the last inspection in April 2016, staff told us that the biggest issue had been bed pressures and that the situation had been intense. During the current inspection, staff reported that the additional 12 beds and new bed management system had a major impact. Patients and families were less frustrated, wards were safer, and staff had more time to provide care to patients.
- The daily bed management meetings involved mangers and senior nurses discussing available beds. It also involved identifying patients who may become well enough to discharge. Where social or housing issues could delay a patient's discharge, these were identified early on. Individual staff were tasked with contacting other agencies, so that any delays could be minimised.
- Staff from home treatment teams visited the wards daily to assess patients who may be appropriate for early discharge. The home treatment team provided additional support to the patient when they were discharged. However, wards at the Woodlands Unit did not always have home treatment team visits every day. We were told that this was due to a shortage of staff in the Bexley home treatment team.

Are services well-led?

Good

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

Good governance

- At the previous inspection there was a directorate risk register for the wards but no local risk registers. On this inspection we found that local risk registers were in place. The risks included on the risk registers included staffing levels, blind spots, violence and fire risk. Staff understood what items were on the risk registers, and these were discussed in staff team meetings. Staff understood the actions required to minimise risks on the risk registers.

Leadership, morale and staff engagement

- During this inspection, staff told us that they experienced less stress and had increased morale. They linked this to the change in bed management systems and being able to spend more time with patients. Staff also reported that the wards felt safer.
- Staff on each of the inpatient sites commented on supportive managers. They reported that senior managers were more visible and made weekly visits to the wards. Staff also reported that management were listening to staff concerns and there had been significant improvements.
- Following the April 2016 inspection, the senior management team in the trust had reflected on the inspection findings. They had changed their approach and thinking on acute inpatient care and recognised significant changes were required. The changes made went beyond the minimum required, and were undertaken and embedded, quickly. The trust board had increased awareness of the pressures on acute inpatient care and were monitoring these.