Surrey and Borders Partnership 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)
RXXZ4	St Peter's Site	Spenser Ward	KT16 OTA

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

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

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

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found the following issues that the provider needed to improve:

- the ward was regularly accommodating female patients in rooms in an area of the ward assigned to male patients.
- the ward design hampered staff's ability to observe patients safely.
- the bed space areas in the communal dormitories were restricted and there were low levels of light during the daytime which presented a hazard to patients
- not all staff working with patients had completed the trust's dementia awareness training.

However we found the following areas of good practice:

- staff were knowledgeable about the needs of the patients on the ward and the shifts were filled by permanent staff.
- all patients had comprehensive risk assessments and had their risks regularly reviewed by the multidisciplinary team.
- all patients had current care plans which were personalised to their assessed needs.
- staff monitored patients' physical health regularly using recognised health assessment tools.
- patients had good access to psychological interventions and occupational therapy on the ward

Summary of findings

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

Are services safe?

We found the following issues that the provider needed to improve:

- the three dormitories were dimly lit during the day and had restricted space around the bed areas. This could present a mobility hazard to patients.
- the ward was accommodating female patients in a male patient area
- the semi-circular layout of the ward, and the position of the ward office at one end of the ward, meant that observing patients on the ward was challenging for the staff.

However we found the following areas of good practice:

- the ward was clean and the communal areas were bright and welcoming.
- the staffing numbers matched the minimum staffing for the ward. Shifts were covered by permanent staff who had good knowledge of the needs of the patients.
- all patients had up to date risk assessments and these were regularly reviewed by the multidisciplinary team.
- staff were knowledgeable about how to raise safeguarding concerns and the ward was recording incidents and making changes as a result of any lessons learned from the investigation of these.

Are services effective?

We found the following areas of good practice:

- all the patient records we reviewed contained personalised care plans which matched the assessed needs of the patient.
- staff reviewed patients' physical health regularly and used recognised measures to monitor patients' physical and mental wellbeing.
- the patients had good access to occupational therapy and psychological interventions from the ward based specialists.
- the multidisciplinary team communicated well and had time away together as a team for learning and professional development.

However we found the following issues that the provider needed to improve:

- staff had not attended the trust's dementia awareness training although a plan was in place for this to happen.
- not all the staff we spoke with were confident in explaining the use of the Mental Capacity Act.

Summary of findings

- staff had not completed assessments for mental capacity to consent to treatment for all patients at the start of our inspection.

Summary of findings

Information about the service

Spenser ward was a 20 bedded acute assessment and treatment inpatient unit for older people. It was a mixed gender ward for older adults experiencing a mental illness, such as depression schizophrenia and mood disorders, who needed an admission into hospital. This unit was based at the Abraham Cowley Unit, St Peter's Hospital, Chertsey.

Our inspection team

The team was led by Jayne Norgate, Inspection Manager.

The team comprised one CQC inspector and a psychiatrist specialist advisor.

Why we carried out this inspection

We undertook the inspection of Spenser ward as part of a focused, responsive inspection of this location which was prompted by the trust notifying CQC that a patient had died on one of the adult inpatient wards at the Abraham Cowley Unit. We decided that we should inspect the inpatient ward for older people at the same time as the adult wards at this location. This was an unannounced inspection .

When we last inspected the trust in March 2016 we rated wards for older people with mental health problems as good overall. We rated the core service as requires improvement for Safe, good for Effective, good for Caring, good for Responsive and good for Well-led.

On this inspection, as well as responding to the recent concerns, we assessed whether the trust had made improvements to the specific concerns we identified during our last inspection. We had issued Spenser had ward with a requirement notice in relation to the positioning of nurse call alarms in the adapted shower room.

How we carried out this inspection

We asked the following questions of the service:

- Is it safe?
- Is it effective?

During the inspection visit, the inspection team:

- toured the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the ward manager and a deputy ward manager
- spoke with six other staff members; including doctors, nurses and health care assistants
- attended and observed two hand-over meetings and one ward round
- looked at 10 treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

Patients told us that they felt safe on the ward and that there were enough staff available to meet their needs. They said that staff were kind and showed a respectful approach to meeting their needs.

However, all patients we spoke with were unhappy with the new catering arrangements which had started the same week as our inspection. Patients told us that the portion sizes were smaller than they were used to and that the quality of the food was not as good as it had been previously.

We passed the patients' views to the ward manager who said that she would contact the new caterers to discuss how improvements could be made.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the risks to patients accommodated in dormitories are mitigated by ensuring there are sufficient levels of light in the sleeping areas, and that all patients have sufficient space to move around these areas safely

Action the provider SHOULD take to improve

- The trust should review their inpatient facilities for older people to remove dormitory bedrooms and replace these with single room accommodation for patients
- The trust should ensure that placing a female patient in a room on the male part of the ward only occurs in extreme circumstances.
- The trust should ensure that all staff on Spenser ward complete the trust training in dementia awareness.
- The trust should ensure that all staff on Spenser ward are confident in applying the principles of the Mental Capacity Act.

The trust should ensure that staff complete consent to treatment assessments for patients detained under the Mental Health Act as per the trust policy for all patients.

Surrey and Borders Partnership 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
St Peter's Site	Spenser Ward

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.

CQC undertook a Mental Health Act monitoring visit to Spenser ward on 19 December 2016. This identified a number of concerns: lack of segregation of facilities for male and female patients; inappropriateness of facilities for patients with a dementia diagnosis on the ward; deficiencies in explanations of patients' rights under section 132 where patients had not understood these; and lack of evidence of mental capacity assessments prior to treatment.

During this inspection, we found that some progress had been made by the ward staff in addressing these findings. The ward manager had prepared an action plan to respond to the areas of improvement required. However the ward environment meant that access to segregated facilities remained unchanged and we found two patient records that did not contain a completed consent to treatment assessment.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received, or were planning to attend, training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The staff that we spoke with varied in the extent of their knowledge of the legislation relating to mental capacity.

Detailed findings

However, we found evidence that mental capacity assessments were used appropriately for the purposes of discharge plans for patients and linked to best interests decision meetings.

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

- The ward was laid out in a circular shape with the ward office situated near the main entrance. The ward had three, five-bedded dormitories and five single rooms providing accommodation for up to 20 patients. There was a large lounge for all patients and a smaller lounge available for female patients.
- At the time of our visit female patients were mainly accommodated in the three dormitories. One female patient was accommodated in a single room, and four male patients were accommodated in single rooms. Staff said that this arrangement could change depending on the gender mix on the ward at any time.
- Due to the circular layout of the ward there was not a clear line of sight to observe patients from the ward office. There were no convex mirrors in place and therefore the ward had many blind spots where patients could not be observed easily, along the three bends of the ward corridor. Staff told us that they regularly walked around the ward and carried out safety checks on the whereabouts of each patient and we saw that this was taking place. Closed circuit television (CCTV) was used to observe and record activity in the communal areas. There was a TV screen in the ward office displaying this. However, we observed that nursing staff were often busy with other tasks and there was no dedicated staff member whose duty it was to monitor the CCTV images.
- The ward was clean and well maintained. Cleaning schedules were in place for the ward areas and we saw that these were being followed by house-keeping staff. The main corridor was bright and decorated with posters and quotations from classic films. There were well-presented patient information boards along the length of the corridor. The lounges, dining room and meeting room areas were tidy and had appropriate furnishings.
- Emergency equipment including defibrillators and oxygen was stored on the ward. Staff were able to show us where the ligature cutters were stored and how to use them.
- We reviewed the ward equipment log and this confirmed that medical devices and other equipment were receiving regular checks and that these were recorded.
- All the rooms had clear signage on the entrances to rooms to enable patients to locate the different ward areas. The same signs also reminded staff to respect patient privacy before entering patients' sleeping areas.
- Spenser ward provided inpatient services for older adults with a functional illness. However four people had been admitted to Spenser ward with a diagnosis of dementia between December 2016 and April 2017 . The layout of the ward, with a long circular corridor and the shared sleeping areas could present difficulties for a patient with dementia to find their bearings on the ward.
- On the occasions when a person with dementia was admitted to Spenser ward because a dementia ward bed was not immediately available, ward staff created a care plan to address their specific needs on the ward in order to support the patient safely. The trained mental health nurses supported the patient until a transfer to an appropriate specialist dementia bed could take place. All newly admitted patients with a diagnosis of dementia were placed on 1:1 observations until it was established that the patient was safe in the ward environment.
- All staff had access to personal alarms to call for urgent assistance from colleagues. These were tested in the ward office and the tests were being regularly recorded. There were call buttons for patients to call for staff assistance next to the bed area in all of the dormitory bedrooms and single rooms and also in all bathroom and toilet areas.
- The ward's three dormitory areas each contained one en-suite shower room. The five single rooms did not have en-suite facilities. The main bathroom, disabled access shower room and male and female toilet facilities were located together on one side of the corridor .

Are services safe?

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

- At the time of inspection a female patient had been accommodated in one of the five single rooms in the ward area which had been designated as the male sleeping area. This was because there were no beds available in the three dormitories which had been designated as female beds. This had happened on five occasions between January and March 2017.The ward manager had noted each occurrence on the electronic incident records stating that that this was contrary to the department of health same sex guidance. She informed us that this was a temporary situation and that the patient would be moved as soon as a female bed became available. A risk management plan and care plan was routinely put in place when admitting any female patient to an area designated for male patients to support maintaining people's safety and dignity.
- The space between the sleeping areas, and around each individual bed in the dormitories, was limited. This presented a restriction for any patient requiring a mobility aid such as a walking frame or other walking aid. The lighting level in the dormitories was low meaning that potential hazards could be difficult for patients to see. This could place patients at increased risk of trips or falls.
- The beds in the dormitory areas were separated by a curtain. Each patient bed area contained a wardrobe with a chest of drawers with one lockable drawer. The drawers we looked at were unlocked with no keys present. Staff told us that patients did not like to carry around a key. This meant that patients left any valuable possessions in a lockable safe in the ward office rather than secured in their personal space.
- The ward had completed an assessment of fixtures and fittings where patients could be at risk of harming themselves by tying a ligature. This had been most recently reviewed by the ward manager and an external reviewer in November 2016. The risks were banded as high, medium or low. The ward had 21 risks which were rated as high and these related to movable beds, toilet seats, a shower head and a chair. The ligature assessment stated that the risks were currently being managed via regular checks of these areas, and staff supervision of patient activity in the areas of higher risk. Staff we spoke with could describe the areas of the ward with ligature risks. However, we found that one of the toilet seats identified as a high risk area was broken and detachable, and had not been identified as in need of repair by ward staff. This was pointed out to the ward manager and repaired during our visit.
- Ward staff carried out an environmental assessment every three months. Health and safety in the ward and the prevention and control of infections were included in the assessment. The most recent assessment had taken place in February 2017.

Safe staffing

- Ward staff worked a 12 hour shift with staff handing over to the next shift at 8am and 8pm. The daytime staffing establishment was two qualified nurses and four health care assistants, at night there were two qualified nurses and three health care assistants. We reviewed three months of staffing rosters and saw that these staffing numbers had been maintained over that period.
- The total ward nursing team comprised of a ward manager, nine qualified nurses and 21 health care assistants. There was adequate medical cover. A ward consultant psychiatrist covered the ward four days per week and two other doctors each worked three days per week.
- Several of the nursing staff had recently left the ward which meant that there were four qualified nurse vacancies and three health care assistant vacancies. At the time of our visit the ward was using two qualified agency nurses to cover the vacant hours. These nurses worked regularly on the ward and were familiar with the needs of the patients.
- The manager told us that staff sickness rates were low and the absence rate of less than 1% for April confirmed this.
- Records showed that 86% of ward staff were up to date with their mandatory training. This included courses in assessing clinical risk, infection control, basic and intermediate life support, management of violence and aggression and conflict resolution, safeguarding adults, the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty Safeguards.

Assessing and managing risk to patients and staff

- We reviewed ten patients' care records and found that all patients had received a risk assessment on

admission to the ward. The risks were updated and reviewed regularly and we observed that ongoing patient risk was discussed and recorded as part of the morning handover. If significant changes had taken place affecting the patient's risk rating these were discussed by nursing staff and a doctor after the handover so that risk ratings could be reviewed and altered if necessary.

- All patients had a falls assessment completed on admission and this was reviewed regularly. The falls risk level was banded low, medium or high and this was displayed on the electronic patient information which formed part of the morning handover discussion. The ward completed a safety cross which was displayed on a board in the office. Incidents of patient falls over a calendar month were displayed on the cross and this information was reviewed by the team at the team meeting to establish if there were patterns in incidents, or actions the ward could take to reduce the risk of falls.
- The ward had a clear policy which described how nursing staff should monitor patients and record the frequency and levels of patient observations. Information about which patients were on increased levels of observation was clearly displayed in the ward office. We saw nursing staff completing patient observations and noted that these had been recorded consistently by staff on the observation chart which was kept in the ward office.
- Medicines were securely stored in the ward clinic room in accordance with trust policy and manufacturing guidelines. Fridge temperatures were regularly checked, recorded and displayed in the clinic room which was clean and well organised.
- Staff were aware of the process for raising safeguarding concerns and current safeguarding concerns affecting patients were discussed at team handover.

Safeguarding concerns had been identified by staff when formulating the team response to incidents affecting patients. Staff had completed mandatory training in safeguarding but had not identified a safeguarding lead for the ward.

Track record on safety

- Data provided by the trust showed that between 1 January and 26 March 2017, 53 incidents had been recorded on Spenser ward. The most frequent incident was patient falls; 19 falls had happened in this period. There had been ten incidents of patient aggression to staff and fellow patients. There were two incidents recorded of patients having physical health problems which required further investigation at accident and emergency. On five occasions an incident was recorded because a female patient had been admitted to a single room alongside male patients in single rooms.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on the trust's electronic system known as datix. We reviewed the record of incidents from January to March 2017. Incidents had been investigated and were rated in severity of potential harm. Nearly all incident records showed follow up actions and detailed any changes that the ward had made to practice as a result of the incident.
- Lessons learned from investigating incidents were shared in 'datix huddles' where ward staff gathered together to share information about the outcomes of incidents reported on the trust's electronic system. The outcomes and lessons from incidents were also standing items on the agenda for the ward team meeting.

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

- The admitting nurse completed a detailed assessment of each new patient who was referred to the ward. The admission process included a mental and physical health assessment. This information was stored on the electronic patient record.
- We reviewed ten electronic care records for patients. Most of the care plans were up to date and personalised with a range of needs which reflected the content of their assessment. These included physical health needs, mental health, nutrition, managing areas of risk such as falls and discharge plans.
- Care plans showed evidence of frequent review and amendments when the patients' needs had changed. In some care plans the view of the patient had been recorded. However, most of the patients we spoke with could not tell us if they had received a copy of their care plan.
- Records of physical health assessments on admission to the ward were in place and there was evidence of ongoing physical health monitoring of all patients. Vital signs checks for each patient were completed daily by ward staff. The checks included blood pressure, heart rate, temperature and dietary intake. The patients' weight was also monitored and recorded each week.
- The staff used the modified early warning score (MEWS), a regular record of a set of physical health indicators used to better understand the condition of a patient's health. We reviewed 15 patients' MEWS charts for a four week period and all had been regularly completed with MEWS scores attributed. Where a MEWS score was elevated, staff had recorded in the patient's clinical records that further investigations or closer patient monitoring were undertaken. The ward manager told us that the ward had recently audited the use of MEWS as a tool and the outcome of the audit had been shared with the team in the team meeting in November 2016.
- The staff also completed Health of the Nation Outcome Scales (HoNOS). This tool monitors 12 areas of patients' wellbeing to give an holistic score and can be used over time to establish progress or deterioration in a patient's health.

Best practice in treatment and care

- There was a range of therapeutic activities available to patients. These included a coping skills group led by psychology staff, music therapy, a concentration skills group led by an occupational therapist, awareness sessions in wellness and recovery, and preparing for discharge. There was also a timetabled visit form a therapy dog and regular aromatherapy and baking groups. Patients had access to weekly visits from a hospital chaplain.
- The medication charts we reviewed showed that medicines were being administered in accordance with the prescribed medication. However in three cases for detained patients the relevant T2 and T3 treatment authorisation forms were not stored alongside the medication charts. This meant that staff administering medication could not check that it was consistent with the medication detailed on the T2 or T3 form. We raised this with the ward manager at the time of inspection and the correct forms were placed with the medication charts for each patient.

Skilled staff to deliver care

- The multidisciplinary team comprised a ward manager and deputy ward managers, a ward consultant and junior doctors, registered mental health nurses, health care assistants and an occupational therapist. In addition, there was a half-time ward psychologist, a part-time psychology assistant, and a half-time ward physiotherapist. The team also had a full time activity co-ordinator and patients had access to an aroma-therapist for two hours each week.
- The mandatory training for staff on Spenser ward did not include training to work with patients with a dementia diagnosis. We raised this with the trust during our inspection visit and they informed us that dementia expertise was available to the Spenser team via the intensive support team who support dementia patients with complex needs. The team consultant had led a dementia training session on the team's development day in November 2016. The trust informed us that all staff in the Spenser ward team would receive the trust's dementia awareness training by September 2017.
- All ward staff had a supervisor appointed to them who was appropriate to their role. Staff were receiving supervision at regular intervals. All staff had completed their annual appraisals.

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.

Multi-disciplinary and inter-agency team work

- We observed a well-structured morning ward round. It was attended by a range of professional staff including a consultant psychiatrist, the ward manager, a community care co-ordinator, health care assistants and an occupational therapist. The discussions for two patients involved discharge planning and were supported by an up to date risk assessment by nursing staff. There was a discussion about the use of best interests assessments for two patients who were perceived as lacking capacity to make a decision around future placements.
- Every second month, the ward staff held a whole team professional development day. This included a team meeting, teaching sessions and presentations. In November 2016 the team had used this day for a presentation from the consultant psychiatrist about aspects of dementia, feedback on a recent MEWS audit, a presentation on the role of psychology in the team and feedback from the dietitian's audit on malnutrition.
- We observed two ward handovers. The morning handover was thorough and included full updates about patient progress, incidents affecting the patient and any changes to patient risk. The handover also included discussions concerning significant upcoming events such as physical health assessments, leave from the ward or other planned activities. Decisions were recorded on the ward's allocation sheet which was updated electronically during the handover. The allocations document contained the current risk ratings for each patient, including falls risk for the patient, their Mental Health Act status, physical health information, the patient's diagnosis and any forthcoming meetings such as a CPA (Care Plan Approach) meeting with their community care co-ordinator. .
- Staff from social services and from the community mental health teams for older people regularly attended discharge planning meetings and care programme approach meetings which took place on the ward.
- All the managers of the trust's older people inpatient wards met monthly. These wards were located on other trust sites in Epsom and Guildford. There was not however a regular forum at the Abraham Cowley Unit for the Spenser Ward manager to meet with the managers of the three adult inpatient wards which comprised the hospital unit.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Staff we spoke with demonstrated a good knowledge of the Mental Health Act. Training in the Mental Health Act was part of the ward staff's mandatory training and this was also part of the induction for new staff starting on the ward.
- There were ten detained patients on Spenser ward at the time of our visit. Patients had access to an independent Mental Health Advocate (IMHA) and information about the advocacy service was on display on the ward noticeboard.
- Following feedback from a Mental Health Act monitoring visit, the ward manager was working to improve the manner in which staff explained to detained patients their rights under the Mental Health Act. The ward manager was also auditing patients' notes for records of section 132 rights being explained to patients. This issue had also been discussed in team meetings and individual staff supervision sessions.
- Two of the seven medication charts that we reviewed did not clearly state the detention status of the patient. This was highlighted to the ward manager during our inspection.
- In the notes of two patients detained under the Mental Health Act, we could not find any record that staff had completed an assessment of the patient's mental capacity to consent to treatment. We pointed this out to the ward doctor during our visit and the assessments were completed during our inspection.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was mandatory for staff working on the ward. However, we did find variation in knowledge and awareness in the staff we spoke with about the principles of the Act, and when considerations of a patient's capacity might be tested.
- At the ward round we observed discussions about assessing a patient's capacity in relation to making decisions about levels of care and support needed upon discharge. However we did not see evidence that staff had considered patients' capacity in any other areas of decision making.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The trust had not ensured that patients accommodated in dormitories were able to move about these areas safely without impediment and with adequate levels of light.** This is a breach of regulation 15(1)(c)

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.