Central and North West London NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

This was an announced focused inspection of the acute wards for adults of working age and psychiatric intensive care units core service. We carried out this inspection to follow up on concerns raised about the safety and quality of the service being provided. We used CQC's interim methodology for monitoring services during the COVID-19 Pandemic.

The acute wards for adults of working age and psychiatric intensive care units core service was last inspected in 2019 with a rating of requires improvement in the safe domain and good across the effective, caring, responsive and well led domains. The core service was rated good overall. As this was a focused inspection, we did not inspect and rate against all key questions.

We visited four wards during this inspection. Crane ward is an acute admission ward for up to 18 female patients based within the Riverside Mental Health Centre, Hillingdon. Frays ward is an acute admission ward for up to 19 male patients based within the Riverside Mental Health Centre, Hillingdon. Eastlake ward is an acute admission ward with 21 beds for male and female patients separated into different areas. This ward is located within the Northwick Park Mental health Centre, Harrow. Willow ward is an acute admission ward for up to 18 female patients based at the Campbell Centre, Milton Keynes.

The service is registered by the CQC to provide the regulated activities: Treatment of disease, disorder or injury, Assessment or medical treatment for persons detained under the 1983 Act and Diagnostic and screening procedures.

We found the following areas of good practice:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose. The wards complied with guidance in relation to mixed sex accommodation.
- Staff followed infection control protocols, all staff wore face coverings and measures were in place to cohort new admissions awaiting severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) test results. Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.
- Staff made attempts to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff assessed the physical and mental health of all patients on admission. When patients were first admitted to the ward, they were seen by a doctor who completed a full assessment and recorded this in the patient's notes. This was reviewed by the multidisciplinary team at a ward round within the first few days of admission.
- Staff on Frays, Crane and Willow Wards participated in quality improvement initiatives. As a result of learning from incidents on Crane Ward in 2019, the Riverside improvement programme had been introduced.

Our findings

- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- Patients on all wards told us that permanent staff treated them with kindness dignity and respect. We observed positive interactions between staff and patients which demonstrated that respect and understanding of individual patient needs.
- Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Frays ward and recently reduced their number of beds from 23 beds to 19 beds. Eastlake ward had reduced their number of beds from 23 to 21 with an aim of reducing these further. This was in line with best practice guidance for acute adult inpatient wards.
- Leaders had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

However, we also found the following areas the service needed to improve:

- We saw that Willow ward was an outlier in that high staff turnover and patient acuity had led to high levels of bank and agency usage which had led to inconsistent care. We also saw that staff on Willow ward were not receiving regular support through supervision or team meetings. Some staff on this ward told us that they did not feel able to speak about their concerns.
- Whilst the trust had taken action to ensure that care on Willow ward was safe and effective after incident data showed the ward was an outlier, this action had not been timely or robust enough. During the inspection we raised concerns with the trust that led to a voluntary pause on admissions to the ward whilst additional assurance was obtained and additional measures were put in place by the trust.
- Planned building works to remove dormitory accommodation at Willow ward had been delayed by the pandemic and were scheduled to commence shortly after our inspection.
- We saw that on Eastlake ward, the trust had learnt from a recent medicines incident. Some new systems had been introduced to ensure that medicines were managed and administered safely.
- Patients on Crane and Frays Wards who received intramuscular rapid tranquilisation injections did not always have adequate physical health checks. Actions to improve this were being considered at the time of this inspection.
- Some patients on Willow ward, did not have their assessed needs addressed by a comprehensive care plan. Detained and informal patients on this ward were not aware of their legal rights.

How we carried out the inspection

During the inspection, the inspection team:

- observed four handover meetings, one on each ward
- conducted a tour of the environment on each ward
- spoke with two occupational therapists, seven registered nurses and four unregistered nurses over the four wards
- spoke with the discharge coordinator at the Riverside Mental Health Unit
- spoke with a peer support worker from Crane ward
- spoke with the Frays ward activities co-ordinator

Our findings

- spoke with a pharmacy technician, a pharmacist and a medication safety officer on Eastlake ward as well as the deputy chief pharmacist for the trust
- spoke with three ward managers, the trust director of Hillingdon services, three matrons and three consultant psychiatrists
- spoke with 16 patients over the four wards
- spoke with two sets of relatives of people who were using the service
- looked at 17 patient care and treatment records and six patient observation records
- reviewed documents relating to the running of the service including records of incidents on the ward.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Most of the patients we spoke with told us that staff treated them with kindness, dignity and respect. Patients told us that staff were compassionate and kind and understanding towards their needs.

All patients we spoke to said that they felt safe on the ward and most patients said that they felt involved in their care and treatment plan. Patients told us that they received one to one nursing interventions and staff supported their needs.

Patients on Willow ward told us that agency staff did not always treat them well or behave kindly towards them.

Patients told us that they could feedback on the service that they received and knew how to make a complaint if they wished to.

Is the service safe?

Inspected but not rated

We inspected elements of the safe domain during this focused inspection but did not re-rate it. We found the following areas that the service needed to improve:

- Staff turnover and the admission of patients with complex needs had resulted in the increased use of bank and agency nursing staff on Willow Ward. This had impacted on the consistency of care that patients received. Between April and November 2020, registered nurse turnover had been almost 40%. Between September and December 2020, unregistered nurse turnover had been 36%. Between 1 June and 30 November 2020, more than half of all shifts were provided by bank or agency staff. For example, in November 2020, 45% shifts were covered by bank staff and 17% covered by agency workers. The trust mitigated the risk of using staff who were unfamiliar with the ward by allowing permanent staff to cover additional shifts as bank staff. The ward also used agency staff who were familiar with the ward. However, between 1 August and 30 November 2020, almost 100 members of staff worked on Willow ward each calendar month. The trust had identified this area of concern and was working to improve. Between September and December 2020, nine registered and 11 unregistered nurses were recruited. In addition, staffing had been reviewed in October 2020 and increased to include an additional registered nurse between 9am and 5pm.

Our findings

- Willow ward had a significant number of patient safety incidents. Between June and November 2020, staff had recorded 284 incidents on Willow ward. This included 123 incidents of self-harm, 50 incidents of distressed behaviour including attempts to abscond, 18 incidents of assault or physical violence and 18 incidents relating to security including vandalism. Whilst staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm, there continued to be a number of incidents on the ward that involved patients harming themselves with prohibited items.
- The trust had identified the ward as being an outlier in the high number of incidents that had occurred. Additional measures to support staff to be able to safely care for acutely unwell patients were put in place in September 2020. These included staff training sessions that involved the simulation of incidents involving the management of sepsis, choking and cardio-pulmonary resuscitation. The service had also developed programmes of work to improve physical health outcomes for patients, to improve partnerships with patients' families, providing support to staff, improving the level of staffing on the ward and improving arrangements to prevent unnecessary delays in discharge from the ward.
- We carried out a review of incidents between 1 November and 3 December 2020 on Willow ward and were concerned at the continuing high number of incidents. There were 36 incidents of self-harm, 15 of which involved ligatures. On four occasions, patients were taken to A&E. One admission occurred due to a patient swallowing the battery from an e-cigarette whilst on 1:1 observations. At least one ligature incident involved the patient losing consciousness and requiring oxygen. We raised our immediate concerns with the trust who undertook a voluntary pause on admissions to the ward to facilitate a review of treatment pathways for patients who were self-harming and a review of staffing. The ward reopened to admissions when clear treatment pathways and discharge plans had been identified for patients at high risk of self-harm. The trust had also assured itself that safe staffing levels were in place on the ward. The trust identified additional learning from the inspection in relation to how patients were cohorted throughout the trust depending on their treatment pathway. Monitoring of incident data throughout December 2020 and January 2021 showed that the occurrence of incidents on Willow ward had significantly reduced.
- On Eastlake Ward, improvements were needed to systems and processes to safely manage medicines. A recent serious incident had occurred on the ward when a patient had not been administered a critical medicine upon admission. Learning from this incident had taken place and revised systems and processes to safeguard against this type of serious incident had been introduced. Further improvements were required on Eastlake ward to ensure that fridge temperatures were appropriately monitored, in line with trust procedure, to ensure the efficacy and safety of the medicines stored in them. The ward also needed to ensure that checks on controlled drugs were carried out and recorded in line with trust policy. The trusts medicines optimisation department were working with Eastlake ward at the time of our inspection on an action plan to address these issues.
- On Frays and Crane Wards, improvements were needed to ensure that patients received physical health checks after intra-muscular rapid tranquilisation had been administered. Whilst a physical health monitoring form was available to support staff to record checks after this medicine was administered, we saw that for three out of nine patients over these two wards some checks had not been completed. The matron for Crane Ward was carrying out regular audits to drive improvement in this area.

However, we also found the following areas of good practice:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose. Staff had easy access to alarms and patients had easy access to nurse call systems in their bedrooms and communal areas. The wards complied with guidance in relation to mixed sex accommodation. Staff followed infection control protocols, all staff wore face coverings and measures were in place to cohort new admissions awaiting severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) test results. Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Our findings

- Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk management plans were detailed in daily progress notes. Risks were reviewed during handover and multidisciplinary team meetings.
- Staff made attempts to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. On Willow ward, where there had been high levels of patient acuity, between June and November 2020, staff had physically restrained patients on 72 occasions. On four of these occasions, patients had been restrained on the floor using a technique known as prone restraint. During the same period, staff on Willow ward had placed patients in seclusion on 12 occasions and administered rapid tranquilisation on 23 occasions.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff liaised with external agencies where children were involved, such as social services. Each ward had a dedicated safeguarding lead.

Is the service effective?

Inspected but not rated

We inspected elements of the effective domain during this focused inspection but did not re-rate it. We found the following areas of good practice:

- Staff assessed the physical and mental health of all patients on admission. When patients were first admitted to the ward, they were seen by a doctor who completed a full assessment and recorded this in the patient's notes. This was reviewed by the multidisciplinary team at a ward round within the first few days of admission.
- Staff on Eastlake, Crane and Frays Wards had developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff on Frays, Crane and Willow Wards participated in quality improvement initiatives. As a result of learning from incidents on Crane Ward in 2019, the Riverside improvement programme had been introduced. We saw that 'See, Think, Act' training had been rolled out that helped staff identify different factors that could lead to an incident. We saw the 'See, Think, Act tool being used on Frays ward as part of the handover process. There were also plans to roll out 'See, Think, Act' to Willow Ward.
- The ward teams on Eastlake, Crane and Frays Wards included or had access to the full range of specialists required to meet the needs of patients on the wards. Staff on all wards ensured that patients had good access to physical healthcare.
- Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.
- Staff on Eastlake ward, Crane ward and Frays ward understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them

Our findings

- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However, we found the following areas the service needed to improve:

- On Willow ward, we looked at three patients care and treatment records and found that two did not contain care plans. For one patient who was identified as restricting their food and fluid intake, a care plan addressing this need was not in place. We reviewed the patient's record for the three weeks following their admission. There were two food and fluid charts on the record. This meant that staff did not have any accurate information about whether the patients needs in relation to food and fluid intake had been addressed.
- On Willow ward, a number of patients with complex personality disorders had been admitted to the ward in crisis. Difficulties in discharging these patients to a specialist in patient or community service meant they had stayed on the ward for an extended period of time. Two patients we spoke with said they did not feel they were making any progress. During the course of the inspection the trust identified treatment pathways and discharge plans for remaining patients on Willow ward with a need for treatment and support in relation to complex personality disorders. The trust had plans in place to improve care and treatment pathways in the Milton Keynes community for patients diagnosed with complex personality disorders
- Managers on Willow ward did not support staff through regular, constructive clinical supervision of their work. Registered and unregistered nurses said they had not received regular supervision during 2020. Managers had also not held regular team meetings on Willow ward. This meant that staff had not had regular opportunities to meet to discuss care and treatment, to discuss incidents or raise any other concerns.
- Some patients on Willow Ward told us staff had not explained to them their rights under the Mental Health Act in a way that they could understand. One patient said that it had not been clear that they had been sectioned. They had been informed by their daughter. No one at the hospital had told them they were detained for assessment under the Mental Health Act. There was also a risk that informal patients on Willow ward would have their liberty restricted without the safeguards provided by the Mental Health Act as some did not clearly understand their rights to leave the hospital.

Is the service caring?

Inspected but not rated

We inspected elements of the caring domain during this focused inspection but did not re-rate it. We found the following areas of good practice:

- Staff treated patients with compassion and kindness. Patients on all wards told us that permanent staff treated them with kindness dignity and respect. We observed positive interactions between staff and patients which demonstrated that respect and understanding of individual patient needs.
- Staff ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. Carers told us that staff invited them to attend virtual ward rounds, to ensure that they were updated on their relatives' care and treatment during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic.

However, we found the following areas the service needed to improve:

Our findings

- All the patients we spoke with on Willow ward raised concerns about agency staff. They said that some agency staff were rude and abrupt, had an insufficient understanding of patients' needs. They also commented that agency staff did not know patients' names and did not always apply restrictions consistently. The trust was working to ensure that staffing on the ward stabilised and was consistent.

Is the service responsive?

Inspected but not rated

We inspected elements of the responsive domain during this focused inspection but did not re-rate it. We found the following areas of good practice:

- Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Frays ward and recently reduced their number of beds from 23 beds to 19 beds. Eastlake ward had reduced their number of beds from 23 to 21 with an aim of reducing these further. This was in line with best practice guidance for acute adult inpatient wards.
- Robust bed management processes, in conjunction with cross-team and interagency working at the Riverside Mental Health Centre, meant that discharges were rarely delayed other than for clinical reasons.
- The design, layout, and furnishings of Eastlake, Frays and Crane wards supported patients' treatment, privacy and dignity. Patients on these wards had their own bedroom with an ensuite bathroom. Patients could keep their personal belongings safe. At the time of our inspection, Eastlake ward was undergoing building works to improve the ward environment, including better access to quiet areas for patients. On Frays Ward a sensory room was planned.

However, we found the following areas that the service needed to improve:

- Nine patients on Willow ward were sharing dormitory accommodation. This comprised of three bedrooms that each had three beds. Work to upgrade Willow ward to single occupancy bedrooms had been delayed because of the pandemic, but was scheduled to start shortly after our inspection completed.
- Some patients on Frays and Crane Wards commented on the lack of activities, particularly during the evenings and at weekends. Plans to address this were in hand, an occupational therapist had been recruited and additional recruitment to peer support worker posts was expected.

Is the service well-led?

Inspected but not rated

We inspected elements of the well led domain during this focused inspection but did not re-rate it. We found the following areas of good practice:

- Leaders had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff on Eastlake, Frays and Crane Wards felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Our findings

- Our findings from the other key questions demonstrated that governance processes on Eastlake, Frays and Crane wards operated effectively and that performance and risk were managed well. Actions to strengthen systems to safely manage and administer medicines on Eastlake ward were in development at the time of our inspection.
- Ward teams had access to the information they needed to provide safe and effective care. Eastlake, Crane and Frays Wards had used that information to good effect.

However, we found the following areas that the service needed to improve:

- Some staff on Willow ward did not feel respected or valued. They also told us that they did not feel able to raise concerns.
- Whilst information relating to Willow ward staffing, incidents and supervision was available which indicated risks to the delivery of safe and effective care, this had not been responded to in a timely or robust fashion. The trust had taken additional measures to ensure the safety and effectiveness of Willow ward as a result of the concerns raised with them during the inspection.

Our findings

Areas for improvement

The trust **must** ensure that

- The trust must continue its work to ensure that patients on Willow ward are protected from the risks associated with receiving care from an inconsistent staff group. **Regulation 12 (1)(2)(c)**
- The trust must continue its work to ensure that appropriate measures are in place to manage and mitigate known risks for individual patients. **Regulation 12 (1)(2)(a)(b)**
- The trust must continue its work to ensure that systems and processes to manage and administer medicines safely on Eastlake ward are fit for purpose. **Regulation 12 (1)(2)(f)(g)**

The trust **should** ensure that

- The trust should expedite plans to remove dormitory accommodation from Willow ward.
- The trust should continue its work to ensure that all patients who receive intramuscular rapid tranquilisation on Crane and Frays Wards, receive post administration physical health checks.
- The trust should ensure that all patients on Willow ward have their assessed needs addressed by a comprehensive care plan.
- The trust should ensure that staff on Willow ward are supported with regular supervision and are able to access regular team meetings.
- The trust should continue its work to ensure that patients on Willow ward understand their rights under the Mental Health Act (1983) or as informal patients.
- The trust should ensure that leaders covering Willow ward identify and respond to indicators of concern in a timely fashion and keep actions in response to concerns under review to ensure their efficacy.
- The trust should ensure that the culture on Willow ward is improved, so that all staff feel safe to raise concerns without fear of retribution.

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