

Southern Health 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)
RW158	Gosport War Memorial Hospital	Daedalus Ward	PO12 3PW
RW158	Gosport War Memorial Hospital	Dryad Ward	PO12 3PW
RW119	Melbury Lodge	Stefano Olivieri	SO22 5DG
RW1AC	Parklands Hospital	Beechwood Ward	RG24 9RH
RW1AC	Parklands Hospital	Elmwood Ward	RG24 9RH
RW155	Western Community Hospital	Berrywood Ward	SO16 4XE
RW155	Western Community Hospital	Beaulieu Ward	SO16 4XE

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

# Summary of findings

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 Southern Health NHS Foundation Trust and these are brought together to inform our overall judgement of Southern Health 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.

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

- All wards were subject to the trusts ongoing environmental improvement plan that included minimising ligature risks. The security arrangements and exit and entrance facilities to Stefano Olivieri were inadequate and there were privacy and dignity issues relating to the bathroom facilities on this unit. We brought these concerns to the attention of the trust who have taken action.
- We found examples where there were inconsistencies and varied practice in the completion of do not attempt cardio pulmonary resuscitation (DNACPR) form on wards at Stefano Olivieri, Berrywood and Beaulieu. Staff told us that they were unclear how best to restrain an older patient when requiring injectable medication, which could cause harm to patients. The trust was currently reviewing their policy to ensure that this intervention could be delivered safely.
- Despite ongoing challenges related to the recruitment of new staff, the trust had undertaken a safer staffing review of all the wards. This had created additional vacancies due to the trust identifying the need to increase staff numbers, which resulted in reliance on bank and agency staff. We found that all wards were providing local inductions to bank and agency staff, although not all of these included the ligature risks. Most staff we spoke with told us that they were happy at work, that there was a good sense of team spirit and that morale was generally high. Staff described ward managers and other senior staff as being accessible and visible.
- Serious incidents were reviewed at a 48-hour post incident panel meeting. Systems and processes were in place to review and learn from serious incidents. There were governance processes in place on all wards, which enabled staff to monitor quality and safety aspects of their services.
- We found overall that patients' physical health needs were, assessed, managed and reviewed regularly. All staff had completed a physical health workbook that included how to monitor patients' blood pressure and temperature and assess for neurological conditions.

# Summary of findings

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

### Are services safe?

- All wards were subject to the trust environmental improvement plan that included minimising ligature risks and were able to provide an up to date ligature risk assessment. This improvement plan was ongoing and work was still required in some areas of the old people service. Not all patients were being observed by staff within agreed time frames. As part of their ligature reduction plan, the trust had introduced a ligature risk safety care plan for all patients. Although these were in place, we found that these were very generic in nature. All contained similar or the same content, regardless of patients' needs or risks, including what role the ward manager and other trust staff would play with regards to annual ligature assessments. All staff had completed ligature care e learning training.
- The security arrangements and exit and entrance facilities to Stefano Olivieri were inadequate. The ward entrance was accessed by a touch and release button. Other people and patients were able to enter Stefano Olivieri ward without proper authority or escort. There were privacy and dignity issues relating to the bathroom facilities on Stefano Olivieri. Patients from the acute ward were able to look into the windows of the bathrooms on Stefano Olivieri ward from the acute wards courtyard. We brought these concerns to the attention of the trust who took action.
- A safer staffing review of all the wards had created additional vacancies. The trust were actively monitoring through weekly reporting of staffing requirements, daily bed management meetings and local operational and governance meetings, the needs of all wards. However, we were concerned to learn that on Beaulieu Ward, patient's observation levels were being reduced in order to manage low staffing.
- Serious incidents were reviewed at a 48 hour panel meeting. Learning from incidents was communicated through newsletters, posters and 'hot spots'. Ward managers were familiar with and engaged in the trusts evidence assurance panels. We saw evidence to show across all wards that where actions had been documented on the incident forms these had been followed through. However, not all incidents of aggression were being reported on Beaulieu ward.

# Summary of findings

## Are services effective?

- We inspected seven wards. With the exception of Stefano Olivieri, Berrywood and Beaulieu wards, all records relating to do not attempt cardio pulmonary resuscitation (DNACPR) were correct and complete.
- Staff told us that they are unclear how best to restrain an older patient when requiring injectable medication. The trust was currently reviewing their policy to ensure that this intervention could be delivered safely.
- We found overall that patients' physical health needs were being met, assessed and reviewed regularly. Where physical health issues were identified, care plans were devised and followed by nursing staff. Staff had up to date training relating to physical health.
- Not all wards were providing local induction information that included ligature risk awareness.

## Are services well-led?

- The trust electronic governance system enabled staff to receive information relating to team performance and other key performance indicators including delayed discharges and transfers of care.
- Learning from incidents was supported through evidence assurance panels.
- The trust monitored clinical demands on the wards through daily bed management meetings.
- Most staff we spoke with told us that they were happy at work, that there was a good sense of team spirit and that morale was generally high. Staff described ward managers and other senior staff as being accessible and visible and that they felt encouraged by the new senior leadership team.

# Summary of findings

## Information about the service

The older people's mental health wards within Southern Health NHS Foundation Trust provide care to people with both an organic and functional mental health disorder.

Organic mental illness is usually caused by disease affecting the brain, such as Alzheimer's.

Functional mental illness has predominantly a psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.

The seven wards we inspected were spread over four sites. These were Gosport War Memorial hospital, Melbury Lodge in Winchester, Parklands hospital in Basingstoke and Western Community hospital in Southampton.

The Stefano Olivieri Unit at Melbury Lodge is a 15 bed acute admission short stay assessment and treatment ward providing care for older people with functional mental health needs.

Beaulieu Ward at Western Community Hospital is an acute admission short stay assessment and treatment ward providing care for older people with organic mental health needs.

Berrywood ward, also at Western Community Hospital is an assessment and treatment ward providing care for older people who have functional mental health needs.

Dryad ward at the Gosport War Memorial Hospital is a 16 bedded ward providing care for older people who have a predominantly functional illness.

Daedalus ward also at the Gosport war Memorial Hospital is a 17 bed ward providing care for older people who have an organic illness.

Beechwood ward at Parklands Hospital is an assessment and treatment ward providing care for older people who have functional mental health needs.

Elmwood ward also at Parklands Hospital is an 18 bedded ward for patients with an organic illness.

All organic wards will accept patients with early onset dementia if their needs are best met on an organic OPMH ward.

## Our inspection team

Team Leader: Karen Bennett-Wilson, Head of Hospital Inspection, for the Care Quality Commission

The team was comprised of: Lisa McGowan, lead CQC Inspector, one other CQC inspector, one assistant inspector, one inspection manager and three specialist advisors

## Why we carried out this inspection

We carried out this short notice inspection of Southern Health Foundation NHS Trust to follow up on some areas that we had previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service. During this inspection we wanted to look in detail at how safe and well led the older people's in-patients wards were.

At the comprehensive inspection in October 2014, we rated the wards for older people with mental health needs as good.

We told the provider that it should consider taking the following action:

- To ensure that robust plans exist on each ward to manage identified ligature risks, and where people are

# Summary of findings

at risk of self-harm and suicide that risk management plans relating to ligatures in the ward environment are identified in individual risk assessments and care plans.

- To improve understanding of the interplay between the Mental Health Act and the Mental Capacity Act to ensure that people are protected from the risk of unauthorised deprivations of liberty.
- To ensure that recruitment continues so that staffing levels and stability of staff teams can be embedded.
- To ensure that relevant learning from the Mental Health division is not lost and the specialism within older people's mental health is retained on a ward level and that teams are aware of their responsibilities under the Mental Health Act.

We served a warning notice against the trust in March 2016 telling that the trust must make significant improvements to protect patients from risks posed by some of the mental health and learning disabilities ward environments.

We re-inspected at the inspection undertaken in September 2016 to check if improvements had been made following the warning notice, we told the provider it must:

- The trust must complete plans to improve and make safe the range of environments across the mental health and learning disabilities services in line with its estates improvement plan.
- The trust must ensure better consistency in relation to the quality and detail of risk assessments across the wards
- The Trust should ensure it monitors the changing requirements of patients that may be admitted to the rehabilitation and older person's wards, to ensure that patient and staff safety is maintained within the environment.

Regulation 12 Safe care and Treatment

## How we carried out this inspection

This inspection focussed mainly on whether the service was safe, effective and well led. Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited seven wards on four different sites.
- spoke with five patients who were using the service and two carers
- spoke with the managers or acting managers for each of the wards.

- spoke with 19 other staff members; including matrons, doctors and nurses.
- attended and observed four hand-over meetings and three multi-disciplinary meetings.
- Reviewed 28 patient records relating to physical health.
- Reviewed 49 records relating to patient ligature care plans and 40 patient records relating to observations.

## What people who use the provider's services say

Patients we spoke with during our visit spoke positively about the care they received on all of the old people's mental health wards.

All patients on all wards without exception spoke fondly of the staff and their positive attitudes.

We spoke with three patients on Stefano Olivieri ward who all said that they felt vulnerable on the ward due to

the lack of adequate security and privacy and dignity issues involving the toilets and bathrooms. Patients from the acute ward were able to look into the windows of the bathrooms on Stefano Olivieri ward from the acute wards courtyard and enter the ward through the entrance without proper authorisation or escort.

# Summary of findings

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must ensure that where patients are on one to one nursing observations, staff maintain and review these in line with organisational policy and they do not change them in order to manage low staffing levels.
- The trust must ensure that all do not attempt cardiopulmonary resuscitation (DNACPR) records and sharing of DNACPR information is correct and consistent at all times.
- The trust must ensure that the privacy and dignity of the patients on Stefano Olivieri ward are adequately protected.

- The trust must ensure that it continues with and completes all work to reduce ligature risks.

### Action the provider **SHOULD** take to improve

- The trust should review the ligature risk care plans to ensure that that they are individualised to patients' needs and risks.
- The trust should consider including in all induction packs for all new starters and agency staff information relating ligature risks on all wards.
- The trust should review the trust mitigation plans for areas that are considered locked and inaccessible to patients.

## Southern Health 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
Daedalus Ward	Gosport War Memorial Hospital
Dryad Ward	Gosport War Memorial Hospital
Stefano Olivieri	Melbury Lodge
Beechwood Ward	Parklands Hospital
Elmwood Ward	Parklands Hospital
Berrywood Ward	Western Community Hospital
Beaulieu Ward	Western Community 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.

# 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 and clean environment

- All wards were subject to the trust environmental improvement plan that included minimising ligature risks. All wards had ligature points (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) and all wards provided an up to date ligature risk assessment. Some areas of the wards were locked and considered inaccessible to patients. We have highlighted this because although these rooms carried less risk due to accessibility, locks can fail or staff may not ensure the door is closed. As not all settings had an induction pack that highlighted ligature risks on the ward, this placed patients at risk. We brought this to the attention of ward managers at the time of our visit. The trust's ligature improvement plan was progressing. However, there were still areas on all wards that required work, including entire bathroom suites.
- The risks posed by potential ligature anchor points was compounded by the fact that none of the wards had clear lines of sight and therefore relied upon nursing observations to keep patients safe. We reviewed 40 records relating to observations of patients across all wards. We found on all wards gaps in observation records, indicating that staff had not observed patients within prescribed periods. These time periods can range between hourly and five minutes intervals. Nursing observations are a process that ensures close monitoring of, and engagement with patients based on their level of risk.
- All staff across all wards had completed on line ligature training. All staff knew on all wards where the ligature cutters were kept.
- As part of their ligature reduction plan, the trust had introduced a ligature risk safety care plan for all patients. We looked at 49 care records across all wards and found that all patients, with the exception of two patients on Berrywood ward had a ligature risk care plan in place. These were very generic in nature and all contained similar or the same content, regardless of patients' needs or risks, including what role the ward manager and other trust staff would play with regards to annual ligature assessments.
- We were concerned to find that the security arrangements on Stefano Olivieri were not adequate and left patients and staff vulnerable to unauthorised visitors on the ward. Patients, staff and visitors accessed Stefano Olivieri ward through the same reception area as the acute admission ward. On arrival, patients from the acute admissions ward that had congregated in the reception area approached our inspectors. This gave us concerns regarding the safety of older patients and their families when entering the building. We raised this issue with the trust at the time of our visit. The trust is currently considering creating an alternative entrance and exit for the older peoples mental health ward. We were also concerned to see that the entrance to Stefano Olivieri was accessed by a touch and release button. On two occasions, the inspectors on site witnessed a male patient from the acute admissions ward entering Stefano Olivieri ward without proper authorisation or escort. We raised our concern with the matron and estates staff who were on site at the time of our visit. The trust fitted a fob only access system to the ward at the time of inspection. In addition, some of the toilet and bathrooms windows on Stefano Olivieri open directly onto the acute admissions ward's court yard. Staff told us of incidents where older patients have been using the toilet or bathing facilities and acute admission patients have been able to look through open windows. We raised this concern with the trust. The trust are currently considering how best to protect the privacy and dignity of the patients on Stefano Olivieri ward.

### Safe staffing

- The trust had recently undertaken a safer staffing review. As a result, additional staff were required, which in turn created vacancies on all wards. Dryad ward held six registered nurse and two health care assistant (HCA) whole time equivalent (WTE) vacancies. Daedalus ward had three registered nurse and four HCA WTE vacancies. The one registered nurse vacancy on Stefano Oliveri ward had recently been recruited too. In addition, a skill

# Are services safe?

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

mix review took place in November 2016 and as a result some staff were moved between Dryad and Daedalus wards. The trust had set safe agency use at 50%. Anything above this was flagged as a risk. The most recent board meeting held in March 2017 identified Dryad, Daedalus and Beechwood wards as all having used in excess of 50% agency staff.

- Arrangements were in place to help ensure the trust had oversight of ward needs and demands. Ward managers reported their staffing requirements for the following week. They also completed a safer staffing review at six monthly intervals to identify whether staffing needs had increased. Staff held bed management meetings on each site daily.
- Despite efforts by the trust to monitor and address shortfalls, shifts still ran short. On Beaulieu Ward, staff reduced patient's observation levels in order to manage low staff numbers. For example, we found evidence to show that patients on one to one nursing observations had these reduced to every 15 minutes, as there were insufficient staff available to maintain the prescribed level. Once the ward had sufficient staff, they placed these patients back on one to one nursing observations. This indicated that the change in observations was not due to a reduction in the patient's risks. This meant that during the time they were on 15-minute observations staff were potentially not monitoring or managing their risks adequately. On Berrywood, one night shift had been without a registered nurse. As a result, Berrywood and Beaulieu ward had shared one RMN for the duration of the shift, leaving at times throughout the night, only two HCA staff on duty on Berrywood.

## Reporting incidents and learning from when things go wrong

- The trust used an electronic incident reporting system. Staff we spoke with were familiar with the system.
- Managers reviewed incidents monthly at operational and governance meetings and we saw minutes to show this was the case.
- Managers reviewed serious incidents at a 48-hour post incident panel meeting which was held four times a week and chaired by a member of the divisional senior management team.
- Managers communicated learning from incidents through newsletters, posters and news bulletins. We found an example of learning following a serious incident on one ward relating to hydration and fluid intake. All wards now had new fluid intake forms that prompted staff to take appropriate action. Ward managers were familiar with, and one was currently involved with, the trust's evidence assurance panels. The trust had introduced evidence assurance panels in September 2016 and required teams involved in serious incidents to present evidence that learning had been embedded and, where required, improvements made to practice or service delivery. One ward manager was able to describe how they had been allocated an incident and senior managers had asked them to explore and present the learning around this incident.
- We saw evidence to show across all wards that where actions had been documented on the incident forms these had been followed through. For example, staff updated risk assessments and followed the falls protocol. However, staff were not reporting all incidents of aggression on Beaulieu ward. We saw records to show that there had been multiple incidents involving patient on staff assaults over one 24 hour period. Due to the high number of incidents in one 24 hour period, staff had not reported every incident. We discussed this with the ward manager. We discovered that high volume incidents of patient on staff assaults in one 24 hour period often went unreported. The ward manager agreed to discuss this issue after our visit with senior colleagues in an attempt to devise a way of reporting multiple assaults.

# 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 28 care records relating specifically to patients' physical health needs. We found overall that staff assessed, managed and reviewed patients' physical health needs regularly. Staff assessed patients' physical health on admission. When staff identified physical health issues, they devised care plans that were followed by nursing staff. Patients received falls assessments and, where necessary, speech and language therapy assessments. We found evidence to show that where falls had occurred, staff reported these using the trust incident reporting system and they followed the trust's falls procedure
- All staff had completed a physical health workbook that included how to monitor patients' blood pressure and temperature and assess for neurological conditions.

### Best practice in treatment and care

- We reviewed five records in total across all wards relating specifically to do not attempt cardio pulmonary resuscitation (DNACPR). With the exception of Stefano Olivieri, Berrywood and Beaulieu ward, all records relating to DNACPR were correct and complete. We found one record on Stefano Olivieri that showed that periodically staff were recording the patient as requiring resuscitation, when in fact the patient was not for resuscitation. We brought this to the attention of the deputy ward manager and the matron at the time of our

visit. On Berrywood and Beaulieu ward, we found one record on each ward that did not show evidence of a best interest meeting having taken place with any family members.

- The trust was reviewing its policy and training arrangements in relation to restraint and older people. Staff told us that they were unclear how best to restrain an older patient when they required injectable medication. This was because staff in older people services do not restrain patients on floors or beds in either a prone (lying face down) or supine position (lying face up). This makes it difficult to administer injectable medication safely when a patient is standing and resisting.
- Where relevant, and with the exception of Beaulieu ward, all other wards showed evidence of adhering to policies and procedures relating to arrangements for administering medication covertly. Staff had given medication covertly (the administration of medication in disguised form - usually in food and drink) to one patient on Beaulieu ward on one occasion. There was no evidence to show that a best interest meeting had occurred with the family, pharmacist or wider multi-disciplinary team.

### Skilled staff to deliver care

- All wards were providing local inductions to bank and agency staff. All wards included the local fire procedure in the induction information. Daedalus, Dryad and Stefano Olivieri ward induction paperwork included ligature risk awareness. However, Berrywood, Beechwood and Beaulieu wards induction paperwork did not contain ligature risk information

# 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 trust used a data management system, which enabled staff to receive information relating to team performance and other key performance indicators including incidents, complaints, delayed discharges and transfers of care.
- The trust was able to monitor clinical demands through daily bed management meetings and weekly reporting of clinical needs.
- Staff said that the evidence assurance panel had been a good opportunity to learn following serious incidents.

### Leadership, morale and staff engagement

- Most staff we spoke with told us that they were happy at work, that there was a good sense of team spirit and that morale was generally high. Staff described ward managers and other senior staff as being accessible and visible.
- Staff said they felt encouraged by the new senior leadership team and had welcomed the chief executive officer's approach, which included holding listening events for families and employees to attend and share their views.

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

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

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

Care and treatment must be provided in a safe way for service users.

Beaulieu ward staff reduced patient observation levels to manage low staff numbers.

We found on Stefano Olivieri, Berrywood and Beaulieu ward issues relating to best interest meetings and the sharing of correct information amongst staff related to DNACPR procedures.

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Service users must be treated with dignity and respect. The trust must ensure the privacy of the service user.

There were privacy and dignity issues relating to the bathroom facilities on Stefano Olivieri. Patients from the adjoining acute admissions ward were able to see into the toilet and bathrooms on Stefano Olivieri ward.

This is a breach of Regulation 10 (1) and (2 a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

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

**Providers must make sure that premises are safe.**

All wards were subject to the trust environmental improvement plan that included minimising ligature risks. Although progressing, the improvement plan was not yet complete.

This is a breach of Regulation 12 (1) and (2 b and d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.