Oxleas NHS Foundation Trust

Wards for older people with mental health problems

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	**Inadequate**

Summary of findings

Wards for older people with mental health problems

Inadequate 

Summary of this service

Oxleas NHS Foundation Trust provides wards for older people with mental health problems across four locations. These are Shepherdleas Ward, based at Oxleas House and Oaktree Lodge, based at Memorial Hospital, both in Greenwich. Scadbury Ward is based at Green Parks House in Bromley and Holbrook Ward based at the Woodlands Unit in Bexley.

Shepherdleas Ward is a 19 bedded ward providing care to people over the age of 65 who have mental health needs.

Scadbury Ward is a 22 bedded ward providing care for people over the age of 65 with functional mental health problems such as depression.

Holbrook Ward is a 22 bedded dementia intensive care unit for people who have complex needs and behaviours related to their dementia.

Oaktree Lodge is a 17 bedded continuing care unit providing care for people over the age of 55, with long term mental health rehabilitation needs.

The regulated activities carried out are treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act 1983

We undertook an unannounced focused inspection of all four wards for older people with mental health problems following an unexpected death of a patient who died following the use of a ligature on Scadbury Ward in February 2020 and the unexpected death of a patient who died following the use of a ligature on Shepherdleas Ward in May 2019. As this was a focused inspection, we only looked at specific areas concerning assessing and managing ligature risks to patients, learning from serious incidents and the governance arrangements for implementing and monitoring actions plans following serious incidents.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent in the service to prevent cross infection. Whilst on site we wore the appropriate personal protective equipment and followed local infection control procedures. The remainder of our inspection activity was conducted off-site. This included staff interviews over the telephone and analysis of evidence and documents.

During the inspection visit, the inspection team:

- visited all four wards and observed the safety of the ward environment;
- spoke with the managers or acting managers for each of the wards;
- spoke with two matrons covering the wards;
- spoke with eight other staff members; including nurses and healthcare assistants;
- looked at a range of policies, procedures and other documents relating to the running of the service

Overall Summary

Summary of findings

We re-rated this core service following this inspection. The overall rating went down and was limited to Inadequate for the safe and well led key questions, due to breaches of regulations. Due to the serious nature of the concerns we had after the inspection, we served a Warning Notice on the trust, requiring them to make significant improvements. This was because we were concerned about the assessment and management of ligature risks to patients and the governance arrangements from board to ward of implementing and monitoring action plans resulting from serious incident investigations.

We rated this service as inadequate because:

- Staff did not adequately assess the risk of all high-risk ligature points, particularly on Scadbury Ward. Staff used an assessment tool to score all ligature points on the wards based on level of severity. It was not clear how some high-risk ligature points had been assessed as a lower score than others.
- Staff did not regularly update the ligature risk assessments of the ward areas. Staff on all four wards had not updated or reviewed their ligature risk assessment immediately or soon after a serious incident had occurred on Scadbury Ward.
- Staff did not clearly put mitigations in place to reduce the risk of ligature anchor points on both Shepherdleas Ward and Scadbury Ward. Environmental ligature reduction works were not due to start on both these wards until March 2021. Ligature risk assessments showed that staff had identified ligature risks without clearly stating what the risk management would be in the meantime.
- Managers did not share lessons learned from a serious incident that occurred on Scadbury Ward with the whole team and the wider service. The trust set out recommendations for staff across the core service to follow after a serious incident. Staff had not implemented these recommendations on the wards.
- Our findings from this inspection demonstrated that governance processes did not operate effectively from directorate to ward level, particularly in relation to the implementation of serious incident action plans. An action plan put in place following a serious incident investigation did not clearly set out who was responsible for the implementation of all actions arising from the investigation at ward, directorate and senior management level. This resulted in a failure to carry out required actions to protect patients from avoidable harm.
- There was not a clear framework of what must be discussed at a ward and directorate level. This did not ensure that essential information, such as learning from incidents and implementing actions plans was shared with staff at ward level. Staff did not keep up to date records of their staff team meetings.
- New staff were not made aware of the ligature risks on the wards. The new staff induction on Scadbury Ward, did not include the assessment and management of the risk of ligature points.
- Staff could not observe patients in all parts of the wards. On Scadbury Ward, three patient bedrooms and a communal bathroom were located on a corridor behind a corner away from the nurses' station and other communal parts of the ward.

However,

- Staff on Scadbury had received a debrief facilitated by a psychologist after a serious incident had occurred on the ward.
- Patients had easy access to nurse call alarm bells to call for help in an emergency.

Is the service safe?

Inadequate 

Summary of findings

This inspection focused on specific areas of safety, such as ligature risk management and learning from a recent serious incident investigation report. As we found breaches of regulations, we have re-rated this key question. As a result, our rating of safe went down. We rated it as inadequate because:

- Staff did not always effectively assess the risk of all high-risk ligature points, particularly on Scadbury Ward. Staff used an assessment tool to score all ligature points on the wards. It was not clear how some high-risk ligature points had been assessed as a lower score than others.
- Staff did not regularly update the ligature risk assessments of the ward areas. Staff on all four wards had not updated or reviewed their ligature risk assessment in the last year or after a serious incident had occurred on Scadbury Ward in February 2020.
- Staff did not clearly put mitigations in place to reduce the risk of ligature anchor points on both Shepherdleas Ward and Scadbury Ward. Environmental ligature reduction works were not due to start on both these wards until March 2021. Ligature risk assessments showed that staff had identified ligature risks without clearly stating what the risk management would be in the meantime.
- Managers did not share lessons learned from a serious incident that occurred on Scadbury Ward with the whole team and the wider service. The trust set out recommendations for staff across the core service to follow after the serious incident, but most staff were unaware of these and had not implemented the recommendations on the wards.
- Staff did not keep up to date records of their staff team meetings.
- New staff were not made aware of the ligature risks on the wards. The new staff induction on Scadbury Ward, did not include the assessment and management of the risk of ligature points.
- Staff could not observe patients in all parts of the wards. On Scadbury Ward, three patient bedrooms and a communal bathroom were located on a corridor behind a corner away from the nurses' station and other communal parts of the ward.

However,

- Staff on Scadbury had received a debrief facilitated by a psychologist after a serious incident had occurred on the ward.
- Patients had easy access to nurse call alarm bells to raise assistance in an emergency.

Is the service effective?

We did not include this key question in this inspection. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Is the service caring?

We did not include this key question in this inspection. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Is the service responsive?

We did not include this key question in this inspection. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Summary of findings

Is the service well-led?

Inadequate 

This inspection focused on a specific area of well-led. As we found breaches of regulations, we have re-rated this key question. Our rating of well-led went down. We rated it as inadequate because:

- Our findings from this inspection demonstrated that governance processes did not operate effectively from directorate to ward level, particularly in relation to the implementation of serious incident action plans. During our inspection, we found out of date ligature risk assessments, a lack of clear mitigation for ligature points that were high risk and staff not implementing actions from serious incident investigations.
- Staff did not clearly set out who was responsible for the implementation of action plans arising from serious incident investigations at ward, directorate and senior management level. This resulted in a failure to carry out required actions to protect patients from avoidable harm.
- There was not a clear framework of what must be discussed at ward and directorate levels. This did not ensure that essential information, such as learning from incidents and implementing actions plans was shared with staff at ward level.

Detailed findings from this inspection

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff did not regularly review or update the ligature risk assessments of the ward areas. Staff did not adequately assess and manage the risk of all high-risk ligature points.

Staff did not always review environmental ligature risk assessments when required. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The trust's ligature management policy states that staff must update the ligature risk assessments for each ward every 12 months or following a serious incident. Staff had not updated the environmental ligature risk assessments for any of the trust's four wards for older people with mental health problems following a recent serious incident, and on two wards the assessments had not been reviewed for more than one year. In the last two years there had been two unexpected deaths, in May 2019 and February 2020, on the trust's wards for older people with mental health problems that involved patients using a tap as a ligature anchor point. After the serious incident on Scadbury Ward in February 2020, the trust's investigation recommended that staff on all the wards review and update the ligature risk assessments immediately. This had not been completed on any of the four wards. At the time of the inspection, the environmental ligature risk assessments for two of the wards, Scadbury Ward and Oak Tree Lodge, had not completed a ligature risk assessment in the last 12 months. The manager on Holbrook Ward said they had updated their ligature risk assessment, but it had not been printed off for staff to use yet. The environmental ligature risk assessment on Sheperdleas Ward had been updated 22 October 2019. The failure to reassess the environmental risks meant that new and current staff may not be aware of the ligature points within the ward and how they should be managed to reduce the risk of patients harming themselves.

After the inspection, we asked the trust to provide us with assurances that they would take immediate action with regards to reviewing and updating the ligature risk assessments across the four wards. The trust provided us with copies of each ward's updated ligature risk assessments shortly afterwards. This meant that each ward had received an up-to-date review of their ligature risk assessments to keep patients safe.

Staff did not adequately assess the risk of all high-risk ligature points. During the inspection, we reviewed the ligature risk assessments for Scadbury Ward and Shepherdleas Ward. Staff used an assessment tool to score all ligature points on the wards based on the level of severity. The recommendations from the investigation report stated that staff in all four wards must increase their patient profile risk rating from a 1 to a 3. The patient profile rating is a factor of the scoring system used by the trust to reach an overall risk score for each ligature point on the ward. The patient profile factor is based on the vulnerabilities and susceptibility of suicide risk within a patient group. Staff on Scadbury and Shepherdleas wards had not done this, therefore high-risk ligature points were being assessed at a lower score overall. For example, on Shepherdleas Ward the ligature risk assessment showed the ligature point of handles on the bedroom doors had a combined assessment score of 18, which is a low score. The smoke detector score had been increased to 27, even though it was in a higher position and harder to reach than a door handle. On Scadbury Ward, in patient bedrooms, the ligature points provided by taps received a score of 18, this was a low risk score. This was compared to the ceiling extractor in the same bedrooms that received a score of 27 making it a higher risk than the taps, even though it was harder to reach.

After the inspection, the trust provided us with updated ligature risk assessments for Shepherdleas Ward and Scadbury Ward, completed after our visit to the wards. Whilst staff on Shepherdleas Ward had changed the scores of ligature points that were easy to reach to the highest-level risk score of 81, Scadbury Ward had not done this with all the ligature points in private areas such as bedrooms and en-suites. The risk posed by a ligature point is greater in a room in which patients spend time without direct supervision, such as a bedroom or bathroom. For example, bedrooms 20, 21 and 22 were located on a corridor away from the rest of the ward that meant staff had limited observation. In these bedrooms,

the tap fittings had been assessed as scoring 54 out of a maximum score of 81. In the communal bathrooms the same tap fitting had been assessed by staff as scoring 81 (the highest risk). It was not clear how the same ligature points, both in private areas, had been assessed at two different scores. Staff had not effectively assessed the risk to the safety of patients resulting in potential avoidable harm.

During the inspection, we found potential ligature anchor points in the service. On the ligature risk assessments completed in 2019 staff had identified ways to reduce the risk of ligature points by removing them but had not carried out the work. For example, on Shepherdleas Ward the ligature risk assessment stated that all wardrobe doors in patient bedrooms were to be removed. Staff had not done this nearly 12 months later. In one female patient's bedroom the ligature risk assessment stated that anti-pick mastic should be placed around the edges of a mirror to prevent the edge of the mirror being used as a ligature point. However, we found that the mirror did not have any anti-pick mastic sealed around it. In addition, we found a loose panel exposing pipes under a sink in bedrooms 11 and nine that was not on the ligature risk assessment. On Oaktree Lodge the wardrobe doors in one of the two anti-ligature bedrooms had not been removed, despite the ligature risk assessment dated July 2019 stating this should be done. Identified ligature risks had not been removed as planned in almost 12 months, leaving patients at risk of avoidable harm,

After the inspection, the trust told us that they would take immediate action with regards to carrying out these remedial works. The trust provided us with evidence that they had fixed or removed these identified ligature risks, which reduced the risk to patients.

Staff did not clearly put mitigations in place to reduce the risk of ligature anchor points, on both Shepherdleas Ward and Scadbury Ward, whilst they were waiting for environmental ligature reduction works to begin. After the inspection, we reviewed both wards' updated ligature risk assessments. Both risk assessments showed that staff had identified ligature risks without clearly stating how they would manage the risk. For example, staff on Scadbury Ward had recorded the mitigation for the ligature point created by a shower head in an en-suite bathroom as 'replacement needed.' On Shepherdleas Ward staff had recorded the mitigation for the standard fitted tap in an en-suite bathroom as 'to be installed in capital project commencing January 2021'. No further mitigation of risks was recorded, including how risks would be managed until the recorded actions had been undertaken. In addition, we reviewed copies of the ligature reduction plans for Scadbury Ward and Shepherdleas Ward. These showed that environmental works to remove and reduce ligature anchor points would not commence on these wards until 8 March 2021 at the earliest and estimated to be completed by July and August 2021. This meant staff had not adequately reduced the risk of ligature points to keep patients safe whilst they were waiting for ligature reduction works to begin.

During the inspection, we found the ligature risk assessments and the mitigations in place did not take account of the location of bathrooms on wards. After the serious incident, the trust had planned to carry out ligature reduction works in the communal bathroom areas. In the meantime, to manage the ligature risks posed in the bathrooms, the trust recommended that staff keep these bathrooms locked. However, during the inspection, we found that communal bathrooms were not kept locked including those areas where staff could not always observe. For example, on Scadbury Ward an unlocked communal bathroom was situated around a corner away from the nurse's office, which staff could not easily observe. On Shepherdleas Ward, a female bathroom with ligature points, was unlocked and could not be seen from the nurses' office. Staff said only patients who were able and had been risk assessed used these bathrooms and bedrooms. However, staff could not always see if patients were in this unlocked bathroom. This meant staff did not adequately reduce the risk of ligature points in the communal bathrooms, which could result in patients harming themselves.

After the inspection, we asked the trust to provide us with assurances that they would reduce the risk of potential ligature points in the communal bathroom areas with immediate effect. The trust stated that communal bathrooms were now kept locked and would be supervised until the ligature reduction works begin in 2021, especially those bathrooms that were in areas that staff could not observe.

Detailed findings from this inspection

Staff could not observe patients in all parts of the wards. Staff had taken some appropriate steps to manage and mitigate the risks associated with blind spots by installing convex mirrors on the walls. On Scadbury Ward, three patient bedrooms and a communal bathroom were located on a corridor behind a corner away from the nurses' station and other communal parts of the ward. The ward manager was reassured that the convex mirrors allowed staff to see around the corner and observe patients coming in and out of their bedrooms and the bathroom.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Whilst managers made sure all bank and agency staff had a full induction to the wards before starting their shift, these inductions did not always include the management of ligature points. On Scadbury Ward the induction check list did not include potential ligature points on the ward and how staff managed these risks. This meant new staff would not know where the potential ligature risks were on the ward to prevent the risk of harm to patients.

Track record on safety

Reporting incidents and learning from when things go wrong

Managers did not share lessons learned from incidents with the whole team and the wider service. The trust set out recommendations for staff across the core service to follow after a serious incident had occurred on Scadbury Ward. Staff had not implemented these recommendations on the wards.

Managers investigated incidents, but there was no evidence that changes, and recommendations had been implemented, particularly after a serious incident had occurred on Scadbury Ward. Senior leaders had investigated an unexpected death of a patient on Scadbury Ward, involving a ligature anchor point in February 2020, and a full investigation report had been completed in July 2020. The trust set out recommendations for staff to follow and improve the safety of care in the future. The recommendations included immediately undertaking a review of each ward's ligature risk assessment and increasing the patient profile rating within the assessment.

Staff were unaware of the recommendations that had been set out in this report. During the inspection, we found that the recommendations had not been implemented on the wards as staff had not received the learning from the report. On Shepherdleas Ward, two staff could not recall the incident from Scadbury Ward or the recommendations from the investigation report. The ward manager knew about the incident but not the recommendations from the report. On Scadbury Ward the ward manager did not know the recommendations from the investigation report, they only reported about planned ligature reduction works taking place. A further two staff were unaware of the learning that had been shared as a result of the incident. The ward manager on Holbrook Ward did not know what the recommendations were from the report and was not aware of any learning sessions for staff. Two staff on Oaktree Lodge did not know about the serious incident that had occurred on Scadbury Ward or the learning from this.

In addition, we looked at the minutes of the staff team meetings from March 2020 to September 2020 on all four wards. These minutes did not show that staff had discussed this serious incident or the recommendations from the investigation report. On Scadbury Ward one staff member said the investigation report had been discussed in the team meeting but did not know what the learning was. We requested the team meeting minutes, but the ward manager was unable to locate them. The ward manager confirmed that the learning from recent serious incidents may not be documented. On Shepherdleas Ward the minutes did not show any record of discussion of learning and the ward manager could not locate the minutes of where this incident may have been discussed. This meant that the recommendations arising from the serious incident that had occurred in February 2020 had not been shared with staff and not implemented to keep patients safe from harm.

Managers debriefed and supported staff after any serious incident. On Scadbury Ward, staff received a debrief facilitated by a psychologist after the serious incident had occurred.

Detailed findings from this inspection

Is the service well-led?

Governance

Our findings from this inspection demonstrated that governance processes did not operate effectively from directorate to ward level, particularly in relation to the implementation and monitoring of serious incident action plans on the wards for older people with mental health problems.

Overall the governance of this core service failed to identify and address the problems that could have a negative impact on patient safety. During our inspection, we found out of date ligature risk assessments, a lack of clear mitigation for ligature points that were high risk, failure to remove identified ligature points that could have been removed and failure to implement actions from serious incident investigations.

Staff did not clearly set out who was responsible for the implementation of action plans arising from serious incident investigations at ward, directorate and senior management level. After the inspection, we reviewed a copy of the trust's updated Scadbury Ward serious incident action plan. This action plan had a named person assigned as the lead for responsibility for the actions for recommendations one and four. However, from the action plan it was unclear that recommendations two, three and five had any actions or named person responsible for them attached as they were embedded in the actions for recommendation one. The matrons for Shepherdleas Ward and Scadbury Ward acknowledged that more work needed to be done to implement and monitor action plans at a ward level. This meant patient safety was put at risk.

There was not a clear framework of what must be discussed at ward and directorate level meetings. We reviewed the minutes from the trusts' governance forums that took place between January – September 2020. These forums included the bi-monthly serious incident, performance and assurance group, the patient safety forum and the older adults care forum. The minutes did not record that staff had discussed the Scadbury Ward serious incident action plan in any of these governance forums. It was not clear how pertinent information such as the implementation of recommendations from serious incidents was shared with staff on the wards. This meant that important information relating to patient safety was not effectively monitored at a directorate or ward level.

The trust held monthly older adults' care forums. These were directorate wide meetings to discuss clinical governance and patient safety across the older adults' wards and community services, which were part of three different directorates. The matrons that covered Shepherdleas Ward and Scadbury Ward did not regularly attend the older adults care forum, as they usually attended the acute care forum instead. This meant that matrons would not have oversight of patient safety issues within the older adults' wards.

Whilst the trust board scrutinised the recommendations from the serious incident investigation report and discussed these within their board meetings. Our findings from the inspection demonstrated that the trust board were unaware that the actions from the serious incident had not been carried out. We reviewed the trust board meeting minutes for March, May, July and September 2020. In March, the board discussed the need for actions resulting from serious incident inquiries to be completed in a timely manner, to ensure they acted to improve practice and quality. In September the board discussed the recommendations from the serious incident investigation report into the death on Scadbury Ward. However, the action plan had been delayed allowing staff time to contribute to it. This meant that information from a ward level had not been passed back up to the board to provide assurance that staff had taken action to improve patient safety.

Areas for improvement

Action the provider **MUST** take to improve

Detailed findings from this inspection

The trust must ensure that staff regularly review and update their environmental ligature risk assessments, at least annually and after a serious incident has occurred. **Regulation 12(1)(2)(a)**

The trust must ensure that all ligature points on the environmental ligature risk assessments are appropriately assessed. **Regulation 12(1)(2)(a)(b)**

The trust must ensure that all environmental ligature assessments record adequate mitigation to reduce the risk of ligature anchor points, especially whilst waiting for ligature reduction works to be completed. **Regulation 12 (1)(2)(a)(b)**

The trust must have effective systems in place to ensure information is shared consistently with the wards, particularly serious incident action plans, making it clear who is responsible for the completion and monitoring of the actions. **Regulation 17 (1)(2)(a)(b)(c)(d)**

The trust must ensure lessons from serious incidents are shared with staff on all wards for older people with mental health problems. **Regulation 12 (1)(2)(a)(b)**

The trust must ensure that the local induction of new and temporary staff includes the ligature risks on the ward and how they are managed. **Regulation 12 (1)(2)(a)(b)**

The trust must ensure that staff keep accurate and detailed records of their staff team meetings. **Regulation 17 (1)(2)(c)**

Action the provider **SHOULD** take to improve:

The trust should continue to carry out their planned ligature reduction works plan on schedule.

Our inspection team

The team that inspected the service was comprised of four CQC inspectors and an assistant inspector.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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.

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