Requires improvement

Barnet, Enfield and Haringey Mental Health NHS 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)
RRP16	Chase Farm Hospital	Dorset ward Somerset villa Suffolk ward Sussex ward	EN2 8JL
RRP23	Edgware Community Hospital	Avon ward (PICU) Thames ward Trent ward	HA8 0AD
RRP46	St Ann's Hospital	Downhills ward	N15 3TH

Summary of findings

Finsbury ward
Haringey assessment unit

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS 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 Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS 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	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Barnet, Enfield and Haringey Mental Health NHS Trust's aute wards for adults of working age and psychiatric intensive care wards as **requires improvement**.

The overall safety of the services was inadequate as there were a number of areas where improvements were needed. Patients safety, privacy and dignity was potentially compromised due to the location of the seclusion rooms. Individual risk assessments were not detailed, did not include all risks and were not updated following incidents. Clinic rooms at St Ann's were not a safe environment for medicine storage and administration. The wards did not always have enough staff and used a lot of agency staff. This affected the continuity of care for patients and also led to the cancellation of some leave. On Downhills ward at St Ann's there was a high level of violence and aggression. All staff at Edgware Community Hospital did not have access to personal alarms. A number of patients had absconded from the wards and a plan had not been implemented to minimize this happening in the future.

Whilst measures were in place to assess patients' physical healthcare needs a tool that was being used to monitor a deterioration in a patients physical health was not being used correctly. Patient care plans were not individualised or outcome and recovery focused and did not document patients' involvement with their care.

The lack of permanent ward managers and consistent medical input on some of the wards impacted on the ward environment and patients' continuity of care. A number of staff did not receive regular supervision. The wards had a lack of psychology input and some patients experienced a long waiting list.

Patients' privacy and dignity were not promoted on the wards. Patients could not close the observation window on their bedroom doors and did not have access to a phone to make a phone call in private. At Edgware Community Hospital, many patients said the quality of food was poor and there was limited choice of food that did not address their cultural needs. The wards did not always support patients' religious or spiritual needs.

However, most care was delivered with kindness and respect. Staff demonstrated good understanding of patients' needs and addressed issues immediately. Patients had regular community meetings and could provide feedback though surveys.

Staff had a good knowledge of how to report incidents and of safeguarding procedures. They could access specialist training and opportunities for professional development. Patients had access to advocacy services.

There was proactive bed management. Patients knew how to complain and the wards managed these well. There was a good choice of food at Chase Farm and St Ann's Hospitals. Patients could access a range of activities. Patients had safes in their rooms to store their personal belongings.

Most staff spoke positively about their teams and managers. They agreed with the trust's vision and values and knew the senior members of the trust. The wards used heat maps and monthly key performance indicators to monitor outcomes.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- The location of seclusion rooms meant that patients safety, privacy and dignity could be compromised.
- Individual risk assessments were not detailed, did not include all risks and were not updated following incidents.
- Clinic rooms at St Ann's did not always provide a safe environment for medicine storage and administration, medical equipment needed cleaning and on Downhills ward medical emergency equipment could not be reached easily in an emergency.
- The ward layouts at Chase Farm and St Ann's had blind spots on bedroom corridors that could be improved through the use of mirrors.
- The wards did not always have enough staff and used a lot of agency staff. On some wards leave was cancelled or postponed. At St Ann's there was a high level of violence and aggression on Downhills ward.
- Ward ligature risk assessments did not include information on actions taken to mitigate risks, dates for work completion and the responsible person.
- Patients were absconding from inpatient wards and whilst individual risk assessments were in place a clear action plan to reduce the overall numbers of absconsions had not been developed.
- The use of rapid tranquillization was not always recognised to ensure patients received the appropriate health checks afterwards.
- Some staff did not always learn from incidents that happened on the wards and across the trust.

However, most of the wards were clean. Most staff were up to date with mandatory training. Staff raised safeguarding concerns and these were documented and investigated. Staff knew the different types of incidents to report.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Patients' care plans were not individualised or outcome and recovery focused and did not document patients' involvement with their care.
- All staff did not receive regular supervision.

Summary of findings

- Most staff said they had not completed any MHA or MCA training. Staff's understanding of the MCA varied on the wards.
- Staff had not ensured that patients knew and understood their rights under the MHA. This was sometimes caused by delays with interpreters.
- The wards were not always accessing psychology input. There was no psychology available on Avon ward and some wards experienced a long waiting list.
- Staff on did not always score patients' MEWS charts which meant that physical health concerns may not always be raised or addressed.

However, the daily morning Jonah meetings on the wards at Chase Farm and Edgware Community Hospitals were effective to review patients on the ward and facilitate discharge. Staff could access specialist training and opportunities for professional development.

Are services caring?

Good

We rated caring as **good** because:

- Most care was delivered with kindness and respect.
- Staff demonstrated good understanding of patients' needs and addressed issues immediately.
- Patients had regular community meetings and could provide feedback though surveys.
- Most patients had good family and carer involvement.
- Thames ward offered "coffee with the consultant" and "medication awareness" sessions for patients.

However, some patients on Downhills ward said that staff attitude was poor and were not always involved with their care planning. Some of the care observed on Dorset ward was short in duration and task focused.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

- Patients' privacy and dignity were not promoted on the wards.
- Patients returning from leave might have to move to a new ward which would disrupt their continuity of care.
- At Edgware Community Hospital, many patients said the quality of food was poor and there was limited choice of food that did not address their cultural needs.
- The wards did not always inform patients' about how they could meet their religious or spiritual needs.
- Patients did not all have access to make a phone call in private.

Summary of findings

However, there was proactive bed management at Edgware and Chase Farm Hospitals. Patients knew how to complain and the wards managed these well. There was good choice of food at Chase Farm and St Ann's Hospitals. Patients could access a range of activities. Patients had safes in their rooms to store their personal belongings.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** because:

- The lack of permanent ward managers and consistent medical input on some of the wards impacted the patients' continuity of care and stability of team leadership.

However, most staff spoke positively about their teams and managers. They agreed with the trust's vision and values and knew the senior members of the trust. Staff were positive about the specialist training and professional development they could access. The wards used heat maps and monthly key performance indicators which provided managers with essential management information to monitor progress on the wards.

Summary of findings

Information about the service

As part of this inspection we visited the following services:

Chase Farm Hospital

Dorset ward – 15 bed mixed sex acute admission ward

Suffolk ward – 18 bed female acute treatment ward

Sussex ward – 18 bed male acute treatment ward

Edgware Community Hospital

Avon ward – 16 bed male PICU ward

Thames ward – 20 bed mixed adult acute treatment ward

Trent ward – 21 bed mixed adult acute treatment ward

St Ann's Hospital

Downhillls ward – 19 bed female acute treatment ward

Finsbury ward – 19 bed male acute treatment ward

Haringey Assessment Unit – 12 bed male acute assessment ward

Chase Farm Hospital had been inspected seven times since 2011 and we published the reports of these inspections between December 2011 and November 2014. The last inspection on the acute wards was in January 2013, which included Sussex and Suffolk wards. This was a themed inspection that focused on seclusion practices. There were no outstanding compliance actions at the time of our inspection.

Edgware Community Hospital had been inspected twice since 2011 and we published the reports of these inspections between December 2011 and July 2013. The last inspection was in June 2013 and included a visit to Trent ward. Following the inspection, a compliance action was made because staff were not clear about informal patients' legal status, the ward used seclusion rooms to admit patients and patients did not have access to secure locked space for their belongings. We followed up these outstanding actions during the inspection visit. Staff were clear on informal patients' legal status. The ward was not using the seclusion room to admit patients. Patients had a lockable safe in their bedrooms.

St Ann's Hospital had been inspected five times since 2011 and we published the reports of these inspections between December 2011 and May 2014. The last inspection was in April 2014. The inspection team visited Haringey ward to check if actions had been taken to meet the requirements following a previous inspection in November 2013 where patients had been admitted to seclusion rooms due to a lack of available beds. We found that the trust was only using the seclusion rooms when it was clinically appropriate.

Our inspection team

The team that inspected the acute and PICU services consisted of four CQC inspectors, a doctor, three experts by experience, three Mental Health Act reviewers, two nurses, two psychiatrists and a psychologist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

Summary of findings

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 visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- Visited all nine of the wards across the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 91 patients who were using the service and collected feedback from 32 patients using comment cards.
- Spoke with the managers or acting managers for each of the wards.
- Spoke with 80 other staff members including activities coordinators, doctors, a drama therapist, healthcare assistants, Mental Health Act administration staff, nurses, occupational therapists, pharmacists, and psychologists.
- Spoke with independent mental health advocates and community advocates.
- Interviewed the Barnet clinical director, Barnet assistant clinical director, Barnet professional medical lead, and Haringey assistant clinical director.
- Attended and observed three multidisciplinary meetings, two ward review meetings, one top discharge meeting, one bed conference meeting, and patient activities.
- Looked at 45 treatment records and 53 health charts of patients.
- Carried out a specific check of the medication management on six wards.
- Looked at 57 risk assessments, 57 care plans, 53 seclusion records and 45 incident reports.
- Looked at nine staff supervision 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

Most of the feedback we received from patients during the inspection was positive.

We received 32 comment cards from patients or staff from the acute and PICU wards. Of these, seven had only positive comments on the caring, respectful and friendly staff and clean environment. Nine had only negative comments and the rest had both positive and negative comments. The areas identified for improvement included not feeling safe on the wards, leave being cancelled, issues with medication, having more activities and access to fresh air and staff being under pressure.

Good practice

- Thames ward's consultant hosted a weekly "coffee with the consultant" afternoon with patients. The consultant met with patients in the lounge and provided tea and cakes. Patients could discuss anything apart from personal medical needs.
- The pharmacist on Thames ward hosted fortnightly "medication awareness" sessions with patients. This session was well organised and informative.
- Trent ward had won funding through the trust's "Dragon's Den" competition to provide a "safe space"

Summary of findings

room for patients on the ward. This was a large inflatable structure that patients could lie down on to relax with staff supervision. They could also use headphones to listen to music while in the room.

- The wards had a daily "Jonah" meeting at 9am attended by staff from all disciplines. Staff used a task master to go into each patient and set out practical tasks such as managing patients' accommodation, reviewing medication or safeguarding alert. Managers allocated tasks to each staff to action and close off every day. Staff said they found these meetings essential to supporting patients and managing their discharge.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the location of seclusion rooms are safe and protect patients' privacy and dignity. (This includes female patients being secluded on a male ward, transporting patients safely, staff being able to observe patients while in seclusion, sharing of bathroom facilities, other patients on the ward not being able to view into the seclusion room).
- The trust must ensure that the clinic rooms are providing a safe environment for medicine storage and administration, medical equipment is clean and on Downhills ward medical emergency equipment can be reached easily in an emergency.
- The trust must ensure patients' risk assessments are completed with sufficient detail and updated following incidents and risk events.
- The trust must ensure there are sufficient numbers of permanent staff working on the wards. This is to ensure consistency of care, avoid leave being cancelled and reduce the incidence of violence and aggressive behaviour especially on Downhills ward at St Ann's.
- The trust must ensure that there are sufficient numbers of mirrors available to help improve levels of observation in corridors on the wards.
- The trust must ensure blanket restrictions are kept under review and only used in response to a current risk such as the locked doors throughout Dorset ward at Chase Farm.
- The trust must review incidents of absconding from inpatient wards to identify the reasons and ensure measures are in place to keep this to a minimum.
- The trust must ensure that the use of rapid tranquillization is recognised so that appropriate health checks take place afterwards to maintain the safety of the patients.
- The trust must ensure that all staff receive regular supervision and this is recorded and monitored.
- The trust must ensure that staff know how to use the modified early warning scores properly as these identify when patients' physical health is deteriorating and that where needed medical assistance is sought.
- The trust must ensure that the wards protect patients' privacy and dignity by enabling patients to be able to close the observation windows on their bedroom doors.
- The trust must keep to a minimum patients returning from leave and needing to be cared for on another ward which disrupts their continuity of care.
- The trust must ensure they recruit permanent ward managers and consultant psychiatrists for the wards and that interim managers are appropriately supported and trained.

Action the provider SHOULD take to improve

- The trust should improve the physical environment on Dorset ward.
- The trust should ensure all the wards are clean including Downhills ward at St Ann's and Avon ward at Edgware community hospital.
- The trust should ensure that all staff have their refresher training in the prevention and management violence and aggression in a timely manner.

Summary of findings

- The trust should ensure that there is a clear record of when medicines have been reconciled after the admission of a patient to a ward. Patients who are taking 'as and when' medication should have this regularly reviewed.
- The trust should ensure that staff working in Haringey meet the trust's targets for the completion of mandatory training.
- The trust should ensure the number of beds on Avon ward follow national guidelines for PICU's.
- The trust should ensure that it reduces the number of times patients are transferred to other wards for non-clinical reasons and that each incident is documented.
- The trust should ensure that staff explain to patients their rights under the MHA, that patients understand their rights and these are repeated. Interpreters must be booked in a timely manner to ensure this is completed.
- The trust should ensure that all information given to informal patients regarding their personal liberty is legally accurate. The trust must also ensure that the MHA guidance available on the wards reflects the current code of practice.
- The trust should ensure that there are systems in place for staff to learn from incidents across the trust.
- The trust should ensure that all staff are aware of the procedures taken when collecting and disposing of illegal substances.
- The trust should ensure doctors provide clinical judgement details in patients' capacity to consent or treatment assessments and that these records are accurate and consistent.
- The trust should ensure that patient care records are recovery focused, include patient involvement and document patients' 1:1 time with their named nurse.
- The trust should ensure patients have access to adequate psychology input especially at St Ann's and Edgware community hospitals.
- The trust should ensure that wherever possible staff involvement with patients is caring and supports patient recovery and is not only task-focussed.
- The trust should ensure that patients can make a phone call in private.
- The trust should ensure they are informing patients' how their spiritual and religious needs can be met.
- The trust should ensure they provide food of good choice and quality that meets patients' cultural and dietary needs at Edgware community hospital.

Barnet, Enfield and Haringey Mental Health NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Dorset ward Somerset villa Suffolk ward Sussex ward	Chase Farm Hospital
Avon ward (PICU) Thames ward Trent ward	Edgware Community Hospital
Downhills ward Finsbury ward Haringey assessment unit	St Ann's Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Acute wards

- Mental Health Act (MHA) training was not mandatory and wards did not keep records of staff completion rates. Staff were unsure of what kind of MHA training was available. Some staff who had been working on the ward for several years had not completed any MHA training or had any updates.

Detailed findings

- Staff said that patients had their rights under the MHA explained to them on admission and patients confirmed this. However, this was sometimes delayed due to a lack of an interpreter.
- Most MHA documentation was completed and stored correctly.
- On Haringey assessment unit detained patients told us that they were not always aware that their leave had changed as a member of staff had not discussed it with them.
- Staff could get advice and guidance from the MHA office in their hospitals
- For patients detained under MHA, they received medicines in line with the MHA Code of Practice. Where required, consent (T2) or authorisation (T3) certificates were completed and attached to patients' medicine charts.
- Patients had access to an independent mental health advocate (IMHA) who regularly visited the wards.

PICU ward

- MHA training was not mandatory and the ward did not have staff completion rates.
- We reviewed six sets of MHA documentation and found them in good order and in adherance with the MHA Code of Practice. In the six records reviewed, all patients had an approved mental health practitioner (AMHP) report in place.
- Staff regularly informed patients of their rights. The MHA office was based onsite and could provide staff with any support and advice. They sent an alert to wards staff when a patient's rights were due and their section due to expire.
- Staff completed patients' consent to treatment and capacity following their admission.
- For patients detained under the MHA, they received medicines in line with the MHA Code of Practice and the relevant legal documentation was kept with their prescription charts.
- Staff referred patients to the independent mental health advocacy (IMHA) service on admission. The ward had posters advertising this service on a notice board and leaflets displayed on the information rack.
- We reviewed six patients' section 17 leave records. Patients were granted internal ground leave as well as external. Copies of leave forms were not given to four of the six patients. We noted two of the patients' leave forms had not been completed by the approved clinician. There were also errors made in completions of the forms by the approved clinician by omitting to write the start and end date, period of leave and also not recording an address on the overnight home leave details.
- We found that patients were able to take leave of absence approved by the authorised clinician. The ward used leave as part of a therapeutic intervention which was planned and any risk was assessed and, when required, a management plan was devised.
- Patients were not being offered the opportunity to draw up advanced decision/directives.
- Detained patients had access to an independent mental health advocate (IMHA) from Voiceability who attended the ward weekly. They also met with any new detained patients. Informal patients accessed an advocate from Mind who were based on site at the hospital. The separate service provision sometimes caused confusion for patients on the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

Acute wards

- The trust was not providing MCA training as mandatory and did not have records of completion rates. Staff had a varied understanding of the MCA. The admitting doctor completed mental capacity assessments on admission. The records did not reflect that other members of the team were completing mental capacity assessments.
- Some staff were able to demonstrate knowledge of some of the guiding principles of the Mental Capacity Act (MCA). However other staff had no knowledge of them at all.
- The provider had a policy relating to the MCA which was available for staff on all wards to refer to.
- There was one deprivation of liberty safeguards (DoLS) application made in the past year on Finsbury ward.

Detailed findings

- A care record showed that a patient at St Ann's was going to be treated under MCA pending an application for DoLS. No evidence of an assessment of the patients' capacity to consent to treatment or consent to stay in hospital was found.

PICU ward

- MCA training was not mandatory and the ward did not have staff completion rates for this. Staff's understanding of the use of the MCA varied on the wards.
- We did not find any documentation of patients' MCA assessments for individual decisions in patients' records.
- The trust had a policy on the MCA available on the intranet.
- There were no patients subject to deprivation of liberty safeguards on the wards at the time of our inspection.

Inadequate

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

Acute wards for adults of working age – Chase Farm Hospital

Safe and clean environment

- The layout of the three wards meant that staff did not have clear lines of sight into every part of each ward. CCTV cameras had been installed to supplement staff observation. No mirrors were in place to help staff to see into areas where there were no direct lines of sight. Staff completed regular environmental and patient checks according to the assessed need of the patient group.
- There were ligature points on each of the wards. These included on the communal doors and in the communal bathrooms. Staff had recorded these risks on the ward audit of ligature points. They had also taken steps to mitigate some of these risks. For example, where staff had identified that a patient was at a risk of harm a staff member would remain in the communal bathroom when they were using it.
- Each of the clinic rooms on the three wards was in good order with all emergency equipment, including for resuscitation and medicines were up to date. Records showed that staff checked all medicines and equipment regularly. Fridges used for storing medicines were all at the correct temperatures and staff made up-to-date checks of these temperatures. Emergency ligature cutters were located in the staff office on each ward and all staff knew their location. Medicines used for resuscitation and emergencies were available, tamperproof and accessible.
- Sussex and Suffolk wards had a seclusion room. Both had the same design and layout with provision for two-way communication. A clock was located in each room and a communal bathroom situated next to each room was for secluded patients. The seclusion rooms were both located on a corridor beside other patients' bedrooms. This meant that other patients could potentially see into the seclusion rooms when the viewing panel located in the door to the room was open. Staff said that patients in seclusion usually wanted this panel open so that they could see the member of staff stationed outside to provide reassurance. To prevent patients on the communal corridor from seeing into the seclusion room staff put up a screen in front of the door. This was also intended to protect the dignity of the patient in seclusion. However, these screens were not high enough and it was easy to see over them into the seclusion rooms. When we pointed this out to staff, they said that they would obtain higher screens.
- The communal bathrooms located next door to both seclusion rooms had many ligature risks in them. Staff had taken steps to mitigate these risks. This meant that a member of staff would always enter the communal bathroom with the secluded patient. To give the patient some privacy when using the toilet in the communal bathroom a curtain was pulled round the toilet area. However, the fact that a secluded patient could only use the toilet when a member of staff was in the toilet with them did not support their dignity.
- The ward areas on Suffolk ward and Sussex ward were visibly clean and well maintained. Cleaning records on all wards were up to date. Both wards had furnishings and equipment which were mostly in good condition. However, the condition and environment on Dorset ward was poor. The walls were grey and drab and there was no object of any colour on the ward. Furnishings were in a poor condition.
- Staff had undertaken regular environment risk assessments on each of wards. Risks were identified and staff had recorded in the assessments how they would mitigate the risks.
- All staff on the three wards had alarms. An emergency nurse call system was in place to summon support from other wards when this was required.

Safe staffing

- Each ward had the same staffing levels. During the day this was three qualified nurses and two healthcare assistants (HCAs). During the night this was two qualified nurses and two HCAs.

Inadequate

Are services safe?

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

- There were staff vacancies on each of the wards. On Suffolk ward there was a vacancy for one qualified nurse and one HCA. On Dorset ward there were vacancies for two nurses and two HCAs. Sussex ward had three vacancies for nurses and one HCA.
- Over the previous three months, all wards had employed bank and agency staff. On Sussex ward 288 shifts had been covered by bank and agency staff. The numbers for Dorset and Suffolk wards were 197 and 272 respectively. Each ward was not able to fill some shifts. On Sussex ward 42 shifts were unfilled, Dorset and Suffolk wards were 13 and 24 respectively.
- The sickness rate from 1 August 2014 to 31 July 2015 was 8.9% on Sussex ward, 6.9% on Dorset ward and 5.5% on Suffolk ward.
- Staff said that there were pressures on staffing levels and that these pressures could reduce the number of staff working on the wards. For example, where close observation duties were required the first member of staff to undertake this work had to come from those staff already working on the ward. Extra staff were only available for multiple close observations. Staff also said that if they were responsible for the health based place of safety then this also impacted on their staffing level. The purpose of this facility was to receive patients who police had brought to hospital as a place of safety. Responsibility for supervising this suite rotated between the wards. Staff said this responsibility had a negative effect on staffing levels. This was because although the ward responsible for the suite received two additional staff members for this work, the ward manager of the responsible ward frequently had to also attend the suite. This was to supervise admissions to the suite and often took the manager away for long periods. Staff on all the wards also said that responsibility for holding the nurse call emergency system could have a negative impact on staffing levels. This responsibility was also rotated between the wards. Staff explained that the ward holding the alarm did not receive extra staff to meet this responsibility. Therefore the senior member of ward staff responsible for supervising emergencies could be frequently absent when undertaking this duty.
- Three patients on Sussex ward also said that there was not enough staff on the ward.
- Staff on each of the wards said that the use of bank and agency staff was reducing. However, some staff did express concerns over the high use of agency staff. Two senior members of staff said that there were too many agency staff employed on Dorset and Suffolk wards. Their concerns were that agency staff were often unfamiliar with how the wards worked or the needs of individual patients. Two members of staff said that a problem with agency staff was that they did not have access to the electronic system relating to patient data. This meant that they could not see vital data relating to patients' care and treatment meaning that they were potentially less able to provide support to patients than permanent staff who could access that data.
- Ward managers said that as far as possible they employed bank and agency staff who had already worked on the acute wards before. This was because these staff were more familiar with how those wards worked and often had worked with the patients on the wards before. However, two ward managers acknowledged that sometimes agency staff worked on the wards who had not worked there before.
- Ward managers were able to adjust levels of staffing to meet their needs. For example, where a patient was to be admitted who required close observation they were able to ask for an additional staff member to undertake that task.
- There was sufficient staff on the wards to ensure a qualified nurse was in the communal areas of the wards at all times. At the time of our visit we observed a qualified nurse on all the wards at all times.
- Staff said that there was enough staff for patients to have regular 1:1 time with staff. Any staff shortages did not affect this.
- Staff shortages affected patients' escorted leave on all three wards. Staff on all wards said that this sometimes happened. Four patients across the wards said that staff had cancelled their leave because of a shortage of staff. Staff on all wards also admitted that because of shortages of staff they sometimes had to reschedule or reduce the length of time of patients' leave. Staff and patients said that when this happened it could cause frustration for patients which was not supportive of their recovery.

Inadequate

Are services safe?

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

- Staff on all wards said that there were enough staff members to always carry out the physical restraint of patients safely. We looked at 10 records relating to restraint and these all showed that there were enough staff to carry out these procedures safely.
- Medical cover consisted of a ward doctor and two consultants for each ward and a psychologist who worked across the three wards. Two doctors covered the night shifts on the wards including any emergencies.
- Mandatory training completion rates for Suffolk ward was 82%, Dorset ward was 87% and Sussex ward was 88%.

Assessing and managing risk to patients and staff

- Between 1 January 2015 and 30 June 2015, there were 21 incidents of staff using the seclusion room on Suffolk ward and 20 incidents on Sussex ward. There was no seclusion room on Dorset ward. Staff took patients from Dorset ward who required seclusion to Sussex or Suffolk wards. This happened 20 times during this period.
- Between 1 January 2015 and 30 June 2015 staff had restrained patients on each of the wards. None of the restraints were in the prone position. On Dorset ward, staff restrained patients five times, Suffolk ward eight times and Sussex ward 17 times.
- We examined 20 risk assessments of patients across the three wards. In all cases staff completed risk assessments of patients on admission. Some of these records were detailed with the level of risk clearly based on evidence and with updated care records showing how staff intended to manage identified risks. However, staff had not updated some risk assessments following incidents. On Dorset ward, eight patients had absconded from the ward in the past few months but the staff had not updated any of the risk assessments of those patients. Similarly, staff on Sussex ward had not updated risk assessments of two patients who had absconded. Another patient's records on Dorset ward showed that they had been assaulted by another patient but staff had not updated their risk assessment.
- Staff had not recorded that they had undertaken an assessment of risk where patients were sharing rooms and in particular where they were unhappy about this arrangement. On each ward there was a double room shared by two patients. Each room was divided by a screen to allow for some privacy. There was no evidence that any incidents had taken place in shared rooms.
- Staff used a recognised tool to assess patients' risk called the historical clinical risk management-20. The tool is based on asking the patient 20 questions in order to assist staff evaluate a risk of violence and aggression and to determine care and treatment options.
- Blanket restrictions were in place on Dorset ward. Staff had locked all rooms including the kitchens, laundry, quiet room and meeting room. Staff said that this was necessary in order to prevent patients damaging the rooms, as this had happened in the past. However, under the Mental Health Act (MHA) Code of Practice staff should only impose blanket restrictions where they are proportionate and in response to an identified risk. Staff did not provide evidence of the risk that was the reason for this blanket restriction.
- Staff told informal patients on the wards that they were free to leave at any time. Staff also placed this information by the entrance to each of the wards. However, on Suffolk ward there were two different notices regarding informal patients' rights. The notice on the ward stated that informal patients were free to leave at any time. But another notice outside the main entrance said that informal patients required the consent of staff to leave. The information on the sign outside the main entrance was wrong. Informal patients have an absolute right to their personal liberty and staff may only restrict this by using powers under the MHA. When we pointed out this notice to staff they immediately took it down.
- Staff on each of the wards said that they only physically restrained patients as a last resort. On Dorset and Suffolk wards the data kept by the hospital confirmed this. On Dorset ward staff had only used physical restraint five times over the first six months of 2015 and on Suffolk ward eight times. However the number on Sussex ward was much higher. Staff had restrained 17 different patients a total of 23 times over the same period. When we asked Sussex ward staff about this many spoke of a previous culture of restraint on the ward that had now changed. They said that since a change of management in June 2015 the culture had changed because a new ward manager had directed that restraints were too high.

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- In six restraint records, staff had carried out these procedures correctly according to the policies of the hospital and national guidance. Staff restrained patients in accordance with prevention and management of violence and aggression (PMVA) training. This training was mandatory for staff. Bank staff who worked on all three wards had also completed this training. However, two senior staff expressed concern that there was a delay in providing refresher PMVA training for existing staff. This was because there were no available courses until March 2016. One member of staff on Dorset ward and Suffolk ward were not up to date with this training.
- Seclusion records on Sussex and Suffolk wards showed that staff had used seclusion appropriately and that staff actions conformed to national guidance. However, Dorset ward did not have a seclusion room. When staff wanted to seclude patients on this ward they took them to either of the seclusion rooms on the other two wards. To do this staff took the patient concerned out of the ward and along a corridor used by staff and visitors to either stairs or a lift to the floor where the other wards were located. Because this process meant that the patient was in contact with and in full view of visitors and other staff it was potentially neither appropriately safe nor supported the dignity of the patient.
- Staff demonstrated that they understood the principles of safeguarding and how to raise a safeguarding alert. Procedures were in place on each of the wards to ensure that safeguarding concerns were dealt with appropriately and without undue delay. For example, a patient had complained to staff on Sussex ward that staff had used inappropriate force when restraining him. Staff recognised that the incident was a safeguarding matter and immediately raised a safeguarding alert with the local authority. A patient raised another concern during our visit regarding the conduct of two staff members on Dorset ward. Staff immediately identified this concern as a potential safeguarding matter and raised an alert.
- Staff on the wards undertook good medicines management including how they stored medicines and dispensed them. This included how staff managed controlled drugs. Staff had properly secured them and kept all records up to date and signed when they had dispensed the drugs. A pharmacist supervised the management of drugs across the three wards. Staff knew how to obtain support from a pharmacist if required, and also how to obtain medicines out of hours. There was an agreed protocol for assessing patients' suitability for self-administration of medicines and staff followed this. There was minimal use of rapid tranquilisation (RT) at the trust. Staff demonstrated a good knowledge of the procedures required for the administration of rapid tranquilisation. Where RT was used, we saw that most records contained sufficient information on post-incident monitoring and physical observations were carried out. The use of high-dose antipsychotics was minimal and appropriately monitored and communicated to the medical team. Medicines were supposed to be reconciled in patients' electronic records and annotated as complete on medicines charts. However, we saw that this recorded confirmation was often missing from the medicine charts.
- Child visitors were not permitted on the wards. Instead patients could see child visitors away from the ward in a meeting room in another part of the hospital.

Track record on safety

- There were three serious incidents on Suffolk ward and one on Sussex ward in the year prior to the inspection.

Reporting incidents and learning from when things go wrong

- Staff demonstrated a good knowledge of how to report incidents taking place on the ward.
- Staff were provided with feedback from incidents at handovers, ward rounds debriefings and monthly meetings. Two nurses confirmed that managers also discussed incidents with them and looked at what happened in order to learn from those incidents. Both gave examples of managers looking at CCTV images from ward cameras with them to analyse how they restrained a patient. The nurses said this process was helpful.
- There was evidence of staff responding to incidents and making changes. For example, on Suffolk ward several incidents had occurred involving patients arguing with each other and staff in the dining area. On more than one occasion patients had thrown chairs, which threatened injury to others. The ward manager decided to change the environment to stop this from happening. As a result staff installed fixed seating in the dining area.

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This seating was also brightly coloured and made an additional positive effect on the environment. The management on Sussex ward decided to copy this change to prevent the same risk of danger and to improve the environment.

- However, a number of incidents took place where there was no evidence of an attempt to learn from those incidents. This year a combined total of 15 patients absconded from the three wards. Although the incidents were reported and recorded there was no evidence of formal investigations taking place to determine the cause of these events. This was despite the fact that eight of the fifteen absconsions took place over the fence in the communal garden where staff took patients. There was no evidence of staff discussing these events in any meetings. In response to other incidents staff had drawn up action plans to address identified problems. But in the case of patients absconding there was no evidence of staff making any action plans to address this. In most cases staff also did not update risk assessments and care plans to address the fact that patients had escaped.
- Staff said that in the event of any incidents taking place on the ward they speak to patients to let them know if anything has gone wrong. Patients said that staff informed them when things went wrong and discussed the outcomes and how the incident had affected them.

Acute wards for adults of working age – Edgware Community Hospital

Safe and clean environment

- The ward environments were clean and clutter free. However, the furnishings and décor on the wards were somewhat tired and dated.
- The wards had ligature risks including windows and taps in patients' bedrooms. Staff were aware of the risks and could describe what they did to mitigate ligature risks including regular patient observations, encouraging patients to come out of their bedrooms, risk assessing and in-depth knowledge of patients' risk and needs. The trust had completed ward ligature risk assessments in February 2015. However the Thames ward risk assessment was not updated to include information on actions taken to mitigate risks, dates for work completion and the details of the lead responsible person. Trent ward ligature risk assessment did not include dates for work completion.
- Thames ward did not have a seclusion room. Patients requiring seclusion used the seclusion room on Trent ward, which was across the hallway on the same floor. Thames ward staff communicated with Trent ward staff to facilitate this and ensured the main corridor was clear before moving the patient. Thames ward staff did the observations and reviews while the patient was in seclusion on Trent ward. When Avon wards seclusion room was full, the patient would be secluded on Trent ward, which involved transporting the patient up stairs. This happened on one occasion in 2015 and one occasion in 2014.
- The seclusion room on Trent ward had an ensuite toilet and shower facilities and a small window panel on the door to observe patients. This panel was scratched, which made it difficult to see inside the room clearly. A clock was viewable in the corridor across from the seclusion room. The seclusion room had an intercom for two-way communication and CCTV. However, it would be difficult for staff observing patients either through the window pane or on the small CCTV monitor to do physical health monitoring and observe whether patients were still breathing. This would be important especially for patients who received rapid tranquilisation.
- The wards had mirrors at the end of the corridors but it was difficult to see all of the parts of the ward from the nursing station. Staff completed hourly environmental checks and generally hourly patient observations, and more frequent checks for patients on increased observations.
- When the alarm when off on one ward, it rang on the other two wards at Edgware community hospital. Each shift had an allocated response team to support staff on other wards. Not all staff on Trent ward wore a personal alarm and there was no system in place to monitor which staff carried alarms.

Inadequate

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- The clinic rooms were all clean and organised. The equipment including emergency resuscitation and medication were up to date and the room and fridge temperature checked daily and staff completed records to monitor these.

Safe staffing

- Ward managers said that the staffing establishment was developed several years ago when the wards had different patient acuity and numbers and had not been adjusted since. Thames and Trent wards had three qualified and two unqualified staff during the day shift and two qualified and two unqualified staff during the night shift. Some staff on Trent ward said that there were not enough staff on the ward to support the high turnover of patients.
- The ward operated on two 12-hour shift patterns. Some staff said this rota impacted on the patients' continuity of care as it meant staff may not be on the ward for a few days. It also made the daily tasks challenging to manage due to staff being off the ward to attend morning meetings and taking breaks in the afternoon.
- Thames ward had a high staff turnover in the previous year due to retirements and internal promotions. The ward had one qualified nurse and one unqualified nurse vacancy. The unqualified post had been recruited to at the time of our inspection. Trent ward had two qualified nurse vacancies that had been advertised and two unqualified nurse vacancies that had been recruited to. One member of staff on Thames ward was on long-term sick leave and the ward manager was managing this appropriately.
- Where one patient required increased observation levels, the ward numbers would absorb this. The ward manager could then increase staffing levels when more than one patient was on increased observation and for escorted leave.
- The wards used regular bank staff and six agencies to provide agency staff. Between 1 August 2014 and 31 July 2015, Thames ward had 157 shifts and Trent ward had 121 shifts filled by bank or agency staff. Ward managers had autonomy to fill shifts with bank staff but had to get their manager's approval to book agency staff. Some staff said that they didn't always use regular agency staff who were familiar with the ward environment or patients.
- There was always a permanent member of staff on shift and we saw nurses present in the communal areas of the wards.
- Staff and patients said the wards rarely cancelled escorted leave and activities. When staff were not available to escort patients on leave, they would reschedule it to another time.
- Thames ward's staff had 88% and Trent ward's staff had 95% completion of mandatory training. Staff completed a five day course on the prevention and management of violence and aggression (PMVA) that they refreshed every two years.
- Thames wards staff sickness rate in October 2015 was 12.7% and Trent wards was 11%.
- A duty doctor was available and an on call senior registrar and consultant available out of hours.

Assessing and managing risk to patients and staff

- We looked at 11 patient records on both wards. Ten of these patients had risk assessments completed on admission and up to date risk assessments. Staff updated patients' risk assessments following a new risk incident.
- On Thames ward, 84% of staff and 100% on Trent ward had completed safeguarding training. Staff could explain the different type of safeguarding and the reporting procedures. They sent a safeguarding alert to Barnet council, the trust's safeguarding lead and the ward manager. Ward managers were responsible for arranging a strategy meeting within five days and then determining if further investigation was required. Safeguarding records showed that staff dealt with concerns appropriately. We observed a safeguarding strategy meeting on Thames ward where staff liaised with the patients' advocate and care coordinator for further information about the patients' social networks. Staff had a comprehensive understanding of this patients' lifestyle and care needs.
- Between July and October 2015, Trent and Thames ward each had four incidents of seclusion. Thames ward had 13 and Trent ward had 19 incidents of restraint. Incident records documented which member of staff held which part of the patient's body during the restraint. One incident where a patient was secluded and rapid tranquilisation was administered on Trent

ward did not include any records that the patient had physical health checks completed. The trust completed audits on seclusion and restraint in March, September and October 2015. In October in the borough of Barnet 37% of patients who had received repid tranquilisation had been reviewed by a doctor within 30 minutes. Only 31% of patients had their physical observations documented. None of the patients' risk assessments or care plans were updated following the use of restraint.

- On Thames ward, informal patients could leave the ward when they wanted and there was a notice on the door informing patients of this. On Trent ward, there were four informal patients that had restrictions on their leave to manage their risk. Some of these patients had recently become informal after being detained under the MHA. Patients said they had agreed to this and this was documented in their care plans.
- The pharmacist technician completed the medicine reconciliation for new patients when they were admitted to the ward.

Track record on safety

- Thames ward had had one serious incident reported in the last twelve months involving an accidental fire. Trent ward had a recent death on the ward that was still under investigation.

Reporting incidents and learning from when things go wrong

- Staff knew what kind of incidents required reporting and the process for completing electronic incident forms and alerting relevant parties including the patient safety team. Records showed that staff reported incidents appropriately.
- Thames ward had a quality board that displayed the daily number of incidents of violence and aggression and medication omissions on the ward.
- Staff discussed recent incidents that occurred on their ward in borough clinical governance meetings, ward clinical governance meetings and staff meetings. However, staff did not demonstrate knowledge of incidents that occurred on other wards at Edgware Community Hospital and across the trust, including the outcomes and learning.
- Staff described examples where patients were informed and apologised to when things had gone wrong.
- One member of staff said that a debrief was held in the ward office, which could be a noisy environment and meant there were frequent interruptions.

Acute wards for adults of working age – St Ann's Hospital

Safe and clean environment

- The layout of Haringey assessment unit ward did not allow for clear lines of sight with many blind spots and no convex mirrors to facilitate observation. Staff were unable to observe the corridor with six bedrooms from the main communal area and there were no mirrors to aid observation. There was a blind spot at the end of the garden and no mirrors were in place to facilitate observations. The wards carried out regular environmental checks. Staff carried out regular observations of patients on the ward. Finsbury and Downhills wards did have blind spots on the ward, however these were mitigated by the use of convex mirrors.
- The environment on Haringey assessment unit was tidy and clean. On Finsbury and Downhills wards, the decoration was tired and was in need of an update. Quality indicators showed that in the month of October 2015, Downhills ward scored 87% for cleanliness. Haringey Assessment unit scored over 95%. The trust's target is 90%. However, the cleaning records on all wards were unavailable.
- On all three wards there were ligature anchor points and none of the rooms were ligature free. The ward ligature audits completed in February 2015 stated that risks were mitigated by staff observation and supervised use of rooms. The trust had a comprehensive ligature reduction plan which had already started. The audits did not state the timescales for this work to be completed. The wards had windows which had metal window restrictors. The restrictors were accessible to patients in the ward gardens. The sanitary wares in bathrooms were not ligature free and were a part of the programme to be changed.
- The accommodation on all three wards was complying with Department of Health's guidance on same-sex accommodation.

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- The two seclusion rooms on Haringey assessment unit had small gaps for observation on the seclusion door, there was two-way communication through an intercom, cameras fitted in the rooms, toilet facilities and a clock in the corridor which could be seen from the seclusion rooms. The bathroom facilities were in the middle of both seclusion rooms therefore these were shared. There was not a shower within the seclusion room. The ward manager made us aware that the seclusion rooms were not being used at the same time. Seclusion records reflected that this was not happening.
- Male and female patients from Finsbury and Downhills wards that needed seclusion would be transferred down a large public corridor via the male bedroom corridor on Haringey assessment unit into the seclusion room. There was a long distance between the wards and the seclusion room which could pose a risk to patient and staff safety. Incident records showed that in the past 12 months five female patients had been secluded on Haringey assessment unit.
- On all three wards, the clinical rooms were disorganised and cluttered. On Haringey assessment unit and Finsbury ward, the rooms were very small and were unable to include an examination bed. The examination beds were put into multi-purpose rooms. On Downhills ward the clinical room was also used as an office space. The room was in a locked part of the ward. This meant that patients had to be accompanied to the clinical room or staff would need to take medication to the patient. Transporting medication down a corridor to another part of the ward can pose a risk to safe management of medicines. The light within the clinical room was also faulty and kept turning off, this was unsafe during the administration of medication.
- Medical emergency bags were kept in all of the clinical rooms and were appropriately maintained and checked. On Downhills ward, the equipment was kept far from the main patient areas in the clinical room, as staff would need to pass through two locked doors in order to access this.
- On all three wards, there was no documentation for the cleaning of medical equipment. For example, the thermometer and blood pressure machine. The cleaning logs were not available. However, on Finsbury ward a decontamination audit was completed within the past three months and all areas were completed. Hand hygiene audits were being completed regularly on all wards visited. The scores were 100% for all wards for the past year.
- Staff had personal alarms on all wards. When activated, the alarms sounded throughout the building, regardless of where an incident was taking place. The staff told us this was to alert members of the emergency response team to an incident.
- Environmental risk assessments had been carried out on all three wards. However, no risk assessment could be found for the occupational therapy kitchen at on Downhills ward. Two patients were observed to be smoking in the corridor of Downhills ward near the garden. Also a patient had been smoking in their bedroom on the ward and staff were aware of this.

Safe staffing

- A safe staffing level notice was displayed showing the numbers of staff on duty with their names and roles clearly indicated. Safer staffing levels were audited by the trust and records showed that these had largely been achieved across the wards visited. The staff told us on Downhills ward that there was a high use of trust bank staff. However, staff told us that bank staff could be difficult to book last minute. Due to the acuity of the ward, at times staffing levels needed to be increased quickly and cannot be planned for. Bank or agency staff had been used to cover 74 shifts in the past six months. Haringey Assessment unit had used bank and agency 106 times and Finsbury ward 157 times.
- A few patients on Downhills ward told us that there was not enough staff during the night. Patients said when there were 1 to 1 observations, they did not always receive appropriate care and attention. Staff told us that leave was sometimes cancelled due to short staffing.
- Many patients told us there was a lot of aggression and violence on Downhills ward. Patients that shared a bedroom told us they have been assaulted by other patients.
- The current staffing establishment did not take into account when more staff were needed for close 1 to 1 observations. However, the ward managers confirmed that they can could increase staffing numbers when required.

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- Staff sickness rates had fluctuated throughout the past 12 months on all three wards. The average sickness rate on Downhills ward was 15.7%. The reason for this was staff had been on long-term sickness and patients had assaulted staff resulting in short periods of sickness. Incidents reporting showed that in the month of October 2015 there had been four incidents of physical harm towards staff members.
- A qualified member of staff was not always present in communal areas of the ward at all times. However, non-qualified nursing staff was present and seen engaging with patients. On Downhills ward, staff were very busy and the ward was chaotic. Staff were completing 1 to 1 observations and attending to emergencies on the ward.
- On average, there were two unqualified vacancies on all wards visited. The ward managers were actively recruiting and filling vacant posts. Finsbury ward has had difficulties in recruiting qualified nurses. The ward manager had planned another recruitment centre and were working with the Middlesex University to recruit newly qualified nurses. The manager was planning to recruit in the next three months. Haringey assessment unit were responsible for managing the health based place of safety. However, the ward manager told us that the ward has recently recruited staff to specifically manage this. This meant that during a time when the health based place of safety was not in use staff worked on the assessment unit and responded to the emergency bleep.
- On Downhills ward the ward manager had retired just prior to the inspection. A nurse was acting up into the position. However, the long-term plan was to re-interview for a ward manager. Senior management told us that they were aware this was a problem and are actively recruiting. Staff told us it has been difficult to recruit a permanent manager.
- There was adequate medical cover during the day and night and a doctor could attend the ward quickly in an emergency. There would be a doctor based on site during the night who could visit the wards in an emergency. However, on Downhills ward staff told us that there had been a succession of locum doctors on the ward and no stability for some time. A permanent consultant psychiatrist recently joined the team within the past three months. Doctors told us that the workload was high and could be stressful.
- The average mandatory training rate for staff was 76% and the trust target was 85%. On all the wards, the completion of mandatory training for information governance, basic life support level 3 was below 65%. Downhills and Finsbury wards had many areas of mandatory training which was below the average training rate.
- Ward managers reviewed and monitored the mandatory training progress and poor completion was raised within supervision. Staff served food on all wards but training records did not show that food hygiene training had been completed.

Assessing and managing risk to patients and staff

- On Haringey assessment unit, records showed that 35 incidents relating to the use of seclusion had taken place in the past 12 months. Three seclusion records were reviewed and two records demonstrated good practice. The period of seclusion was clearly documented including start and end times. The patient had received a physical health check afterwards as well as a de- brief. However, one record did not demonstrate the patient received a physical health check or de-brief. A seclusion audit had been carried out in the past six months for all three wards by senior management. Haringey Assessment Unit scored 96% overall. The domain 'debriefing with patient after seclusion' scored 33%. The other two wards scored much lower in all areas, specifically in the domains of 'searching patients for dangerous items'. On Downhills ward, no evidence in the care records could be found in relation to the question 'was the patient informed of the reason of seclusion?' Areas of improvement were identified within this report for the teams to rectify.
- On Downhills ward, a record of incidents of restraint could only be found in one patient's care record. Three other records contained restraint information, but not specific details for the restraint that had taken place. Risk assessments were not being updated after an incident of restraint. However, this was being recorded via the incident reporting system.

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- Entries recorded showed staff writing that patients should be given a 'depot under restraint if the patient is refusing (oral medication)'. The same language was also observed within an incident report whereby staff had documented that if the patient refused oral medication, an injection would be given. The language used did not demonstrate that a therapeutic, collaborative approach was taken.
- There was no ward level monitoring of rapid tranquilisation (RT) on any of the wards. Staff told us that RT was rarely used, however medicine administration charts stated that sedative injections were to be used for agitation not RT. This meant there was a risk that medicines were not being appropriately managed and monitored as staff may not report these as an incident.
- Staff on all of the wards told us they viewed restraint as the last resort and attempts to verbally deescalate were always the first option. Within the past ten months restraint had been used 35 times across the wards of which prone restraint took place on five occasions. The staff correctly recognised when restraint was used. On Downhills ward prone restraint had been appropriately recorded.
- Staff did not always complete a full risk assessment of every patient on admission. On all three wards, risk assessments were available and updated. However, the assessments lacked detailed and did not always provide relevant actions to the risk highlighted. Occupational therapy (OT) risk assessments were not available for patients to use the OT kitchen. Overall, the assessments lacked detail about current identified risks and the plans did not reflect how the risks were being mitigated. An incident took place on Downhills ward whereby a patient fell. This risk was known to the team, however there was no care plan or risk assessment in place to mitigate this risk.
- The trust had policies and procedures for the use of observation and searching patients. Staff spoken to were aware of this. On Haringey assessment unit, visitors were searched with consent and provided with lockers to store visitors belongings.
- Staff were trained in safeguarding vulnerable adults and children. Some staff were confident of how to raise concerns, others were less sure. Safeguarding alerts were reviewed and sent to the local authority. A recent serious incident had also been raised as a safeguarding, this had been reported appropriately.
- On Finsbury ward, they were trialling electronic medicine administration records, therefore the ward was not using paper records. The records did not show the maximum medicine dosage. A separate folder contained consent to treatment forms, however; staff were not referring back to the folder when they administered medicines, therefore staff were unaware if medicines had been legally authorised. One patient on Finsbury ward was receiving medication above the level set out in the treatment plan on the section form. Staff would not be able to check this as the relevant documents were unavailable. On Downhills ward, medicine sachets were being stored on a clinic trolley. The wards had an identified ward pharmacist who visited regularly and replenished stock.
- The wards had a clear no illicit drugs policy. However, on Finsbury ward drugs had been brought onto the ward. The ward searched patients and visitors with consent for contraband items. Within the past six months, police brought sniffer dogs onto the ward to actively search for illicit substances. None were found on the ward at the time.The pharmacist collected and disposed of illegal substances found on the ward. If these were found during out of hours, they were stored in the controlled drug cupboard and treated as a controlled drug and would be monitored until it was collected. However, staff on Downshill ward had a vague understanding of the procedure.
- The clinical room temperatures on Finsbury and Downhills wards were recorded as being over 25 degrees mostly every day. On Finsbury ward, the room temperatures were recorded as being as high as 30 degrees in the last eight months. The clinical room was on the trust risk register and extractor fans had been fitted. Staff we spoke with told us that this was not making a difference.
- On all wards visited, children were not allowed to visit and there was not a designated visitor's room. However, there was an identified room which was away from the main ward area that was safe and fit for purpose.

Track record on safety

Inadequate

Are services safe?

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- There has been two serious untoward incidents in the past year across the wards visited. The incidents included self-injury and an unexpected death on the ward.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report an incident using the trust's electronic system. All incidents were reviewed by the ward manager and investigated by the service manager. Incidents were discussed at monthly clinical governance meetings with the team. Ward managers emailed information to the ward staff in order to share learning. There was a system in place for ward managers to complete a 24-hour report of the incident taking place.
- New ways of working would be implemented as an outcome from incidents. There was an incident on Haringey assessment unit of violence. As an outcome of the incident the balls used when playing pool were counted in and out when a patient requested to play. This was to ensure staff and patient safety.
- On Finsbury ward, a patient previously attempted to abscond via the garden. As a result, staff decided that the garden door would be locked at midnight. Patients were still able to smoke after this time but staff locked the door after every use. This was to ensure the safety of staff and patients as there were less staff working during the night.
- Following incidents staff were offered support by their line manager and peers. Staff told us they felt supported after an incident and were able to discuss their feelings. Patients on Haringey assessment unit and Finsbury ward felt supported to talk with staff.

Psychiatric intensive care unit – Edgware Community Hospital

Safe and clean environment

- There were some ligature risks on the ward. Staff were mitigating these with risk assessments, regular environmental checks and patient observation. The ligature risk assessment dated in February 2015 did not include how staff mitigated risks, plans to address the risks and timelines for work completion. The provider had not updated the ward ligature risk assessments to reflect new refurbishment plans for Avon ward.
- There was a seclusion room situated on the main corridor, which had a floor mattress and ensuite toilet and shower facilities. A clock was viewable in the corridor across from the seclusion room. The seclusion room had an intercom for two-way communication.
- Avon's ward environment was not clean in some areas. The windows needed cleaning and many of the hinges were broken. The drinking water machine had yellow stains and was dirty with loose electric cable wires.
- Not all the staff had access to a personal alarm on the ward. Staff said that alarms did not always work. Issues with alarms were minuted in team meeting held in April and June 2015, however the ward did not have a plan in place to address these issues.

Safe staffing

- Avon ward had 16 beds and one consultant psychiatrist. The guidance produced by the national association of psychiatric intensive care and low secure units said that for a PICU environment "as a maximum, no more than 14 beds are recommended".
- Nursing staff consisted of three qualified and three unqualified nurses during the day and two qualified and three unqualified nurses at night. When a patient required increased observation, this was first absorbed by the regular staffing numbers. The ward operated a two 12-hour shift pattern. Staff said that this could impact on the continuity of patients' care if they were off for a few days in a row.
- Avon ward had not had a permanent ward manager for over two years. A deputy team leader had been acting up until November 2015 and the current interim ward manager had been in place for three weeks. There was currently one vacancy for a qualified nurse and one for an unqualified nurse due to recent internal staff moves.
- The ward used regular bank and agency staff to cover shifts. Between 1 August 2014 and 31 July 2015, the ward filled 324 shifts with bank or agency staff. Staff said that agency staff were not always familiar with the ward or the patients. Some patients said agency staff frequently worked at night.
- Staff were 87% compliant with mandatory training. The ward manager was responsible for informing staff when their training was due to be updated and ensure they

booked on courses in time. Eighty one percent of staff were up do date with training on managing violence and aggression. Five remaining staff were booked on to complete this course in December 2015.

- The ward's sickness rate for October 2015 was 5.8%.

Assessing and managing risk to patients and staff

- Ninety seven percent of staff had completed safeguarding training. The ward had a safeguarding folder that contained patients' safeguarding alert records, including interim protection plans and strategy meetings. Staff took appropriate action to ensure patients were safeguarded on the ward. However, staff did not update these records to indicate outcomes and when they had closed the case.
- Staff completed random room searches and confiscated any contraband items found. Staff completed pat searches on patients returning from leave. The ward had a metal detector and last year used drug sniffer dogs to address patients bringing drugs on the ward.
- Avon ward had 30 incidents of seclusion and 29 incidents of restraint between July to October 2015. During this time, there were 20 incidents of prone restraint, 11 of which resulted in rapid tranquilisation. Some patients said they had not received a debrief after they had been restrained or secluded. One patient who had been secluded on six occasions did not have a risk assessment or care plan in place. We raised this with the management team at the time of our inspection who informed us the patient now had these in place.
- The ward had 11 episodes of seclusion in the month of November 2015. In the seclusion records, staff followed all procedures for seclusion set out by the trust's seclusion policy. When Avon wards seclusion room was full, the patient would be secluded on Trent ward, which involved transporting the patient upstairs. This happened on one occasion in 2015 and one occasion in 2014. Staff used screens at the entrance point when a patient was in seclusion so other people on the ward could not look into the seclusion room. Staff observed patients through a thin viewing panel in the seclusion room's door and also on CCTV. However, it would be difficult for staff observing patients either through the window pane or on the small CCTV monitor to do physical health monitoring and observe whether patients were still breathing. This would be important especially for patients who received rapid tranquilisation.
- There were effective arrangements in place for the supply of medicines to avoid delays in starting treatment. The ward received pharmacist support three times a week, and additional support if required.Ward staff knew how to obtain support from a pharmacist if required and how to obtain medicines out of hours. Prescription charts were fully completed, showing people were receiving their medicines as prescribed. Patients' allergy status was recorded on their prescription charts.
- Medicines were stored and disposed of safely. The clinic room was clean and tidy. Staff checked the medicines fridge and room temperatures daily and were within the correct range to ensure medicines remained effective. Medicines used for resuscitation and emergencies were available, tamperproof and accessible.
- There was minimal use of high dose antipsychotic medicines. When these were prescribed, this was highlighted to medical staff by the ward pharmacist. High-dose antipsychotic monitoring forms were attached to prescription charts to record that the essential monitoring needed for people's safety, such as ECGs, blood and physical monitoring, was being carried out. Four people were prescribed clozapine, and the necessary blood tests and monitoring had been carried out.
- There was minimal use of rapid tranquilisation (RT) on current prescription charts on the day of our inspection. One patient had recently been administered RT on three occasions. However, we did not see evidence of post RT reporting on the patient's care record, such as the appropriate physical observations that needed to be carried out regularly following RT for patients' safety.This meant there was a risk that staff were not monitoring the safety of this patient.The ward manager told us that the patient's notes had not yet been transcribed onto their electronic record.
- The ward pharmacist told us that when people were admitted to the trust, their current list of medicines was checked with their GP or other sources (medicines reconciliation) and this should be recorded on patients'

Inadequate

Are services safe?

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

electronic record and annotated on prescription charts. We did not see annotations on the current prescription charts on the ward, although trust audits showed that level 2 medicines reconciliation was carried out for 83% of patients admitted to the trust.

- We saw evidence of medicines management audits which had been carried out every two weeks. The pharmacist said that medicines incident reporting had increased recently,although there was still a high turnover of staff on this ward which made training and reinforcing medicine management issues harder. It also made it hard to form a collaborative environment to learn from errors. Trust audit data showed that medicines incident reporting levels had improved and were now in line with other trusts.

Track record on safety

- Avon ward had one serious incident reported in the last twelve months involving an alleged sexual assault.

Reporting incidents and learning from when things go wrong

- Staff knew what kind of incidents required reporting and the process for completing electronic incident forms and alerting relevant parties including the patient safety team. Records evidenced that staff reported incidents appropriately.
- Staff discussed incidents in monthly clinical governance meetings. Meeting minutes for November 2015 showed that staff had discussed 26 incidents that occurred in October including patient assaults, medication errors, property damage and patients going absent without leave from the ward.

Are services effective?

Requires improvement

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

Acute wards for adults of working age – Chase Farm Hospital

Assessment of needs and planning of care

- In 20 patient records, staff had assessed each patient upon admission. Staff undertook physical health assessments of patients on admission and regularly updated these assessments. Staff used a tool to monitor patients' physical health. This was the modified early warning scores tool. This worked by the staff examining patients vital physical health signs, including blood pressure, and then converting the results of the examination into a score. The higher the score the more abnormal the results. A higher score triggered an immediate examination of the patient by the ward doctor to see if any action was required.
- Staff completed care records of patients upon admission. Some of the records we looked at were quite detailed, stating how the staff would meet patients' needs. However, six of the records that we looked at showed minimal or no involvement of the patient. Many care records did not mention how staff planned to support patients' recovery so that they could eventually discharge them. Twelve of the records that we looked at had no focus on patient recovery.
- Staff on all three wards securely stored all information concerning patients and this was accessible to most of the staff on the wards. However, agency staff were not able to access patients' electronic records. This created a risk that agency staff were not able to access important information concerning patients' care and treatment.
- Staff largely relied upon paper-based systems and these were well managed and complete.

Best practice in treatment and care

- Medicines administered were safe, effective and evidence-based according to NICE guidelines and were in line with the trust's policy.
- Patients had access to psychological therapies including 1:1 appointments. The multi-disciplinary team either referred patients for this support or patients could also refer themselves.
- The patients on all three wards had limited access to physical healthcare in the form of health checks done by ward staff. If staff identified that patients required medical support for their physical health they referred patients to other treatment centres for help. For example, staff had referred patients to dieticians, dentists, podiatrists and for pre-natal care. The hospital also provided smoking cessation courses for patients. The provider had also arranged some support for staff to understand patients' physical healthcare including a presentation from University College London. However, some staff expressed concern that all three wards were not able to properly meet the needs of patients' physical health. A senior member of staff stated that staff needed better understanding of physical healthcare to support a patient on Sussex ward with an ulcerated leg. Two doctors said that supporting patients' physical healthcare was a significant problem because patients only received sufficient care if their case was an emergency. They said that where a patients needs was not an emergency they had to wait for appointments in other services to become available. This presented two problems. Firstly, referrals to other services, such as dentistry, could take time which could result in a delay in treating patients. Secondly, where patients were acutely unwell they were not always able to leave the hospital to receive physical healthcare and this also caused delays. Both doctors expressed concern that there was no access to a specialist diabetic nurse available as several patients on the wards were diabetic.
- Clinical staff participated in a range of clinical audits including safe storage of medicines, care planning and physical restraint. Staff also assessed and monitored patients' outcomes using the health of the nation outcome scales.

Skilled staff to deliver care

- A range of professionals were available to support patients on each of the wards. This included doctors, nurses, psychologists, occupational therapists, social workers, activities coordinators and a pharmacist.
- Staff were suitably experienced and qualified to support patients' care and treatment needs.
- All staff were appropriately inducted and received mandatory training during induction on various areas of work.

Are services effective?

Requires improvement

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- Staff received regular supervision and appraisals. The supervision and appraisal of staff was up to date on all wards. We looked at nine supervision records across the three wards. These showed that supervision was detailed and supported staff members with a range of issues with individual staff member's involvement clearly recorded. Staff had access to a range of meetings to discuss clinical and managerial issues.
- Staff were experienced in working on mental health wards and received appropriate specialist training to perform their duties.
- Staff records on each of three wards showed that managers took appropriate steps to manage any cases of poor performance. For example, one manager referred a staff member to occupational health for support.

Multidisciplinary and interagency team work

- Multidisciplinary team (MDT) "Jonah" meetings took place each morning on every ward. We attended two of these meetings on Dorset and Suffolk wards. The main focus of these meetings was patient care and discharge. Staff prioritised tasks according to a traffic light system, with red indicating the most urgent. Decision making was clear, insightful, evidenced-based and patients' views were taken into account.
- We attended two staff handovers on Dorset and Sussex wards. These were effective discussions between ward staff concerning patient care. They included updates on risks to patients and managing staff time so that they could be available to escort patients on leave.
- Staff on the three wards described how they worked with the outside agencies to support patients, including welfare advice, independent advocacy and housing support. During the MDT meetings we observed staff making referrals to local external agencies to support patients. These included a dietician, benefits advisor and children's services. The independent mental health advocate (IMHA) working in the hospital also confirmed that staff regularly made referrals to external agencies to help patients.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act (MHA) training was not mandatory and wards did not keep records of staff completion rates.
- On all three wards staff demonstrated their knowledge of the rights of detained and informal patients. However, on Dorset ward the MHA manual used as a reference for staff was many years out of date. This meant that staff risked not being correctly informed as to new law regarding patients' rights and staff responsibilities under the MHA.
- Staff said that patients had their rights under the MHA explained to them on admission and patients confirmed this. However, one patient on Dorset ward, who did not speak English, had to wait a week before an interpreter was available to help him understand his rights. The MHA requires that staff inform patients of their legal rights as soon as is practicable following admission. The reason for this delay was not clear but it meant that the patient had no understanding for the reason for his detention for several days.The delay also meant that half of the two week period during which the patient was legally allowed to appeal his detention was lost before he understood why he was in hospital.
- Staff had completed capacity assessments of all patients across the three wards and patients' consent or refusal to treatment was appropriately recorded. Staff also kept consent to treatment records with patient medication charts in accordance with good practice. The capacity assessment of one patient recorded that the patient did not have capacity while the electronic summary said that the patient did have capacity. Although a doctor on the ward confirmed that the patient did not have capacity staff were not able to explain why the summary was wrong.
- The MHA office in the hospital gave ward staff advice and guidance on the law.
- Staff had properly completed and stored patients' detention paperwork.
- For patients detained under MHA, they received medicines in line with the MHA Code of Practice. Where required, consent (T2) or authorisation (T3) certificates were completed and attached to patients' medicine charts.
- On each of the three wards staff had displayed information for patients regarding how to contact the local independent advocacy service. Information was also displayed on detained patients' legal rights. An IMHA regularly visited the wards to support patients

Are services effective?

Requires improvement

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raise issues concerning their care and treatment. We spoke with the IMHA who said that staff on all wards and in the MHA office were very supportive of patients' advocacy rights. The staff always promptly informed the IMHA when patients asked for support and sometimes referred patients to the service where they thought patients would benefit from it. The IMHA said that hospital staff were also helpful in providing information to the advocacy service including the time and location of patient meetings.

Good practice in applying the MCA

- Some staff were able to demonstrate knowledge of some of the guiding principles of the Mental Capacity Act (MCA). However other staff had no knowledge of them at all.
- The provider had a policy relating to the MCA which was available for staff on all wards to refer to.
- Support and guidance for staff concerning the MCA was available from the MHA office in the hospital.
- Staff on the three wards had not made any applications for Deprivation of Liberty Safeguards in the past 12 months.

Acute wards for adults of working age – Edgware Community Hospital

Assessment of needs and planning of care

- Patients had an assessment completed on admission. In the five patient records on Thames ward, all had care plans that were up to date and staff gave patients a copy. However, staff did not always followed up the care plans for example ensuring there was a record of when patients received their 1:1 time with their named nurse. On Trent ward, four out of six patients had up-to-date care plans.
- Patients had good physical health input. Patients said staff were addressing their physical health needs appropriately. Staff monitored patients' physical health using the modified early warning scores tool. However, staff had not always added up these scores and one patient who had a high score which indicated the need for urgent medical input did not have a record of what actions staff had taken.
- Patients had good access to physical health care and staff referred them for specialist health care where required. For example one patient who had diabetes said staff were managing this well.
- Patient's records were stored electronically and staff could access this easily. Agency staff did not have access to patient's records and required a permanent member of staff to support them with this.
- Patients' medication charts were accurate, completed and checked regularly by the pharmacist.

Best practice in treatment and care

- Medicines prescribed were safe, effective, and evidence-based according to NICE guidelines and in line with the trust's policy. For example patients who were prescribed high doses of anti-psychotic medication were having their medication and health monitored.
- Psychology input on Thames and Trent wards was provided by a psychologist who was based in the home treatment team and provided half-time coverage to the acute wards. The full-time clinical psychologist was on maternity leave without having interim cover. The psychologist attended some of the morning Jonah meetings and could complete assessments and offer limited individual and group sessions with patients. Staff did not have access to regular reflective practice. Several staff said it would be helpful to have more psychology input on the wards.
- Records evidenced the pharmacist completed fortnightly medication audits on the safe and secure handling of medications
- Trent ward's staff completed a range of audits including audits of care plans, 1:1 time with the named nurse and completion of assessments.

Skilled staff to deliver care

- New staff spoke positively about the induction they received when starting on the wards. They felt supported and were given opportunities to shadow other staff.
- The two wards shared two occupational therapists, two activity coordinators and a part-time drama therapist. Thames ward used a locum OT to cover a staff absence and locum junior doctor.
- Trent ward had not had a substantive consultant since May 2014. The ward was not able to recruit a permanent consultant psychiatrist through the Royal College of Psychiatrists until the ward reduced its bed numbers

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from 21 to 20 beds or increase the senior trainee or speciality doctor input. This meant that the consultant psychiatrist, speciality doctor and junior doctor were all locums. The current locum consultant had been on the ward since June 2015. The trust were in the process of looking at how to reduce the bed numbers on Trent ward. This has been discussed at recent integrated performance meetings, with an expected timescale of resolution by the end of January 2016.

- The wards had supervision charts showing who supervised which other members of the team. Staff did not all receive regular monthly supervision. Records indicated that on Trent ward in November 2015, 16 out of 20 staff had supervision, 9 out of 19 received it in October and 7 out of 22 in July. Thames ward did not keep monthly records of completed supervision. While there were some staff's completed supervision records available, it was difficult to confirm which staff had received regular supervision.
- All staff on Trent ward had appraisals completed in June 2015 and 70% of staff on Thames ward were up to date with their appraisals.
- Staff could access specialist training and professional development opportunities including mentorship courses, motivational interviewing, and supporting patients with alcohol dependency. Some staff on the ward were booked on the mentorship course in the new year and two staff were completing a course on dual diagnosis. Some staff said it was difficult to get time off to do training and did this on their days off.

Multidisciplinary and interagency team work

- The wards had daily "Jonah" meetings that staff from all disciplines attended. Staff worked together effectively to review each patient and manage their discharge. There was also a daily bed management conference and top level discharge meetings.
- The teams had daily handovers between changes in nursing shifts.
- Staff regularly liaised with patients' care coordinators, the home treatment team and other acute wards across the trust. Staff also communicated with patients' GPs and other organisations that provided support to the patients.

Adherence to the MHA and the MHA Code of Practice

- MHA training was not mandatory and the ward did not have staff completion rates. Staff were unsure of what kind of MHA training was available. Some staff who had been working on the ward for several years had not completed any MHA training or had any updates.
- The MHA office was based onsite and could provide staff with any support and advice. They sent an alert to the ward staff when a patient's rights were due to be explained and their section due to expire.
- Staff regularly informed patients of their rights and recorded this in their care records. Patients said they had their rights and treatment explained to them.
- Records confirmed staff completed patients' consent to treatment and capacity assessments following their admission. These forms were completed correctly in the 11 patient records reviewed.
- Detained patients had access to an independent mental health advocate (IMHA) who attended the ward weekly. Informal patients accessed an advocate from Mind who were based on site at the hospital.

Good practice in applying the MCA

- MCA training was not mandatory and the wards did not have staff completion rates.
- Staff's knowledge and application of the MCA varied on the wards. Some staff said that it was the role of the doctor to complete capacity assessments during ward reviews.
- There were no patients subject to a deprivation of liberty safeguard (DoLS) at the time of our inspection.

Acute wards for adults of working age – St Ann's Hospital

Assessment of needs and planning of care

- Clinical staff assessed patients' needs and developed care plans on admission. The four records that were reviewed at the Haringey assessment unit demonstrated that staff completed care plans within 72 hours.
- We reviewed 13 care plans over three wards and each patient had a set of care plans. These were set templates that provided generic interventions and covered mental health, physical health, activities and medication. All the care plans were not personalised and lacked evidence of patient involvement. Staff told us that they were expected to complete the set care

Are services effective?

Requires improvement

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plans regardless of a patients' individual needs. A common theme throughout the care plans was that the goals were not recovery focused or individualised and care plan goals did not focus on patients' strengths.

- On the three wards, all of the care plans did not record that care plan reviews were taking place regularly and these were not being discussed and updated in multi-disciplinary meetings. For one patient, a need was identified but no changes were made to the care plan to reflect this. Old care plans were still available and had not been updated or removed. Two care plans were well completed and recorded how the patients' needs were going to be met.
- On all of the wards visited it was clearly documented within care plans that patients had been given a copy.
- The care records were stored within the trust's electronic computer system and were readily available to permanent staff when needed it. Access to this system was secured to keep information confidential.
- Four records reviewed on the Haringey assessment unit demonstrated that a full physical health examination was taking place on admission. Regular physical health monitoring was taking place on the wards. However, only three of the records inspected show that physical health monitoring was being completed adequately. The wards were using modified early warning scores which is a recognised tool in order to score the patients vital signs. The score will define the most appropriate action if there is a concern. Staff were not calculating and totalling the scores properly, therefore there was no way of assessing if the results were within a normal range and the most appropriate action had been taken to escalate a concern. For example, a patient's pulse rate was 46 and this was not escalated for medical input and the care records showed that the patient then became significantly unwell.

Best practice in treatment and care

- The national institute for clinical excellence guidelines were being met in relation to the management and prescribing of medication across all wards we visited. There was evidence to show medication being prescribed within British national formulary limits. The trust also had a medicines formulary which included licensed and off-license medicines. There was a high dose anti-psychotic monitoring form in place which monitored that the necessary safety checks had been carried out. However, 43% of medicine administration records showed that 'as required' medication had not been reviewed after 14 days.
- There was a lack of psychological therapies input across all wards. This impacted greatly on Downhills ward due to the acuity of their patient group. The wards had a psychologist one day a week, who would see patients individually and provide reflective sessions. There was a waiting list for individual therapy. This also meant that staff were not making many referrals for psychology input.
- On Finsbury ward, staff were given lead roles on a variety of subjects for example, physical health and activities on weekends.
- The wards used health of the nation outcome scales to monitor patients' health and social functioning. However, this was being used infrequently by staff. There was a clear lack of understanding as staff told us they were not sure how this tool was completed. The ward managers were aware this was an area of improvement.
- Senior nurses completed audits for example on infection control and care plan audits. On Haringey assessment unit, the ward manager told us that staff were completing quality assurance audits which included all aspects of the care records.

Skilled staff to deliver care

- The staff working on the acute inpatient wards were from medical, nursing, psychology and occupational therapy background. The ward had an identified pharmacist who visited the ward regularly. Records showed evidence of ongoing physical health care provision. For example, staff had made a referral to acute care for diagnostic assessment.
- Staff we spoke with said there was access to specialist training for example, phlebotomy courses and leadership courses. However, other staff told us that they were not sure they would be supported if they wanted to progress. On Haringey assessment unit, staff had progressed to complete their nurse training. The trust had an educational link with Middlesex University.

Are services effective?

Requires improvement

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.

- Qualified nurses were being provided with an opportunity of preceptorship training and also mentorship training.
- New staff received an induction to the ward and also a two-day formal trust induction.
- Staff received individual supervision with their line manager. In total, 15 records were reviewed across all wards visited and they all lacked detail. The records did not demonstrate that training had been raised in supervision. Four supervision records on Finsbury ward did not focus on the staff members own professional development and wellbeing. Eighty five per cent of staff appraisals had been carried out in the past year. Haringey assessment unit had the lowest appraisal rate of 62%.
- Within supervision, sickness action plans were discussed with the member of staff and documented clearly.

Multidisciplinary and interagency team work

- We attended and observed three multi-disciplinary team meetings. On all of the wards, the meetings were well attended by various professionals. The wards did not use a traditional ward round style. The team discussed every patient which included physical investigations, and observational levels. Care programme approach (CPA) and discharge meetings were organised so that relatives and other professionals could attend. However, medical reviews were organised on an ad-hoc basis, therefore patients did not have the option of asking a relative/carer to attend with them. The wards had a bed conference meeting twice a day to discuss bed movements and possible discharges.
- On Haringey assessment unit, the ward consultant did not see patients until after 72 hours of admission. The junior doctors assessed patients until this point.
- On all of the wards, there was a comprehensive board which displayed all details about each individual patient. The 'patient at a glance' board was very good on Haringey assessment unit. In an emergency the board provided key relevant details.
- The meetings demonstrated that there was good communication with GPs and the home treatment team who were helping to facilitate discharge. The home treatment team were located within the hospital which was beneficial to all teams. The quality indicator for communication with GPs demonstrated that Finsbury ward had not met the target rate of 80% in the months of June and August 2015.

Adherence to the MHA and the MHA Code of Practice

- The trust did not provide mandatory training for the MHA. The wards did not have completion rates available.
- Overall, MHA detention paperwork was filled in correctly, up to date and stored correctly.

On Finsbury ward, a patient was leaving the ward accompanied with no authorisation on file. There was no documentation in the care records that the leave had been agreed. This was raised with the responsible clinician to be rectified.

- Consent to treatment forms were available and attached to medicine administration charts. However, the forms were kept in a separate folder on Finsbury ward due to the ward using electronic medicine administration charts.
- A care record showed that a patient was restrained and given rapid tranquilisation and an interpreter did not attend to de-brief the patient until a few days later. For the same individual, attempts to ensure that the patient understood their rights under MHA were not repeated. This resulted in the patient being unaware of their right to appeal to a tribunal and missing the deadline.
- Records demonstrated that staff were not ensuring that patients understood their rights under the MHA. For two patients who were detained, further attempts had not been made to assist the patients to understand their rights. Another patient had not been informed that their status had changed to being informal.
- Detained patients told us that they were not always aware that their leave had changed as a member of staff had not discussed it with them.

Good practice in applying the MCA

- Mental Capacity Act (MCA) training was not mandatory. Staff had a poor understanding of the MCA. The admitting doctor was completing mental capacity assessments on admission.

Are services effective?

Requires improvement

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.

- There was one deprivation of liberty safeguards (DoLS) application made in the past year on Finsbury ward.
- Records demonstrated that mental capacity assessments were not always taking place on a decision-specific basis.
- A care record showed that a patient was going to be treated under the MCA pending an application for DoLS. No evidence of an assessment of the patients' capacity to consent to treatment or consent to stay in hospital was found.

Psychiatric intensive care unit – Edgware Community Hospital

Assessment of needs and planning of care

- Patients had an assessment on admission and care plans in place. However, they were not outcome focused and staff did not record patients' progress or updates.
- All patients received a physical health assessment upon admission and on-going assessment. The ward doctor carried out physical checks and consultations.
- Patient's records were stored electronically and staff could access this easily. Agency staff did not have access to patient's records and required a permanent member of staff to support them with this.
- Staff completed weekly care plan audits to ensure that care plans are updated weekly and patient views were included and recorded. Audit feedback was displayed in the office and emailed to staff where information was missing or not completed.

Best practice in treatment and care

- Patients had good access to physical health care and staff referred them for specialist health care where required.
- The ward did not have access to psychology input due to the full-time clinical psychologist being on maternity leave without having interim cover. The occupational therapist worked four days on the ward and was due to go on three months leave with no interim cover being arranged.
- Records evidenced the pharmacist completed fortnightly medication audits on the safe and secure handling of medications.

Skilled staff to deliver care

- Avon ward had not had a permanent ward manager for over two years. The trust had advertised the post on several occasions but had not found a suitable candidate. A deputy team leader had been acting up until November 2015 and the current interim ward manager had been in place for three weeks.
- Not all staff had received regular supervision. Records indicated that in November 2015, 10 out of 29 staff received supervision, 11 out of 24 in September and nine out of 24 in July. All staff had appraisals completed in June.
- Staff could access specialist training and professional development opportunities. Staff were booked to attend a mentorship course in February 2016 and two staff were completing a course on dual diagnosis.

Multidisciplinary and interagency team work

- Avon ward had weekly multidisciplinary meetings every Monday morning attended by the consultant, junior doctors, ward manager, ward clerk, and shift lead. The team discussed the previous week, current patients and identified patients for discharge.
- The teams had daily handovers between changes in nursing shifts.
- The team liaised with the acute wards across the trust about admissions and discharges. They provided support to the acute ward staff to manage patients on the acute ward if a PICU bed was not available.

Adherence to the MHA and the MHA Code of Practice

- MHA training was not mandatory and the ward did not have staff completion rates.
- We reviewed six sets of MHA documentation and found them in good order and in compliance with the MHA Code of Practice. In the six records reviewed, all patients had an approved mental health practitioner (AMHP) report in place.
- Staff regularly informed patients of their rights. The MHA office was based onsite and could provide staff with any support and advice. They sent an alert to wards staff when a patient's rights were due to be explained and their section due to expire.
- Staff completed patients' consent to treatment and capacity records following their admission.

Are services effective?

Requires improvement

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.

- For patients detained under the MHA, they received medicines in line with the MHA Code of Practice and the relevant legal documentation was kept with their prescription charts.
- Staff referred patients to the independent mental health advocacy (IMHA) service on admission. The ward had posters advertising this service on a notice board and leaflets displayed on the information rack.
- We reviewed six patients' section 17 leave records. Patients were granted internal ground leave as well as external. Copies of leave forms were not given to four of the six patients. We noted two of the patients' leave forms had not been completed by the approved clinician. There were also errors made in completions of the forms by the approved clinician by omitting to write the start and end date, period of leave and also not recording address on overnight home leave.
- We found that patients were able to take leave of absence approved by the authorised clinician. The ward used leave as part of a therapeutic intervention which was planned and any risk was assessed and, when required, a management plan was devised.
- Patients were not being offered the opportunity to draw up advanced decision/directives.
- Detained patients had access to an independent mental health advocate (IMHA) from Voiceability who attended the ward weekly. They also met with any new detained patients. Informal patients accessed an advocate from Mind who were based on site at the hospital. The separate service provision sometimes caused confusion for patients on the wards.

Good practice in applying the MCA

- MCA training was not mandatory and the ward did not have staff completion rates for this. Staff's understanding of the use of the MCA varied on the ward.
- We did not find any documentation of patients' MCA assessments for individual decisions in patients' records.
- The trust had a policy on the MCA available on the intranet.

Good

Are services caring?

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

Our findings

Acute wards for adults of working age – Chase Farm Hospital

Kindness, dignity, respect and support

- Most interactions we observed between staff and patients demonstrated compassion and support for patients' needs. However, interactions on Dorset ward were generally less frequent, short in duration and task focused.
- Many of the patients that we spoke with said that staff treated them with respect and dignity. Seven patients across Suffolk and Sussex wards said that staff cared for them well. However, five patients on Dorset ward said that staff did not treat them with respect. Three of these patients specifically said that this happened at night when staff did not knock on their door before entering their rooms to conduct checks on them. One patient each on Suffolk and Sussex wards also said that staff were not respectful towards them.
- There was evidence that staff understood and responded to the individual needs of patients. We saw interactions on Suffolk and Sussex wards where staff immediately assisted patients with requests for help. This included where patients needed to call family members or their legal representatives or made requests to go into the hospital garden. The clinical meetings that we observed also showed staff responding to individual patients' needs, including making referrals to external services such as housing and welfare support.

The involvement of people in the care they receive

- Staff mostly gave patients information concerning their stay in hospital and the services available to them. Many of the patients that we spoke with confirmed this. However, two patients on Dorset ward said that staff had not given them any information upon their admission.
- We attended two medical reviews, one each on Sussex and Suffolk wards. At these reviews staff invited patients to give their views and responded to the views and requests made by the patients. For example, in response to a patient's concern regarding welfare payments staff immediately made a referral to a benefits advisor to come to the ward to assist the patient.
- All patients on the wards had access to an IMHA. The IMHA visited each of the wards every week and staff referred patients to the advocacy service where support was needed. The IMHA confirmed that staff on all wards were supportive of independent advocacy.
- Staff said that patients' carers and family members were involved in their care and treatment. Several patients confirmed that that their carers and families were involved in their care planning. We also saw one patient record that documented some family involvement in the patient's care.
- Patients were able to give feedback on the services they received at weekly community meetings that took place on each of the wards. We attended two of these meetings and saw a range of issues discussed including patient leave and therapeutic activities. Staff were respectful of patient views and responded positively to patients' concerns, providing practical solutions where possible. We examined community meeting minutes from each of the wards over a period of several months. All minutes were very detailed and showed that staff had previously also responded to patients' concerns.

Acute wards for adults of working age – Edgware Community Hospital

Kindness, dignity, respect and support

- We saw staff engaging positively with patients on the wards. Several patients on Thames ward were in the communal areas throughout our visit, reading newspapers and attending group activities on the ward. Staff had good rapport with patients on Trent ward and showed care and empathy.
- Most patients said that staff were caring and respectful. Patients on Thames ward said staff were approachable and engaged well with them.
- Staff demonstrated a good understanding of patients' individual needs.

The involvement of people in the care they receive

- Patients received an information booklet on admission that included information about the ward and their

Are services caring?

Good

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

rights. One patient said they arrived on the ward late at night and staff did not give them an induction to the ward. We saw another patient who was admitted to the ward left in an interview room with another patient without being supported by staff.

- Thames ward had monthly patient council meetings delivered by Barnet Voice, which was facilitated by two external former patients. Ward managers also met with Barnet Voice to discuss patient feedback.
- The wards had weekly community meetings for patients to provide feedback about the ward. The wards had a "you said, we did" board and community meeting minutes displayed on the ward. Actions that had been completed from patient feedback included ordering marmite for the ward and having a regular movie night on Thames ward and getting a green house in the garden on Trent ward.
- Thames ward's consultant hosted a weekly "coffee with the consultant" afternoon with patients. The consultant met with patients in the lounge and provided tea and cakes. Patients could discuss anything apart from personal medical needs.
- The pharmacist on Thames ward hosted fortnightly "medication awareness" sessions with patients. This session was well organised and informative.
- Staff regularly asked patients to complete questionnaires to provide feedback about the service. Thames ward was in the process of buying an electronic tablet to help facilitate this.
- Patients had the opportunity to participate on staff recruitment panels and attend the monthly borough-wide clinical governance meeting. The trust employed a former patient as an activity coordinator.
- Patients were aware of the advocacy service and some had accessed this.

Acute wards for adults of working age – St Ann's Hospital

Kindness, dignity, respect and support

- Staff were observed to be supporting and caring towards patients. Positive interactions were observed on Haringey assessment unit and the ward provided a calm environment. However, a patient told us that on Finsbury ward the atmosphere had not always been positive and did not respond to the people using the service. This was documented on the 'you said, we did' notice board. The notice clearly stated the ward was addressing this issue.
- On Downhills ward, Patients identified members of staff who were particularly supportive to their needs. Patients told us there were extensive waits for an admission bed and at times beds were not available. On Downhills ward, patients described not feeling safe and felt misunderstood as staff did not have time to talk with them. A patient told us that they would have to repeat a conversation many times to different staff in order to get an answer.

The involvement of people in the care they receive

- There were information packs available to all new patients but it was not clear as to how readily available this information was and whether the information was being used.
- On all wards, patients had good access to advocacy services and advocates were available by request or would visit the wards regularly to talk with patients. There were visible posters to display contact information.
- Family and friends surveys were carried out on all of the wards. The outcomes were monitored by the trust. The wards also had regular community meetings which were attended by patients and staff.

Psychiatric intensive care unit – Edgware Community Hospital

Kindness, dignity, respect and support

- We saw good interactions between staff and patients on the ward. In particular, one member of staff was good at de-escalating a patient using a variety of techniques.
- Patients said the majority of staff were caring and engaged well with them.
- Staff demonstrated a good understanding of patients' individual needs.

The involvement of people in the care they receive

- Patients said that they were not involved in the planning process of their care, were not aware of their care plans and that staff had not engaged them in discussions and decision making.

Good

Are services caring?

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

- The ward had daily planning meetings but staff provided limited information to patients about the ward during this meeting.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Acute wards for adults of working age – Chase Farm Hospital

Access and discharge

- In the first six months of 2015, the average bed occupancy rate on Dorset ward was 100%. On Sussex ward this figure was 109% and on Suffolk ward 104%. The average figure across the trust in acute and intensive care settings was 96%. Where percentages were greater than 100% this was because sometimes wards had more patients than beds. This was because some patients were on leave.
- Staff said that beds were not always available to patients in the borough where they lived. This was because all of the three wards were mostly full. We attended two bed management conferences where ward managers across the trust discussed admissions and discharges on all wards. These conferences confirmed that there were no free beds on any of the three wards at the time of our visit. Ward managers said that the provider sometimes placed patients into the independent sector when there was a shortage of beds in the trust. However, this option was often limited because these hospitals did not always take patients if they were acutely unwell.
- When patients returned from leave in the community the bed that they had previously occupied was not always available. This was because of the pressure across the trust to find beds for people needing immediate admission to hospital. When a patient's bed was not available for this reason staff found the patient another appropriate bed on one of the three wards. However, some staff said that these transfers could cause problems for patients. This was because it meant that the transferred patient would be potentially in an unfamiliar ward environment and supervised by different staff. One ward manager explained that at the time of our visit there were three patients on their ward who might return to find that their bed was occupied. This was because there were three more patients officially on their ward than there were beds. Two of these three patients were on community leave and the third was an informal patient and experimenting with leave at home to see if it was successful. The manager said that the hospital would find beds for all three if necessary but it was not certain that these beds would be on the same ward.
- Staff sometimes transferred patients between wards for non-clinical reasons in order to provide a bed for someone requiring immediate admission to hospital. Two senior members of staff said that this was only done if there was no option and that the hospital was taking additional steps to prevent this from happening. To address this, the bed manager for the hospital had revised the bed management system to help ensure that staff transferred patients as little as possible and that discharges were not delayed. The new system introduced monthly meetings between hospital managers and external agencies including the local authority to discuss how discharges could happen more quickly and to identify the causes of delay. The bed manager also begun to meet ward managers every week to discuss specific cases of delayed discharges. Any cases of transfer of for non-clinical reasons triggered an immediate bed management meeting to address why this had happened. As part of the new system information regarding available bed spaces at other hospitals and rehabilitation locations was collated and displayed in the bed management office. This allowed staff to reduce discharge delays and so free bed space for new admissions. A further improvement to the system was the introduction of standard letters sent by hospital staff to the local authority when they were planning to discharge a patient. These letters set out how the authority could best help facilitate the patient's discharge in terms of organising services including housing.
- On all three wards staff did not transfer or discharge patients after 8pm unless there was the need to make a bed available for an emergency admission.
- The managers on all of the three wards said that it was not always immediately possible to find a psychiatric intensive care (PICU) bed if one was required. This was because of the lack of available PICU services in London. However, the Sussex ward manager said that it was sometimes possible to manage this problem on the ward itself. For example, where one patient had become

Are services responsive to people's needs?

Requires improvement

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unwell and highly aggressive on the ward, requiring a PICU admission, staff were able to improve the patient's condition through appropriate care and treatment making the transfer unnecessary.

- Discharge or transfer from each the wards was frequently delayed due to non-clinical reasons. This either was because appropriate services or housing for patients were not always available or there were no beds free on acute treatment wards. At the time of our visit seven out of 15 patients on Dorset ward were delayed. Senior staff had newly revised the system of bed management to address delays.
- In the first six months of 2015 there were 27 delayed discharges. None on Dorset ward, 20 on Sussex and 7 on Suffolk.

The facilities promote recovery, comfort, dignity and confidentiality

- On each of the wards there were a range of facilities to support patients' needs. These included a lounge, kitchen, clinic room, dining room, laundry and meeting room.
- There were quiet rooms on each of the wards and a room for patients to meet visitors.
- Most patients could make private calls on their mobile phones unless staff thought that it was not appropriate for a patient to have their phone. In these circumstances staff allowed patients to use the phone in the ward office. However, it was not clear how patients were able to make a confidential call in the ward office. All the patients' pay phones on the wards were broken at the time of our visit and were awaiting repair.
- Patients on all wards had access to a garden. Staff on each of the wards drew up a daily schedule of access to the garden. Staff supervised patient access to the garden.
- A wide variety of food was available for patients on the wards, including food to meet specific dietary and religious requirements. Menus were placed on noticeboards in the wards and patients pre-ordered their meals. On the menus was dietary information to help patients make their selections, indicating whether food was high or low in fibre, calories and fat content. Several patients told us that the food was of good quality and that they appreciated the variety available.
- Patients had access to hot drinks and snacks on each of the wards day and night although this was only possible with assistance from staff. This is because all the kitchens on the ward were locked to patients. Staff said that this was to prevent patients damaging the kitchens.
- Staff allowed patients to personalise their bedrooms in an appropriate manner with personal possession in their rooms.
- There were cupboards in each of the patients rooms to allow them store their possessions. Where patients needed to store valuables they could do so in a safe located in the nursing station.
- Patients had access to activities including at weekends.

Meeting the needs of all people who use the service

- Notices and information concerning patients' rights and services were displayed in a variety of languages on all three wards.
- Information was displayed on all the wards for patients covering a range of subjects. This included how to make complaints, local faith and legal services and information on therapies and medications.
- An NHS translating service was used by the wards where patients did not speak English.
- Food was available on the wards to meet the dietary needs of patients from different religious and ethnic groups, including halal meat.
- Patients had access to spiritual support from a range of faiths. There was information on each ward explaining to patients how they could access this support.

Listening to and learning from concerns and complaints

- In the past 12 months staff on Suffolk and Sussex wards had received five formal complaints each and there were four on Dorset. None were upheld and none were referred to the ombudsman.
- Information was displayed on the ward for patients about how to make a complaint. Staff also reminded patients during weekly community meetings how they could make a formal complaint. Most of the patients that we spoke with said that they knew how to make a

Are services responsive to people's needs?

Requires improvement

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

complaint. Many also said that they felt confident that staff would listen to them if they wanted to complain about something. However three patients said that staff did not listen to complaints when they had made them.

- Patient records indicated that staff responded to patient complaints in a timely and effective manner. The IMHA who visited the hospital also said that in their experience staff responded promptly to patient complaints.

Acute wards for adults of working age – Edgware Community Hospital

Access and discharge

- Thames ward bed occupancy rates from January to the end of June 2015 was 97% and Trent ward was 99%.
- All admissions to the wards went through the crisis resolution home treatment team who first assessed patients. The wards received referrals from all three boroughs. Thames ward had two patients from Enfield and two from Haringey at the time of our inspection.
- The average stay on Thames and Trent wards was four weeks. There were two patients who had delayed discharge on each ward due to waiting for accommodation. The wards had daily meetings to discuss patients ready for discharge. The longest patient had been on Thames ward for four months. The ward discharged most patients back home with the support of the home treatment team. Patients had a care programme approach (CPA) meeting before being discharged. A small percentage of patients with substance misuse issues could be discharged to a rehabilitation service.
- The wards had a daily "Jonah" meeting at 9am attended by staff from all disciplines. Staff considered each patient and set out practical tasks such as such as supporting patients' with accommodation issues or reviewing medication. Managers allocated tasks to each staff to action and close off every day. Staff said they found these meetings essential to supporting patients and managing their discharge.
- Patients admitted to independent sector beds were allocated to the discharge intervention team and care coordinators regularly reviewed these patients to transfer them to a local bed as soon as one became available.
- When patients went on overnight leave, this was done with the plan for them to return for a review and then discharged from the ward. They were informed that their bed may not be available for them. If a patient returned from leave and required a bed, staff would locate a bed for the patient, which may be on another ward or hospital within the trust.
- If male patients became acutely unwell on the wards, they could be assessed to be transferred to the psychiatric intensive care unit (PICU) ward located on site. Staff from the PICU ward also supported the acute ward staff on how to manage the patient on the ward. Female patients who became acutely unwell had their observation levels increased and if they could not be managed on the ward, were referred to a bed outside the trust.
- Staff and patients said patients were sometimes moved for non-clinical reasons. One patient was admitted to Thames ward but then transferred to Trent ward due to the need for a female bed. This patient said they found this process unsettling. Another patient on Thames and said they were moved to Chase Farm Hospital due to the ward needing their bed for an admission. They were unhappy with this move as the staff on the new ward were not familiar with them. This patient later returned to Thames ward when another bed became available. The trust did not comprehensively collect data on non-clinical moves prior to October 2015.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards did not always promote patients' privacy and dignity. The privacy blinds on the observation windows of patients' bedrooms controls was located on the outside of the doors in the corridors. This meant that patients did not have control over who could look into their bedrooms. Thames ward put up notices in the rooms to remind patients to close the blinds and had replaced some of the doors. The clinic room door on Trent ward also had a viewing window, which meant that patients on the examination couch could be viewed from the ward. Staff told us that a blind had been ordered to cover the window.
- Thames and Trent wards were mixed gender and had separate corridors for male and female patients. The wards had three flexi rooms in another corridor. These

Are services responsive to people's needs?

Requires improvement

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

rooms were kept all the same gender. However, the ward review room was at the end of the flexi room corridors. This meant that patients of the opposite sex could walk by other patients' bedrooms.

- Patients could use personal mobile phones on the wards. Trent ward did not have a phone for patients to use in private. We saw a patient using the phone in the staff office where there was confidential information displayed. We raised this with the trust during the time of our inspection.
- Patients had safes in their rooms to store their possessions and could request staff to lock their bedroom doors when they went out.
- Patients on Thames and Trent wards could access Avon ward's gym facilities and garden area for exercise. There was a computer and the internet patients could use, however this was done using staff's work accounts.
- Patients had scheduled smoking/fresh air breaks. If patients wanted to smoke during the night outside of the break times staff offered them nicotine replacement therapy. Patients could use electronic cigarettes on the ward.
- Patients had access to a variety of activities and groups including music therapy, nutrition, and gardening. Patients were positive about the range of activities offered on the wards, although said these could be limited during weekends. We observed a healthy living activity on Thames ward that the dietician and OT led. It was a well-structured session using visual props and patients actively participated.
- Trent ward had won funding through the Trust's "Dragon's Den" competition to provide a "safe space" room for patients on the ward. This was a large inflatable structure that patients could lie down on to relax with staff supervision. They could also use headphones to listen to music while in the room.
- Thames ward displayed art on the walls of the ward that former and current patients had made during their stay. The words "hope" and "calm" were on the corridor as people entered the ward. One patient had also put together a display board of inspirational quotes.
- Patients said their choice of food was limited and was served on a first come first serve basis, which meant patients who arrived after other patients had to eat what was left. They also said the food quality was all right, one patient was regularly ordering a takeaway on Trent ward.
- Patients had access to hot drinks until 8.30pm and were offered fruit juice and biscuits during the night.

Meeting the needs of all people who use the service

- Trent ward did not have a toilet or bath adapted for people requiring disabled access. The ward had an adapted toilet. Patients with reduced mobility were admitted into the bedroom with an ensuite toilet.
- The ward had a range of information including leaflets on medication and mental health conditions available in numerous different languages on their intranet that patients could request. Information was also available in easy read format and braille. Patients could access interpreters when needed.
- Staff identified patients' religious or spiritual needs and where they wished they could arrange for them to meet with the trust chaplain or other community spiritual leaders who could come and see them in the service. The wards did not have information about spiritual support displayed.
- Patients said that the food was not good quality, they had limited choice and it did not meet their cultural needs. One patient on Thames ward said there was poor choice of halal meals.

Listening to and learning from concerns and complaints

- Staff could describe recent complaints and the learning. For example, following one complaint on Thames ward staff worked on improving communication with patients' family and carers. The ward recorded complaints and compliments and had received a lot of thank you cards from patients. Staff resolved informal complaints on the wards immediately.
- The trust recorded the wards' number of formal complaints on their monthly heat maps. In the last 12 months, Thames ward had five and Trent ward had two formal complaints. Records showed that staff responded to complaints within timescales.

Are services responsive to people's needs?

Requires improvement

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

- Most patients said they knew how to make a complaint and some described how they had made complaints in the past and staff had dealt with them.

Acute wards for adults of working age – St Ann's Hospital

Access and discharge

- The average bed occupancy over the last six months was 107%. Two out of three wards were over 100% occupied. This meant that patients that had gone on leave and their beds were used for new admissions. Staff told us that they are unable to keep beds open for long periods of time due to the bed shortage.
- The ward managers told us that there was not always a bed available for a patient within the borough where they lived. This would mean the patient would be prioritised if a bed became available in their catchment area.
- On all wards, records demonstrated that patients were being moved from one ward to another for non-clinical reasons due to lack of bed availability. For example, the observation records on Haringey assessment unit showed that a patient was transferred to another ward late at night. Patients were also being discharged to recovery houses at inappropriate times of the day. Staff told us that patients are always accompanied to their accommodation regardless of the time of day.
- On Downhills ward, a patient that had been absent without leave (AWOL) returned to the ward. On return there was no bed on the ward and staff informed the bed management team. The patient had been on the ward over eight hours without any bed space to rest. Staff told us that the wards are frequently used in this way when there is not an identified bed. Senior management were aware of this and recognised the need for a bed. The trust bed management were liaising with other boroughs in order to source an available bed.
- Staff told us that if a patient required a psychiatric intensive care (PICU) bed, a referral would need to be made to bed management. Bed management would then attempt to find a bed. At times there had been delays of up to 24 hours. This has meant that wards were managing acutely unwell patients in an environment which was not supporting their needs.
- On Haringey assessment unit, a leaflet given to all patients stated that if patients went on leave they should take their personal belongings with them as the beds could be used in an emergency but on return a suitable bed would be found.
- The average length of stay for all three wards was 48 days. The wards with the highest number of delayed discharges were Finsbury and Downhills wards. This was due to housing problems and complex patient needs. The wards were inviting external agencies to clinical meetings in order to improve the discharge process. Across the two wards, 17 (75%) patients had been on the ward for more than three months.

Staff told us that the demographic of patients had changed and that patient's social needs were now far more complex.

- On Finsbury and Downhills wards, staff told us that the lack of permanent medical input had impacted greatly on the stability and the decision making on the wards. Ultimately this had impacted on the high number of delayed discharges.
- Three records showed there were concerns about delays to admission following the trust being made aware that there was a clinical need for the patient to come into hospital. Staff told us the threshold for admission was now higher due to bed shortages and there were concerns about the impact on patient safety.
- Patients told us they were unhappy with the length of stay on the ward. They felt that this was excessive and there were not any goals to work towards.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had a variety of rooms for use including quiet rooms, therapy rooms and clinic rooms. There were no dedicated visitor's rooms available across any of the services.
- The viewing panels on bedrooms doors could close, on Haringey assessment unit staff had the key to open and close the panel. However on Downhills ward, staff could not find the key to close it. Patients were not aware that this was an option and one patient said that they would have preferred it closed. Curtains for the panels were also available. On Finsbury ward, the viewing panels did not close and there were no curtains. This did not protect patient's privacy and dignity.

Are services responsive to people's needs?

Requires improvement

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

- Patients were asked to consent to a search for contraband items. However, we observed that one patient was searched in the corridor on Finsbury Ward in front of other patients. Another patient on Downhills ward told us that during a 1 to 1 observation, a member of staff asked them to keep the bathroom door open.However, this meant anyone passing by could potentially see into the bathroom. This did not protect a patient's privacy or dignity.
- There was a not a private patient phone available on the three wards. Patients were using the nursing office phone. However, patients were unable to speak privately which impacted on confidentiality. On Finsbury ward, this issue was being actively addressed and the ward were in the process of purchasing a cordless phone which could be used by patients.
- The garden on Haringey assessment unit did not provide a private environment for patients as the garden had a transparent fence. The garden could be seen by the public and nearby road. This was on the team risk register.
- Four patients on Finsbury and Downhills wards shared dormitories and wash basins. Privacy was maintained by drawing curtains around each bed. Patients in these rooms told us that they really disliked the shared dormitories. There was not continuous supervision in these bedroom areas. However, staff were observed to be completing regular observational checks.
- Haringey assessment unit provided an open kitchen where patients could access hot and cold drinks. On Finsbury and Downhills wards hot drinks were provided regularly, patients did not have access to a kitchen to make drinks independently. Staff told us that they were able to make drinks for patients.
- Overall, patient bedrooms were not very personalised but a few bedrooms were observed to have patient's own belongings. All bedrooms had a secure safe for patients to store their possessions. Patients on Finsbury and Downhills wards told us that they were not given keys to their bedroom.
- It was not clear as to whether activities were taking place at the weekends on Finsbury and Downhills ward. On Finsbury ward, the ward manager told us the wards were addressing this and has allocated a staff member to lead on this. The wards also had a support worker to provide activities to the ward on the weekends. Staff felt that more resources were required in order to provide regular activities
- The food provided on the three wards was 'cook chill'. The overall feedback about the quality of the food was positive. Patients' tolds us that they were happy with the ward food and that the portion sizes were good.
- The patient led assessments of the care environment (PLACE) survey were carried out in 2015 and the scores for ward food were meeting the England average.

Meeting the needs of all people who use the service

- The geographical area covered by the trust was highly diverse with different cultures. Staff had access to interpreters to support patients and carers during meetings and assessments.
- A few patients told us that they had contact with local faith representatives. However, information about this was not clearly available on the wards. On all wards there was not a multi-faith room.
- The wards were located on the ground floor and bathrooms and toilets had been adapted for people requiring disabled access.

Listening to and learning from concerns and complaints

- A total of 15 complaints were made in the past 12 months across all wards . Five of these complaints were raised informally. Staff said that they attempted to resolve complaints through an informal process initially and will then be raised formally if required.
- Some patients told us that they would feel confident to make a complaint if required and knew how to do this. However, a few patients were not aware of how to make a formal complaint. One patient told us that they would like to complain, this was raised to the ward manager.
- On all wards the staff received feedback from outcomes of incidents and complaints. This was through monthly clinical governance meetings where lessons learned were covered.

Psychiatric intensive care unit – Edgware Community Hospital

Access and discharge

Are services responsive to people's needs?

Requires improvement

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

- Patients stayed on Avon ward for an average of six to eight weeks. The longest patient had been there for six months. As the only male PICU ward for the trust, they took admissions from across all three boroughs. Patients were then transferred back to an acute ward on discharge if they were from Haringey or Enfield.
- The ward informed the patient that their bed may be used when they went on leave. They also informed the bed management team. Patients' access to leave was part of their discharge planning.
- Avon ward's bed occupancy rate from January to the end of June 2015 was 95%.

The facilities promote recovery, comfort, dignity and confidentiality

- Avon ward had a communal lounge, dining area, laundry, activity room and games room. The ward had direct access to a large garden where patients could play outdoor games such as football and basketball. There was also a second enclosed garden patients could access under staff supervision at set times for smoking and fresh air. Patients had painted the ceiling tiles of the ward with flags from countries around the world.
- Patients had access to a range of activities in the shared activities room which included a pool table, exercise machines and piano. There was also a separate room where patients accessed musical instruments, art work and OT activities.
- Two patients' bedrooms had an adjoining bath and toilet. This could present privacy and dignity issues for patients who were unwell.
- Avon ward had one ensuite bathroom with disabled access.
- Patients could use a phone in a private room and there was a payphone located on the corridor of the ward. Patients could use a computer with internet access under staff supervision. They had to access the internet using the staff's personal log in details.
- Patients could personalise their bedrooms.
- Staff provided patients access to hot drinks and cold water dispensers were on the ward.
- One patient was concerned that they had some items stolen from their room and did not feel the staff had supported them to recover the items.

Meeting the needs of all people who use the service

- Patients said that the ward did not provide cultural diets and meals were of poor quality, with small portion sizes. Staff informed us that halal and special diets were offered to the patients but Afro-Caribbean meals were not. Many patients ordered takeaways daily. Patients were concerned of spending a large amount of their money on food orders. Staff said that halal and special diets were offered to the patients but Afro-Caribbean meals were not. Patients requested larger portions which the ward was unable to cater for as the recommended portion size was sent to the ward by catering.
- Edgware community hospital had a multi-faith room located outside of the wards, however it was used as an office during the time of our inspection. There was a chapel based on the hospital site, both of these could only be accessed by patients entitled to leave. We saw one patient praying in the communal area on Avon ward. The wards did not have religious or spiritual information displayed.

Listening to and learning from concerns and complaints

- Avon ward had a complaints and compliments folder, which only contained compliments. Avon ward had received seven complaints in the last 12 months. Complaints were recorded on the ward's monthly heat map. There were no complaints reported for the month of October.
- Staff tried to resolve complaints locally on the ward. They provided the patient the opportunity to formally escalate it if it could not be resolved to their satisfaction. Not all staff were aware of the patient experience team that patients could access to support them with making a complaint.

Are services well-led?

Requires improvement

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

Acute wards for adults of working age – Chase Farm Hospital

Vision and values

- Staff had displayed the vision and values for the wards and the trust as a whole on the ward notice boards. This was also done in pictorial form. In addition staff had displayed the aims and objectives for the next five years. Staff demonstrated that they mostly understood these aims and objectives.
- Most staff on the wards said that they knew the senior staff of the hospital and they sometimes visited the hospital.

Good governance

- The trust produced information at a ward level relating to key performance indicators (KPIs) to determine whether managers needed to take action. For example, wards produced KPIs in relation to the number of incidents of restraint. Senior managers had identified that the number of restraints on Sussex ward was too high and action was taken to reduce this. Ward managers shared this data with staff at monthly clinical governance meetings so that all staff members were aware of their ward's performance and with senior managers in the trust so that provider level KPIs could be assessed. Managers shared other data with staff, including colour-coded heat-maps, to indicate how the wards were performing and where improvements had been achieved or were required. This recording system allowed the reader to see the frequency of different types of events clearly. Staff used heat maps containing key information about the ward at meetings to discuss performance. Staff also put heat maps on the notice board on Suffolk ward so that patients could also see this information.
- Ward managers said that they had sufficient authority and support to undertake their duties.
- Ward managers were able to submit items to the trust risk register.

Leadership, morale and staff engagement

- Sickness and absence rates for the first six months of 2015 were high on Sussex ward, though not Suffolk or Dorset. However, senior managers explained that since the summer changes to staffing and ward culture had meant fewer staff absences. Many staff on the ward confirmed that the working environment was much improved in the past few months.
- Staff said that they understood how the NHS whistleblowing policy worked. Staff also said that they were confident they could raise concerns without fear of victimisation.
- Morale among staff on the wards was generally good. Many staff on Sussex ward said that morale had improved since the summer owing to new management on the wards. This had led to an improved working culture and staff feeling that they were very supported and cared for. However, one staff member on Suffolk ward said that the morale of staff was often negatively affected by the aggressive nature of some patients.
- Senior managers in the trust had approved a plan to accelerate the development of senior ward nurses on the wards where ward managers had identified their potential to become managers.
- Many staff across all three wards said that the best thing about working at the hospital was the team working. They spoke positively that colleagues were mutually supportive and this was a vital part of meeting the considerable challenges of working on mental health wards.
- There was evidence that staff were open and transparent with patients when things went wrong.
- Ward staff said that they could raise issues with their managers and were listened to. For example, three staff on Sussex ward said that they had asked their manager for support with external training and this had received a very positive response. Another member of staff on Suffolk ward said that the ward manager was very responsive to ideas and requests from staff for help. For example, with family commitments who needed to change their patterns of work. Ward managers also commented that senior trust staff were directly accessible and keen to hear their ideas. The Sussex ward manager had been invited to discuss his work and ideas directly with the board of the trust.

Acute wards for adults of working age – Edgware Community Hospital

Are services well-led?

Requires improvement

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.

Vision and values

- Staff agreed with the trust's vision and values. Staff felt the values were important to keep patients at the centre of their care.
- Staff knew the senior managers of the hospital and trust. They said senior managers were visible and approachable. Staff commented how senior managers knew them by name and sometimes visited the wards just to check in without having a specific work-related reason.

Good governance

- Staff spoke positively about the recent restructure from service line directorates to borough specific directorates. This meant that teams could recruit by borough rather than trust-wide which helped speed up and improve the process.
- Edgware Community Hospital's wards had monthly borough-wide clinical governance meetings. The assistant clinical director, consultants from all inpatient wards, psychiatric liaison team leader, Barnet elderly care ward, home treatment team, pharmacist and Barnet Voice attended these meetings. The meetings discussed incidents, key performance indicators and issues across the borough.
- The wards had monthly heat maps that included patient and carer feedback, incidents, staff vacancies and sickness and infection control. Thames ward had a quality board that displayed the daily number of incidents and staff sickness on the ward.

Leadership, morale and staff engagement

- Permanent staff who had previously been a locum or student on the ward spoke positively about their experiences and ward environment, which encouraged them to apply for permanent posts. Several staff had been working at the trust for numerous years and spoke positively about how the trust supported them to do their jobs.
- Staff said they felt comfortable to raise concerns to their manager and that they would be listened to and actioned on.
- Staff spoke positively about the opportunities for professional development.
- Staff informed a patient after they gave them the wrong medication.
- There were no staff bullying or harassment cases on the wards.

Commitment to quality improvement and innovation

- Thames ward's consultant hosted a weekly "coffee with the consultant" afternoon with patients. The consultant met with patients in the lounge and provided tea and cakes. Patients could discuss anything apart from personal medical needs.
- The pharmacist on Thames ward hosted fortnightly "medication awareness" sessions with patients. This session was well organised and informative.
- Trent ward had won funding through the Trust's "Dragon's Den" competition to provide a "safe space" room for patients on the ward. This was a large inflatable structure that patients could lie down on to relax with staff supervision. They could also use headphones to listen to music while in the room.
- The wards had a daily "Jonah" meeting at 9am attended by staff from all disciplines. Staff used a task master to go into each patient and set out practical tasks such as managing patients' accommodation, reviewing medication or safeguarding alert. Managers allocated tasks to each staff to action and close off every day. Staff said they found these meetings essential to supporting patients and managing their discharge.

Acute wards for adults of working age – St Ann's Hospital

Vision and values

- Some staff knew who the senior managers were in the organisation and some were less sure. Posters of vision and values were visible around the three wards visited.

Good governance

- There were local governance processes such as care plan audits, infection control and medicine administration record audits. Ward managers monitored staff training and appraisals, safer staffing levels as well as reporting and learning from incidents.

Are services well-led?

Requires improvement

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.

- The ward managers had access to the trust risk register and were able to submit items to this. However, the high temperatures of clinical rooms were not on the ward's risk register.
- Sickness and absence rates were monitored by the trust for acute inpatient services. Sickness rates were highest on Downhills ward.
- Managers were not aware of the key information that the ward was collecting and monitoring about the quality of care and treatment. This type of information was visible on the wall at Finsbury ward for all staff and patients to see.
- The ward managers told us they felt supported by the senior managers and felt autonomous within their management role. Administrative staff worked on all wards to provide additional support.

Leadership, morale and staff engagement

- All ward managers had opportunities to develop their leadership skills further for example, completed a master's degree in a relevant subject, management and leadership modules.
- On Downhills ward there was a difficulty in recruiting a permanent ward manager and the interim ward manager did not have a background in managing a ward. Training for this post had not been provided. This impacted on the wards stability and the overall management. Patients described feeling unsafe and that the environment was stressful.
- Finsbury and Downhills ward have not had consistent medical input which had impacted on patients feeling that they had been on the ward for an extensive amount of time.
- Some staff told us that they felt supported and enjoyed working on the wards. Some staff had been working for the trust for a substantial amount of time.
- Most staff felt confident to discuss any concerns with their line manager and were aware of the whistle-blowing process. Staff that were new to trust had not received information about this and were waiting for a formal induction.

Psychiatric intensive care unit – Edgware Community Hospital

Vision and values

- Staff agreed with the trust's vision and values.
- Most staff knew the senior managers of the hospital and trust and said they had visited the ward.

Good governance

- Avon ward had not had a permanent ward manager for over two years. A deputy team leader had been acting up until November 2015 and the current interim ward manager had been in place for three weeks.
- The trust provided the wards with heat maps that including monthly data on patient and carer feedback, quality assurance audit, staffing and infection control.
- The ward had a monthly clinical governance meeting and monthly team meeting, although these were not happening regularly.

Leadership, morale and staff engagement

- Some staff had completed mentorship training and were mentoring on the ward. Leadership training was offered to staff. The ward had regular student placements and encouraged students to apply for a job when they completed their course. Staff said that the trust encouraged and supported their career progression and professional development.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care:** The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. On Dorset ward at Chase Farm blanket restrictions were in place with doors locked throughout the ward. This was a breach of regulation 9(1)(2)(3)

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 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect:** The trust had not ensured that patients were treated with dignity and respect: The trust had not protected patients privacy and dignity by ensuring patients could close their observation windows on their bedroom doors.

This section is primarily information for the provider

Requirement notices

Many patients were returning from leave and were not able to return to their previous ward. This was disrupting their continuity of care and in some cases causing distress.

This was a breach of regulation 10(1)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The trust had not ensured that care and treatment was provided in a safe way for patients.

The seclusion rooms across the three sites did not protect the patients safety, privacy and dignity. This was due to to where the rooms were located, being able to observe patients and other patients on the ward being able to see into the seclusion rooms.

Patient risk assessments were not always completed with sufficient detail and had not been updated following incidents.

The trust had not kept under review the details of patients absconding from inpatient wards to ensure measures were put into place to keep this to a minimum.

The trust had not ensured that when rapid tranquillization was used that health checks took place afterwards to maintain the safety of the patients.

This section is primarily information for the provider

Requirement notices

Tools to monitor if a patients physical health was deteriorating were not being used properly and medical assistance requested when needed.

This was a breach of Regulation 12 (1)(2)

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 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment**

The trust had not ensured the premises and equipment used by the patients was appropriately secure, suitable and maintained.

Some clinic rooms at St Ann's were too warm for medication storage, the lighting was not working properly and on Downhills ward the emergency equipment was hard to access from the main ward area.

At St Ann's regular fire drills were not taking place on Finsbury and Downhills wards.

Poor lines of sight in some ward corridors had not been mitigated with mirrors.

Not all staff at Edgware community hospital had access to personal alarms.

This was a breach of Regulation 15 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed and that they had the appropriate supervision to enable them to carry out their duties they are employed to perform.

The trust had not ensured there were sufficient numbers of permanent staff working on the wards to ensure consistency of care, avoid leave being cancelled and minimize the incidence of violence and aggression especially on Downhills ward.

The trust had not ensured that staff had access to regular supervision and that a record of this was maintained.

The trust had not ensured that permanent ward managers were in post across the wards and consistent medical input.

This was a breach of regulation 18(1)(2)