Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Ann's Hospital

St Ann's Road, Tottenham, London, N15 3TH

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Date of Inspection: 22 November 2013

Date of Publication: January 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖ Enforcement action taken

Details about this location

Registered Provider	Barnet, Enfield and Haringey Mental Health NHS Trust
Overview of the service	Barnet, Enfield and Haringey Mental Health NHS Trust provides a range of services from St Ann's Hospital. These include community health services and inpatient treatment. The inpatient wards at this hospital are Haringey Assessment ward, for the assessment of men and women who are acutely ill, Finsbury ward for men, Downhills ward for women and Phoenix ward for people who have an eating disorder.
Type of services	Community healthcare service Community based services for people with a learning disability Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Community based services for people who misuse substances
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether St Ann's Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 November 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information given to us by the provider.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

Two inspectors and a Mental Health Act Commissioner visited Haringey Ward and the s136 suite which is a designated 'place of safety' where people who are detained under s136 or s135(1) of the Mental Health Act are brought while awaiting a formal assessment at St Ann's Hospital to see if improvements following the inspection of 19 June where we found that people were not experiencing care, treatment and support that met their needs and protected their rights.

We spoke with seven members of nursing and medical staff on Haringey Assessment Ward, one member of staff on duty on the s136 suite, we checked the records of six patients on the ward at the time of the inspection and spoke with seven patients. We also requested further information from the Trust after the inspection.

We found that some care was provided in an environment that did not meet the needs of individual patients. We found that people were cared for by staff who knew and understood their responsibilities. We found that most patients had care plans which were recorded and had up to date risk assessments although some patients told us they were not aware that they had care plans.

People told us that they did not have enough activities on the ward and staff told us that the activities which were timetabled to take place did not always take place. Some people also told us that they did not always know their rights and whether they were detained under the Mental Health Act (1983) or whether they had been admitted to the ward informally.

We checked the two seclusion rooms on the ward and looked at the general ward

environment. We found that the two seclusion rooms on Haringey Assessment Ward and the s136 suite had been used to admit patients when there were not enough bedrooms in the Trust. This meant that the provider had not made the changes which were indicated in the action plan which was sent to us following the inspection in June 2013 and continued to be non-compliant.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have taken enforcement action against St Ann's Hospital to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services	✖ Enforcement action taken

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

During this inspection we visited Haringey Assessment Ward and the s136 suite at St Ann's Hospital. The s136 suite is an area of the hospital which is a designated 'place of safety' where people are taken for a period of up to 72 hours, to wait for a Mental Health Act Assessment.

When we visited St Ann's Hospital on 19 June 2013 we found that planning and delivery of care did not always meet people's needs as when there were not enough beds, Barnet, Enfield and Haringey Mental Health NHS Trust admitted patients to seclusion rooms on Haringey Ward. These rooms were not designed to be used as bedrooms and this practice compromised the dignity and wellbeing of people who used the service. We also found that some patients were not protected against the risk of receiving care or treatment which was inappropriate because staff were not always aware of the legal status of patients so there was a risk that people may be treated unlawfully.

During this inspection, we spoke with seven patients some of whom were detained under the Mental Health Act and some of whom were informal patients which meant they had chosen to remain on the ward for treatment and were free to leave. Some people told us they were not aware of their legal status while they were on the ward. One person, who was not detained, told us "I am not clear if I am informal or detained", another person who was detained told us "I have been here for three days and no one has sat with me and told me about my 'section'", another person, who was not detained told us "I don't know if I'm on 'section' as the doctor told me I cannot go out".

We asked staff how they ensured that people who were detained and people who were not

detained knew their rights. We were told that there was written information available for people who had been detained under the Mental Health Act (1983) and people were told what their rights were to appeal against their detention. We were told that there was no information specifically to give to people who were not detained to explain their rights to them.

We saw that there was a notice in the nurses' office which explained that informal patients were free to leave the ward at any time however this notice was not on display in any of the areas which were accessible to patients. The lack of information available to patients who are not formally detained on the ward means that there is a risk that people will not be aware of their rights to leave the ward when they are not detained under the Mental Health Act.

We asked the ward consultant about how they ensured that people who were not detained were aware of their rights to leave the ward and how the staff team ensured that when there was a risk involved that people were aware that they did not have the right to leave, at will. The consultant told us that people had care plans which indicated any restrictions that they may have agreed to relating to remaining on the ward. We looked at the care plans for six people. We found that one person, who was not detained, did not have a care plan. This meant that it could not be evidenced that they agreed to care, treatment and support which they were receiving on the ward or that their consent to remain on the ward informally could be confirmed. There was a risk that people may not be clear about their legal status on the ward.

Most people told us the staff were very busy on the ward. Two people, who were patients on the ward, told us the staff were rude to them and one person told us that the staff ignore them and another person said the medical staff do not listen to them. One person told us "I have no complaints". One person told us that there was no access to illicit substances on the ward.

We looked at the records for six people. Most people had care plans and risk assessments which were up to date. Three people told us they either did not have a care plan or did not know whether they had a care plan. This meant that some people had not been aware of the care planning process and had not been engaged with it. One person said "Nobody talked with me about my difficulties or to discuss what help I might need to cope better at home." Another person said "I do not have a key worker and I do not have a care plan... noone has told me how my medication helps."

On most of the records we looked at we saw that there was an indication of capacity to consent to admission or treatment as appropriate. On one care plan we saw that it said that "allocated nurse on duty to spend at least 20/30 mins with [patient] and allow [them] to ventilate thoughts and feelings." We did not see that this was evidenced in the daily recording.

Some patients told us that there were not frequent activities on the ward. One person said "There are no activities - nothing happens except pool and TV and some patients get bored", another person said "lack of activity is the worst thing." We saw that there was an activity timetable in the lounge of the ward. A member of staff told us this timetable was out of date and "The OT [occupational therapist] hasn't updated the schedule - someone needs to phone to find out if there are any activities on". Another member of staff told us "Activities don't happen because we are short staffed" and another said "We don't have a lot of activities as we just have a pool table and football - we liaise with OTs twice a week".

We saw no evidence that any structured activities were arranged during the course of our inspection visit when we spent a day on the ward.

We looked at people's daily records and saw that some activities were recorded for some people on most days however this was not consistently recorded for all people. The ward had 'Protected Engagement Time' (PET)between 3.30pm and 4.30pm. We asked staff what happened during this time. We were told that staff sit and chat to patients, play board games and that some patients have leave from the ward or have 1:1 time. One member of staff said "during the engagement time, we ask them what they [patients] want to do - the problem is we don't have a lot of activities". Another member of staff told us, about PET, "it's the same as what happens normally." We did not see evidence in the daily records that PET was being used to meet individual needs of patients. This means that there was not a consistent programme of meaningful activities available to all patients on the ward if they chose to participate.

We looked at the two seclusion rooms on Haringey Ward. Seclusion rooms are for nursing patients in isolation for short periods, when they are a risk to others. The Mental Health Act (1983) Code of Practice 15.43 states "Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others." At our last inspection on 19 June 2013 we found that sometimes these rooms had been used to admit patients when there were no other beds available in the Trust. This practice had been raised as a concern to us by members of staff during the last inspection. The two seclusion rooms shared a toilet. They are rooms which contain raised mattresses and no other fixtures or fittings. We were told that by staff on the ward that they were not aware of any occasions when both seclusion rooms were used at the same time. When patients were admitted to the seclusion room when there was not the clinical need to be secluded, we were told that the door was left open.

There was a locked door between the seclusion rooms and the main ward area which included the lounge, dining room, kitchen, bathrooms and showers so people were not be able to access these areas independently. We were told by the staff that people could knock on the door of the nursing office to gain access to the main ward area. One seclusion room had constant CCTV which could not be turned off by the staff. The CCTV for the other seclusion room was broken. There were intercoms for both seclusion rooms which allowed nursing staff to communicate with people who were being secluded. These intercom systems could not be initiated by patients. The Mental Health Act Code of Practice (1983) 15.60 states that "The room used for seclusion should... be quiet but not soundproofed and should have some means of calling for attention (operation of which should be explained to the patient)." The lack of a patient-initiated contact from the seclusion rooms and the reliance on a member of staff looking at the CCTV images meant that this was not the case. When patients were admitted to the seclusion room when there was not the clinical need to be secluded, they would not be able to shut the door to enable privacy as the door could not be opened from the inside and if someone shut the door, they would be locked in the room.

We asked staff how often people were admitted to the seclusion room when they did not require seclusion. Staff told us that it happened occasionally. We asked staff about how they prepared a seclusion room if it was to be decommissioned and used as a bedroom. Staff told us they ensured that the room was cleaned and they put bedding on the raised mattress. They ensured the door was open and they told us they explained to patients that they were not 'in seclusion' and that a bed would be found for them as soon as possible. After the previous inspection the Trust provided us with an action plan which stated that

seclusion rooms were not being used to admit patients however we found at this inspection that this was not the case and that this had continued to happen.

We were provided with information from the Trust about the use of seclusion rooms to admit patients when there were no other beds available for people. From this information we saw that between 28 August 2013 and 17 November 2013 the seclusion rooms had been used as bedrooms for thirty nights. On eleven occasions they had been used for more than twenty four hours which included one person who was admitted to a seclusion room for a period of five nights when there were no other beds available. This affects the welfare and dignity of people as seclusion rooms are not intended or designed to be used as bedrooms.

We saw that the Trust had a procedure to ensure a risk assessment took place regarding patients who needed to be admitted and made a clinical decision on this basis. We saw the records for one person who had had a risk assessment as they had been admitted to a seclusion room. The risk assessment we saw was sparse and did not address risk factors which were specific to the individual. It did not clearly define either the risks present nor incorporate a risk management plan. It did not clarify that the patient had been admitted to the seclusion room as an admission, rather than because they had a clinical need to be secluded, nor did the daily entry notes indicate clearly how long they remained in the seclusion room before being transferred to a bedroom. This meant that the process of assessing risks present to each individual for the temporary use of rooms which were not designed to be bedrooms was not robust enough to protect patients from the risk of inappropriate care and treatment.

During this inspection we looked at the s136 suite which is a room set aside from a ward which is used as a 'place of safety' for people to come while they are waiting for assessments under the Mental Health Act (1983). It is always staffed by a nurse. The nurse on duty told us that it had been used for patients to sleep in when bedrooms were not available. The s136 suite had an intercom system which was not able to be activated by the patient and relied on a member of staff observing the patient. In the s136 suite there was a mattress. There was no place to sit down apart from on the mattress. We requested information from the Trust regarding times when this room was used as an additional bedroom outside its function as a nominated place of safety. We found that it had been used in this way on eight occasions since the last inspection. We found that this was not appropriate to ensure the dignity or protection of people who need to be admitted to psychiatric inpatient care and this practice meant that there was a risk that people would not receive the appropriate care and treatment.

We have issued a warning notice to the Trust which was served on 13 December 2013.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 31 March 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
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 people who use services**
	How the regulation was not being met: The provider had not planned and delivered care and treatment in such a way to ensure the welfare and safety of the service user and to meet the service user's individual needs as they had a policy of admitting people to seclusion rooms and to the rooom known as the s136 suite which were not appropriately furnished or designed as patient bedrooms. (Regulation 9 (1) (a) (b) (i) (ii) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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