Care Quality Commission

Camden and Islington NHS Foundation Trust

Services for older people

Quality Report

Tel: 0203 317 3500
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Highgate Mental Health Centre	TAF72	Adult inpatient treatment wards, Jasper and Pearl	N19 5JG
Highgate Mental Health Centre	TAF72	Inpatient services for ageing and mental health, Garnet ward	N19 5JG
Highgate Mental Health Centre	TAF72	Community services for ageing and mental health	N19 5JG
St Pancras Hospital	TAF01	Community service for older people in mental health,	NW5 2TX
Stacey Street Nursing Home	TAF65	Nursing care for older people	N7 7JQ

This report describes our judgement of the quality of care provided within this core service by Camden and Islington 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 Camden and Islington NHS Foundation Trust and these are brought together to inform our overall judgement of Camden and Islington NHS Foundation 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.

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

Camden and Islington NHS Foundation Trust provides care and treatment and for older people who may have a functional mental health illness, such as depression and anxiety, and/or people who have organic mental health illness, such as dementia. The community-based services provide a range of services such as memory assessment and treatment, care home liaison services, dementia signposting and community recovery services. People may also have physical health problems. The trust's older people's inpatient services are provided in three wards based at the Highgate Centre for Mental Health.

The care and treatment that people experienced was well-led. The inpatient and community services worked well together to provide care that focused on recovery. People told us that they were treated with kindness and that they felt well respected.

People's physical health needs were met and staff were quick to respond to any changes. However, we found that the inpatient service did not always manage falls well and did not take enough action to prevent them happening again.

Incidents and accidents were monitored. However, the service failed to share findings and recommendations quickly, which made learning from serious untoward events ineffective.

The service monitored its compliance with the Mental Health Act 1983 and where gaps were found these were addressed by ward managers. Staff's knowledge and application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was not good enough.

Summary of findings

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

Are services safe?
The service did not always protect people from known risks to their health, safety and welfare. For example, people using inpatient services who experienced multiple falls were not having this addressed thoroughly.

In addition, the service did not use learning from serious untoward incidents to promote safety in the future.

Are services effective?
People were treated quickly if they became physically unwell. There were also good links with the acute and primary healthcare services. However, despite various tools that identified risks, action was not consistently taken to address these.

Staff's understanding of the Mental Capacity Act 2005 and its application was not always good enough.

The service has been very effective in reducing and monitoring the use of anti-psychotic medicines when treating older people.

Are services caring?
Staff were caring, respectful and kind in the way they treated and cared for people. There were also initiatives to promote and encourage staff to be compassionate in their care and treatment.

Are services responsive to people's needs?
People benefitted from care and treatment being led and delivered by a multidisciplinary team. There were also good links between both community and inpatient services, and there was a strong focus on providing treatment people's homes, where possible.

Are services well-led?
Services were well-led, staff reported that ward managers and the modern matron were very supportive. There was management support and funding for new training and staff development projects.

The trust engaged with people who use services or their relatives at several levels.

Summary of findings

Background to the service

Camden and Islington NHS Foundation Trust is the largest provider of mental health and substance misuse services to residents within the London boroughs of Camden and Islington. They also provide substance misuse services in Westminster and substance and psychological therapies services in Kingston-upon-Thames.

Services are provided to adults of working age, adults with learning disabilities and to older people.

The trust has three registered locations. These are their two main inpatient facilities at the Highgate Mental Health Centre and St Pancras Hospital. They have also registered a nursing home for older people at Stacey Street. The trust provides community-based services throughout the boroughs of Camden and Islington. Those located in Camden fall under the registration at St Pancras and those in Islington fall under the registration at the Highgate Mental Health Centre.

The people who use the services provided by the trust come from diverse ethnic and social backgrounds encompassing the extremes of wealthy and deprived areas. They also serve a large immigrant population speaking over 290 languages and a transient population of young adults.

The trust works with partner agencies and the voluntary sector to provide a range of services. The services are delivered through five divisions:

- Acute division.
- Rehabilitation and recovery division (psychosis services).
- Community mental health division (non-psychosis services)
- Services for ageing and mental health division.
- Substance misuse division.

Camden and Islington NHS Foundation Trust has been inspected on nine occasions. At the time of this inspection there was non-compliance at two locations. Stacey Street Nursing Home was non-compliant with outcome 9: management of medicines. St Pancras Hospital was non-compliant with outcome 2: consent to care and treatment and outcome 4: care and welfare. We followed-up this non-compliance as part of our inspection and found the trust had made the necessary improvements.

Camden and Islington NHS Foundation Trust older people's community-based services provide assessment and treatment and support services for adults who come into contact with mental health services. The service provides care and treatment and for people who may have a functional mental health illness, such as depression and anxiety, and/or people who have organic mental health illness, such as dementia. The community services are based in offices across Camden and Islington. The older people's community services provide a range of services such as memory assessment and treatment, care home liaison services (for people already accommodated in care or nursing homes), dementia signposting and community recovery services. People may also have physical health problems.

Camden and Islington NHS Foundation Trust older people's inpatient services are provided in three wards based at the Highgate Centre for Mental Health. Two of the wards sit in the acute directorate and they are treatment wards. People treated on these wards may be diagnosed with a functional or an organic mental illness. A third ward provides continuing care services for older people. People admitted to all three wards may have physical health conditions in addition to their mental health diagnoses.

The trust also provides nursing care to older people with dementia or mental health issues at Stacey Street Nursing Home.

Our inspection team

Our inspection team was led by:

Chair: Dr Steve Colgan, Medical Director, Greater Manchester West NHS Foundation Trust

Summary of findings

Team Leader: Jane Ray, Care Quality Commission (CQC)

The team of 35 people included: CQC inspectors, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors which included consultant psychiatrists, psychologists, senior nurses, junior doctors and social workers.

We were additionally supported by four Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected the older people's services included a CQC inspector and a variety of specialists: a consultant psychiatrist, a registered mental health nurse, a CQC Mental Health Act Commissioner, a pharmacist and an expert by experience who had experience of older people's care.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme. This trust was selected to enable CQC to test and evaluate its methodology across a range of different trusts.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

The inspection team always inspects the following core services at each inspection:

- Acute admission wards.
- Health-based places of safety.
- Psychiatric Intensive Care Units (PICUs).
- Services for older people.
- Adult community-based services.
- Community-based crisis services.

We visited the older people's services of Camden and Islington NHS Foundation Trust from 27 to 30 May 2014. Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

Before our inspection, we met with five different groups of people who use the services. We also met with two carers groups from the two boroughs of Camden and Islington. They shared their views and experiences of receiving services from the provider.

We visited both the hospital locations and the nursing home, and inspected all the acute inpatient services and crisis teams for adults of working age. We also visited the psychiatric intensive care unit at the Highgate Centre and went to two of the three places of safety located in the accident and emergency departments at University College Hospital and the Whittington Hospital. We also inspected the inpatient and some community services for older people and visited a sample of the community teams.

During our visit the team:

- Held focus groups with different staff members such as nurses, student nurses and healthcare assistants, senior and junior doctors, allied health professionals and governors.
- Talked with patients, carers, family members and staff.
- Looked at the personal care or treatment records of a sample of patients.

Summary of findings

- Observed how staff were caring for people.
- Interviewed staff members.
- Reviewed information we had asked the trust to provide.
- Attended multidisciplinary team meetings.
- Collected feedback using comment cards.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

What people who use the provider's services say

We spoke with people who use the service, and their relatives, who were positive about their experiences of the inpatient and community services. They described staff as kind and respectful. People told us they benefited from the activities the service provided and said that they were appropriate to their needs.

Good practice

- The use of anti-psychotic medicines when treating older people was low.
- There was a strong, recovery-focused model of care.
- The care home liaison service, which provided quick assessment and support, skilling care home staff.
- The compassionate care initiative that was used in the community teams.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that there are adequate arrangements in place so people are safe. Where a person is identified as at risk of falls, there must be an assessment and management plan in place to protect them. The provider must review its falls management policy and make sure that it reflects current guidelines.
- The trust must make sure that learning from incidents is distributed to staff quickly.
- The trust must make sure that staff are trained in the Mental Capacity Act 2005 and its application, including Deprivation of Liberty Safeguards (DoLS).

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure that the shared garden space is safe for both groups of people who use the service.
- The trust should continue to review whether having people with different needs on inpatient wards is a safe and effective model of care.
- The trust should work towards staff being managerially supervised more consistently.

Detailed findings

Camden and Islington NHS Foundation Trust

Services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Jasper, Pearl and Garnet wards	Highgate Mental Health Centre
Services for ageing and mental health	Highgate Mental Health Centre
Community mental health services for older people	St Pancras Hospital
Care home with nursing	Stacey Street

Mental Health Act responsibilities

The use of the Mental Health Act (MHA)1983 was found to be good on the older people's wards. Mental health documentation reviewed was mostly found to be compliant with the Act and the MHA Code of Practice in the records of people detained under the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff working in inpatient services were not appropriately assessing people's ability to make decisions about their care and treatment. Staff were inconsistent in their understanding and application of the Mental Capacity Act 2005 and of the associated Deprivation of Liberty Safeguards (DoLS). Subsequently, we were not satisfied that best interest decisions were consistently robust and in the spirit of the legislation.

Are services safe?

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

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

Summary of findings

The service did not always protect people from known risks to their health, safety and welfare. For example, people using inpatient services who experienced multiple falls were not having this addressed thoroughly.

In addition, the service did not use learning from serious untoward incidents to promote safety in the future.

Our findings

Inpatient services for older people

Track record on safety

The service reported all incidents on an electronic system that was accessed and monitored by relevant teams within the trust. Staff we spoke with knew how to report incidents on the system and we saw these reports contained a good level of detail about the event and any injuries sustained.

The trust collated and monitored incidents and where needed provided a 'patient safety alert'. We saw that recent alerts on patients choking and falls had been sent to the inpatient wards.

On a monthly basis, staff completed a national safety thermometer report which included the incidents that may occur in the ward population, such as falls, pressure sores, leg ulcers, chest infections and urinary tract infections.

Learning from incidents and improving safety standards

The trust shared with us their report on incidents for the last quarter of year 2013/14. There had been a slight increase in the number of falls which peaked in January 2014, but reduced again through February 2014 and continued dropping in March 2014. The report noted the highest incidences of falls on two wards. The report also noted that one older person's treatment ward had more than double the incidence of falls than another. This was accounted for by a few people experiencing multiple falls. The trust issued a patient safety alert regarding the management of falls in 25 April 2014.

We reviewed a root cause analysis into an accident that eventually led to the person's death after sustaining a fractured femur in a fall. The incident that caused the fall and fractured femur occurred in a patio area shared by a treatment ward and a continuing care ward. Staff on both wards were able to recount the event and what caused the fall. They told us there had been a serious incident investigation into the event. However when we asked about the findings neither ward manager had seen the report and confirmed they were not advised of its findings or recommendations. The event occurred in September 2013, and the report had been approved on 8 April 2014. The delay in getting the report to the ward manager to cascade any possible learning to staff could affect patient safety.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The wards were clean and tidy and maintained to a high standard. Cleaning schedules to ensure a consistent level of cleanliness and infection control were in place.

Equipment used in an emergency was available and checked regularly. Staff were able to explain how they would respond in the event of an emergency and how to access the resuscitation team, if required.

Staff we spoke with understood their responsibilities in terms of raising safeguarding concerns. They had access to written safeguarding processes to refer to; these were up to date and in line with current guidance. Each office had a flow chart displayed so staff had a quick point of reference. Ward managers had good links with the safeguarding team and actively sought advice from them.

We reviewed how the service risk assessed and monitored falls on two wards which the trust had identified as having high fall rates. In the trust's report, the higher rate of falls was partially accounted for by a few people experiencing repeat falls, for example in the final quarter of 2013/14, one person had fallen seven times.

There was evidence of a gap in staff skills and knowledge in falls prevention. We spoke with the senior manager who

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had recently been designated as the trust's lead on fall prevention. They confirmed that they had not undertaken any up-to-date training on falls prevention, although they had plans to link with other trusts.

The trust's falls policy was last updated in 2011 and had not been reviewed in 2013 to reflect new National Institute of Clinical Excellence (NICE) guidance. In interviews staff were unaware of the revised guidance, although a patient safety alert issued by the trust in April 2014 referred to this.

Whilst the alert highlights the need for staff to consider a wide range of factors in the assessment of people at risk of falls we saw little evidence of this on the care records we tracked. For example on one ward we saw that a person had fallen six times. Five of these falls had been within in a short period of time, and on one day the person had fallen twice. We were not satisfied that the service took robust preventative action in the form of multi factorial assessments or fully considered the involvement of other disciplines such as pharmacy. Equally we were not satisfied that the service took adequate and sufficient action in a timely manner to review the person's care and treatment arrangements after the cluster of falls.

On a second ward we saw another person had fallen eight times in the seven weeks preceding our inspection. The multiple factors that predispose older people to fall were not adequately considered in the person's falls risk assessment despite an extensive medical history and medication that may have contributed to their unsteadiness. The care plan to prevent and reduce the falls only stated that the person should be referred to the physiotherapist.

When other risks were identified they were not always addressed promptly. For example one person who was assessed as being at risk of inadequate nutrition had been prescribed a fortified drink to supplement poor dietary intake; however the person had not had the drink for eleven days because it was "not available".

When we reviewed people's care records we saw that on admission they had physical health checks and the likelihood of pressure sores and malnutrition assessed. The national safety thermometer report showed a very low incidence of pressure sores with one reported in the first three quarters of 2013/14. At the time of our inspection no pressure sores had been reported. We saw conditions such as diabetes were well managed and staff reported good links with acute health services.

Assessing and monitoring safety and risk

People on the continuing care wards told us they felt safe and this was corroborated when we spoke with relatives who visited regularly.

On both the acute treatment wards we received mixed feedback. For example, one person described that they were frightened because they were uncertain what would happen next. However, they also told us they felt staff would protect them. People treated on these wards had a range of mental health diagnoses. People with severe depression or acute anxiety were accommodated with people who were cognitively impaired. The trusts report on the incidence of violence and aggression for inpatient services in the final quarter of 2013/14 showed there were 32 reported incidents of violence and aggression. The data showed that some of these were directed at staff or other people who use the service. Anecdotally, staff described to us how they distracted and de-escalated potentially violent and aggressive situations, and from our own observations we saw that staff skilfully diffused possible events.

The nursing staff and healthcare assistants worked long days. We received mixed feedback from staff about the long days with some people telling us they were too tired to work effectively during these long shifts. We also found that as nurses worked a few long days and then took several days off this presented a challenge for their role as a "primary nurse". Patients and relatives were unable to tell us who their named nurse was. We also heard how hard it is for primary nurses to catch up after several days off work.

Staff were trained in physical interventions. However there had been no incidents of restraint on the inpatient wards and staff described and we saw the effective use of de-escalation techniques.

Understanding and management of foreseeable risks

A serious incident report in April 2014 made several recommendations, two of which concerned the garden/patio area that was shared by two wards that accommodated people with differing abilities and needs which presented some identified risks to people who use the service. We observed that people went into the garden

Are services safe?

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unsupervised and there were no management arrangements in place to address these known risks. We also noted low level planting that may contribute to tripping hazards.

On one ward there had been a recent incidence of an infectious disease. The trust, and its infection control team, responded appropriately to protect other people, staff and visitors such as reviewing staff immunity, isolating the person and using universal procedures in infection control.

When we walked around the wards we saw no obvious ligature points, the wards had ligature risk assessments and accessible ligature cutters.

Community services for older people

Track record

There was a clear system for recognising and reporting notifiable incidents.

Managers were notified of any safety alerts through bulletins from the trust and these were cascaded to staff.

Learning from incidents and improving safety standards

Staff described to us how learning from incidents was a key aspect of their role. For example in the care home liaison team staff described how an event was reported to the service manager, an electronic report completed and the incident review formed part of their reflective practice. They described how they reviewed the incident with their manager and possible triggers were identified and how to avoid repeat occurrences. We saw that incident reviews also formed part of staff team meetings.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

There were designated safeguarding champions within the community teams and safeguarding was discussed individually in supervision and was also an agenda item at team meetings. The trust had both detailed guidance and protocols along with 'quick reference' flow charts available at community bases.

We observed a member of staff taking details of a safeguarding issue. We noted they described the next steps to the caller and inputted the information on the electronic system before it was forwarded to the local authority's safeguarding team.

Staff were able to describe to us the types of safeguarding they dealt with in particular settings. For example, pressure ulcers in care services, or financial abuse of people with memory difficulties.

Assessing and monitoring safety and risk

Managers and staff told us that the number of people being supported by a mental health practitioner was considered high, with up to 25 people at any given time. Staff sickness and leave was absorbed by the team.

Strategies were in place to ensure people's safety. When we reviewed people's records we saw that risks were identified by the person, their carer or relative and the service. These risks were then addressed as part of the person's care plan.

Are services effective?

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

Summary of findings

People were treated quickly if they became physically unwell. There were also good links with the acute and primary healthcare services. However, despite various tools that identified risks, action was not consistently taken to address these.

Staff's understanding of the Mental Capacity Act 2005 and its application was not always good enough.

The service has been very effective in reducing and monitoring the use of anti-psychotic medicines when treating older people.

Our findings

Inpatient services for older people

Assessment and delivery of care and treatment

We inspected the medicines management on Garnet Ward and saw that medicines were stored securely on this ward, and records were kept of the medicines fridge and medicines room temperatures, providing evidence that medicine was stored appropriately to remain fit for use. Prescription charts were clear and completed fully, providing evidence that people were receiving their medicines as prescribed. Staff completed a 'Medical Omissions' sheet every day, recording how many gaps in recording appeared on people's prescription charts. We saw that in the last 28 days, only one dose had not been signed for.

We saw that people were not prescribed excessive medicines for agitation or sleeping, so were not overly sedated. One person had been assessed as not understanding the implications of not taking their medicines, and had been refusing essential medicines, placing their health at risk. We saw evidence that a multi-disciplinary best interests meeting had been held, where a decision had been made to administer this person's medicines in food to ensure they received essential medicines. This is called covert administration, and we saw that the trusts policy had been followed, so that the appropriate agreements and safeguards were in place. We saw that pharmacists had added instructions for nursing staff on how to administer these medicines in food. Therefore we saw that arrangements were in place to safely administer medicines to people.

Throughout our inspection we saw that the service was very good at responding when people became physically unwell and attention was consistently sought promptly. People's needs were assessed on admission and care plans based on initial findings were created. Known risks for older people were also assessed using tools such as FRASE for falls, MUST for malnutrition and Waterlow for pressure ulcers. People received physical health checks and appropriate referrals were made.

The service had recently introduced a modified early warning system (MEWS) which is a tool used to assess changes in people's routine observations that can indicate changes in their physical health. Not all staff were confident in using the tool and we saw evidence of this for a person who was on medication for blood pressure and had experienced a cluster of falls. Nursing staff told us that they had not received recent training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and they were not clear about their legal responsibilities. DoLS provide protection to people who may be deprived of their liberty and freedom of movement and who are not detainable under the Mental Health Act. There was a considerable variance in qualified nursing staffs understanding of their responsibilities. Ward managers told us that at the time of our inspection one application had been made to seek authorisation for a DoLS which had been refused as the assessors felt the person should be assessed under the Mental Health Act. We saw people who were on the ward who were not detained under the Mental Health Act and were being told they could not leave the ward where a capacity assessment and authorisation may have been needed for their own protection.

We did see medical staff using the Mental Capacity Act, although we saw one best interest meeting taking place to discuss the person's future accommodation and there were no family, carers or independent advocates present.

Staff, equipment and facilities

The service had step-free access and facilities to meet the needs of people with mobility difficulties or those

dependent on wheelchairs. The service also had appropriate equipment used in the prevention of pressure ulcers such as pressure relieving mattresses and chair cushions.

Stakeholders told us that inconsistent standards of staff supervision arrangements were an ongoing theme. We reviewed a sample of management supervision records and our findings concurred with this. Where there were clear gaps that impacted on people's safety and wellbeing these were not addressed and followed through. However the records did evidence that staff had some supervisory support whilst they varied in content the records corroborated staff feedback that they felt well supported by their managers.

People had good person centred occupational care plans and people spoke very highly of the group and individual activities provided. On the treatment wards we saw people attended both individual and group activities. For example people were supported to develop computer skills or creative writing or yoga. Some people, as part of their discharge planning, attended the community recovery teams for support in managing their mental health. Another person who used the service told us "I enjoy the activities here; there is something to do every day it's my choice to attend or not". There were no activities provided at weekends.

People accommodated in the continuing care unit were provided with an excellent range of appropriate activities, such as chair based exercises, and hand massages. We saw that the activity co-ordinator was very skilled at engaging people in a baking activity.

Multidisciplinary working

The wards' care teams were made up of psychiatrists, nurses, occupational health therapists, psychologists, activity co-ordinators and health care assistants. Social workers attended wards rounds to coordinate care arrangements for planned discharge.

Mental Health Act (MHA) 1983

We saw on the trusts quarterly score board for the last quarter of 2013/14 both treatment wards did not score well in relation to detained people being provided with information about their legal rights. This had been fed back to staff at a team meeting. We found on this inspection that the records relating to detained patients to be compliant with the Mental Health Act and the Code of Practice in the files we examined.

Stacey Street nursing home

Assessment and delivery of care and treatment

At our last inspection of Stacey Street nursing home we found the service was non-compliant in how medicines were managed.

At this inspection we found that a new medicines management procedure had been written specifically for the home in April 2014, and we were shown evidence that staff with responsibilities for medicines had received training in the new procedure. The registered manager told us that a pharmacist employed by the trust now visited the home once a month to audit medicines, and had provided medication training to staff. We saw evidence that medication competency had been checked for all staff with responsibilities for medicines, and the registered manager told us that this would be repeated every six months. Medicines were no longer being secondarily dispensed by nursing home staff. Therefore medicines were now being administered safely by staff who had the appropriate training and guidance to do so.

The registered manager told us that medication for every person at the home was checked every week, and we were shown the medication audit reports for the last four weeks. No significant issues had been picked up during these audits. Therefore arrangements were now in place to check whether medicines were being managed safely.

We checked the storage of medicines, and found that medicines were stored securely in individual lockers in people's rooms. Temperature monitoring records were now kept for all areas where medicines were stored, and these showed that medicines were now being kept at the correct temperatures to remain fit for use.

We saw that appropriate arrangements were in place to prescribe and order medicines. All prescribed medicines were available at the home, and we saw evidence that the GP visited the service every week, and the trust's consultant reviewed people's medicines every three months.

We checked the Medication Administration Record (MAR) sheets for people who used the service and we saw that these were now completed accurately and in full.

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.

When we reconciled medication in stock with information on the MAR sheets, there were no discrepancies. We noted that minor improvements were needed to how non-nursing staff recorded the use of creams. We discussed this with the registered manager and the trust's chief pharmacist and we saw that this had already been identified, and discussions had taken place on how best to record the use of creams.

We found that arrangements had been put in place to dispose of medicines appropriately, by returning medicines for disposal to the trust's on-site pharmacy from May 2014.

Therefore we saw that the required improvements had been made and that medicines were now being managed safely.

Community services for older people

Assessment and delivery of care and treatment

When we reviewed care records we were satisfied that people were at the centre of their care arrangements and were supported to identify their own goals. The care plans detailed the joint agreements between the service and the people in relation to how their identified needs were to be met.

In the community recovery service the care plans we reviewed told us that people's active participation was a focus of supporting them manage their mental illness.

The community mental health liaison service provided services to 19 care homes across the two boroughs. Each care home had a named community liaison nurse who provided a rapid response when difficulties arose in the management of a person's care within the home. Aside from the assessment and formulation of individual management plans the service also provided support to care home staff through education about mental health conditions, awareness of dementia, the management of behavioural challenges associated with dementia and other mental illnesses.

Outcomes for people using services

The memory assessment and treatment service followed the latest NICE guidance which set standards on how to support people to live well with dementia. The service provided people who had been diagnosed with dementia the opportunity to be involved in a group programme that provided cognitive stimulation. Carers were provided with a support network to help them better understand issues like carer stress, how to access emotional and practical support and understand behaviours that can challenge.

Staff described to us how the involvement of the care home liaison team, along with other disciplines and services, actively worked to support people in care homes with the aim of preventing avoidable admission to hospital. This was in line with the government's National Dementia Strategy 2009.

Staff, equipment and facilities

Staff we spoke with were unanimous in their view that they were well supported in supervision in terms of quality and quantity. One member of staff said supervision here "is excellent, if it's missed one week I get double the next time round". We saw that within the multidisciplinary team make-up there were appropriate arrangements in place for supervision. For example when the team/service was managed by a social worker then nurses had appropriate peer support and points of contact for practice issues.

Staff were enabled to undertake training that would enhance their skills and contribution to the service. For example a team nurse was undertaking a cognitive behavioural therapy course.

Multidisciplinary working

When we reviewed people's care pathways we saw that practitioners and clinicians from a wide range of disciplines were involved in the assessment, planning and delivery of people's care and treatment. When people's needs were assessed and a care plan reviewed this information was presented at the weekly team meetings with the aim of keeping everyone informed.

People care's was coordinated by either a nurse, social worker or an occupational therapist. A range of other disciplines then made up the team such as psychologists who provided both clinical contact to people using the service and an advisory function.

The services within the trusts community mental health teams work closely with other external professionals like GPs, acute healthcare, housing and social care. Islington's Clinical Commissioning Group (CCG) told us that the service was "excellent". They said that GPs who refer people to the memory assessment service described it as "world class".

Mental Health Act (MHA) 1983

Approved Mental Health Professionals (AMHP) worked within the trust's community teams. They were funded and approved by both local authority social services departments to organise and carry out assessments under the MHA.

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.

We found staff were knowledgeable and understood their legal responsibilities under the Mental Capacity Act 2005. They provided us with examples within their service when people were assessed to lack the capacity to make a specific decision and how they needed to clearly demonstrate why the service made the decision in the person's "best interest". From a review of records we saw that when staff suspected a person lacked capacity to make a decision then assessments were undertaken.

We saw the community teams working effectively with organisations outside the trust in the management of antipsychotic medication. We were told that out of 671 people only 12 were prescribed anti-psychotic medications. An electronic alert flagged the need for the person's GP to review this prescription at eight weeks.

Are services caring?

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

Summary of findings

Staff were caring, respectful and kind in the way they treated and care for people. There were also initiatives to promote and encourage staff to be compassionate in their care and treatment.

Our findings

Inpatient services for older people

Kindness, dignity and respect

On the continuing care unit we undertook a short observational framework of inspection (SOFI) at lunchtime. This is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe these themselves because of cognitive or other problems. We observed very positive and enabling interactions from staff where people requiring more support and assistance were provided with that at an appropriate pace to suit them. People who were waiting to be discharged to the community were supported to use their skills and abilities in a respectful manner. We observed interactions that were warm and inclusive where people who use the service were comfortable and at ease with staff.

One relative told us "this isn't an act, they (staff) are always like this, they are wonderful to him (relative) and to me, I'm made so welcome here". [Garnet Ward]

One person who used the service told us "they have been very good to me, They (staff) are very busy but always make time to come and chat to me". [Pearl Ward]

People who use the service were accommodated in private rooms with en-suite facilities. There were bathrooms with good access for wheelchair dependent people.

People using services involvement

We saw that on the continuing care unit community meetings took place approximately every two months and relatives were invited to attend. Issues raised by people using the service could be escalated quickly as the modern matron attended the meeting. We saw examples of 'you said, we did' such as changes to evening meals, making mealtimes more sociable and supporting relatives understand more about people's conditions.

On the treatment wards people had service user meetings weekly. People's involvement was further enabled by other service user groups, for example Islington Borough User Group (IBUG) who visited the wards each week.

We received very mixed feedback on the level of people's involvement in their care arrangements. Some people did not recognise the term 'care plan' but told us staff spoke to them about their care arrangements. Other people told us they felt involved in their care arrangements and a person told us they had not been involved but were happy to "leave it to the experts".

We observed a ward round which considered the care arrangements and future plans of five people who use the service. Four of the five people were invited and supported to attend the meeting, relatives also were welcomed.

Emotional support for care and treatment

All the wards had a protected engagement time (PET) from 11.30am until 1pm where staff focused on working with people either in group or one to one activities. Staff told us how much they recognised the value and positive impact this had on people who use the service. However, they also reported that it was a challenge to provide this time. On one ward we were told that there was insufficient time or staff for the engagement.

Relatives of people who use the service told us that they felt supported and welcomed on the wards. We spoke with a relative who told us they had been reassured by the quality of information staff had about the person's wellbeing.

Community services for older people

Kindness, dignity and respect

Feedback from people who used the service was extremely positive about staff's approach.

We saw an initiative that the service used to promote and highlight good practice in terms of compassionate care and treatment. On joint visits staff rated their colleague's interaction with people who use the service against behaviours consistent with compassionate care and treatment.

In a service user satisfaction survey of people who received ongoing contact with the community teams we saw for the year ending 2013/14, just under 100% of people reported they had "definitely" been treated with dignity and respect.

Are services caring?

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

People using services involvement

People using community services told us they were very involved in their care arrangements one person said “I have a care plan at the centre, staff have helped me set some goals and I keep my own copy”. Another person told us “we are going to have a review of my medication as I told staff that I didn’t feel it was doing me any good”.

Emotional support for care and treatment

People were provided with a recovery model of care with access to psychological therapies to support people to maintain their good health. Carers of people who use the service were provided with group and individual support, signposted to non-statutory services and consulted about the care packages to be provided.

Are services responsive to people's needs?

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

Summary of findings

People benefitted from care and treatment being led and delivered by a multidisciplinary team. There were also good links between both community and inpatient services, and there was a strong focus on providing treatment people's homes, where possible.

Our findings

Inpatient services for older people

Right care at the right time

Care was led and delivered through the multi-disciplinary team, and we saw that when people required specialist physical healthcare it was provided promptly.

Care pathway

Staff on the wards were aware of the need for specific care relating to people's cultural and religious needs. People had access to meals which met their religious needs such as kosher and halal foods. Cultural dietary requirements were also catered for such as Caribbean foods. Chaplaincy services were arranged in line with people's individual beliefs. The trust had provided access to interpreting services and the ward managers told us the service was routinely booked for multidisciplinary meetings, when required.

Learning from concerns and complaints

The trust had a complaints procedure the guidance of which was summarised and advertised on the ward. One ward had used part pictorial guidance on how to make a complaint as a means of making the process more accessible to people.

Community services for older people

Planning and delivering services

The services for ageing and mental health were provided separately in each of the boroughs, with the exception of the community recovery service, which was located in Camden. The Islington team did not have a clinical space and their office could not accommodate either service users or their carers. However staff told us they could book rooms and locations at other sites if required.

Right care at the right time

Each service had performance targets. For example in Islington people attending the memory service for assessment should have a diagnosis within 12 weeks. From a trust report we saw that in the year 2013/14, 61% of people seen did not have their diagnosis within this time. It was positive to note the improvement through the year from when only 26% of people in the first quarter had their diagnosis within 12 weeks improving to 84% in the final quarter.

Staff and team managers told us that whilst caseloads were high they did not feel pressurised to discharge people from the service to accommodate new referrals.

We saw a bar chart on service user feedback which captured information surveys run by the Advisory Group for Older people. We noted that just fewer than 70% of people surveyed were satisfied (to some extent or definitely) with the organisation of their initial appointment.

Care pathway

People were referred to the service through their GP directly to the memory service. The memory assessment and treatment team aimed to see people for memory assessments, undertaken in their own home, within two weeks. The outcome of the assessment decided people's ongoing care pathway. If people received a diagnosis of Alzheimer's Disease they may commence treatment, whilst people with a vascular type dementia were signposted to other support services.

Learning from concerns and complaints

The service had a comprehensive complaints system and where necessary people were supported to access the complaints process via the patient advice and liaison service (PALS). The trust maintained records of all formal complaints and we had access to these during our inspection. Staff described learning from complaints, through discussions with their manager and, where appropriate, other team members.

Are services well-led?

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

Summary of findings

Services were well-led, staff reported that ward managers and the modern matron were very supportive. There was management support and funding for new training and staff development projects.

The trust engaged with people who use services or their relatives at several levels.

Our findings

Inpatient services for older people

Vision and strategy

Staff we spoke with knew the trust's vision of the best possible recovery within available resources. Everyone spoke about being committed to people who use the service. Staff spoke to us about how the changes had affected the service and the people that used them.

Responsible governance

The line management structure from ward manager level had altered with recent directorate changes. Both treatment wards came under the acute mental health services and were line managed by the modern matron from the acute mental health directorate. The continuing care unit sat in the older people's services directorate. On each ward there were clear lines of reporting and accountability. We saw that staff rosters identified the shift leaders and who was allocated to attend multi-disciplinary team meetings.

Staff meetings took place each month on the wards and the minutes were made available afterwards. Staff attendance at the meetings was relatively low and we were told this was because of the shift patterns. We reviewed the minutes of the most recent meeting on one ward and saw that this gave information rather than offering an opportunity to discuss issues.

The trust used a performance dashboard as a monitoring tool we saw that on both treatment wards were scoring well for managing risks, care plans and activities. Where there was an area of poor scores we saw that this was followed through at the team meeting.

Ward managers meet weekly but unfortunately this is not attended by the modern matron who attends a different meeting at that time.

Leadership and culture

Staff at all levels told us they felt well supported at a local level, by both their ward managers and the modern matron. We saw the modern matron was highly visible undertaking a daily 'walk- around' on the wards. Staff told us he was approachable and supportive.

Staff described to us the challenges they experience with the level of administration and balancing the actual delivery of care with the recording.

Staff at all levels told us they felt well supported at a local level. We saw the modern matron was highly visible, undertaking a daily "walk around" on the wards. Staff reported they felt well supported by the modern matron and their ward managers.

The modern matron reported that they were well supported by the nursing directorate. They gave examples of new training initiatives for healthcare assistants and band 5 nurses that had received full management support and funding. It was very positive to note that the director of nursing was planning to undertake a shift as a nurse working on a ward.

Engagement

The continuing care ward had an active carers group who spoke on behalf of the people who use the service. The ward manager told us that relatives were very involved and active in the unit, and relatives said they were made to feel very welcome. We reviewed the minutes of carers meetings and saw the issues they raised and could also see that these were being followed up.

Community services for older people

Vision and strategy

Staff told us they knew about the trusts vision and providing best services within its resources. However, staff were still critical of the impact of the decisions stemming from the changes that had taken place in the trust in 2012. Following the restructuring of community services, one staff member said it had been "a catastrophic loss of skill and expertise" whilst another colleague considered the trust had "been very brave" to deliver such a programme of change.

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.

Responsible governance

There were clear lines of accountability and responsibility within the teams and staff described to us who they would seek advice and guidance from. There were weekly team meetings where incidents and learning points were discussed

Leadership and culture

Staff told us they felt very well supported locally. Staff told us that they enjoyed working in the team and were proud of the range of services they provided. For example in Camden the memory group also ran a food group about "nutrition for the brain". In Islington staff were considering an innovative support group for men.

Staff told us they felt very well supported through their line management structures that supervision was "excellent" and they felt they had opportunities to develop their skills further. Managers described senior management as "transparent" and said that they were provided with clear information.

We were impressed with the level of enthusiasm and pride staff took in the service they provided. We saw that there was good teamwork and staff commented how they enjoyed working within a supportive and varied team.

Engagement

The trust engaged with people who used the service at several levels. The teams within the service sought feedback through satisfaction questionnaires. The trust also used the Advisory Group for Older People to tell them about the experiences of older people who use the services.

Each of the boroughs had a user group, for example Islington Borough User Group (IBUG) actively engaged with the trust and promoted advocacy and self-advocacy for service users. It also facilitated service user involvement in the commissioning and delivery of mental health services.

Performance improvement

The staff were aware of team and performance targets for their area of work and told us that these were discussed and monitored by their manager through team meetings and individual supervision sessions.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 18 HSCA 2008 (Regulated activities) Regulations 2010** **Consent to care and treatment** The trust did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people or where that did not apply for establishing and acting in accordance with people's best interests. Many staff in inpatient areas had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and this meant that decisions were being made that might not take into account people's human rights. This was a breach of Regulation 18 (1)(a)(b) (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 10 HSCA 2008 (Regulated activities) Regulations 2010** **Assessing and monitoring the quality of service** The trust did not have an effectively operating system to share learning from incidents in order to make changes to people's care in order to reduce the potential for harm to service users. This was in breach of Regulation 10(2)(c)

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 2008 (Regulated activities) Regulations 2010** **Care and Welfare of Service Users**

Compliance actions

The trust did not ensure that service users were protected against the risk of receiving care and treatment that was unsafe by having an up to date policy for managing falls and by ensuring that guidance provided to staff is effectively used within the older people's inpatient services.

This was in breach of Regulation 9(1)(b)