healthwatch Enfield

Healthwatch Enfield

Enter & View Report

Pymmes Zero Ward, North Middlesex University Hospital, 23 February 2016

Healthwatch Enfield Enter and View Report

Premises name	Pymmes Zero Ward
Provider name	North Middlesex University Hospital NHS Trust
Premises address	Sterling Way, London N18 1QX
Date of visit	23 February 2016

Contents

Purpose of visit 2

Executive summary 2

Recommendations for the management of North Middlesex University Hospital Trust, with response from the Trust 3

Recommendations for:

Hertfordshire Adult Social Care 7

Enfield and Haringey Clinical Commissioning Groups and Enfield and Haringey Councils 7

The Enter and View Team 8

General Information 8

Methodology 8

Acknowledgements 9

Disclaimer 9

Key area 1: Physical and mental health care 10

Key area 2: Personal Choice and Control 17

Key area 3: Information, communication and relationships 20

Key area 4: The Environment 23

Key area 5: Staffing and management 24

Conclusion 27

Appendix: Patients' and carers' experiences of care at home in Enfield 28

Information page: What is Healthwatch? What is Enter and View? 29

Purpose of the visit

Authorised Representatives from local Healthwatch have statutory powers to 'Enter and View' health and social care premises to observe and assess the nature and quality of services and obtain the views of the people using those services.

This was an announced Enter and View visit as part of a planned strategy to look at several hospital wards in Enfield where the majority of the patients are elderly. This forms part of a wider project to find out about the experience of frail elderly people both as patients and as users of local social care services. Our visit to Pymmes Zero ward at North Middlesex University Hospital therefore had a dual purpose: to find out from patients and their relatives about the nature and quality of care on Pymmes Zero ward itself, and to listen to any comments they might have about care the patients had received in their own homes prior to their stay in hospital.

Executive summary

At the time of our visit in February 2016 we formed the impression that Pymmes Zero ward is well-led and that the matron, manager and team all strive to provide high quality compassionate care to frail elderly patients, albeit in rather challenging circumstances. We noted some examples of good practice in the ward, which we would like to commend, including an open culture amongst the team; the mentoring of less experienced staff by those who have more experience; a well-designed welcome pack; and good systems in place to ensure adequate nutrition and hydration.

Comments from patients and carers we met during our visit were mixed. Some patients and their relatives told us that care in the ward is good, and said staff are "lovely and helpful". Others told us that staff are not always gentle, and that at times there are not enough staff to provide prompt attention when patients require assistance.

The physical environment in this ward is poor, and accommodation is cramped for patients and staff. There are persistent staff shortages which may compromise patient care and safety. All the patients in the ward are over 75, and although many of them have dementia and some are approaching the end of their lives, no specific Trust strategies for the care of people with dementia or for end of life care are currently in force. Not all staff have completed their mandatory training, and few if any have received in-depth training in care of the elderly, dementia care and end of life care. Provision of specialist therapeutic support appears to be minimal. Additionally, patients sometimes experience delayed discharge, due to local authorities being unable to arrange appropriate care packages in the community. The fact that most of these problems are long-standing suggests to us that that insufficient attention, at senior management level, has been paid in recent years to ensuring that the experience of elderly patients admitted to North Middlesex University Hospital is of the highest quality.

In the light of the challenges to recruiting and retaining sufficient numbers of high quality staff to work in the care of the elderly wards, we suggest that the practice

of 'central' recruiting to all teams should be reviewed and other approaches considered. A determined effort should be made to recruit nursing staff who are keen to work in this field, and they should be supported to attain professional accreditation in nursing care for the elderly, dementia care and end of life care.

We have made a number of recommendations for the Trust, arising from our visit to Pymmes Zero ward; many of these recommendations may apply equally to other wards. We have also made some recommendations to other bodies, where we believe this could improve the experience of frail elderly patients who are admitted to local hospitals.

Since our visit, there have been significant changes in the senior management of the Trust, and we are delighted to learn that our recommendations have been accepted in full and that many of the suggestions we made have already been implemented while others are in the pipeline.

The main text of this report and the recommendations we drew up relate to the situation in the ward in February. In this final report, we have included in full the detailed response to each of our recommendations which we have received from Deborah Wheeler, who joined the Trust as Director of Nursing in August 2016 (see pp.3-7).

We hope that the improvements which have been put in place since our visit are making a real difference to the experience of patients and their carers, and we look forward to visiting again in 2017 to see the progress which has been made.

Recommendations for the management of North Middlesex University Hospital NHS Trust, with response from Deborah Wheeler, Director of Nursing and Midwifery.

1. ***Therapeutic support****: we recommend that consideration is given to increasing the amount of specialist therapeutic support available to patients on Pymmes Zero ward. (p.10)*

   Response: I have arranged to meet with the Head of Therapies. I will be discussing support to the Care of the Elderly wards with him, so that I can fully understand the current position. You will see under recommendation 10 that we will also be undertaking reviews of our staffing for the Care of the Elderly wards, and I will be including therapy support as part of this.

2. ***Dementia care****: we recommend that a comprehensive Trust-wide dementia strategy and action plan should be drawn up and implemented; family carers of people with dementia should be involved and invited to contribute their ideas. Consideration should be given to creating a dementia specialist nurse practitioner post, and all staff working on wards with a high proportion of elderly patients should receive in-depth training in dementia care. Relatives who want to stay with patients who have dementia, or who are confused or frightened, should be supported to do so. (p.12)*

Response: the Trust does have a dementia strategy, which has been in place since 2013. It is therefore in need of a refresh and update. A Dementia Strategy Steering Group was set up in January 2016, and Healthwatch Enfield has been a member of that committee since June 2016. The group has been overseeing the initial action plan that was developed in 2016. We have recently advertised for a lead nurse in dementia, which is a new post for the Trust; in the meantime I have asked the nurse consultant in dementia from UCLH whether she would be able to come and offer us some expert advice and support with the strategy, action plan and ward priorities. The ward has already begun to run study sessions on dementia awareness for all staff, led by one of our Practice Development Nurses. Approximately half the staff have attended one of these to date, and there are further dates arranged so that the remainder can attend. The ward manager has been working with his staff to review how they can best support or enable relatives to stay overnight when appropriate. This will also become part of a wider piece of work I have planned to review our visiting times across the hospital.

3. ***Aids and equipment**: we recommend that prompt action is taken to harmonise the equipment used to support patients in Pymmes Zero Ward with the equipment being supplied by local council Occupational Therapy (OT) departments to support patients in their own homes after they have been discharged. (p.14)*

   Response: we will look to raise this with our commissioners, as we don't manage the community services. The ward manager has advised me that the discharge team can, however, now order equipment for both Enfield and Haringey residents ahead of discharge, which has speeded up the process. It is not always possible to have exactly the same equipment in hospital as would be used in the community, for example our hospital mattresses are of a different and higher specification than would routinely be used in the community. Andy has been working with his team to ensure that relatives and carers are given full explanations and information about equipment, for example that the mattress may look different, before the patient is discharged home.

4. ***End of life care**: We recommend that the Trust develops and implements a clear strategy for end of life care, based on best practice. Patients (where possible) and relatives should always have the implications of a Do Not Attempt Resuscitation (DNAR) notice explained to them, and should always be informed if a decision is taken not to attempt resuscitation. Every effort should be made to ensure patients reaching the end of life can have a private room, if they so choose, to facilitate visits and overnight stays from family members of any gender. (p.16)*

   Response: The three Care of the Elderly wards, including Pymmes 0, introduced the use of the IPELC (individualised plan for end of life care) approximately two months ago. This now means there is better information available for relatives, to support discussion with staff. The Trust DNAR (do

not attempt resuscitation) forms have also been revised to improve recording of information, with better prompts to ensure good communication with relatives. We do try to make side rooms available for people at the end of life, but we recognise that this is not always possible. We have a limited number of side rooms, and patients who have an infection must take precedence, for clinical reasons. The staff on Pymmes 0 have established good contacts with our palliative care specialist nurses, who visit the ward to support the care of patients at the end of their life. Some families prefer their relative to remain on the ward, as they can feel shut away in a side room, and staff also work to respect this.

5. ***Individual patient nursing care plan templates**: we recommend that the individual patient nursing care plan templates are reviewed and redesigned, to ensure greater consistency and to remove the need for multiple records all relating to the same aspect of care. Different kinds of communication difficulties should be distinguished from each other and specific templates drawn up accordingly. New templates should be created for patients with dementia and for those who are approaching the end of life. A new template should be created to record and address emotional and mental health needs. (p.18)*

   Response: Your points about the nursing documentation are well made. I have identified that there could be better coherence in our nursing documentation; there are too many individual pieces of paper and multiple forms. I am therefore setting up a complete review of all nursing documentation across the Trust, which the Deputy Director of Nursing will lead. We have already made some initial changes to the nursing assessment booklet, and have updated a number of the care plans, including the introduction of one specifically for care of the elderly. End of life care is covered by the IPELC document as described above.

6. ***Activities**: we recommend that a variety of individual and group activities should be offered to patients. These could include puzzles, knitting, arts and crafts, reading, audio books, memory boxes, sensory boxes or bags, reminiscence activities etc. Volunteers could be recruited to assist in providing these activities, under the supervision of the occupational therapist. (p.19)*

   Response: Our estates team have already undertaken some initial work on the dayrooms in all three care of the elderly wards, to make them better environments for patients, including those with dementia. This will enable the wards to make better use of them for activities, as they are now separated from the staff office areas. We are working on a plan to improve the activities available for patients, including the use of reminiscence boxes and recruiting volunteers to help with co-ordinating activities for patients.

7. ***Carer support**: we recommend that the Carers' Passport Scheme information leaflet should be revised and updated at the earliest opportunity. Staff from*

Enfield Carers Centre could be asked to contribute their suggestions. (p.21)

Response: the ward manager has confirmed that the Carers' Passport is well used on the ward by staff, and that they also have information available about Enfield Carers' Centre. We do still need to update the general information leaflet for carers, and I have asked my Deputy Director of Nursing to lead on that.

8. ***Communication**: teams should be encouraged to explore how best to facilitate good communication between doctors and family carers/relatives; where appropriate, families should be asked to nominate an individual relative to liaise with staff. (p.22)*

   Response: I will be starting a programme of work over the next few months to review our vising times and consider extending them, which amongst other things will give relatives better access to discussions with medical staff. In the meantime, the ward do encourage relatives to visit during the day outside the regular visiting hours and to be present for ward rounds so that they can be part of the discussion about the plans for care.

9. ***The environment**: Pymmes Zero ward should be redecorated and made dementia-friendly as a matter of urgency. Fabric curtains should be replaced by disposable curtains. The day room should be reserved for use by patients and visitors. Appropriate accommodation should be allocated for staff to hold meetings and for their administrative duties. (p.23)*

   Response: Pymmes 0 Ward is currently undergoing a refurbishment, with the staff and patients temporarily relocated to Ward T4 to facilitate this. The day room will be altered as described above so that staff don't access office areas through it. There will also be a quiet room available next to the day room, where staff can have discussions with relatives. Office accommodation for staff, including doctors and therapists, is also being improved. The ward expects to move back in early October.

10. ***Staffing and recruitment**: we recommend that the practice of 'central' recruiting should be reviewed, in order to recruit and retain staff who are interested in care of the elderly. Incentives including protected time for mandatory and specialist training should be considered. Staffing numbers should be reviewed to ensure that there are enough nurses to provide care, to attend training and meetings and to accompany the doctors when they are doing their rounds. (p.26)*

    Response: I am working with our HR team to look at how we recruit staff, to ensure we do this as effectively as possible. We are currently advertising for experienced nurses to work across all our medical wards, including care of the elderly, and will be interviewing at the end of September. I do agree that ward managers should be interviewing for their own staff. We are also about to introduce a daily acuity and dependency report for

every ward; this will list the level of care that each patient requires and give us "real-time" information to assess our staffing numbers against. I have also enrolled the Trust in a national Rapid Improvement Collaborative to improve the management of e-rostering, so that we make sure we use our existing staff as efficiently as possible. This programme has just commenced and the Matron for Care of the Elderly is one of our nominees on it, with the intention that we implement the learning in the care of the elderly wards first.

11. ***Raising concerns**: senior management should adhere to the procedures outlined in the Trust's Raising Concerns Policy. (p.26)*

    Response: We are actively encouraging staff to report all concerns using the Trust's central reporting system, "Datix". All reports for the previous 24 hours are reviewed at a meeting each morning, chaired by either the medical director or myself. This ensures that appropriate action is taken in response to each incident. I have also requested a summary of all incidents reported relating to staffing over the last six months, so that I can identify key themes, and assure myself that action has been taken.

Recommendation for Hertfordshire Adult social care

Every effort should be made to expedite arrangements for appropriate care at home for patients who are medically ready for discharge. (p.14)

Recommendations for Enfield and Haringey Clinical Commissioning Groups and Enfield and Haringey Councils

1. *We recommend that a review is undertaken to ascertain whether frequent re-admissions may be the result of patients being discharged before they are fit enough to manage at home, and whether or not services in the community are sufficient to ensure that frail elderly people can be kept safe, and have their fluctuating health needs met, in their own homes. (p.15)*

2. *We recommend that all patients who have been identified as approaching the end of life, including patients with dementia, should receive a fast track assessment for Continuing Healthcare, to enable more people to die at home, with appropriate palliative care, if that is their preference. (p.17)*

The Enter & View Team

The Authorised Representatives who took part in the visit were Elisabeth Herschan, Janice Nunn, Noelle Skivington, and Lucy Whitman (team leader).

General information

Pymmes Zero ward is one of three wards at North Middlesex University Hospital designated as "care of the elderly" wards, all of which are located in the Pymmes building. All patients admitted to these wards are aged 75 or over. Pymmes Zero and Michael Bates wards are for female patients only, while Charles Coward ward is exclusively for male patients. Each ward has beds for 29 patients.

The matron with overall responsibility for the care of the elderly wards is Mary Butler, and the ward manager of Pymmes Zero ward is Andy Lang.

We were told that most patients are admitted to these wards after transfer from A & E or the Older Persons' Assessment Unit (OPAU). The most common reasons for admission are because they have a urinary tract infection or chest infection, atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) or vascular problems etc. Patients tend to have a number of comorbidities (different health conditions at the same time). We were told that patients usually stay in the ward between one week and one month; their medical treatment is usually complete within one or two weeks and longer stays are often due to delayed discharge.

Methodology

A team of four Enter and View Authorised Representatives from Healthwatch Enfield visited the ward and engaged in conversation with patients, relatives and staff, focusing on the following five key areas:

1. Physical and mental health care
2. Personal choice and control
3. Communication and relationships
4. The environment
5. Staffing and management

The team also asked patients who are resident in the borough of Enfield, and their relatives, if they wanted to comment on any care the patients had received in their own home from care providers or community health services.

As part of our preparation for the visit, we consulted the Care Quality Commission's 2014 inspection report on North Middlesex University Hospital NHS Trust[1].

Before we came for our formal visit, one of the team members went to meet the Elderly Care Matron, Mary Butler, ten days earlier. (The Ward manager Andy Lang was on leave at this time.) This was because we wanted to find out how the ward

[1] http://www.cqc.org.uk/location/RAPNM

is organised, and discuss how to plan the Enter & View visit in such a way that it would not be disruptive to the patients or interfere with their care and treatment. Some of the factual information provided in this report, about how the ward is organised and managed, was given to us in this preliminary meeting. We then sent some posters for display, and letters to be distributed to all current patients and their relatives, announcing our imminent visit, along with the Healthwatch Enfield "Tell us your story cards", inviting patients and relatives to contact us with any comments about care on the ward. When the full team arrived for the visit, we met Andy Lang for the first time and two members of the team spent some time in conversation with him. During our visit we also spoke with 4 patients, 5 relatives, 1 therapist, 1 healthcare assistant (HCA), 2 nurses, 1 administrator, 1 junior doctor.

We noted that all the patients appeared to have been informed about the visit and had received the "Tell us your story" cards.

This report has been compiled from the notes made by team members during the preliminary meeting and the visit, and the conclusions and recommendations agreed amongst the team after the visit. The recommendations also appear at the appropriate point in the report, close to the relevant pieces of evidence. In making our recommendations we have borne in mind the findings and recommendations included in a number of recent national reports on care of the elderly, care of people with dementia and end of life care.[2]

A draft of this report was sent to the management of Pymmes Zero ward and North Middlesex University Hospital NHS Trust, to be checked for factual accuracy and for an opportunity to respond to the recommendations prior to publishing.

This report will be published on the Healthwatch Enfield website, and will be sent to interested parties (including the Care Quality Commission and the relevant clinical commissioning groups and local authorities).

Acknowledgements

Healthwatch Enfield would like to thank the people we met at Pymmes Zero Ward, including the elderly care matron, the ward manager, ward staff, patients and relatives, who welcomed us and whose contributions have been very valuable.

Disclaimer

This report relates to the service viewed on the date of the visit only, and is intended to be representative of the views of the patients, relatives and staff who met members of the Enter & View team on that date.

---

[2] For example:
National Dementia Strategy, DoH 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
National Audit of Dementia Care in Hospitals 2012-2013, Royal College of Psychiatrists et al, 2013
http://www.rcpsych.ac.uk/pdf/NAD%20NATIONAL%20REPORT%202013%20reports%20page.pdf
Counting the Cost, Alzheimer's Society 2009
https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=787
Fix Dementia Care: Hospitals, Alzheimer's Society 2016
https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2907

Key area 1: Physical and mental health care

To find out whether patients' physical and mental health needs are met

Do patients feel well looked after, and do carers feel the care on the ward is good?

We heard a mixture of comments about the quality of care on the ward. Several patients and family carers expressed very positive views. One patient said she found the staff "lovely and helpful". Another patient told us that treatment by staff was very good, she "loved all of it, and staff were very helpful". One family carer told us that she found the staff on Pymmes Zero ward "very caring and supportive". Another family carer said the nursing care was "good".

On the other hand, we also heard some concerns expressed about the quality of care. We heard from two people that staff on the ward were sometimes "rough". A family carer told us that their relative has a lot of bruises and said she complains that staff are rough with her in the shower. A different patient showed us that her arms were bruised, and said this had happened on the ward. However, she did not elaborate on this. Unfortunately, we were not able to follow up these accounts on the day of the visit. (See *Dealing with serious incidents and concerns* on p.13.)

We were told that the doctors carry out ward rounds each day. There is a multi-disciplinary team meeting (MDT) each weekday and a full MDT with the consultant once weekly. However, the nurses informed us that they are not always free to accompany the doctors on their rounds, so may not always have the opportunity to contribute to the patient review. (See recommendation 10 on p.25.)

Specialist nursing and rehabilitation services e.g. physiotherapists, occupational therapists etc

There is one physiotherapist and one occupational therapist (OT) for this ward. We heard that the physiotherapist relies on other staff to support her and sometimes needs to bring in physiotherapists from other wards. We were told that most of the OT's time is taken up sorting out discharge arrangements, and she does not have much time to spend with patients, or provide absorbing activities for them. This means that patients sometimes feel bored, which could contribute to low mood and slower recovery times.

Recommendation 1
Therapeutic support: *we recommend that consideration is given to increasing the amount of specialist therapeutic support available to patients on Pymmes Zero ward.* (See response on p.3.)

(See also recommendation 6 on p.19.)

Access to specialist dementia support

A high proportion of patients in Pymmes Zero ward have dementia, and the ward manager told us that patients with dementia tend to stay on the ward longer than patients who do not have dementia. [3]

We understand that a good deal of work was previously done at the Trust to raise awareness about the needs of patients with dementia, led by consultant geriatrician Sophie Edwards. However, there is no dementia specialist nurse consultant at North Middlesex University Hospital, and there does not seem to be a dementia strategy or specific guidance in force at present. It appears that weaknesses with regard to dementia care identified in the 2014 Care Quality Commission Inspection report have yet to be fully addressed.[4]

We were told that all staff have received dementia awareness training; however, it appears that this training is general awareness delivered in a one hour session, rather than an in-depth course designed for staff who are working in a care of the elderly ward where a high proportion of the patients have dementia.[5]

The ward manager told us that a lot of staff had been booked on to a more advanced dementia care course last year (provided externally), but that unfortunately the course had been cancelled. They have put in another bid for the same training this year. We also heard that some staff have attended a hand massage course which is valuable for patients with dementia.

We understand that there is a dementia champion, who has received enhanced training, on every ward in the hospital. Unfortunately, on the day of our visit, the dementia champion for Pymmes Zero ward was not on duty.

There is a large dementia information board on the ward corridor. Staff use the "Ten important things about me" form for patients with dementia[6]. This includes

---

[3] Research over the past ten years indicates that at any given time, at least a quarter of hospital beds are occupied by people with dementia, with a significantly higher proportion in care of the elderly wards. It is also known that on average, patients who have dementia stay in hospital more than twice as long as other patients aged over 65, and "often leave hospital with poorer health and wellbeing than when they arrived".
See Alzheimer's Society reports: *Fix dementia care: hospitals* (2016) available here: https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2907
and *Counting the cost* (2009) available at:
https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=787

[4] http://www.cqc.org.uk/location/RAPNM

[5] "All staff should be dementia aware; those delivering care should receive dementia training appropriate to their role." *Fix Dementia Care: Hospitals*, Alzheimer's Society 2016

[6] A slightly different version of this form, Eight important things about me, can be found here: http://www.rcpsych.ac.uk/pdf/NAD%20CCQI%20event%20120713%20Dementia%20Champions%20-%20Kingston%20Hospital.pdf
An alternative in use in many hospitals is "This is me", published jointly by the Alzheimer's Society and the Royal College of Nursing, available here:
https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1290

"The person who knows me best and looks after me is… Please let them come in and support me when I need it."
In a care of the elderly ward, where many of the patients may be confused and frightened (and where some may not speak English), we believe that family carers/relatives should not be discouraged from staying with patients and keeping them company. Carers can play a valuable role, helping to keep their relative calm and carrying out or assisting with non-clinical tasks, which can support the work of the ward staff.

It is increasingly recognised that people with dementia or delirium in hospital benefit from the reassuring presence of familiar people around them. The case for permitting relatives "to stay with people with dementia in hospital" is set out in detail on the website for *John's Campaign*[7] which was founded by the author Nicci Gerrard after the sad decline of her father during a hospital stay. 290 hospitals or hospital wards around the country have now signed up to *John's Campaign*.

We are aware that the Trust has recently re-established its dementia steering group in order to focus on improving this aspect of care. We hope that the dementia steering group will bear in mind the following recommendation, which reflect best practice identified in a series of major reports.[8]

Recommendation 2
Dementia care*: we recommend that a comprehensive Trust-wide dementia strategy and action plan should be drawn up and implemented; family carers of people with dementia should be involved and invited to contribute their ideas. Consideration should be given to creating a dementia specialist nurse practitioner post, and all staff working on wards with a high proportion of elderly patients should receive in-depth training in dementia care. Relatives who want to stay with patients who have dementia, or who are confused or frightened, should be supported to do so.* (See response on p.4)

Good nutrition and hydration

We were able to observe patients having their lunch. We could see that the red tray system (which identifies patients who may need help with eating) is in operation. A number of patients were able to feed themselves, but others were being helped by staff. Patients were eating a variety of food including soup, pasta, chicken and vegetables, with fruit or yoghurt for dessert. All patients had small cups of squash as well as water. After their meal they were offered tea or coffee and asked if they wanted sugar.

---

[7] http://johnscampaign.org.uk/#/

[8] *National Dementia Strategy*, DoH 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
National Audit of Dementia Care in Hospitals 2012-2013, Royal College of Psychiatrists et al, 2013 http://www.rcpsych.ac.uk/pdf/NAD%20NATIONAL%20REPORT%202013%20reports%20page.pdf
Counting the Cost, Alzheimer's Society 2009 https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=787
Fix Dementia Care: Hospitals, Alzheimer's Society 2016 https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2907

One of the patients confirmed to us that water is readily available at all times.

Dealing with serious incidents and concerns

We asked the ward manager to explain how any serious incidents are dealt with. He mentioned two recent cases: in one case a patient had fallen and sustained a fracture; in another case a patient had developed a pressure ulcer. He said these incidents are investigated and once the investigation is complete he speaks to the relatives and then the learning is shared with the team. He said there is a new regular "safeguarding learning from experience session" and one of his team is expected to attend this. However, he said that there are often not enough nurses to be able to release them for meetings of this kind.

After our visit, we asked the manager for his comments on the reports of bruising, mentioned above on p.7. He expressed his regret that he had not been made aware of these concerns earlier on. He explained the system for dealing with such an incident as follows: *If a patient or relative reported that bruising had appeared while the patient was on the ward, then the nurse in charge would be told, either by the patient/relative or by another staff member. Once a concern like this is raised, an incident form would be completed and the incident would be investigated either by the ward manager or by a more senior nurse. If the bruising is suspicious and cannot be explained (many of our patients receive blood thinning injections/medications that can cause extensive bruising) then a SOVA (safeguarding of vulnerable adults) alert would be completed and sent to social services. Safeguarding alerts can be completed by any staff member, and they are encouraged to do so. All staff receive safeguarding training as part of their induction to the Trust and this is a mandatory requirement. The training is then re-taken every two years. Junior staff would usually get the support of the senior nurse on duty when doing a SOVA. The bruising would be documented in the medical notes and all staff are encouraged to ensure they document bruising so as to ensure there is a record of this. We would get photographs of the bruising (more so in the case of extensive bruising and suspicious bruising) to ensure there is evidence of this.*

We also told the ward manager about another case. A family carer told us they had made a verbal complaint about the way their relative was treated, in an undignified and inconsiderate way, when she was taken to another department for a diagnostic test. We did not find out exactly who the complaint was made to, and the ward manager was unaware of this incident. He explained the system for dealing with such an incident as follows: *If we are made aware of the incident on the ward we would complete an incident form and send to the appropriate investigating officer. Ward staff are not usually present when patients have [diagnostic tests]. This means we may not actually see the incident but would report it as an incident and inform the family/patient we have done so. The concerns of the family/patient should also be entered into the patient's notes on the ward so the MDT are aware and there is a record of the concern in writing.*

In this case it would appear that the verbal complaint was not followed up in accordance with this procedure, as no one had informed the ward manager about it.

Discharge procedures

The elderly care matron told us that there is a thorough discharge procedure. We were told that an occupational therapist (OT) usually assesses the patient and will recommend a care package on the basis of this assessment. The occupational therapist contacts the family to discuss the arrangements. Occasionally the occupational therapist will visit the patient's home before they are discharged.

We were given a copy of a checklist used when arranging discharge for patients. The manager told us that approximately 70% of patients are discharged back to their own home. Others may go to a rehabilitation ward such as Capetown ward at Chase Farm or Magnolia Unit at St Michael's, or move into a care home.

Most patients in Pymmes Zero ward are residents of Enfield or Haringey, but some are from Hertfordshire. This complicates discharge arrangements as ward staff have to liaise with adult social care teams in several different local authorities to ensure that an appropriate care package is in place before the patient goes home. We were told that there are some social workers from Enfield based on the premises, and that social workers from Haringey sometimes attend the multi-disciplinary team meeting (MDT), but it is harder to liaise with social workers from Hertfordshire as they do not have a presence at North Middlesex University Hospital. It takes longer to arrange a care package and installation of any necessary equipment for Hertfordshire residents and this often leads to delayed discharge.

Recommendation for Hertfordshire Adult social care
Every effort should be made to expedite arrangements for appropriate care at home for patients who are medically ready for discharge.

Equipment needed at home after discharge is categorised as either "nursing led" or "occupational therapist led". Some equipment provided in the community is different from what the patient has experienced in hospital, which may delay discharge. The special mattresses delivered to people's homes are different from those used in hospital and families need to learn how to use them.

Recommendation 3
Aids and equipment*: we recommend that prompt action is taken to harmonise the equipment used to support patients in Pymmes Zero Ward with the equipment being supplied by local council Occupational Therapy departments to support patients in their own homes after they have been discharged.* (See response on p.4.)

For Enfield residents, a 'Home from Hospital' service is provided by local voluntary sector organisations; they accompany patients home if they live on their own and do not have family involved, to make sure that there is food in the house etc.

What measures are taken to reduce the likelihood of repeat admissions?

We heard that quite a few patients are repeat admissions, following falls, infections etc. The ward manager pointed out that community services are not provided 24/7, and said that if someone's condition deteriorates in the middle of the night, they are often readmitted via A & E.

Recommendation 1 for Enfield and Haringey Clinical Commissioning Groups and Enfield and Haringey Councils
We recommend that a review is undertaken to ascertain whether frequent re-admissions may be the result of patients being discharged before they are fit enough to manage at home, and whether or not services in the community are sufficient to ensure that frail elderly people can be kept safe, and have their fluctuating health needs met, in their own homes.

End of life care

We heard that very few patients come into the ward with an advance care plan or a decision as to whether they wish to be resuscitated if they experience a cardiac arrest. In some cases, we understand that an advance care plan is drawn up in consultation with patient and carers when the patient is admitted to the ward. Without an advance care plan it is more difficult to ensure that a patient's wishes – as to whether or not resuscitation should be attempted, or where they would prefer to die - are adhered to.

We understand that doctors sometimes initiate "Do Not Attempt Resuscitation" (DNAR) forms, which are kept in patient notes, but were told that relatives are not always informed when this is done. This mirrors the national situation identified in a recent report by the Royal College of Physicians.[9]

The elderly care matron told us that the nursing team identify patients who are approaching the end of life, and where possible they organise a family conference as soon as possible to agree how to support them. The patients in question usually have advanced dementia or a heart problem.

The manager told us that the consultant and other doctors are usually very good at dealing with end of life, and comfortable talking to the relatives. He commented on the careful judgement that is needed for the team to recognise when a patient is dying, at which point palliative care is needed, rather than continued medical interventions. It is often the more experienced nurses who recognise that a patient has reached this stage, and the manager encourages the nurses to tell the doctors if they have observed signs that the patient is likely to die soon.

We heard that ward staff have no specialist palliative care training. The manager said he encourages less experienced nurses to work with more experienced nurses to learn how to care for a dying patient.

The hospital palliative care team are based in the oncology department and deal mainly with patients with cancers. They can provide support to patients on

[9] http://www.bbc.co.uk/news/uk-36184760 ; https://www.rcplondon.ac.uk/news/new-rcp-end-life-care-audit-shows-steady-progress-care-dying-people

Pymmes Zero ward, but the manager said he feels that patients dying with advanced dementia are less likely to get specialist support. We were told that the palliative care nurse used to attend multi-disciplinary team (MDT) meetings in the ward but no longer does so.

We heard that ward staff try to support the relatives of patients who are dying, including making it possible for them to stay overnight. However, this can be a problem if the patient is on the main ward (not in a side room) and a relative of the opposite gender wishes to stay, as this can cause a breach of the rules regarding mixed sex wards.

There are four side rooms, all en suite, on Pymmes Zero Ward, which can be used for patients at end of life if they want a private room, but on the day of our visit, all four were being used for infection control.

Overall, we formed the impression that dying patients and their relatives are treated with care and compassion on Pymmes Zero ward, but we were concerned to find that staff appeared to be unaware whether any specific strategy or protocol for end of life care had been put in place at North Middlesex University Hospital, as recommended in the national guidelines which were published after the Liverpool Care Pathway for the Dying Patient was phased out in 2014.[10]

We were told that if a patient approaching the end of life is discharged so that they can die at home, the ward staff will make referrals to the community palliative care team and the district nurse service and a community prescription is provided. We asked if patients are always offered the choice to go home to die, and the manager said this does not always happen. This is also noted in the 2014 Care Quality Commission Inspection report on North Middlesex University Hospital. We heard that one of the main reasons for delayed discharge and for patients not dying in their preferred place is that the Continuing Healthcare team at Enfield Clinical Commissioning Group do not always accept fast track referrals for patients dying with advanced dementia.

Recommendation 4
End of life care*: We recommend that the Trust develops and implements a clear strategy for end of life care, based on best practice. Patients (where possible) and relatives should always have the implications of a Do Not Attempt Resuscitation (DNAR) notice explained to them, and should always be informed if a decision is taken not to attempt resuscitation. Every effort should be made to ensure patients reaching the end of life can have a private room, if they so choose, to facilitate visits and overnight stays from family members of any gender.* (See response on p.4.)

[10] ***One chance to get it right***, Leadership Alliance for the Care of Dying people, 2014.
https://www.gov.uk/government/news/new-approach-to-care-for-the-dying-published
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/450391/One_chance_-_one_year_on_acc.pdf

Recommendation 2 for Enfield and Haringey Clinical Commissioning Groups and Enfield and Haringey Councils
We recommend that all patients who have been identified as approaching the end of life, including patients with dementia, should receive a fast track assessment for Continuing Healthcare, to enable more people to die at home, with appropriate palliative care, if that is their preference.

Key area 2: personal choice and control

To find out whether the care is truly person-centred

Do patients feel informed and involved in decisions about their care and treatment?

One patient told us she had received a full explanation of her treatment plan. Another said that they tell her what is happening, and that she had been given enough information so far.

Do the individual care and treatment plans reflect the needs, abilities and wishes of the patients?

The manager told us that individual, handwritten care plans are kept in the patient's bedside folder, along with observations etc. The main medical notes and multi-disciplinary team records are kept at the nurses' station. We were informed that the senior nurse on duty at the weekend reviews all completed care plans.

We were given blank copies of about a dozen different 'Individual patient nursing care plan' templates, which are intended to help staff provide personalised care based on the patient's individual needs. Templates received included those for: communication difficulties, dehydration, falls, pain control, pressure sores, visual impairment etc. We are aware that we did not see copies of all the care plan templates and forms in use; however, based on the samples which we were given, we make the following observations:

The templates lack consistency – at least three different formats are in use – and in some cases there appear to be both older and newer versions of the same care plan in circulation. On many of the forms, there is an instruction to carry out a nursing intervention and then sign that it has been done, but in most cases these interventions are not "one-offs", and need to be repeated and recorded each time, along with any new observations or information. For example, the pressure sore care plan includes the following nursing interventions:

- *Assist the patient to change position and move them into a comfortable position, ensuring that the position is changed every two hours.*
- *If the patient is admitted with a pressure sore, document the location, size and grade of the sore completing Datix if the sore is Grade 2 or above.*

- *Dress any pressure sore with a suitable dressing and ensure that a separate care plan is completed. Document the type and frequency of dressings.*

All of these interventions require further documentation and it seems it would be easier for staff if there was one document covering all aspects of pressure sore care, rather than multiple different records.

There is one template for patients who may have communication difficulties. This form does not distinguish between the additional communication needs of different groups of people such as those who are not fluent in English, those who are profoundly Deaf and use British Sign Language (BSL), those who are hard of hearing, those who have had a stroke, people with learning disabilities, people with dementia etc.

It was noticeable that there was no specific care plan template for patients with dementia (the manager checked and did not find one on the system) or for those approaching the end of life.

We did not see any care plan templates relating to mental, emotional or cultural needs. However, we got the impression that all patients/families are asked to complete the '10 important things about me' sheet (see p.11), which gives them an opportunity to say something about the patient as a person and record some of their preferences.

Recommendation 5
Individual patient nursing care plan templates*: we recommend that the individual patient nursing care plan templates are reviewed and redesigned, to ensure greater consistency and to remove the need for multiple records all relating to the same aspect of care. Different kinds of communication difficulties should be distinguished from each other and specific templates drawn up accordingly. New templates should be created for patients with dementia and for those who are approaching the end of life. A new template should be created to record and address emotional and mental health needs.* (See response on p.5)

How are the needs of patients with dementia, sensory impairment or other disabilities identified and met?

There is currently no flagging system to identify patients who have dementia. (In other trusts, the forget-me-not or butterfly symbol is used next to the patient's name on the ward whiteboard, and/or above the patient's bed to discreetly identify patients with dementia.) We understand that there are plans to adopt the "forget me not" symbol at North Middlesex University Hospital.

The manager told us that if a patient is deaf they will write this on the board above the bed. He said he was not aware that any BSL user had stayed in the ward. However, many elderly patients have significant hearing loss. Therefore, there needs to be a good awareness amongst all staff about how to communicate with people with hearing impairment, to make sure such patients understand and can consent to their treatment, and do not miss out for example when cups of tea are offered. We are aware that there is a Deaf patients' working party at North

Middlesex University Hospital, and understand that deaf awareness training is to be provided to frontline staff. We heartily endorse this initiative. [11]

Are cultural needs and preferences identified and supported?

Many ethnicities and language backgrounds are represented both amongst the staff and the patients.

We were told that for patients whose English is limited, Languageline (interpreting and translation service) is used for medical or social worker consultations, but that family members, or staff from the same language background, are sometimes asked to interpret informally for patients.

Is there a good choice of food, meeting individual dietary requirements and preferences?

One patient told us that the choice of food was "OK", and said, "It's enough to keep you alive". However, one family carer commented that the choice of food on the menu is "limited" and does not cater for people from all cultural backgrounds.

Is there a good choice of planned activities where appropriate?

We heard that patients get very bored and "there is nothing to do". There are no activities offered except for scheduled sessions with the physiotherapist and occupational therapist.[12]

Patients on this ward do not have televisions, and a relative told us "This is the first time there has been a radio on the ward."

Recommendation 6
***Activities**: we recommend that a variety of individual and group activities should be offered to patients. These could include puzzles, knitting, arts and crafts, reading, audio books, memory boxes, sensory boxes or bags, reminiscence activities etc. Volunteers could be recruited to assist in providing these activities, under the supervision of the occupational therapist.* (See response on p.5.)

[11] The deaf patients' working party was formed in response to recommendations made in the joint report by Healthwatch Enfield and Enfield Disability Action on *Improving the experience of deaf patients in Enfield*.
http://www.healthwatchenfield.co.uk/sites/default/files/improving_services_for_deaf_patients_in_enfield.pdf

[12] The Alzheimer's Society's ***Fix Dementia Care: Hospitals*** report highlights as good practice the approach at Kingston Hospital where "the hospital runs therapeutic activity sessions for patients with dementia every day, including painting, listening to music, craft, knitting and jigsaw puzzles. These sessions are led by hospital staff along with a group of trained dementia activity volunteers."

Key area 3: information, communication and relationships

To find out about communication and interaction between patients, staff and relatives

Kindness, compassion and human warmth

The manager impressed us as being very caring and committed. The staff we spoke to all appeared enthusiastic about their jobs and keen to give good care and support. Comments from patients and carers were mixed, as reported above (p.10).

Response time to call bells

We received mixed comments about whether call bells were answered promptly.

One family carer said that in their opinion the ward was "understaffed", and there were not always sufficient staff to assist patients to the toilet. This person said their relative had waited 50 minutes to go to the toilet on one occasion, and 35 minutes on another occasion. This person said they had witnessed patients who had wet themselves while waiting for assistance. On the other hand, one of the patients we spoke to told us that if she needs a bedpan then she rings for assistance, and there had been "no problem" with this.

What information is provided to patients and carers?

We saw that there were a number of noticeboards in the corridors, including a dedicated noticeboard for carers, with a variety of informative posters and leaflets on display.

We were given a copy of the *Welcome pack* which every patient admitted to a ward at North Middlesex University Hospital should receive. This is a plastic pouch containing many useful items including: an information booklet, an eye mask, ear plugs, a toothbrush and small tube of toothpaste, a pen and a small note pad.

The 32-page booklet is nicely produced and contains plenty of useful information including "our values and behaviours", "life on the ward", "helping us reduce the risk of infection", "food and drink on the ward", "your visitors", "preparing to go home" etc. We were impressed with this booklet and regard it as a good practice model which could be emulated in other Trusts.[13]

The booklet contains information for relatives and carers, including mentioning the Carers' Passport scheme which provides concessionary parking and other benefits for those who need to visit on a frequent basis. Separate information about the Carers' Passport is also available at the Nurses' station.

[13] The booklet can also be found on the Trust website: http://www.northmid.nhs.uk/Patients-Visitors/Inpatient-Information

Although the Carers' Passport leaflet contains useful information as to how carers are supported at North Middlesex University Hospital, we found that much of the information it provides about charities which support carers is inappropriate and out of date. Most of the organisations listed are national, rather than local, and some are based in Bristol or Nottingham. There is no mention of Enfield Carers Centre, or their dedicated Hospital Support worker who regularly attends the hospital, or of the Carers Hub in Haringey, nor of the Carers Trust which is the national umbrella organisation to which most local carers' centres are affiliated. Many of the organisations listed are for carers of people with learning disabilities, and organisations supporting carers of people with other conditions such as dementia are not mentioned.

Recommendation 7
Carer support: *we recommend that the Carers' Passport Scheme information leaflet should be revised and updated at the earliest opportunity. Staff from Enfield Carers Centre could be asked to contribute their suggestions.* (See response on p.6.)

Do relatives/carers feel informed and involved?

Communication with families appears to be variable.

One family carer said they had not received any information when their relative was admitted to the ward. Another family carer told us they hadn't been given much information about their relative's condition.

Two family carers told us they had been invited to complete the "Ten important things about me" form for their relative.

One family carer said they did not feel involved in their relative's care; this person was concerned about their relative's medication, and had been trying to arrange to speak to a doctor for several days (from Thursday to Tuesday) without success.

However, two family carers said that doctors were available to speak to.

We spoke with a doctor who told us that they were so busy, looking after 29 patients, that it was hard to find the time to talk to families. One problem was that in some instances, relatives do not agree amongst themselves who should be the family spokesperson, and several different relatives all expect to talk to the doctor separately. We were told that carers can make an appointment to speak to a doctor, but sometimes it is not possible to find a convenient time, as relatives often visit in the evenings, when doctors are off duty.

We appreciate that doctors have a heavy workload and that their clinical work has to take priority. However, we believe that good two-way communication with carers and relatives is a vital part of ensuring the best outcomes for frail elderly

patients.[14] We have heard of a system operating in some hospitals, whereby the doctors make themselves available to talk with families at a certain time each day, for example, 3pm. Relatives who wish to speak to the doctor can then make arrangements to attend at that time rather than simply hoping to meet the doctor "on the off chance" that they will be around at the time that they visit.

Recommendation 8
***Communication**: teams should be encouraged to explore how best to facilitate good communication between doctors and family carers/relatives; where appropriate, families should be asked to nominate an individual relative to liaise with staff.* (See response on p.6.)

Are relatives/carers free to visit at any time?

Visiting hours are from 2-8. However, the ward manager said that if a patient is very unwell, confused, disorientated, agitated or approaching the end of life, or has very limited English, ward staff have discretion to allow family members to stay with them at all times, including overnight.

However, see comment and recommendation 4 on p.16 regarding difficulties if the family member is of a different gender from the patients in the ward.

One family carer we spoke to told us that visitors are not encouraged to come before 2pm. A couple who were visiting their relative told us that generally they can "sneak in" before visiting time "without a problem". This suggests that families are not informed that they may be permitted to visit outside official visiting hours.

What practical and emotional support is available for carers?

The Hospital Support Worker from Enfield Carers Centre[15] makes regular visits to North Middlesex University Hospital including the care of the elderly wards, and can provide advice and information. A Carers' passport scheme is in place, as mentioned above.

Response to concerns or suggestions made by patients or relatives

There was a noticeboard in the corridor with a "You said we did" section. One item read: "**Patients said**: *ward could do with a redecorate*. **We did**: *we are arranging for the ward to be redecorated in a dementia friendly way*." However, no dates were given, and we were told that the ward has been on the waiting list to be redecorated for 14 months.

[14] See the reports on dementia care already cited, and also: ***The Triangle of Care - Carers Included: Best practice in dementia care*** Royal College of Nursing and Carers Trust, 2013. http://static.carers.org/files/the-triangle-of-care-carers-included-best-practice-in-dementia-care-final-6870.pdf

[15] Email: hospitalsupport@enfieldcarers.org

Key area 4: the environment

To find out whether the physical environment is pleasant, clean, comfortable, safe, facilitates movement and good interaction between people.

We were told that the three care of the elderly wards were designed for 24 patients each, with four patients per bay plus four individual rooms. They now have to accommodate 29 patients each, with five patients in each bay. (By comparison, when we visited a stroke and neurological rehabilitation ward at Chase Farm Hospital, they had reduced the number of beds per bay from five to four. This gives patients more privacy, and more space for equipment.)

The manager told us most of the beds on this ward are new and of a good standard. We noticed that the curtains around the beds are made from cotton fabric, rather than being modern disposable paper curtains. We were told that they are changed about every six months, or more often if they are visibly soiled. We were concerned that this poses a risk of infection.

The four side-rooms were all being used for patients in "enteric isolation" (those being kept in isolation because of an infection of the gut). A student nurse gave a good account of infection control procedures around care of patients in isolation.

We checked out a few of the toilet facilities which were clean and tidy. There were sanitisers around the ward and at the entrance. There were plenty of seats for visitors. A notice above every bed states, "Two visitors at a time".

We noticed at one point that a large hoist had been placed directly in front of a double fire exit door. Afterwards we noticed that it had been moved.

There is a pleasant day room, but the whole time we were there it was being used for staff to write reports or have meetings. We did not see patients or families using the room. The occupational therapist pointed out a small office adjacent to the day room but said it was not big enough for all staff to use.

Pymmes Zero ward has not been decorated for some years, and the Trust recognises that it needs to be redecorated and redesigned to be more dementia-friendly. Michael Bates and Charles Coward wards have already been upgraded, but Pymmes Zero is still on the waiting list. The manager told us he has put the poor state of decoration on the risk register as he regards it as unsafe and unhygienic.

On our way out, some members of the team looked around one of the other wards in the Pymmes building in order to compare the physical environment. This ward has been redecorated and made more dementia-friendly and more cheerful. Brightly coloured paint has been used, with contrasting colours to emphasise door frames and other features. Signage on the toilets is clear, and clocks show the day and date as well as the time. The ceilings and general décor appeared much better than Pymmes Zero. However, we noticed that fabric curtains were still being used.

Recommendation 9
The environment: *Pymmes Zero ward should be redecorated and made dementia-friendly as a matter of urgency. Fabric curtains should be replaced by disposable curtains. The day room should be reserved for use by patients and visitors. Appropriate accommodation should be allocated for staff to hold meetings and for their administrative duties.* (See response on p.6.)

Key area 5: staffing and management

Leadership
We gained the impression that the manager is experienced, enthusiastic and a good team-leader, committed to provide a caring service. He told us he has worked in care of the elderly all his career (10 years), and has been manager of this ward for two years. He gave many examples of how he personally mentors and coaches less experienced staff, working alongside them, and encourages individual staff to develop professionally. The manager told us that the elderly care matron is supportive and fully engaged, but commented that senior executives at the Trust rarely come on to the wards to see what's going on.

Staff numbers, recruitment and retention and use of bank or agency staff

We were told that the full staff team for each of the three elderly care wards is:

- Ward manager (senior sister, band 7), who is responsible for care on the ward; expected to spend 50% time on clinical care; 50% on management duties
- 3 deputies: band 6
- 12 registered nurses band 5
- 12 or 13 healthcare assistants (one more may be permitted if they have a higher than usual number of patients with dementia.

We are aware that there is a problem of recruiting permanent staff across the Trust and across London, and we were told that it is particularly hard to recruit staff for the care of the elderly wards. The matron told us that at the time of our visit there were vacancies for 5 registered nurses on each of the care of the elderly wards, 15 in all. They also need more healthcare assistants. Where possible, vacancies are covered by bank staff. In some cases, staff can be "borrowed" from other wards to fill gaps. The matron said the Trust was doing a big recruitment drive, including specifically for care of elderly wards.

Each shift is supposed to have 4 Registered Nurses, in addition to the ward manager, and 4 healthcare assistants. However, on the day of our visit the notice board showed that the ward was short of 2 healthcare assistants. When we asked if this was a common occurrence, we were told it happened two or three times a week, which gave us great cause for concern. The manager said that he is short of 4 HCAs on his permanent staff, and that it is not always possible to cover these vacancies with bank staff, although they always try to do so.

The manager told us that there is a high staff turnover, especially of healthcare assistants. Recruitment at North Middlesex University Hospital is done centrally,

and new staff are allocated to wards where there is a shortage. The manager told us that newly recruited staff do not always want to work in a care of the elderly ward and sometimes move on to a different type of ward at the first opportunity, six months later. However, he said there were seven nurses on the ward with more than three years' experience here.

Staff shift patterns and skills mix

Staff work 11-hour shifts (excluding their breaks) and handovers are paid. The matron confirmed that they try to have a good skills mix amongst the staff allocated for each shift, and bear this in mind when working out the roster.

We were told that most staff do a mixture of day and night shifts, which seems to work well. The manager works office hours and is not allowed to work overtime at weekends on his permanent contract, as that would be too expensive. He is able to work additional shifts at weekends through the bank system (at a lower rate). He said he always tries to ensure that a band 6 nurse is on duty at weekends and if possible each night; otherwise, an experienced band 5 nurse.

Staff training

The 2014 Care Quality Commission report on North Middlesex University Hospital NHS Trust stated that fewer than 50% staff had completed their mandatory training. The manager estimated that the figure on his ward is now about 74%. He said it was a battle to get everyone fully trained. We heard that staff don't get protected time for professional development; this means they may have to undertake training in their own time. The high turnover of staff also means that some start training but do not manage to complete it.

We asked how the Trust tries to ensure all staff are fully compliant with mandatory training requirements and we were told that if staff keep missing training opportunities they are "performance managed". We heard that there is a possibility that in future training may be linked to annual increments – in other words, staff who are not fully trained would not receive their increment.

All new staff are required to do the Trust induction programme which includes a one-hour session on dementia, using 'Barbara's story', a film produced at Guys and St Thomas's.[16] Staff are not required to do any other dementia training. The manager has applied to do a dementia care training course which will require day release. We understand that no specialist training for care of the elderly is offered at North Middlesex University Hospital.

We heard that about half of the healthcare assistants have relevant qualifications when they are appointed; others are trained on the job. We spoke to a healthcare assistant who said she had done all her mandatory training; she had done some online and some by attendance at group sessions, for example for manual handling and CPR (cardiopulmonary resuscitation; emergency procedure for those experiencing a cardiac arrest).

[16] http://www.guysandstthomas.nhs.uk/education-and-training/staff-training/Barbaras-story.aspx

Recommendation 10
***Staffing and recruitment**: we recommend that the practice of 'central' recruiting should be reviewed, in order to recruit and retain staff who are interested in care of the elderly. Incentives including protected time for mandatory and specialist training should be considered. Staffing numbers should be reviewed to ensure that there are enough nurses to provide care, to attend training and meetings and to accompany the doctors when they are doing their rounds.* (See response on p.6.)

Staff supervision and support

All the members of staff we spoke to appeared happy and said they enjoyed working with this team.

The manager told us there is a whole team meeting every two months, where he tries to ensure that learning is shared, for example after a serious incident. He says he has an open door policy and encourages staff to come and talk to him if they need to. He told us he is very hands on and tends to support and supervise by working alongside staff as mentioned above, rather than having supervision meetings with them. He said he would have an individual supervision meeting with a staff member if necessary, and mentioned that he had recently done so with an healthcare assistant after an issue arose the previous week. He told us staff have an annual appraisal and 90% have currently been appraised.

There is a ward managers' meeting across the hospital every two months.

The manager told us the staff on the ward have a night out together every few months.

Raising concerns

The manager said he tried to encourage an open culture where staff would tell him of any concerns. The healthcare assistants who we spoke to told us that if she had any concerns, she would report it to the nurse in charge, and said she was confident that her concerns would be properly dealt with. As mentioned above (p.13), there have been two recent clinical incidents which the ward manager has had to investigate and bring to a conclusion by seeing the relatives and reviewing procedures.

However, the manager told us that on a recent occasion, when a concern was raised with senior management about short staffing, putting patient safety at risk, this was not dealt with appropriately. This had been reported as a serious incident, but five weeks later, no reply had been received. We were given a copy of the Trust's "Raising concerns" policy, which states that "All concerns must be given full and sympathetic consideration" and that "The outcome of the investigation together with details of any action taken should be notified to the member of staff by the manager within 28 calendar days of the initial discussion."

Recommendation 11
***Raising concerns**: senior management should adhere to the procedures outlined in the Trust's Raising Concerns Policy.* (See response on p.7.)

Conclusion

At the time of our visit in February 2016, we formed the impression that Pymmes Zero ward is well-led and that the matron, manager and team all strive to provide high quality compassionate care to frail elderly patients, albeit in rather challenging circumstances. We noted some examples of good practice in the ward, which we would like to commend, including an open culture amongst the team; the mentoring of less experienced staff by those who have more experience; and a well-designed welcome pack.

Comments from patients and carers we met during our visit were mixed. Some patients and their relatives told us that care in the ward is good, while others said that staff are not always gentle, and that at times there are not enough staff to provide prompt attention when patients require assistance.

The physical environment in this ward is poor, and accommodation is cramped for patients and staff. There are persistent staff shortages which may compromise patient care and safety. All the patients in the ward are over 75, and although many of them have dementia and some are approaching the end of their lives, no specific Trust strategies for the care of people with dementia or for end of life care are currently in force. Not all staff have completed their mandatory training, and few if any have received in-depth training in care of the elderly, dementia care and end of life care. Provision of specialist therapeutic support appears to be minimal. Additionally, patients sometimes experience delayed discharge, due to local authorities being unable to arrange appropriate care packages in the community. The fact that most of these problems are long-standing suggests to us that that insufficient attention, at senior management level, has been paid in recent years to ensuring that the experience of elderly patients admitted to North Middlesex University Hospital is of the highest quality.

In the light of the challenges to recruiting and retaining sufficient numbers of high quality staff to work in the care of the elderly wards, we suggest that the practice of 'central' recruiting to all teams should be reviewed and other approaches considered. A determined effort should be made to recruit nursing staff who are keen to work in this field, and they should be supported to attain professional accreditation in nursing care for the elderly, dementia care and end of life care.

Since our visit, there have been significant changes in the senior management of the North Middlesex University Hospital NHS Trust. We have now received a detailed response to our draft report, and are delighted to learn that our recommendations have been accepted in full and that many of the suggestions we made have already been implemented while others are in the pipeline.

We hope that the improvements which have been put in place since our visit are making a real difference to the experience of patients and their carers, and we look forward to visiting again in 2017 to see the progress which has been made.

Appendix
Patients' and carers' experiences of care at home in Enfield

We had hoped to speak to several patients from the borough of Enfield about any experiences they had had of care at home. However, we found that most of the people who were able to speak to us on the day were not Enfield residents.

One family carer said that their relative (a resident of Enfield) had previously been receiving care at home, first from the Enablement Team and then through an agency. They said the administration side of the business was "dreadful". They found that the care workers often arrived up to three-quarters of an hour late, including at mealtimes. One evening the care worker arrived so late that the family carer had already helped their relative to bed.

Healthwatch Enfield will bear these comments in mind as part of our ongoing work on adult social care.

What is Healthwatch Enfield?

Healthwatch Enfield is an independent organisation which exists to represent patients and service users. Our job is to make sure local people's voices are heard by those who design and deliver services. We are part of a national network of Healthwatch organisations.

What does Healthwatch Enfield do?

- Healthwatch Enfield is here to help secure improvements to services such as GP practices, dentists, opticians, pharmacies, hospitals, care homes and day centres.
- We work on behalf of the local community, children, young people and adults.
- We provide information about the health and social care system.
- We collect the views and experiences of local people about health and care services; what works well and what needs to be improved.
- We have formal powers called 'Enter and View' so we can go and see for ourselves how adult health and social care services are working.
- We have a place on bodies like the Health and Wellbeing Board and we attend the Clinical Commissioning Group. This enables us to influence the way services are planned, commissioned and delivered.
- We work with local Healthwatch organisations in neighbouring boroughs because their residents share some services with Enfield residents.
- We pass on information and recommendations to Healthwatch England, to the local Council and the Care Quality Commission.

Further information about Healthwatch Enfield can be found on our website: www.healthwatchenfield.co.uk

Healthwatch Enfield
311 Fore Street
London N9 0PZ

Email: info@healthwatchenfield.co.uk; Phone: 020 8373 6283

Healthwatch Enfield is registered as a Community Interest Company no 08484607 under the name of Enfield Consumers of Care & Health Organisation CIC.

What is Enter and View?

Healthwatch Enfield has the authority to carry out **Enter and View** visits in health and social care premises to observe the nature and quality of services. This is set out in Section 225 of the Local Government and Public Involvement in Health Act 2007.

Enter and View is part of our wider duty to find out what people's experiences of local health and social care services are, and use our influence to bring about improvements in those services. We can hold local providers to account by reporting on services and making recommendations.

Further information about Enter and View is available on our website: http://www.healthwatchenfield.co.uk/enter-and-view