Kent and Medway NHS and Social Care Partnership Trust

Wards for older people with mental health problems

Quality Report

Littlestone Lodge, Bow Arrow Lane,
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Date of inspection visit: 21 May 2015
Date of publication: 30/07/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXYAK	Littlestone Lodge	Littlestone Lodge	DA2 6PB

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership 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 Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust.

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

This was a focused, unannounced inspection that looked at three of the five questions: “Are services safe, are they effective, and are they well led?”

In March 2015 we inspected Littlestone continuing care unit (previously called Littlestone Lodge) as part of a comprehensive inspection of Kent and Medway NHS and Social Care Partnership Trust. During our inspection we found that the trust was not meeting the standards expected with regards to the care and welfare of patients, and how it assessed and monitored the quality of the service at Littlestone continuing care unit (CCU)

We found the trust to be in breach of regulations 9(1)(2) and 10(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued warning notices under each of these regulations on 30 March 2015. We told the trust that they must comply with the requirements of the regulations by 15 May 2015. The trust sent us an action plan, and later confirmed that it believed it was compliant with the requirements as of 15 May 2015.

We carried out an unannounced, focussed inspection on 21 May 2015 to assess if the trust had addressed the concerns identified at our inspection in March 2015, and to determine if it was now compliant with the requirements of the regulations. We found that the trust had taken action, marked improvements had been made to the services delivered at Littlestone CCU since our visit in March, and staff were positive about the changes to the unit. A number of new or revised processes had been implemented for ensuring that patients' care needs were met. However, we found that these were not always carried out or recorded consistently.

Our inspection in March 2015 assessed compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations were replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on the 1 April 2015. As such, the inspection carried out on 21 May 2015 looked at the trust’s compliance with the 2014 regulations (namely the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Due to the improvements made we have withdrawn the warning notices. However, we found that the trust had not met all the requirements of the regulations and as such have issued a requirement notice in respect of Regulation 17(1)(2)(b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

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

Are services safe?
We found that improvements had been made since our inspection in March 2015, but action was still required to ensure that services were safe.

Are services effective?
We found that improvements had been made since our inspection in March 2015, but action was still required to ensure that services were effective.

Are services caring?
We did not look at this question as part of our focused inspection.

Are services responsive to people's needs?
We did not look at this question as part of our focused inspection.

Are services well-led?
We found that improvements had been made since our inspection in March 2015, but action was still required to ensure that services were well led.

Summary of findings

Information about the service

Littlestone continuing care unit (CCU) has 16 beds for men and women with a diagnosis of dementia. On the day of our inspection there were 12 patients on the ward.

Our inspection team

The team was comprised of an inspection manager, two inspectors and a mental health nurse with experience of working with older people.

Why we carried out this inspection

We inspected Littlestone CCU in March 2015 as part of our ongoing comprehensive mental health inspection programme. We found areas of concern and issued warning notices for non compliance with Regulation 9 (care) and Regulation 10 (governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust implemented an action plan and told us that all the concerns would be addressed by the 15 May 2015. We carried out an unannounced inspection to check on whether the trust had taken all the action required and met the requirements of the regulations.

How we carried out this inspection

We carried out an unannounced inspection visit on the 21 May 2015. During the inspection visit, the inspection team:

- visited Littlestone CCU
- spoke with a relative of a patient
- spoke with 11 staff members including managers, doctors, nurses and assistants
- looked at parts of the care and treatment records of 12 patients
- looked at 12 medication charts
- observed care, and a medication round.

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

Areas for improvement

Action the provider MUST take to improve

The trust had processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. However, these were not consistently implemented or recorded and therefore the trust must ensure this is actioned accordingly in order to meet the requirements of the regulation. This specifically relates to pain management, regular health tests (such as blood tests and ECGs), recording fluid intake and output on fluid balance charts, assessment of continence, and weight monitoring.

Kent and Medway NHS and Social Care Partnership Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Littlestone Continuing Care Unit (previously called Littlestone Lodge	Littlestone Lodge

Mental Capacity Act and Deprivation of Liberty Safeguards

- At our last inspection we found that nine of the 15 patients had forms stating that they were not to be resuscitated in the event of a medical emergency (often known as "do not attempt resuscitation" (DNAR) forms). Five of these forms contained minimal detail, and six had not been signed by a consultant. Four had been completed on the same date with identical wording for the reason for not resuscitating the person, without any documentation of discussion with the patient or relatives. At this inspection we found that two DNAR decisions had been reviewed in the ward round, the discussion documented, and the forms signed by the consultant. The other forms had not been changed, but they had been signed by the consultant, although there was no evidence that that this had been discussed with relatives or the review documented. However, the interim ward manager had reviewed every patients' best interest consents and discussed this with the patients' families, and documented this clearly. The assessments were detailed and included resuscitation, Deprivation of Liberty Safeguards (DoLS) and medication.
- At our last inspection we found that most patients were receiving medication covertly. Staff told us this was in the best interests of each patient, as they were unable to give informed consent or make decisions for themselves. This typically involved tablets being crushed and put into food, though this was not advised for some medication. There had been no care plans stating why patients required covert medication, or what form this should take. At this inspection we found that all the patients had had their medication reviewed and most were found able to take medication normally. There were now only two patients who had their medication administered covertly. There was a plan attached to each patient's medication chart, and a

guide to the tablets they were taking and what form they should be provided in to ensure they were administered safely. This was signed off by a pharmacist. Staff told us that a pharmacist visited the ward twice a week to check medication, and attended the fortnightly ward round to provide medication advice. The covert medication policy had been signed by registered nursing staff to confirm that they had read and understood it.

- However, we found that not all the medication was included on the plan, and although staff told us that a patient who received covert medication took antibiotic capsules (which should not be crushed or broken up) non-covertly, this was not recorded on the chart or in the care plan. Another medication stated on the prescription chart and the covert medication care plan that is should not be crushed (it has a film coating, which prevents it disintegrating until it has passed through the stomach), and should be given in an orodispersible (dissolves in the mouth) format. However, there were no orodispersible tablets available, or liquids, only the standard tablets which should be swallowed whole. Staff told us that they didn't believe other staff would crush the tablets, and that they might put the tablet whole in the patient's food. This was not recorded in the care plan.
- At our last inspection we found that there was no system for ensuring patients subject to Deprivation of Liberty Safeguards (DoLS) were provided with information about their rights, and there was no access for patients to an Independent Mental Capacity Advocate (IMCA). The system to regularly assess and monitor the quality of the service had not identified that it was not making suitable arrangements to ensure that service users are enabled to make, or participate in making, decisions relating to their care or treatment by providing appropriate information in relation to their care. At this inspection we found that most patients on the ward were subject to DoLS, and there was a process for reviewing this annually, that had been implemented. There was information on display about how to contact and refer a patient to the IMCA service, which was provided through the local authority. However, staff confirmed that the IMCA service would only provide an IMCA if a patient had no family. We saw that the service had engaged with the family members for most of the patients, and where this was not possible or the family did not wish to be involved they were following this up with the IMCA service to ensure that all patients had someone independent of the ward to speak up for their interests.

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

Summary of findings

We found that improvements had been made since our inspection in March 2015, but action was still required to ensure that services were safe.

Our findings

Safe and clean environment

- At our last inspection we found that although a ligature audit had been carried out, it had not been reviewed since 2010, and there were no individual risk assessments to mitigate against this. At this inspection we found that the ligature audit had been updated, and potential risks identified. However, the risks were being managed through the provision of a blanket statement that stated that ligatures were not a risk because "patients not cognitively aware", rather than risks being managed on an individual basis.

Safe staffing

- At our last inspection we found that there were staffing problems on the ward, which included a number of staff who were progressing through formal performance management processes but this had not been formally identified as an issue, or actions implemented to mitigate against this. At this inspection we found that experienced staff had been brought in from other units, some staff had been transferred elsewhere, and there was recruitment under way. Staff told us that the service was much better with the extra support for the unit. However, there were concerns about what would happen once the staff returned to their own wards.

Assessing and managing risk to patients and staff

- At our last inspection we found that not all patients had a fully completed risk assessment, or that this had not been updated. At this inspection we found that all patients had had a risk assessment, and since our last inspection this had been reviewed on a monthly basis. However, an incident had occurred which put a patient at risk, and the risk assessment had not been updated to reflect this new behaviour. However, aside from the risk assessment not being updated, the situation had been managed appropriately and steps taken to keep patients safe.
- At our last inspection we found that not all patients had an up to date falls assessment. At this inspection we saw improvements in the recording of moving and handling and falls risk assessments. However, staff told us that it would be helpful to have equipment such as "wander mats" (commonly used to detect when people get out of bed) for patients who were at a high risk of falling, but these were not available.
- At our last inspection we found that risks had not been included on the local risk register which had not been updated since 2012. At this inspection we found that the risk register had been updated, and was discussed at staff meetings. It included action plans and progress against them to remove, reduce or mitigate against risks. However, the new risks on the register were only those that had been identified at the CQC inspection. Subsequent risks had not been recorded. For example, there were a number of interim staff working on the ward, and it was not clear how the situation was going to be managed when they returned to their respective wards. This had not been identified as a risk, and there were no stated plans for how this was to be managed. Similarly, the week before our inspection 23 shifts had not been covered by staff – but this was not an issue recorded on the risk register with plans for how to mitigate against this happening again.

Reporting incidents and learning from when things go wrong

- At the last inspection we found that incident forms were not fully completed, and did not include all the necessary information. This meant that incidents were not taken account of and analysed, so that action could be taken to prevent reoccurrence and keep patients safe. At this inspection we found that incident forms were now recorded on the trust's electronic incident management system (DATIX). The sample of six incident forms we reviewed contained the necessary information. There was evidence of learning from

Are services safe?

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

incidents. For example, following an incident where a patient obtained a potentially dangerous object this was discussed with staff, and practices were changed to prevent it happening again.

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.

Summary of findings

We found that improvements had been made since our inspection in March 2015, but action was still required to ensure that services were effective.

Our findings

Assessment of needs and planning of care

- At our last inspection we found that a patient had had an injury that had not been appropriately assessed, treated or followed up. The trust told us that it had addressed this, and at this inspection we confirmed that this had happened.
- At our last inspection we found two specific incidents where patients had refused specific interventions, such as to attend healthcare appointments or to take food supplements, and it was not clear what further action was taken to address this. At this inspection we found that the specific incidents had been addressed. More generally, the service had implemented a checklist/ spreadsheet for recording when patients' required physical health tests (such as blood tests), what they were for, when they were requested and when they were carried out. This was monitored by staff on the ward. However, we found an example where a patient with diabetes was not having their blood sugar levels monitored consistently.
- At our last inspection we found that continence assessments were not always carried out, and the only aids used were pads. There had been no individually tailored plans for meeting people's continence needs and we found the majority of patients wearing pads. At this inspection we found that continence assessments had been carried out but they did not contain detailed information such as the type of pads to use, or how often they had been changed. There was a lack of correlation between these, the care plans and the information contained within the stool charts. All patients had stool charts, to monitor their bowel movements. However, they were not completed consistently; some charts had no name or identifying details on them, and some had abbreviations that other staff did not know the meaning of. We found an example where a patient was regularly passing very loose stools, but was still being given medication to treat constipation.
- At our last inspection we found that the recording of patients' weight and nutritional status had improved since our last inspection, and was now documented on RIO (the trust's electronic care record). However, weights had not been recorded for some patients, and the height had been recorded inaccurately in some cases. This led to an incorrect body mass index (BMI) being calculated, which determined if a patient was a healthy weight. Staff did not take account of a patient's weight in order to adjust air mattresses, which were used to reduce the risk of pressure sores, and did not know if the mattresses adjusted automatically.

Best practice in treatment and care

- At our last inspection we found a lack of appropriate assessment and response to patients' pain management, and specific concerns about how an individual patient's pain was being managed. At this inspection we found that pain management charts had been implemented. These were based on the Abbey pain chart, a recognised tool for identifying pain in people with dementia who may not be able to express this directly. All patients had a pain chart attached to their medication chart. This had been completed for each patient, but not consistently. Most patient's charts recorded the level of pain as "0" which meant they were in no pain. However, there were no plans to indicate when the assessment should be carried out, and it was completed sporadically. For example, sometimes a chart was completed twice a day, and at other times not for several days. In a chart where a patient had been given pain medication, it was not clear that a follow up assessment had been carried out a short time afterwards to check if it had been effective. In other charts pain killers had been administered but they did not match the information on the Abbey pain chart.
- At our last inspection we identified specific concerns about an individual patient's pain management. At this inspection we found that this had not been fully resolved, but action had been taken. There had been problems with the response from other organisations, such as an acute hospital, but the entries in the records did not always make it clear what action had been taken

or was required, and at times appeared contradictory. The patient was prescribed several painkillers, but the pain management chart did not correlate with the medication administered.

- At our last inspection we found that food and fluid monitoring charts were not fully completed, and not all patients who needed them had a chart available to record the information on. At this inspection we found that patients had a chart, but the recording of food was inconsistent, particularly about the quantity of food or fluid taken.
- At our last inspection we found gaps in patient care. For example assessments had not been carried out or were incomplete. At this inspection we found that the systems for identifying where there were gaps in care, and taking action to rectify these, had improved since the last inspection but there were still gaps. The service used "intentional rounding", which is a recognised practice where staff check on patients at regular intervals (typically hourly) and carry out any required routine checks. All patients had intentional rounding forms, but none of them were completed in accordance with the guidelines on the form.

Good practice in applying the Mental Capacity Act

- At our last inspection we found that nine of the 15 patients had forms stating that they were not to be resuscitated in the event of a medical emergency (often known as "do not attempt resuscitation" (DNAR) forms). Five of these forms contained minimal detail, and six had not been signed by a consultant. Four had been completed on the same date with identical wording for the reason for not resuscitating the person, without any documentation of discussion with the patient or relatives. At this inspection we found that two DNAR decisions had been reviewed in the ward round, the discussion documented, and the forms signed by the consultant. The other forms had not been changed, but they had been signed by the consultant, although there was no evidence that that this had been discussed with relatives or the review documented. However, the interim ward manager had reviewed every patients' best interest consents and discussed this with the patients' families, and documented this clearly. The assessments were detailed and included resuscitation, Deprivation of Liberty Safeguards (DoLS) and medication.
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- However, we found that not all the medication was included on the plan, and although staff told us that a patient receiving covert medication took antibiotic capsules (which should not be crushed or broken up) non-covertly, this was not recorded on the chart or in the care plan. Another medication stated on the prescription chart and the covert medication care plan that is should not be crushed (it has a film coating, which prevents it disintegrating until it has left the stomach), and should be given in an orodispersible (dissolves in the mouth) format. However, there were no orodispersible tablets available, or liquids, only the standard tablets which should be swallowed whole. Staff told us that they didn't believe other staff would crush the tablets, and that they might put the tablet whole in the patient's food. This was not recorded in the care plan.

Are services caring?

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

Summary of findings

We did not look at this question as part of our focused inspection.

Our findings

We looked at whether services were caring as part of our comprehensive inspection in March 2015.

This was a focused, unannounced inspection that looked at three of the five questions: “Are services safe, are they effective, and are they well led?”

Are services responsive to people's needs?

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

Summary of findings

We did not look at this question as part of our focused inspection.

Our findings

We looked at whether services were caring as part of our comprehensive inspection in March 2015.

This was a focused, unannounced inspection that looked at three of the five questions: "Are services safe, are they effective, and are they well led?"

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.

Summary of findings

We found that improvements had been made since our inspection in March 2015, but action was still required to ensure that services were well led.

Our findings

Good governance

- At the last inspection we found that the interim ward manager had identified that the service was not aware of current safeguarding investigations, and any actions they should be taking with regards to this. They had set up a local log for recording safeguarding concerns in January 2015, and this was still in place when we carried out this inspection.
- At our last inspection we found that there was no system for ensuring patients subject to Deprivation of Liberty Safeguards (DoLS) were provided with information about their rights, and there was no access for patients to an Independent Mental Capacity Advocate (IMCA). The system to regularly assess and monitor the quality of the service had not identified that it was not making suitable arrangements to ensure that service users are enabled to make, or participate in making, decisions relating to their care or treatment by providing appropriate information in relation to their care. At this inspection we found that most patients on the ward were subject to DoLS, and that there was a process for reviewing this annually, that had been implemented. There was information on display about how to contact and refer a patient to the IMCA service, which was provided through the local authority. However, staff confirmed that the IMCA service would only provide an IMCA if a patient had no family. We saw that the service had engaged with the family members for most of the patients, and where this was not possible or the family did not wish to be involved they were following this up with the IMCA service to ensure that all patients had someone independent of the ward to speak up for their interests.

Leadership, morale and staff engagement

- The interim ward manager was due to leave in two weeks, but was working with the new manager (also interim) to complete a thorough handover. Staff told us that the service was much better with the extra support for the unit. However, there were concerns about what would happen once the staff returned to their own wards.
- At our last inspection we found that there was no direct senior medical input to the wards. There was a locum associate specialist who had limited previous experience of working with people with dementia. They received support from a consultant, but the consultant did not visit the ward or see or directly review patients. At this inspection we found that a specialist doctor provided four sessions to the unit each week plus additional support as required and there were now two consultants for the ward who visited the ward once a fortnight to hold a ward round and provided support to the ward doctor. Each patient had a named consultant allocated on RiO. Both consultants worked within older people services elsewhere in the trust.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Kent and Medway NHS and Social Care Partnership Trust had processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. However, these were not consistently implemented or recorded. This included with regards to pain management, regular health tests (such as blood tests and ECGs), fluid balance charts, continence assessment and weight monitoring. This was in breach of regulation 17(1)(2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.