Inspection Report

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

Chase Farm Hospital

The Ridgeway, Enfield, EN2 8JL

Tel: 08451114000

Date of Inspections: 26 September 2013
25 September 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Management of medicines	✓ Met this standard
Safety and suitability of premises	✖ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

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 mental health services at Chase Farm hospital. These include the following inpatient services: acute assessment wards for adults, continuing care wards for people with dementia and cognitive impairment, forensic wards, a specialist forensic ward for people with a learning disability, a rehabilitation ward, and a forensic intensive care service for people in the boroughs of Barnet, Enfield, Haringey, Camden and Islington.
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
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury

Contents

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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

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 25 September 2013 and 26 September 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We were accompanied by a pharmacist, reviewed information sent to us by other authorities and talked with other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We carried out this inspection to look at the progress had been made since we last visited the older adults mental health wards based at Chase Farm Hospital. When we last visited on 27 March 2013 we found that the Trust was failing to meet regulations 9 and 20 of the Health and Social Care Act because the Trust had not protected patients against the risk of receiving inappropriate care and treatment by ensuring, where appropriate, that their capacity had been assessed and decisions were made in their best interests. It had also not ensured that all records were appropriately maintained.

This inspection was carried out by three inspectors, an expert advisor, an expert by experience and a pharmacist inspector.

During this inspection, conducted on 25 and 26 September, we visited four wards which were The Oaks, which is an admission and assessment ward for older adults who have functional and organic mental health needs which, at the time of our inspection, was in the process of changing to a ward which will cater for older people with functional mental health needs, Silver Birches, which was a continuing care ward for people with dementia and was in the process of changing to an admission and assessment ward for people with organic mental health needs, including dementia, Cornwall Villas which was a dementia continuing care ward and Bay Tree House which was a rehabilitation and 'step down' ward

for older adults with functional mental health needs which had some continuing care beds. The Oaks, Silver Birches and Cornwall Villas are at the Chase Farm Hospital site. Bay Tree House is registered to Chase Farm and located about a mile away from the hospital site.

We visited The Oaks and Silver Birches in the morning and afternoon of 25 September before returning in the evening to observe the night shift. We visited Cornwall Villas in the morning of 25 September and Bay Tree House on the afternoon of the 26 September.

We found that most staff interaction with patients was good but we saw some examples which could still be improved.

Understanding and use of the Mental Health Act (1983) and the Mental Capacity Act (2005) varied between the wards. In some areas we saw that it was used and documented well but on other wards we found that there was a risk that people were subject to restrictions without having access to legal processes and protection.

We found that medication was safely stored and administered.

The Trust had adequate staff on the wards however in some areas there was a high use of agency staff. The Trust had systems in place for monitoring and improving the service but these were not used effectively to improve care across all wards for older adults. We saw that many improvements had been put in place on The Oaks ward where concerns had been raised previously, however we identified similar concerns in other wards.

Personal records, including medical records, were not accurate or fit for purpose. Although we saw records on The Oaks, were comprehensive, on some other wards we found significant gaps in records and some records which were not up to date.

Our overall findings from this inspection are that there are significant improvements in the care provided to patients on The Oaks but that there is non-compliance in many of the same areas on the other wards for older adults. This shows poor leadership as lessons from the failings in one part of the hospital are not being robustly applied across other wards even within the same service area.

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

What we have told the provider to do

We have asked the provider to send us a report by 19 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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 ✖ Action needed

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 moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

When we visited previously on 27 March 2013 we found that the Trust was not meeting this standard. This was because the Trust was failing to ensure patients' capacity was being assessed and that patients were supported appropriately at all times.

Provision of personal care

Throughout the days we visited we undertook ongoing observations, spoke with people using the service and spoke with their relatives. In general, patients appeared to be clean and appropriately dressed and looked cared for. When patients needed support by staff to ensure their personal hygiene was appropriate they received this support. When we spoke with patients they were generally positive about the service, although some did not like it. The following are examples of what we were told by patients or their relatives:

"Yeah. Is okay here." (The Oaks.)
"Basically it's ok as hospital wards go" (Silver Birches.)
"Nurses are ok." (Silver Birches.)
"I like it here"; and "The staff look out for us". (Cornwall Villa.)
"The care is fantastic. When I leave here I have no worries about how my husband is looked after." (Cornwall Villa.)
"I'm not really that happy, but I guess it is okay. I was previously on The Oaks. I really did not like it there." (Bay Tree House.)

When we visited the Oaks we attended the daily 'White Board' meeting, where a multidisciplinary team led by the ward consultant discussed each patient. We observed that appropriate discussion of each person's care plan and progress took place, including a discussion of each patient's medication, discharge plans, physical health and legal

status. We saw planners were being kept to ensure that patients received all the tests they required on the appropriate days.

At the time of the inspection The Oaks ward still had patients with functional and organic conditions. The Trust was in the process of moving to a model of single specialties on the wards.

When we visited Cornwall Villas ward we observed that patients had care plans in place describing their individual needs. We observed that most patients were wearing continence pads. When we looked at people's individual care records we found that patients had not received individual assessments regarding their need to wear these. Also when we looked at the records of how people had been supported to wash, it was not indicated whether it had been a bath, a shower or a strip wash.

Activities and staff interaction

During our inspection we saw staff interacting in a positive manner with patients on all the wards we visited. However, we also saw examples of poor interaction and that many patients were not engaged in activities throughout our inspection. We also found some examples of activities that were scheduled to take place that were not happening in practice.The lack of interaction between nursing staff and patients may mean that some people are not stimulated and supported through their inpatient stay.

During our inspection of Silver Birches we observed most staff to be caring on this ward. We saw examples of good interaction. For example, whilst we were observing patient interactions, a Music Therapist visited. She spent some time showing patients a "sound bowl" (an unusual musical instrument). We saw one patient engage and attempt to play the instrument and reminisced about its similarity to an African instrument that she knew.

However, we did see examples of poor interaction with patients. We saw one member of staff refer to a patient as "good girl." This infantile language was inappropriate. Staff were observed to remain with the care areas so that patients were not left unsupervised. However, we noted that at times there was minimal interaction between these staff and patients.

There were activity timetables up in each of the units however some of the activities which were written were not taking place for example, on the day we visited, the activity timetable indicated that 'spiritual activites' would be taking place but the nurses on duty told us that the priest who was scheduled to visit was not visiting. The activity timetable had not changed to take account of this.

During our time on Cornwall Villas we observed good interaction between staff and patients. For example, we observed a member of staff taking time to sit and comfort someone who had become distressed and begun shouting.

During our inspection of The Oaks we saw some examples of good interaction, although individual interaction between staff and patients was limited. In the afternoon we observed a music group taking place. Three patients were involved in this activity, although we noted that other patients on the ward were not being engaged in this activity. In general we saw limited interaction between patients and staff. We saw one Healthcare Assistant who took time to engage with each patient as they were doing there tea round. This was good. However, we also saw examples of staff sitting near patients without

interacting with them. We also observed one member of staff telling a patient that they had made a mess, which was inappropriate.

When we visited Bay Tree House we spoke with 10 patients. Most told us they found the access to activities to be good. One person explained they attended church on Sunday and they liked this. Another person told us they attended activities at a Day Centre run by the trust. During our inspection we saw people being accompanied for a walk in the community by a member of staff. A community meeting was undertaken during the afternoon of our inspection.

Support at meal times

During our inspection we observed the support patients received in eating their meals. We saw examples of good support, with staff taking time to sit and support patients. We also saw examples of where the organisation of meals did not meet the needs of the patients and where interaction was poor .

We observed lunch on one unit of Silver Birches ward. Patients had meals which were heated by microwave in each unit. We saw that patients were offered a choice by being shown the precooked meals in their packaging. As each meal had to be cooked individually in the microwave, this meant the process was slow and unwieldy. We saw patients were brought into the dining room individually to choose their meal and wait for it to be cooked. Patients were observed to wander off whilst waiting for their meal to be cooked. At one point we saw a member of staff pulling a patient into the dining room by their wrists. Another member of staff came and two of them walked the patient into the dining room. The staff then left the patient there and walked away. After sitting for 10 minutes with no one interacting with them, the person got up and left the room. One patient took a sandwich from a trolley while waiting for the meal they had chosen to be cooked. The arrangements for meals on Silver Birches meant that patients could not eat together at the same time, could not see the cooked food in order to make choices and caused confusion as patients were waiting for their meal to be served whilst watching other people eat their food.

When meals were served staff did not always explain to patients what they were. For example, one person was only told "that's for you" as a meal was put in front of them. Patients were not always offered a choice of drink.

On Cornwall Villa we saw three members of staff supporting patients in a 1:1 capacity. We saw that when patients required assistance with eating they received it.

We observed lunch on The Oaks. We saw examples of good support. We saw one member of staff engaging with patients in an excellent manner. They took time to sit with the person and assist them with their meal. However, we also noted that when a member of staff was going to give a person a banana, another member of staff loudly said that you should not give a diabetic patient a banana. This was inappropriate.

The ward manager was keeping a record of patients to ensure that all patients received there meal. Different colour trays were being used to highlight the level of support patients required with eating. We saw that patients who had requested Kosher meals were receiving these.

When we visited Bay Tree House we observed dinner. We saw that staff offered people a

choice of food and explained what it was. When patients required assistance with eating they were receiving this. When we asked patients on this ward whether they liked the food, most told us they did. They told us they were offered a choice. Some patients told us they would like more fresh fruit.

Mental Capacity

When we visited the wards last time we found that there was little or no evidence in patients' files that capacity assessments had been done in respect of living on the ward, treatment or care.

When we visited The Oaks ward this time we looked at the records for three patients. In these files appropriate capacity assessments had been completed and consideration had been made of patients' capacity in their care planning process. We saw that there was an understanding of the appropriate use of the Mental Capacity Act and this was reflected in the records we saw.

When we visited Silver Birches ward we looked at the records for seven patients. We saw that there were capacity assessments which had been recorded relating to peoples' capacity to manage their personal care needed and we saw some evidence that this was being monitored daily however it was not always necessary or appropriate for capacity decisions to be documented on a daily basis.

We did not see any capacity assessments or indication in the progress notes that consideration had been made about decisions which related to more significant factors such as peoples' capacity to consent to admission to hospital or to the treatment or medication which they were receiving. For example we saw progress notes which said "[patient] has no capacity to attend [their] self-hygiene. [They] get everything done for them". The provider may find it useful to note that, on the basis of the records we saw and the conversation we had with staff, we found that staff were not always assessing the capacity of patients to make decisions appropriately.

All the patients on Silver Birches at the time of our inspection, had been admitted to hospital informally and they were not detained under the Mental Health Act. No one was subject to an authorisation to deprive them of their liberty under the Deprivation of Liberty Safeguards (DoLs) We saw one record of a patient where a decision had been made to detain them under the Mental Health Act. The assessing practitioner had made the decision that they lacked capacity to consent to admission and met the criteria for formal admission and had recorded this however on their arrival on the Silver Birches, they were admitted as an 'informal' patient and the doctor wrote "agreed we would keep [patient] as an informal patient and if necessary use a DoLs". This indicates that there is a lack of understanding of the difference between the way that the Mental Capacity Act and the Mental Health Act are used in psychiatric inpatient settings and means that this person is at risk of being unlawfully deprived of their liberty without recourse to the protection provided in the Mental Health Act or the Mental Capacity Act and there is a risk that their rights under Article 5 of the Human Rights Act were breached. We informed the ward staff of this during our inspection. There was no record of a best interests decision being made in relation to this patient where people involved with their care, including their family were involved or the process by which they were able to remain on the ward 'informally'.

For another person who had been admitted to the ward under section 2 of the Mental Health Act, the decision made to take them off 'section' was recorded by stating "[patient]

clearly does not have capacity to make decisions regarding his care but equally does not need to be detained in hospital under the MHA. Therefore I have taken [them] off [their] section but [they] will remain in hospital for [their] best interests" We could find no record of a capacity assessment and best interests meeting in relation to this and how the criteria for admission had changed since they were admitted. It was not clear why this person was no longer being treated under the Mental Health Act (1983). This means that people who may not have the capacity to consent to admission or treatment and who needed treatment were not protected by legislative frameworks within the Mental Health Act or the Mental Capacity Act.

We spoke with staff and asked them what they would do if an informal patient wished to leave the ward. Some staff told us that people would be allowed to leave, but only with 1:1 support from staff as they were vulnerable. Whilst supporting a vulnerable person would be appropriate, staff should be aware that informal patients should be allowed to leave should they wish to if they are not formally detained or an application has not been made to deprive them of their liberty.

Patients on Silver Birches were at risk of being deprived of their liberty without the protection of legislation under the Mental Health Act or the Mental Capacity Act because staff were not aware of patients' rights for legal protection.

We checked the records on Cornwall Villas and Bay Tree House and found that people were assessed and treated appropriately with consideration of the Mental Capacity Act.

Blanket Restrictive Practices

When we inspected Cornwall Villas and Silver Birches we found that all the bedroom doors were locked from the outside. On both wards we were told that this was because patients could not remember which was their room and might wander into another person's room. On Silver Birches we saw the doors from the lounges to an enclosed garden were locked even though the weather was nice. These are examples of blanket restrictive practices that do not reflect individual patient's needs.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We assessed the management of medicines on four wards, The Oaks, Silver Birches, Cornwall Villas and Bay Tree House, by reviewing people's medicines charts, seeing how medicines were prescribed, administered and stored, and speaking with staff and patients. Appropriate arrangements were in place in relation to obtaining medicines. Staff on the wards told us that the pharmacy department had an effective system in place so that newly prescribed medicines were obtained without delay and people did not have to wait to receive treatment. We saw that most of the medicines prescribed for people were held on the wards as stock items, to avoid delays in starting treatment.

Patients were prescribed and administered medicines safely. We saw evidence that when patients were admitted to the hospital, checks were made to ensure that they continued to get the medicines that they were taking at home. We saw that these medicines checks were carried out promptly once people had been admitted. We saw that prescribers were following prescribing guidelines and the Trusts medicines policy. On three wards, people's allergy information was obtained and recorded promptly. On one ward, this information was missing on a number of medicines charts, however staff told us that they had this information on older charts but had not transcribed it onto the latest chart.

Appropriate arrangements were in place in relation to the recording of medicines. We looked at medicines charts on four wards and saw that nursing staff had signed for medicines given, providing evidence that medicines had been given as prescribed. There were no gaps on charts, so it was clear when medicines had been given. If any doses of medicines had been omitted for any reason, staff made a note to explain why. Doctors had written out the prescription clearly, and additional information was added to medicines charts by pharmacy staff to further clarify the prescription and add supplementary information for staff such as when medicines needed to be taken in relation to food, to reduce the likelihood of side effects.

Medicines were safely administered. Staff told us that people were not allowed to self-administer any medicines because of their mental health needs, therefore staff administered all medicines. We observed staff giving people their medicines, and saw that this was done safely, with records completed at the time. We also saw that people were

prescribed medicines for their physical health needs and minor ailments, as well as for their mental health needs. When people required treatment under the Mental Health Act, the appropriate treatment consent forms were in place. We noted that on Bay Tree House, one person had been detained under the Mental Health Act; however the appropriate treatment consent form was not kept with the medicines chart. This meant that staff could not check that this person had been prescribed medicines that had been legally authorised. We discussed this with staff on the day of the inspection, and this was rectified straight away.

Medicines, including controlled drugs, were stored securely in locked cupboards and trolleys, and staff were monitoring the temperature of medicines storage areas and medicines fridges to ensure that medicines were being kept at the correct temperatures to remain fit for use. We noted that on one ward, the temperature of the medicines storage room should have been 25˚C or below, however records showed that the temperature had been over 25˚C on 21 out of 25 days in September 2013. We asked the ward manager to look into this. We also noted that on two wards, some oxygen cylinders were not stored securely, as they were leaned against a wall, which meant they were at risk of falling over.

Medicines were disposed of regularly on three of the four wards. On Bay Tree House, we found a number of expired medicines and oxygen cylinders, and also medicines which were no longer prescribed or were for people no longer on the ward. We discussed this with the Ward Manager, and they told us they would address this immediately.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The environment of the wards varied significantly. We found that there was some refurbishment which had taken place and some of which was planned for the near future. There were some wards where we saw that issues relating to the physical environment and particularly items which had broken, were not being promptly repaired.

Silver Birches

Silver Birches Ward had 23 beds. It was split into three units, Emerald and Sapphire for male patients and Ruby for female patients. It is a continuing care ward which was in the process of changing to an admission and assessment ward for people with organic mental health needs.

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In general the environment of the ward looked worn. Signs had been removed from doors and the residual glue was still evident. A door knob had been removed from an entrance to Ruby area, leaving the rough wood under surface and screw holes unfilled or decorated.

Patients were able to move freely between the units. Each unit had a lounge with a doorway to the garden area. The garden is enclosed by hedging and we were told that patients were able to access the garden when the weather was good. There was fine weather on the day of inspection but the garden areas were not used and the doors from the lounge areas were locked.

In the lounges,the televisions were mounted flat against the wall in the corner, making themdifficult to be viewed comfortably from some parts of the lounge. On Ruby the television was broken. This meant that we observed some people who were looking at the space where the television had been. The staff put a radio in the lounge area. When we asked staff about when this was going to be fixed, we were told it had been broken for three weeks. In another lounge we saw a television, which people were watching but had no sound on. We asked someone watching the television if they wanted to hear the sound and they told us they did.

In the Sapphire wing a light was broken in the lounge. The assisted shower rooms were not in use.
In the Ruby wing there was a wheelchair stored in the toilet, directly between the toilet and waste bin so if anyone wanted to sit on the toilet seat they would need to move the wheelchair. This may have presented a risk of falls.

When we were shown into rooms we did not see any personal memorabilia about the patients' lives or memories. There were no names of people's doors to help people to understand and orientate themselves to their environment.

In general the ward was clinical in nature and lacked enhancements for patients with dementia to interact with, such as rummage boxes.

The Oaks

When we visited The Oaks last time we noted that in the lounge area all the chairs were pushed against the wall. When we visited this time, the lounge had been divided up into smaller seating groups, which encouraged greater interaction.

We also previously noted, the large physical size if the ward made it difficult to manage the client group. The trust now has plans to redevelop the ward to make it into two smaller spaces. The ward had already been reduced to 22 beds, although the night before the inspection one bed had been reopened in the night, meaning 23 were open.

Cornwall Villas

The ward had 23 beds. It was not specifically designed for people with dementia. We noted that none of the rooms had pictures or visual aids to help orientate people to their environment. .

Bay Tree House

Bay Tree House is located about a mile from the main hospital site in a quiet location. It has 23 beds. It is primarily a rehabilitation ward for older adults with functional mental health needs, although some continuing care patients are on the ward. In addition to the main lounge area, there were single sex spaces available so that women could choose whether to sit separately. When we spoke with people they told us they liked the ward, with the garden space being especially valued.

In the bathrooms emergency pull cords had been replaced by buttons. We were told that this was because they presented a ligature risk. However, not all cords had been removed so this risk was still present.

We noted that some of the bedrooms were decorated very sparsely. When we asked patients if they were allowed to personalise their rooms, they told us they were.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

When we visited on 27 March 2013 we found that the Trust was meeting this standard, but we found there was a high level of sickness on the wards we visited. There were also a high number of temporary bank and agency staff being used. This meant that there was a risk that staff working may not always know the specific needs of the patients on the wards. When we visited in September 2013 we found that the Trust was actively recruiting staff but some areas still had high numbers of agency staff working.

During the inspection we noted staff were working a long day shift pattern, from seven in the morning until seven-thirty in the evening. When we spoke with staff most told us they found this very tiring and that towards the end of the day this made it difficult for them to do their job.

The Oaks

Since we last visited The Oaks, a dedicated ward consultant had been appointed to be responsible for all the patients during their time on the ward. Staff told us they felt this had been a positive step. When we visited we saw them undertaking a daily 'White Board Meeting' discussion of the patients on the ward.

On the day of our visit there were three qualified members of nursing staff and three healthcare assistants. Two were bank staff and two were from an agency. We were told that since the last inspection the ward had undertaken recruitment and that agency usage was reducing.

When we spoke with staff on the ward they told us that morale on the ward had previously been poor but they felt it was now improving.

Silver Birches

We were told that the establishment for the ward is designed to ensure that there is minimum staffing of three trained nurses and three healthcare assistants (HCAs) during the day and two trained nurses and two healthcare assistants during the night.

When we visited the ward, the ward manager, two qualified nurses and 10 HCAs were working. When we spoke with staff, they told us they felt this was adequate to meet the needs of the patients. In total seven of the staff were agency staff. There were four patients who were receiving 1:1 support. We were told that the ward was recruiting new staff and had interviews set up for the afternoon on the day of the inspection. When we spoke with a relative they told us , "A lot of agency staff have 'I don't care' attitudes and they are short of their own staff. Sometimes staff sit on their phones." There were high numbers of agency staff being used to meet the needs of patients. These staff may not know the needs of the patients as well as permanent staff do so there is a risk that people may not receive the care which they need.

The ward did not have a dedicated consultant.

Cornwall Villas

On the day of the inspection there were three members of qualified nursing staff and three healthcare assistants. One member of staff was dual general nursing and mental health nursing qualified, which meant they could provide skills in supporting people's general health needs. At night there are two qualified staff and two healthcare assistants

Staff told us they felt there were adequate staff to meet the needs of the patients and that if they needed extra staff for 1:1 observations they were able to get these.

The ward did not have a dedicated consultant. We were told that the consultant came for two out of four ward rounds a month. A junior doctor is on the ward daily.

Bay Tree House

On the day we visited the ward there were three qualified nurses and two healthcare assistants working, in addition to the ward manager. Two were Bank staff and one was from an agency. When we spoke with patients they told us they felt the staffing was adequate, although some expressed concern that at night there were only three members of staff.

The ward is supported by a consultant, who undertakes a weekly ward round, and a specialist registrar. When we asked the nursing staff about the medical cover the ward received, they said it was good.

The Service Manager for this ward was currently also covering the role of ward manager on The Oaks.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

When we visited the wards previously on 27 March 2013 we found that the Trust was failing to meet regulations 9 and 20. In response to this report the Trust produced a service improvement plan for The Oaks ward. When we visited we looked at the progress the Trust had made against this plan. In general, there was evidence of positive progress on The Oaks ward. The Trust was looking to change the model of care on the ward and change the environment. We saw there was a clear plan to achieve this. There was an aim to separate functional and organic provision and reduce the number of beds prior to rebuilding the ward. At the time of our visit, there was still a mix of patients on the ward, although the number of dementia assessment patients had been reduced and Silver Birches had begun to be used as an assessment ward. We saw that the action taken by the Trust to improve the Oaks had had a positive impact on the patients who were there.

The plan had outlined a need to train staff in particular behaviours which may be challenging to the service. We were told that the Trust had developed a programme of allowing one day every two months for staff development. Training sessions, including role play, had been designed to allow staff to work through how they would respond to situations. Training had also been provided on wound care and privacy and dignity.

The plan had identified the need to monitor people's physical health needs. When we visited we saw people were having regular monitoring as required. Their physical health needs were also discussed at the daily multi-disciplinary 'White Board Meetings'.

A need to increase the leadership on the ward had been identified. A dedicated consultant had been appointed to the ward. The service manager was currently acting as ward manager. Recruitment had taken place on the ward and the sickness rate had been reduced. Staff told us morale on the ward had improved.

We saw that the Trust was doing work to gather the views of patients' carers. In August 2013 a carers' survey was undertaken on The Oaks, to gather the opinions of carers to

people who were on the ward. The responses that had been received to this survey were generally positive. For example, one person had commented "[…] is settled and that is a relief to me." We saw that the answers to this survey had been analysed and themes had been identified which would drive further improvement.

There was evidence the Trust was monitoring its quality of service. In the week prior to our inspection, the Trust had undertaken an internal review of The Oaks to assess its progress. When we visited Cornwall Villa Ward we saw an example of a service peer review which had been undertaken on the ward. In this a non-ward member of staff had undertaken a review to look at the ward's compliance against the national minimum standards.

When we visited Silver Birches ward we were told there was a monthly improvement group away day where the ward manager/service manager meet and discuss service improvement. At the last meeting they discussed behaviours which may present as challenging to the service. Staff told us they felt this had led to improvements in how they managed situations which arose. All staff attend these groups where the first part is a meeting and second part is a practice development area.

Although we noted that the Trust has made good progress in addressing areas of concern we identified on The Oaks ward during our previous inspection, we also found similar issues to ones that had previously been identified on The Oaks in other wards. For example, in two of the wards we visited we found missing patient's records and some use and understanding of the Mental Capacity Act was not appropriate. In addition, we found on-going examples of poor staff interaction, activities planned but not taking place, arrangements for meals which did not meet the needs of the patients and examples of blanket restrictions. We also found poorly maintained environments and equipment that needed to be repaired. An effective quality assurance system would ensure that lessons learnt are implemented not only on the ward where the original concerns are identified but across other services in the Trust.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

When we visited on 27 March 2013 we found that the Trust was not meeting this standard. This was because people's personal records including medical records were not accurate and fit for purpose. When we visited The Oaks ward we had found not all patients care plans were being updated at least once monthly and that one person did not have a care plan at all.

When we visited The Oaks on 25 September, we looked at the records for three patients. In these we saw that the care plans had been updated regularly and that when risks had been identified appropriate strategies had been put in place to manage these. We did not see any gaps in the daily updates. We noted there had been an improvement in the notes on this ward since we last visited. We looked at the records for patients who had been subject to restraint on the ward. These had all been completed appropriately.

When we visited Silver Birches ward we looked at the records for seven patients. We found that for six of these patients there was at least one day in the previous month for which there was no daily notes. For one person there were five days for which no notes had been made.

We noted that in one person's file they had assaulted a fellow patient in early August. When we looked at this person's risk assessments it did not record their potential risk to other patients and had not been updated since 08 July 2013.

Another person's care plan had not been updated since 19 June 2013. When we looked at this plan it noted that a walking chart was required. When we asked staff why this had not been completed they told us it was no longer required as the person could not walk. The plan had not been updated to reflect this.

On Silver Birches ward we asked staff to show us hard copies of patient's care plans. We wanted to see these as we wanted to see examples of what agency staff could refer to when they were delivering care, as they did not have access to the RiO notes system.

The files we were shown did not contain care plans. This was a concern as the ward had seven members of agency staff on the day we visited who would not therefore have had access to the prescribed care guidance for their duties.

When we visited Bay Tree House we looked at the records for seven patients. For all of them there were multiple days on which there were no notes for the patients. For example, for two peoples there were six days in the previous month were there had been no daily notes recorded. For another person there were eighteen days in the month prior to our inspection where there had been no daily notes recorded. This included a consecutive period of five days where there were no daily records. This means that there was a risk that important information about people's nursing needs was not recorded and passed on to members of staff.

When we asked to see the records of a safeguarding alert that had been made, these were not available. We checked the records of one instance of restraint that had taken place. We saw that it was not recorded completely on the daily progress notes as the time and duration of the restraint was not indicated. We checked with the Trust and saw that this information had been recorded centrally however the audit of the records which we saw indicated that the time and duration of the restraint had been recorded and therefore the audit contained a false declaration. This means there is a risk that internal auditing may not be accurate.

One person had not had their risk assessment updated since 28 April 2013 and their last care plan was dated 01 December 2012. The notes for this person mention concerns about physical health needs symptoms, for which they had been referred to a consultant. There was nothing in their risk assessment which reflected these physical health concerns.

When we looked at the management of people's medications we noted that on two wards, a few peoples' care plans did not make reference to their medical conditions. For example, one person had hypertension and had been prescribed medicines to reduce their blood pressure; however there was no evidence that this person's blood pressure had been monitored since 10th June 2013. Staff told us that this person was refusing to have their blood pressure monitored. The records did not make this clear.

Although we found that the Trust had made improvements in the areas were we had raised concerns when we last visited, we found that in other wards personal records were not being completed at all times and that risk assessments were not always being updated as appropriate.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Nursing care 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 registered person had not taken steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by not planning and delivering care and, where appropriate, treatment, in such a way to ensure the welfare and safety of the service user as the legal rights of someone who is experiencing the effect of being detained without a legal framework were not ensured and the use of blanket restrictions. (Regulation 9 (1) (b) (ii) of the Health and Social Care Act (2008 (Regulated Activities) Regulations 2010).
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises by means of adequate maintenance and,

This section is primarily information for the provider

Nursing care Treatment of disease, disorder or injury	where applicable, the proper operation of the premises as there were some items which were stored in toilets and bathrooms to which people had access and may be trip hazards and items which were identified to us as ligature risks had not been removed. (Regulation 15 (1) (c) (i) of the Health and Social Care Act 2008 (Regulated Activies) Regulations 2010)
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person had not protected service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity as risks which had been identified previously had not been addressed across the service. (Regulation 10 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person had not ensured that patients were protected against the risks of unsafe or inappropriate care or treatment arising from the lack of proper information about them by means of maintaining accurate records which should include appropriate information and documents in relation to the care and treatment provided to each service user as there were gaps

This section is primarily information for the provider

disease, disorder or injury	in the daily records and some information recorded was out of date. (Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 19 December 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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