Oxleas NHS Foundation Trust

Wards for older people with mental health problems

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)
RPGAR	Oaktree Lodge	Oaktree Lodge	SE18 3RZ

This report describes our judgement of the quality of care provided within this core service by Oxleas NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas NHS Foundation Trust.

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.

Summary of findings

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

As this was a focussed inspection of one ward we did not change the ratings of this core service.

Following this inspection we issued Oxleas NHS Foundation Trust with a Warning Notice.

On this inspection, we found:

- Two patients had full risk assessments completed a significant time after they were admitted to the ward. One was completed after 19 days, the other after 10 weeks. This meant staff were not aware of actual and potential risks when patients were admitted.
- Staff interactions with patients were brief. Patients sat in the communal areas of the ward with little to occupy them. Staff appeared to spend more time talking with each other than with patients.
- The recording of patients' capacity to make decisions was poor, particularly when decisions were made not to resuscitate a patient if their heart stopped. There was no record that patients' had been assisted to make such decisions, or that these decisions were reviewed.
- Staff communication with patients was not always therapeutic. We observed a member of staff telling a patient she would be 'jabbed' if she did not take her medicines.
- Two patients said that staff did not spend time with them. Other people said the same, and said that staff were sometimes dismissive of patients and were preoccupied with routine and tasks.
- The quality of patients' care plans varied and some patients did not have care plans that met all of their needs. Some care plans were not detailed and specific to the patient.
- There was a lack of activities on the ward. Activities were not always designed to meet patients' needs and did not follow best practice.
- A patient was significantly underweight and had not been referred to a dietitian. The patient's care plan recommended staff refer the patient to a dietitian if they were concerned about the patient's weight but this had not been done.
- The nursing team had discussed the findings of a recent safeguarding investigation. There had not been more widespread learning to ensure other patients were not affected. Other patients on the ward experienced poor care.
- The leadership team on the ward were unable to monitor and maintain good standards of care and treatment for all patients.
- The systems to monitor and improve quality and safety for patients on the ward had not been effective.

However:

- When patients were at risk of falls staff completed a falls risk assessment. Patients at risk of pressure ulcers were assessed using a recognised assessment tool.
- Specialist staff, including dietitians, physiotherapists and district nurses came to the ward following a referral. The palliative care team also attended the ward when this was necessary.
- All patients had an annual physical health check.

Summary of findings

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

Are services safe?

As this was a focussed inspection we did not change the rating for safe.

On this inspection, we found:

- Two patients did not have a full risk assessment completed following admission to the ward. One patient's risk assessment was completed after 19 days. The other patient's was completed after 10 weeks. A further patient had not had their risk assessment reviewed for one year and nine months.
- Visits to patients by the general practitioners were not recorded in patients' electronic care and treatment records. Details of patients' physical health assessment and the reasons for treatment were not always available for staff.
- The nursing team had discussed the findings of a recent safeguarding investigation. There had not been more widespread learning to ensure other patients were not affected. Other patients on the ward experienced poor care.

However:

- When patients were at risk of falls staff undertook a falls risk assessment. Staff assessed patients at risk of pressure ulcers using a recognised assessment tool.

Are services effective?

As this was a focussed inspection we did not change the rating for effective.

On this inspection, we found:

- The quality of patients' care plans varied and some patients' did not have care plans that met all of their needs. Some care plans were not detailed and specific to the patient.
- There was a lack of activities on the ward. Activities were not always designed to meet patients' needs and did not follow best practice.
- Patients were limited in the amount of time they could spend off the ward. Staff rotated the frequency of patients going on leave from the ward. This meant that patients might not leave the ward for more than a week and that patient's needs and wishes were not met.

Summary of findings

- A patient was significantly underweight and had not been referred to a dietitian. The patient's care plan recommended staff refer the patient to a dietitian if they were concerned about the patient's weight.
- Two patients' care and treatment records recorded that they should not be resuscitated if their heart stopped. Both patients were assessed as not having the capacity to make this decision. There was no record that these decisions had been discussed with the patient, that the patient had been supported by an Independent Mental Capacity Advocate, or that the decisions had been reviewed.
- One patient's care plan stated that the patient had capacity to make decisions. The care plan did not record what decisions. The care plan and did not reflect that patient's capacity to make decisions can fluctuate.

However:

- Specialist staff, including dietitians, physiotherapists and district nurses came to the ward following a referral. The palliative care team also attended the ward when this was necessary.
- All patients had an annual physical health check.

Are services caring?

As this was a focussed inspection we did not change the rating for caring.

On this inspection, we found:

- Staff interactions with patients were brief. Patients sat in the communal areas of the ward with little to occupy them. Staff appeared to spend more time talking with each other than with patients.
- Staff communication with patients was not always therapeutic. We observed a member of staff telling a patient she would be 'jabbed' if she did not take her medicines.
- Two patients said that staff did not spend time with them. Other people said the same, and said that staff were sometimes dismissive of patients and were preoccupied with routine and tasks.

Summary of findings

- Patients' care plans were written in a way describing what staff needed to do for the patients. There was limited information regarding patients' preferences or offering patients choices. Patients' input into their care plans was limited to brief comments.
- Four out of five patients did not have a copy of their care plan.
- A patient was recorded as having the capacity to make the decision that they should not be resuscitated if their heart stopped. There was no record of how the patient had been involved in this decision, the information they had been given, or the patient's views.

Are services well-led?

As this was a focussed inspection we did not change the rating for well-led.

On this inspection, we found:

- The leadership team on the ward were unable to monitor and maintain good standards of care and treatment for all patients.
- The systems to monitor and improve quality and safety for patients on the ward had not been effective.

Summary of findings

Information about the service

Oaktree Lodge is a 17 bed ward providing continuing care to older adults with mental health problems. The ward provides care and treatment to male and female patients, and most patients also have physical health problems. There were 13 patients on the ward and one patient in a general hospital at the time of the inspection.

All of the trusts wards for older adults with mental health problems were inspected in April 2016. At that time, the core service was rated as good for being safe, effective, caring, responsive and well-led. The overall rating was good.

Our inspection team

The team was comprised of: two CQC inspectors, a CQC assistant inspector and a specialist advisor, who was a senior nurse.

Why we carried out this inspection

This unannounced inspection took place following a safeguarding adult investigation, which had upheld allegations of poor care provided to a patient.

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?

As this was a focussed inspection, we inspected some areas of safe, effective, caring and well-led.

Before the inspection visit, we reviewed information that we held about this service.

During the inspection visit, the inspection team:

- visited the ward and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the acting ward manager
- spoke with four other staff members; including nurses, a technical instructor and a student nurse
- spoke with two visitors who were visiting a patient
- looked at six care and treatment records of patients
- looked at the provider's guidelines concerning decisions regarding the resuscitation of patients

What people who use the provider's services say

A patient reported that some staff were not kind, there was no-one to talk to and that there was nothing to do all day. This patient, and another patient, said that staff did not spend time with them. Three other people we spoke with during the inspection told us that some staff did not frequently speak with patients. We were told that staff sat

and drank coffee with each other, leaving patients sitting alone. We were also told that staff were sometimes dismissive of patients and were preoccupied with routine and tasks.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients' are involved in their care to the maximum extent possible. This must include decisions regarding future treatment.
- The provider must ensure that risk assessments of patients are undertaken following admission to the ward and are reviewed regularly. Action must be taken to minimise potential risks.
- The provider must ensure that patients are treated with dignity and respect and that staff interact appropriately with patients.
- The provider must ensure that patients can undertake activities, which promote their autonomy and independence.
- The provider must ensure an effective system is in place to assess, monitor and improve the quality and safety of care provided to patients.

Action the provider SHOULD take to improve

- The provider should ensure that patient's care and treatment records include details of assessment and treatment by other healthcare professionals, such as GPs.

Oxleas NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Oaktree Lodge	Oaktree Lodge

Mental Capacity Act and Deprivation of Liberty Safeguards

Two patients' care and treatment records recorded that they should not be resuscitated if their heart stopped. This was recorded on a standard form. The decision for one of the patients had been made in a general hospital before they were admitted to the ward. Both patients were recorded as not having the capacity to make this decision. There was no record of how the patients' capacity to make the decision had been assessed. There was no record that the patients had been supported by an Independent Mental Capacity Advocate to try and make the decision. There was no record that a number of attempts had been made to discuss this with the patient, as the decision was not urgent. We were told that once such decisions were made they were not reviewed. The way do not resuscitate decisions were made and recorded did not follow the trust policy or national best practice guidelines.

A further patient had a care plan regarding capacity. The care plan recorded that the patient had capacity. However, the care plan did not describe what decisions the patient had capacity for. Patients' capacity can fluctuate and is assessed according to specific decisions. The patients' care plan did not describe the type of decisions the patient had the capacity to make. The care plan did not consider that patients' capacity can fluctuate over time.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe staffing

- On an early shift there were two registered nurses and three healthcare assistants. On a late shift and night shift there were two registered nurses and two healthcare assistants. When a patient required continuous observation or an escort to appointments additional staff were booked to work.

Assessing and managing risk to patients and staff

- We reviewed the care and treatment records of six patients. Two patients did not have a comprehensive risk assessment undertaken when they were admitted to the ward. For one patient, a falls risk assessment was completed the day after they were admitted. This followed best practice. However, a full risk assessment was not completed until 10 weeks later. Another patient had a full risk assessment completed 19 days after their admission. For both patients there were identified actual and potential risks. The lack of patient risk assessments following admission meant there was no clear plan for how staff could minimise potential risks. A further patient had not had their risk assessment reviewed for one year and nine months. This meant that during that time, staff did not have up to date information concerning the patient's potential risks. The acting ward manager informed us that patients' risk assessments should be completed following admission, and be reviewed every year, unless a review was required sooner in response to a change in the patient's condition or an incident/risk event.
- Staff completed a falls risk assessment for patients at risk of falling. This assessment identified ways to minimise patients falling. When patients were at risk of developing pressure ulcers, the Waterlow score was used. This is a recognised tool for assessing the risk of patients developing pressure ulcers.
- Two general practitioners (GPs) visited the service to provide physical healthcare to patients. Staff recorded the patient's name and the reason for the GP to see them in a book. However, after the GP had seen the patient, there was no record on patients' electronic care and treatment records recording the GPs assessment and any treatment prescribed. This meant that patients' electronic care and treatment records were incomplete. There was no record of how patients' physical health was being assessed and treated.

Reporting incidents and learning from when things go wrong

- In late 2017, a safeguarding investigation had been undertaken regarding allegations of poor care provided to a patient. Four of the five allegations had been substantiated. The nursing team had discussed the findings of the safeguarding investigation, and improvements had been made to the patient's care. However, similar instances of poor care were observed regarding other patients on the ward. There had not been more widespread learning from the safeguarding investigation, to ensure that other patients were not affected.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We reviewed six patients' care and treatment records. Patients' care plans varied in quality. Two patients' care plans were detailed and specific. They met the patients' needs. However, other patients' care plans were not specific. One patient had general care plans that could have been written for any patient. A patient had cognitive deterioration, which meant their memory, concentration and thinking could have been affected. There was no care plan for the patient regarding how the cognitive deterioration affected them. This meant that staff did not know how they could support the patient effectively. The patient's care did not follow the National Institute for Health and Care Excellence (NICE) guidance on supporting people with dementia (2006). The patient also had chronic obstructive airways disease. They did not have a care plan for this, describing the monitoring to take place and how to minimise the patient's distress. Another patient had not had teeth or dentures for the six months they had been on the ward. The patient had not been asked if they would like dentures.

Best practice in treatment and care

- There was an activity programme for patients on the ward. However, during the inspection we did not observe any activities taking place. A number of patients in the ward had cognitive deterioration and were considered to be developing dementia. There were no activities such as reminiscence therapy or multi-sensory stimulation which are recommended for such patients (NICE, 2006). Patients were able to have exercise and could have leave from the ward. However, this was dependent on staffing levels and which other patients wanted to leave the ward. Staff rotated the frequency of patients being escorted on leave from the ward. This meant that patients might not leave the ward for more than a week if other patients also wanted leave. This meant that leave was not always based on patients' needs or wishes.
- One of the GPs from a local GP practice visited the ward four days a week to assess and treat patient's physical health problems. Patients had an annual physical health assessment.
- A patient had been assessed as being underweight and had a care plan for this. The care plan stated that if staff were concerned a referral to a dietitian should be made. The patient had a consistently low body mass index and was visibly underweight. There was no record that a referral to the dietitian had been made in the five weeks they had been on the ward. The patient's care plan did not record the patient's likes and dislikes regarding food.

Multi-disciplinary and inter-agency team work

- In addition to the nursing team and consultant psychiatrist an occupational therapy technical instructor was on the ward four days a week. Specialist staff, including dietitians, physiotherapists and district nurses came to the ward following a referral. The palliative care team also attended the ward when this was necessary.

Good practice in applying the Mental Capacity Act

- Two patients' care and treatment records recorded that they should not be resuscitated if their heart stopped. This was recorded on a standard form. The decision for one of the patients had taken place in a general hospital before they were admitted to the ward. Both patients were recorded as not having the capacity to make this decision. There was no record of how the patients' capacity to make the decision had been assessed. There was no record that the patients had been supported by an Independent Mental Capacity Advocate to try and make the decision. There was no record that a number of attempts had been made to discuss this with the patient, as the decision was not urgent. We were told by staff that once such decisions were made they were not reviewed. The way do not resuscitate decisions were made and recorded did not follow the trust policy or national best practice guidelines.

  A further patient had a care plan regarding capacity. The care plan recorded that the patient had capacity. However, the care plan did not describe what decisions the patient had capacity for. Patients' capacity can fluctuate and is assessed according to specific decisions. The patients' care plan did not describe the type of decisions the patient had the capacity to make. The care plan did not consider that patients' capacity can fluctuate over time.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed that most staff interactions with patients were brief. Staff appeared to spend more time talking with each other than with patients. Patients sat in communal areas of the ward with little to occupy them. Staff communication with patients was not always therapeutic. A patient did not wish to take medicines and a staff member said to the patient that staff would 'jab' her if she did not take her prescribed medicines. This occurred in a communal area of the ward. This interaction did not demonstrate compassion, respect or privacy for the patient.
- A patient reported that some staff were not kind, there was no-one to talk to and that there was nothing to do all day. This patient, and another patient, said that staff did not spend time with them. Three other people we spoke with during the inspection told us that some staff did not frequently speak with patients. We were told that staff sat and drank coffee with each other, leaving patients sitting alone. We were also told that staff were sometimes dismissive of patients and were preoccupied with routine and tasks.

The involvement of people in the care that they receive

- Patients' care plans showed that some patients were involved in planning their care. Some patients' input into their care plans was limited to brief recorded comments. Some patients' mental health problems meant they were limited in how much they could become involved in developing their care plans. However, all of the patients' care plans were written in a way which recorded what staff needed to do for the patient. There was limited information regarding patients' preferences or offering patients choices in most patients' care plans.
- Four out of five patients did not have a copy of their care plan.
- One patient's care and treatment records recorded that the patient should not be resuscitated if their heart stopped. The patient had been assessed as having capacity to make this decision. However, there was no record of how the patient had been involved in this decision. There was no record of the information the patient had been given, such as the likely effects of successful resuscitation. There was no record of the patients' views.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Good governance

- The systems used to monitor and improve safety and quality had not been effective in identifying areas of poor care on the ward.

Leadership, morale and staff engagement

- The leadership team on the ward were unable to monitor and maintain good standards of care and treatment for all patients. They lacked knowledge of some local policies and national guidance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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 Patients did not always have care planned and delivered, which was appropriate to their needs and reflected their and preferences. Patients were not supported to make decisions about their care and treatment, such as decisions about resuscitation. This was a breach of Regulation 9(1)(b)(c)(3)(a)(c)(d)

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 Patients were not always treated with dignity and respect by staff. Patients were not always supported to maintain their autonomy and independence. Patients' continued involvement in the community was not fully supported. This was a breach of Regulation 10(1)(2)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for patients. Staff did not always assess the risks to the health and safety of patients in a timely way. Risks were not always mitigated when this was reasonable practicable. This was a breach of Regulation 12(1)(a)(b)

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance Following a safeguarding investigation concerning a patient on the ward, the trust had not effectively assessed, monitored and improved the quality and safety of the service provided. The trust had not effectively assessed, monitored and mitigated the risks to the health, safety and welfare of patients. This was a breach of Regulation 17(1)(2)(a)