

Requires improvement 

Derbyshire Healthcare NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

London Road Community Hospital, DE1 2QY
Cubley Court, Kingsway site, DE22 3LZ

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXMF4	London Road	Wards 1 and 2	DE1 2QY
RXM14	Kingsway site	Cubley Court	DE22 3LZ

This report describes our judgement of the quality of care provided within this core service by Derbyshire Healthcare NHS trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Derbyshire Healthcare NHS trust and these are brought together to inform our overall judgement of Derbyshire Healthcare NHS trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated wards for older people with mental health problems as **requires improvement** overall because:

- Staff had not completed all cleaning records to show that staff had cleaned all areas of the wards.
- Some staff needed training in the use of strategies for crisis intervention and prevention.
- Some staff had not recorded observations of patients' physical health needs.
- Staff did not always apply the Mental Capacity Act correctly and some staff did not fully understand how it related to the patients they cared for.
- Staff had not correctly recorded all documents relating to the Mental Health Act.
- Some staff were not aware of what to do if a patient who was not detained under the Mental Health Act wanted to leave the ward.
- Staff had not recorded the discharge plan for each patient and showed that planning began at the point of admission.
- Not all staff had received specialist training so they knew how to care safely for all patients.
- Staff had not offered all patients a range of activities to interest them and meet their need.
- Managers had not regularly supervised all staff.
- Staff had not fully completed records and assessments relating to the Mental Capacity Act.
- The wards for older people with mental health problems were now meeting Regulations 13 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Summary of findings

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

Are services safe?

We re-rated safe as **requires improvement** because:

- We found at this inspection that staff were not consistently aware of the process for allowing informal patients to leave the wards at will.
- In June 2016, there was no clear evidence that patients were being risk assessed prior to utilising Section 17 leave. In January 2017, we saw that staff did not consistently complete a risk assessment of patients before the patient used their Section 17 leave.
- Staff had not completed all cleaning records to show that staff had cleaned all areas of the wards.

However:

- The service had addressed the issues that had caused us to rate safe as inadequate following the June 2016 inspection.
- In June 2016, we found that a staff had made a safeguarding alert regarding the alleged theft of an individual patient's money. Managers had not investigated the possible links of this alert with alleged thefts and losses of patients' belongings over a four-year period. At this inspection in January 2017, we found that the trust had trained staff in safeguarding and all staff knew how to make a safeguarding alert. The trust had put systems in place to reduce the risk of patients' belongings going missing. In addition, the trust had systems in place to make sure that all staff learnt lessons from incidents to reduce the risk of them happening again.
- At our previous inspection, we saw that risk management plans were basic in formulation and lacked identification of strategies to reduce risk. At this inspection, we found that staff assessed patients' risks and followed the strategies identified to reduce these.
- In June 2016, rooms in Cubley Court had ligature points (fixtures and fittings that patients could use for tying or binding as a means of hanging oneself). Risk assessments did not contain plans to mitigate the risk to patients. In January 2017, we saw that managers had reviewed environmental risks and agreed funding for work to reduce these risks.
- At our previous inspection, electronic patient records were incomplete and not accessible to all members of the multidisciplinary team. At this inspection, the trust ensured that this had been addressed.

Requires improvement



Summary of findings

Are services effective?

We re-rated effective as **requires improvement** because:

- At our previous inspection, care records did not show that staff had followed the Mental Capacity Act. At this inspection, in five of the records that we reviewed at London Road Hospital, there was limited evidence available to demonstrate the reasons patients had an assessed lack of capacity.
- The trust had not provided staff at Cubley Court with the specialist training they needed to care for patients.
- Some staff needed training in the use of strategies for crisis intervention and prevention.
- Staff at Cubley Court had not completed all records relating to patients' physical healthcare needs.
- The trust had not provided nursing assistants with training in the care certificate standards.
- Managers had not regularly supervised staff.

However:

- The service had partly addressed the issues that had caused us to rate effective as inadequate following the June 2016 inspection.
- At our inspection in June 2016, care records did not show why 'Do Not Attempt Resuscitation' orders were in place. At this inspection, records we looked at clearly identified the reasons for this order.
- At our previous inspection, structured therapies were not available or detailed in care records. At this inspection, records we looked at showed where psychological therapies were used and the outcome of these for the patient.
- At our previous inspection, care records did not show that staff had followed the Mental Capacity Act. At this inspection, records at Cubley Court showed that staff had assessed patients' capacity to make a decision, and where needed, the decision was made in the patient's best interests.
- In June 2016, there was no clear evidence that audits in relation to the application of the Mental Health Act or Mental Capacity Act were in place. In January 2017, we saw that there were monthly audits.
- At our previous inspection, staff did not explain to patients' their rights under Section 132 of the Mental Health Act. At this inspection, staff had explained these to patients regularly.

Requires improvement



Summary of findings

Are services caring?

Good



- Following our inspection in June 2016, we rated the service as **good** for caring. Since that inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Good



We re-rated responsive as **good** because:

- The service had addressed the issues that had caused us to rate responsive as requires improvement following the June 2016 inspection.
- In June 2016, there was no information on display about how patients and carers could complain. At this inspection, we found that patients knew how to complain and staff responded to these and improved the service as a result.
- In January 2017, we found that community rapid response teams responded well to patients' needs in the community to reduce admissions to the wards.

However:

- At our inspection in June 2016, records did not show that staff planned patients' discharge. At this inspection, we observed that staff discussed patients' discharge in handovers and multidisciplinary meetings however, they did not record this in patients' records we looked at.
- We observed that staff did not offer all patients activities suitable to their interests and needs.
- The environment at Cubley Court was not fully adapted to meet the needs of patients living with dementia.

Are services well-led?

Requires improvement



We re-rated well led as **requires improvement** because:

- Care records at London Road did not adequately record the reasons for decisions made in the best interests of patients. Reasons for assessing patients as lacking capacity to make their own decisions were also not clear within care records. The leadership of the trust had not addressed these issues, despite there being evident gaps in the recording of capacity assessments.
- Staff had not recorded where they had explained to patients their rights under Section 132 of the Mental Health Act.
- Audits had not identified where records lacked detail in relation to the Mental Health Act and Mental Capacity Act.
- Managers had not supervised staff regularly.

Summary of findings

- The trust had not provided staff with the specialist training that they needed to meet patients' needs.

However:

- The service had partly addressed the issues that had caused us to rate well led as inadequate following the June 2016 inspection.
- At our inspection in June 2016, staff did not have a full understanding of the Mental Capacity Act. In January 2017, staff knowledge and understanding of the Mental Capacity Act had improved. Records we saw at Cubley Court recorded the reasons why staff assessed the patient to lack the capacity to make decisions and why decisions were made in their best interests.
- At our previous inspection, managers at London Road hospital had failed to link a safeguarding alert made in 2015 with other reported allegations of theft and loss made dating back four years. At this inspection, we found that systems to monitor safeguarding incidents had improved.
- In June 2016, we found that staff had lost a degree of faith in the trust leadership team because of a high profile employment tribunal in 2015 that had criticised individual staff within the trust board. In January 2017, staff told us they had moved on from this. All staff we spoke with were aware of the trust's vision and values and demonstrated the core value of aspiring to deliver excellence.

Summary of findings

Information about the service

Wards 1 and 2 at the London Road Community Hospital admit both men and women. Both have 16 beds for assessment and treatment of people over the age of 65 with functional mental health problems such as depression, schizophrenia, mood disorders or anxiety.

Cubley Court is a 36-bedded assessment and treatment unit for both men and women with an acute organic illness, such as dementia who require a period of assessment. There is one ward for men (Cubley male) and one ward for women (Cubley female).

When the CQC inspected the trust in June 2016, we found that the trust had breached regulations. We issued the

trust with five requirement notices for wards for older people with mental health problems. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

The team comprised one inspection manager, seven inspectors, one assistant inspector and one expert by experience (a person who has experience of caring for a relative living with dementia). The lead inspector was Sarah Bennett.

Why we carried out this inspection

We undertook this inspection to find out whether Derbyshire Healthcare NHS Foundation Trust had made improvements to its wards for older people with mental health problems since our previous comprehensive inspection of the trust on 6-10 June 2016.

When we inspected the trust in June 2016, we rated wards for older people with mental health problems as **inadequate** overall. We issued a warning notice to the trust that required improvements to be made.

We rated the core service as inadequate for safe, effective and well led; as requires improvement for responsive; and as good for caring.

Following the June 2016 inspection, we told the trust that it must take the following actions to improve wards for older people with mental health problems:

- The trust must ensure that learning from incidents and safeguarding alerts are captured in a way that allows managers to identify themes and trends in order to keep people who use the service safe.
- The trust must ensure that potential themes or hot spots that relate to patient safety are captured on the trust risk register in order for the executive team to be fully aware.
- The trust must ensure that Mental Capacity Act documentation and assessments are fully completed and filed correctly in patients' records. The provider should also ensure that staff apply the Mental Capacity Act correctly and that they fully understand how it relates to the patient group that they are caring for.
- The trust must ensure that documentation relating to section 17 leave is completed, up to date and filed correctly.

Summary of findings

- The trust must ensure that detained patients are reminded of their rights under Section 132 of the Mental Health Act on a regular basis.
- The trust must ensure that the discharge process is properly documented and that it demonstrates that planning begins at the point of admission.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 11 Need for consent
- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 17 Good governance

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection, we reviewed information that we held about wards for older people with mental health problems and requested information from the trust. This information suggested that the rating of good for caring, that we made following our June 2016 inspection, was still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as inadequate for safe, effective and well led and as requires improvement for responsive.

During the unannounced inspection visit, the inspection team:

- visited all four wards at the two hospital sites, looked at the quality of the ward environment, and observed how staff were caring for patients.
- spoke with nine patients who were using the service and four of their relatives/carers.
- spoke with the managers or acting managers for each of the wards.
- spoke with 22 other staff members, including doctors, nurses, occupational therapists and volunteers.
- attended and observed three hand-over meetings.
- looked at 13 care records and 18 medicine charts of patients.
- carried out a specific check of the medication management on four wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients told us that the food was good and staff offered them choices about their food.
- Patients and their relatives said they knew how to make a complaint. One relative said that when they had made a complaint, this had improved the service offered.
- Patients said they took part in different leisure activities on the ward, such as games, quizzes, arts and crafts.

Areas for improvement

Action the provider MUST take to improve

- The trust must provide training to staff so they can safely meet the needs of all patients.
- The trust must ensure that managers regularly supervise all staff.

Summary of findings

- The trust must ensure that all staff fully complete Mental Capacity Act documentation and assessments. The provider should also ensure that all staff apply the Mental Capacity Act correctly and that they fully understand how it relates to the patient group that they are caring for.
 - The trust must ensure that documentation relating to section 17 leave is completed, up to date and filed correctly.
 - The trust must ensure that detained patients are reminded of their rights under Section 132 of the Mental Health Act on a regular basis
- Action the provider SHOULD take to improve**
- The trust should ensure that all staff complete cleaning records to show that all areas have been cleaned.
 - The trust should ensure that all staff are aware of what to do if a patient who is not detained under the Mental Health Act wants to leave the ward.
 - The trust should ensure that all staff are trained in the use of strategies for crisis intervention and prevention.
 - The trust should ensure that all staff record observations of patients' physical health needs.
 - The trust should ensure that staff offer all patients activities suitable to their interests and needs.
 - The trust should ensure that staff record the discharge process for each patient and that records show that discharge planning begins at the point of admission.
 - The trust should consider how the environment at Cubley Court could be fully adapted to benefit patients with dementia.

Derbyshire Healthcare NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Wards 1 and 2	London Road Community Hospital
Cubley Court	Trust HQ, Kingsway site

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- We looked at eight care records for the purposes of checking adherence to the Mental Health Act (MHA) and the MHA code of practice.
- Staff on Cubley Court told us that they made automatic referrals to an independent mental health advocate when patients lacked the capacity to access these themselves.
- Each ward had a checklist in place to review Mental Health Act documents on admission and staff routinely removed unnecessary paper work.

- Staff demonstrated their knowledge of the different Mental Health Act sections.
- Staff explained to most patients their rights under the Mental Health Act on admission and at regular intervals throughout their stay on the wards.
- There was no clear evidence that staff completed a risk assessment of patients before the patient used their Section 17 leave. This remained outstanding from our previous inspection.
- The staff attendance rate for Mental Health Act training was 88% on Ward 1, 93% on Ward 2 and 100% at Cubley Court.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at eight care records for the purposes of checking adherence to the Mental Capacity Act.
- Adherence to the five statutory principles of the Mental Capacity Act (presumption of capacity, support to help patients make their own good and unwise decisions, making decisions in the patient's best interests and that decision making was least restrictive) was not evident in the five records we looked at in London Road. The patient records indicated a lack of capacity but there was limited evidence available to demonstrate why this was.
- The records we looked at in Cubley Court showed that staff had followed the five statutory principles of the Mental Capacity Act. Records clearly showed how the multidisciplinary team, with the patient and their relatives, had made decisions in the patient's best interests.
- The staff attendance rate for Mental Capacity Act training was 94% on Wards 1, 2, and 100% at Cubley Court.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Staff were not able to observe all parts of the wards. Staff used observations and positioned themselves in areas where they could see all parts of the ward to reduce these risks. Staff also completed individual risk assessments for patients who were at risk of self-harm to minimise these risks.
- The manager and the trust head of safety had updated the ligature (fixtures and fittings that a patient could use for tying or binding as a means of hanging her/himself) risk assessment since our previous inspection. Staff had taken action to reduce the risks of these at London Road by using observation and not allowing patients unsupervised access to rooms where managers had identified risks, for example, in the staff office. At Cubley Court, the trust estates department had agreed funding to reduce risks, for example, replacing taps and door handles with anti-ligature types. Staff on all wards could locate the whereabouts of ligature cutters immediately. This meant that they would be able to cut a patient away from a ligature point quickly in an emergency.
- Cubley Court had separate wards for men and women. At London Road, there were separate lounges for women. The layout of the ward meant that patients did not have to pass bedrooms of patients of opposite sex to reach the bathrooms or toilets.
- The fully equipped clinic rooms were clean, tidy and organised. Staff checked the temperatures of the rooms and fridges daily so that medicines were stored safely. Staff checked emergency equipment at the beginning of each shift to make sure it was available and safe to use. All staff could access the emergency equipment.
- There were no seclusion rooms on any of the wards.
- Housekeeping staff were cleaning the wards during our inspection. Wards were clean, had good furnishings and were well maintained. Patients that we spoke with told us that the wards were clean.
- Staff followed guidelines on infection control and hand washing. The trust had provided hand gel in each area of each ward for staff to use.
- Staff checked and cleaned equipment to make sure it was safe for patients to use.
- Housekeeping staff recorded on three wards where they had cleaned, which showed that staff had cleaned the wards regularly. However, on Ward 1 at London Road, staff had not completed the daily cleaning rota for four days and the weekly cleaning rota three times in December 2016. This meant that it was not clear that staff had cleaned these areas.
- Managers had reviewed environmental risk assessments since our previous inspection and taken action where needed to reduce risks.
- Alarm call bells were not near to patients' beds in their bedrooms at London Road Hospital. If a patient needed to call staff from their beds, patients would use a bell to summon attention. Staff at Cubley Court observed patients when they were in their bedrooms and bedroom doors were locked during the day to promote patients' safety. Staff had risk assessed this for each patient and all patients needed staff supervision to access their bedroom. This meant that patients were safe when they went in their bedroom. We saw that nurse call bells were available for patients to use in communal areas.
- Staff carried alarms to summon help from other staff if needed.

Safe staffing

- Ward managers used electronic rostering to make sure there were registered nurses present for essential monitoring of communal areas of wards and to safely meet patients' needs.
- Managers' set staffing levels at Cubley male were as follows; on the early shift, two registered nurses and six nursing assistants, on the late shift, two registered nurses and five nursing assistants, and at night, one registered nurse and seven nursing assistants. On Cubley female on early and late shift: two registered nurses and four nursing assistants; night: one registered

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nurse and four nursing assistants. During the day, an occupational therapist and the ward manager were available on each ward. Rotas we looked at showed these staffing levels were met. The senior nurse on Cubley female ward told us that the following week three staff would transfer from London Road, which would fill staff vacancies. Managers' set staffing levels at London Road on Wards 1 and 2. On early shift: two registered nurses, three nursing assistants; late two registered nurses and two nursing assistants; night: three registered nurses across both wards and two nursing assistants on each ward. The week after our inspection, the trust planned to merge the two wards for a temporary period due to low patient numbers. The trust's set staffing levels for this were early shift: two registered nurses and four nursing assistants; late: two registered nurses and three nursing assistants; night: two registered nurses and two nursing assistants.

- The trust employed bank staff to fill shifts that were unfilled due to sickness absence. The electronic rostering system automatically sent shift requests to the nurse bank. The system had a facility to request preferred staff. Ward managers tried to book bank and temporary staff known to the wards and rotas we looked at confirmed this. This meant that staff understood ward procedures, were familiar with the patients and managed risk effectively. Ward managers told us the trust bank system rarely failed to fill shifts. This meant there was less frequent movement of staff between wards than at our previous inspection.
- Ward managers were able to adjust staffing levels daily to take account of staff skill mix and patients' needs.
- Staff and patients told us and we observed that a registered nurse was present in communal areas of each ward at all times.
- Staff rarely cancelled escorted leave or ward activities because there was too few staff.
- Doctors told us that at night, there was one junior doctor to cover both sites at London Road and Cubley Court in addition to another of the units in Derby city. However, they said that they could call consultants directly and there was always a senior registrar on call. Staff told us that they could always access a doctor who could attend the ward quickly in an emergency.

- Staff on all wards had received and were up to date with the appropriate mandatory training.

Assessing and managing risk to patients and staff

- We looked at 13 sets of care records. Staff completed a risk assessment of each patient on admission. Staff reviewed and updated these weekly, or as the needs of the patient changed. Staff assessed patients on admission for their risks of falls, safe moving and handling or pressure ulcers and liaised appropriately with tissue viability nurses.

However, at London Road staff had not reviewed risk assessments before patients detained under the Mental Health Act went off the ward on Section 17 leave.

- Staff used the functional analysis of care environments (FACE) tool to assess the patient's risks and needs.
- Staff had imposed few blanket restrictions on patients and encouraged independence on all wards. At Cubley Court, we saw that patients could not access their bedrooms during the day. Staff had completed individual risk assessments for patients that showed the reasons for this. We saw staff enabled patients to go into their bedrooms when they wanted to and staff made sure that the patient was safe. Staff did not search patients on any of the wards.
- At London Road, we saw that the ward doors were locked and staff, patients and visitors could only get on and off the ward using a coded keypad. Staff told us that they verbally told informal patients that they could leave the ward when they wanted to. Staff we spoke with did not know what to do if an informal patient wanted to leave the ward. The locked door policy stated that if non-detained patients had the mental capacity to understand the keypad code, staff would give them this. However, records did not show that staff had used the risk screening or capacity assessment tools to assess this.
- Staff followed the policies for the use of observation of patients. Staff told us that they tried to reduce the amount of time spent observing patients as soon as it was safe to do so. We saw that staff did not follow patients around but spent time talking with the patient when observing them.
- Staff we spoke with told us that they had not used restraint since our previous inspection but used de-

Are services safe?

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escalation techniques to help patients to calm down when needed. There was one recorded incident of restraint at our previous inspection. We observed staff distracting patients when they became upset or agitated. Staff had not reported incidents of restraint on any of the wards.

- None of the wards had used rapid tranquilisation (medicines given to patients who are very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others and allow them to receive the medical care that they need) since our previous inspection. However, appropriate protocols were in place for the use of rapid tranquilisation and these were in line with the national institute for health and care excellence (NICE) guidelines.
- There were no seclusion rooms on any of the wards. Staff told us they did not use other rooms or bedrooms to seclude or segregate patients.
- The trust had trained 97% of staff in safeguarding adults and children from abuse and harm. All staff we spoke with knew how to make a safeguarding referral.
- Staff managed medicines well on all the wards and this had improved since our previous inspection. There were good links with pharmacists. Medicines reconciliation, transport, storage, disposal and dispensing practices were good. On each ward, nurses audited the medicine charts weekly. We looked at these audits on Ward 1 and found that on 31 December 2016 nurses had not fully completed the chart to say they had given medicines on seven occasions. The nurse completing the audit had emailed the nurses responsible and completed an incident form. In the audit staff completed on 8 January 2017, there was only one occasion where the nurse had not completed the medicine form. This showed that audits had improved how staff recorded the administration of medicines.
- The trust provided safe visitors rooms for children that visited the ward.

Track record on safety

- At our previous inspection, we found that the trust had not learned lessons after incidences of alleged thefts and losses of patient's belongings between 2010 and May 2016 at London Road. Staff at director level, despite being aware of the incidents, had failed to link the events together in a systematic approach to safeguarding. There was also no evidence of a safeguarding plan to protect vulnerable patients from further loss of their belongings. Since our previous inspection, the trust had made staff aware of how they were to protect patients from harm. This included checking the safe where patient's valuables were kept at the handover of each shift.
- The trust had not reported any serious adverse events since our previous inspection.
- The trust had notified CQC of one death at Cubley Court and it was being investigated by the Coroner.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to report incidents and had access to the electronic incident reporting system.
- Staff were open and transparent and explained to patients when things went wrong. For example, a relative told us that another patient on the ward had hit their family member. Staff told the relative about this and explained that staff had referred it to the local safeguarding team.
- Staff told us that the trust used their 'blue light' system to tell them about incidents that had happened on other wards or community teams and lessons learned from these. Staff discussed these in team meetings and supervision.
- Staff received a debrief following incidents, and managers and other staff offered them support.
- Managers told us that incident forms went to the risk team and they identified themes, which they fed back to managers. The risk team expected managers to take action within their teams to reduce further incidents.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We saw evidence in 13 care records that staff completed timely assessments with the patient on admission to the ward.
- Eleven of the records showed that staff had completed detailed care plans with the patient and their relatives/carers where appropriate. Care plans were recovery orientated, holistic and person centred. The multidisciplinary team reviewed the care plan during meetings with the patient. However, one record stated that the patient had diabetes and multiple sclerosis but there was not a care plan that showed staff how to support the patient to meet these needs.
- Records we looked at showed that staff had undertaken a physical health examination of each patient on admission. At London Road, records showed and patients told us that staff observed patients' physical health needs daily. At Cubley Court, staff recorded when a patient had a bowel movement. This was important for patients who were not able to communicate this and who could be at risk of constipation. However, staff had not recorded this for several days at a time in three of the patient records seen. At Cubley Court, we observed that staff responded appropriately to one patient's physical health need. They called an ambulance and kept the patient safe and comfortable until it arrived. At Cubley Court, staff used a tabard, which had body parts made of felt to help explain to patients about physical healthcare issues in a way that was easier to understand.
- The trust stored all information needed to deliver care securely on the electronic records system. All staff could access the records so they would know how to care for each patient. Community team staff could also access these records. This helped ward staff to know what contact community teams had with the patient before admission and helped community teams to plan for the patient's discharge.

Best practice in treatment and care

- We looked at 13 care records of patients. Records showed that staff had followed national institute of health and care excellence guidance when prescribing

medication for patients. For example, they considered the age and physical health needs of the patient to ensure that medication prescribed did not have a negative impact on the patient's health and wellbeing. Staff followed the national institute of health and care excellence guidance when treating patients with dementia.

- Psychological therapies were offered to patients, in line with national institute of health and care excellence guidance. Psychologists treated inpatients as a priority and prepared them for receiving psychological interventions in the community following discharge from the ward. Nurses offered cognitive behavioural therapy to patients where appropriate on the wards.
- Staff referred patients to specialists where needed to meet their physical healthcare needs. One patient's records showed that staff had made a referral to a dietician. Another patient's record showed that staff referred the patient to the specialist in Parkinson's disease.
- Dieticians had assessed patients' nutritional needs and nursing staff had followed guidelines where needed. Speech and language therapists had assessed the needs of patients who had difficulty swallowing. Patients' records we looked at showed that nursing staff had followed guidelines where appropriate.
- Staff used the health of the nation outcome scale to assess and record severity and outcomes for each patient on their admission and discharge. These scales measure behaviour, self-injury, cognitive problems and activities of daily living and are designed to help build up a picture of a patient's responses to nursing and medical interventions.
- Clinical staff participated actively in clinical audits. This included medicine records, storage and administration, care records and physical health monitoring. Audits we looked at showed that staff had improved their practice as a result.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Skilled staff to deliver care

- The trust ensured that staff received an induction when they first started working there. However, on Ward 1 only two of eleven nursing assistants and none of the nursing assistants on ward 2 had completed the care certificate.
- Managers had annually appraised all staff at Cubley Court and all but one staff member at London Road.
- Managers had supervised 59% of staff each month on Ward 1, and 77% of staff on Ward 2. Managers and staff at Cubley Court told us that they did not have monthly supervision with their manager. However, they had regular team meetings, peer group supervision and informal supervision, which they did not record.
- Staff at Cubley Court did not receive the necessary specialist training for their role. Staff fed one patient through a tube surgically inserted in their stomach. An enteral feeding specialist had visited the ward and advised that nursing staff needed the training to be competent in this. However, the trust had not provided this training. Some staff had received training in previous roles and shared their knowledge, but the trust had not assessed staff as competent in their current role. We discussed this with the trust at this inspection and they told us they would provide this training so there were sufficient staff members on duty at all times to meet this patient's needs. At London Road, we saw that 73% of staff on Ward 1 had completed the medicines competency booklet and been assessed as competent. Only 50% of staff had completed this on ward 2.
- Managers addressed poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- The staff team included doctors, nurses and health care assistants, occupational therapists and pharmacists. Staff also had access to a local tissue viability nurse, speech and language therapists, physiotherapists and dieticians.
- The multidisciplinary team met on each ward weekly.
- We observed staff handovers between shifts. These were detailed and effective in providing staff with the information they needed about patients' needs.

- Staff in community mental health teams attended multidisciplinary team meetings on the wards. This meant that they knew the needs of the patients before the hospital discharged the patient into the community and helped to plan for this.
- Staff from the dementia rapid response teams visited the wards at Cubley Court and attended multidisciplinary meetings there.
- Patients' records we looked at showed that staff worked with the patient's GP and care homes where appropriate.

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

- On a patient's admission, a competent member of staff examined their Mental Health Act papers. This made sure the patient was legally detained under the Act and staff knew what treatment they needed.
- Staff on all wards knew who the trust Mental Health Act administrators were and how to contact them. The Mental Health Act administrators offered support to staff on the wards to make sure staff followed the Act.
- Staff on the wards kept clear records of leave granted to patients. Patients, staff and carers where applicable were aware of what leave was granted and where the patient could go on leave.
- The trust had trained 88% of staff on Ward 1, 93% on Ward 2 and 100% at Cubley Court in the Mental Health Act. The trust target was 100%.
- Doctors and registered nurses we spoke with showed that they had knowledge of the Mental Health Act, the code of practice and the guiding principles.
- Consent to treatment forms were in place and staff attached these to medication charts where applicable. This meant that nurses were able to administer the medication under the correct legal framework.
- Records of detention of patients were completed, up to date and stored correctly. However, on the electronic records system the Mental Health Act administrators' office had not updated the legal status summary forms for all patients. This could mean that nursing staff were not aware of this for each patient.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff explained their rights to most patients detained under the Mental Health Act on admission and routinely after. However, in one of six records we looked at in London Road, staff had not recorded that they had done this.
- Staff from the Mental Health Act office completed monthly audits to ensure that staff applied the Mental Health Act correctly. There was evidence that staff learnt from these audits as any errors were rectified by the next one.
- Patients who were detained under the Mental Health Act had access to the independent mental health advocacy service. Staff referred all patients detained under the Act to this service.
- We looked at capacity assessments on each ward. At Cubley Court, we saw that staff detailed clearly, why they had assessed that the patient did not have the capacity to make the specific decision. However, at London Road we looked at five assessments of patients' capacity to make a specific decision. None of the assessments clearly stated the decision that the patient needed to make; for example, to spend their money on a specific item or consent to having treatment for a physical health condition. Staff had stated on one assessment, that the patient did not have an impairment of the mind, mental disorder or illness. This means that there is not a reason to continue with the assessment. However, the staff member had completed the rest of the assessment, which showed a lack of understanding of the Act.

Good practice in applying the Mental Capacity Act

- The trust had trained 94% of staff on Wards 1 and 2 and 100% at Cubley Court in the Mental Capacity Act. Most staff had a good understanding of the Mental Capacity Act 2005. However, one registered nurse and one nursing assistant we spoke with did not have an understanding. One doctor told us how they helped staff to learn more about the Act by discussing this in multidisciplinary team meetings and assisting staff to complete capacity assessments for patients. They had also produced guidance for staff on what a good capacity assessment looked like.
- We did not ask for the numbers of Deprivation of Liberty Safeguards applications made in the last six months. However, staff at London Road told us they rarely had to apply for these. Staff kept a log of how many Deprivation of Liberty Safeguards applications they had sent to the local authority for assessment and authorisation if appropriate.
- The trust had a policy on the Mental Capacity Act. Staff told us that they knew where this was and could refer to it when needed.
- Two of the patient records we saw at Cubley Court showed that the multidisciplinary team had followed the Mental Capacity Act. They had involved the patient and their relatives and made a decision in the patient's best interests.
- At Cubley Court, we saw clear, detailed records of where the multidisciplinary team had made a decision that the patient was staff were not to attempt resuscitation if the patient had a cardiac arrest. There was a clear medical rationale for this decision and the team regularly reviewed this so if the patient's medical condition improved the team may revoke this decision.
- Staff knew where to get advice regarding the Mental Capacity Act within the trust. The trust lead for the Mental Capacity Act visited the wards and provided advice and training to staff.
- The trust had arrangements in place to monitor adherence to the Mental Capacity Act.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

- Not inspected at this inspection. This domain was rated good at our inspection in June 2016 and we have received no further intelligence to suggest that this is no longer the case.

Our findings

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Since our previous inspection, the bed occupancy had reduced on all wards. At the time of this inspection, there were 21 patients at Cubley Court with 15 vacant beds. At London Road, there were 18 patients with 14 vacant beds. Staff told us that this was due to the work of the community older people's rapid response teams. The trust set these teams up with the aim of supporting people to continue to live in the community and reduce hospital admissions. The trust planned to merge both wards at London Road for a temporary period, in the week after our inspection, which they would regularly review. Trust managers told us that they could open the closed ward within 48 hours if needed. The trust planned to use their staffing resources to fill vacancies at Cubley Court and to increase staffing in the community rapid response teams.
- At the time of the inspection, there were no patients placed out of area because of bed shortages.
- Beds were available when needed to patients living in the 'catchment area.'
- The average length of stay for patients on older people's wards from April to December 2016 at Cubley Court Female Ward was 56 days; Cubley Court Male Ward 81 days; 59 days on Ward 1; and 75 days on Ward 2. The average lengths of stay for all wards had reduced since our previous inspection.
- Staff prepared patients for the ward merger at London Road by holding activities on one ward so that the surroundings and other patients became familiar. The service manager informed relatives of the move by letter. Staff did not tell patients until nearer the planned move as they thought this would increase patients' anxiety.
- Staff had not completed discharge plans in four of six patient records we looked at in London Road. At Cubley Court, staff had not completed discharge plans in any of the seven records we looked at. However, we observed that staff talked about discharge plans at handovers and with staff from the community team but staff had not recorded this. This remains outstanding from our previous inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- There were rooms available on all wards for therapeutic activity and patients had access to well-maintained outdoor spaces including gardens. The trust provided adapted kitchens on the wards. The occupational therapists assessed patients in these kitchens to plan their discharge home from hospital.
- At Cubley Court, we saw that the sensory room had several chairs in it, which made it look like a storeroom. This meant that patients could find it difficult to relax there. Staff told us that patients rarely used the room. The décor in the green lounge of Cubley Female ward was tired. The walls in the purple lounge were sparse so did not provide stimulation for patients.
- At Cubley Court, there was a large communal lounge. Staff said patients had group activities in there and visitors used this lounge. There was a piano and several small tables and chairs where patients and visitors could sit. The drinks machine in this room was broken. Staff told us that visitors could ask for drinks and staff would make them. However, two visitors we spoke with were not aware of this and said that staff had not offered them drinks during their visits.
- The trust provided cordless phones on all wards so that patients could make a phone call in private.
- Patients told us that the food was good and they always had a choice. Relatives said staff offered a choice of drinks and snacks to patients during the day. At Cubley Court, we saw that the menu was in small print and staff were not able to read it. Mealtimes were displayed in the wards but they were in the 24-hour clock, which could cause confusion to patients.
- Patients were able to personalise their bedrooms if they wanted to. At Cubley Court, staff showed us memory boxes, which each patient had in their bedroom. Staff worked with the patient and their relatives to put items in the memory box that were meaningful to the patient. This meant that staff could engage with the patient and talk with them about their life and the things they liked to do.
- Patients told us that they had somewhere secure to store their possessions.

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

- The trust employed occupational therapists and assistants on each ward from Monday to Friday. The trust had plans to extend activities on each ward to seven days a week. Occupational therapists told us they worked with nursing assistants to help them to plan and lead activities. At Cubley Court, we observed that staff spent time with patients playing dominoes and reading the newspaper. There were no planned activities on the day of our inspection. Staff had not recorded in care records we looked at that the patients took part in regular activities. We saw "twiddle muffs" (a sensory woollen muff with things like laces, bows and buttons to pull and fiddle with) around the ward but did not see staff use these with patients. Therefore, patients who were not able to play games or read did not have activities to do. Staff told us and we saw that the Alzheimer's Society visited and led 'Singing for the brain' sessions there. There were also visitors from the Pat dog scheme. Occupational therapists spoke with us about cognitive stimulation therapy groups that they ran on the ward. However, we did not see records of this or observe any groups during our inspection. At London Road, we observed patients taking part in arts and crafts group. Patients told us they played bingo, games, had quizzes and did arts, crafts, and relaxation groups. Patients also used the kitchen and laundry with staff. Occupational therapists ran cognitive stimulation therapy groups, anxiety management groups and relaxation groups. These groups took place off the ward. On Ward 2, we saw an activity timetable that was blank so it was not clear what activities took place. Staff told us that patients talked about what activities they would like to do in the weekly patients meetings and we saw minutes of these.

Meeting the needs of all people who use the service

- Patients who had mobility difficulties could access all wards. The trust provided accessible baths, toilet chairs and showers.
- The trust provided aids and adaptations for patients who needed assistance with eating and drinking. We saw patients using these where appropriate.
- At Cubley Court, information leaflets were displayed behind the reception desk. Staff said this was due to patients' needs as when they put these leaflets in the

- wards they had been torn and taken off the walls. However, visitors told us they did not really know what information was available and would like the information to be more accessible. Staff gave all relatives a carers and family handbook on the patient's admission to the ward.
- Some signs were on doors such as bathrooms and toilets at Cubley Court.
- At London Road, information was available for patients and relatives in the reception area. This was available in different formats and languages relevant to cultural groups in the local area.
- Staff told us that they had access to interpreters and signers, which the trust provided when needed for patients.
- A multi faith chaplain service was available. Patients who were Christian had access to appropriate spiritual support. Local church groups provided Christian services at Cubley Court and a volunteer chaplain visited the ward. Three patients at London Road told us they could access spiritual support when they wanted it.

Listening to and learning from concerns and complaints

- From April to December 2016, there had been two complaints made about Cubley Male ward. Staff had responded to these and given feedback to the complainant. One relative told us that when they had made a complaint, staff listened to them and the service improved as a result.
- The trust also recorded compliments. From April to December 2016, there had been several compliments recorded about this core service: Cubley Court Male: 22 compliments, Female: six compliments, Ward 1: two compliments; Ward 2: 11 compliments. This meant that staff were aware of what they were doing right and what they needed to do to improve the service.
- All staff we spoke with knew how to handle complaints appropriately and saw them as a way of making improvements.
- Staff received feedback from managers on the outcome of complaints investigation and acted on these findings.

Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff we spoke with understood the values of the trust and agreed with these.
- The objectives of each team reflected the values and objectives of the trust.
- Staff knew who the most senior managers in the trust were and told us that these managers had visited the ward. At the end of our inspection, the trust senior managers visited Cubley Court to receive feedback from us about our findings and showed commitment to make the improvements needed.

Good governance

- The trust provided mandatory training for staff. However, at London Road some staff had received updated training in the Mental Health Act and the Mental Capacity Act.
- Managers appraised all staff annually.
- Managers did not supervise all staff regularly. At London Road, managers had supervised 59% of staff each month on Ward 1, and 77% of staff on Ward 2. Managers and staff at Cubley Court told us that they did not have monthly supervision but had opportunities for development through team meetings and peer group supervision.
- Staff participation in clinical audit was evident. For example, nurses audited medicine charts. This had improved recording to show that patients had received their medicines as prescribed.
- Staff were aware of key performance indicators at a local and national level and ward managers communicated these well through team meetings.
- Ward managers had sufficient authority and administrative support to direct staff.
- Staff were aware of the trust risk register and how to submit concerns that would be fed into a directorate wide register. The electronic incident reporting system sent incident reports to managers and the trust risk

team. The trust risk team identified themes from these, which they fed back to the managers. Managers discussed these with staff in team meetings and supervision to reduce the risk of them happening again.

- Staff reported incidents and managers identified action they would take to reduce risks to patients' safety and welfare.
- Staff learnt from incidents, complaints and patient feedback.
- Staff followed safeguarding procedures. For example, they referred incidents of aggression between patients to the local authority safeguarding team.
- Staff did not follow procedures for the Mental Health Act consistently. For example, staff did not complete a risk assessment for patients before they went on Section 17 leave and did not always record they had explained to patients' their rights.
- Staff at London Road did not follow procedures for the Mental Capacity Act consistently. For example, patient records indicated the patient lacked capacity but there was limited evidence available to demonstrate why this was.

Leadership, morale and staff engagement

- There were no bullying and harassment cases on any of the wards.
- Staff knew how to use the whistle blowing process.
- Staff told us they felt able to raise concerns without fear of victimisation.
- Most staff spoken with said that morale and job satisfaction was good on the wards. Some staff at London Road were unhappy with how the trust had communicated the ward merger to them and did not want to move wards.
- Some staff at Cubley Court thought, as there had not been a permanent manager for five months this had affected teamwork and the monitoring of standards by managers.
- Most staff we spoke with said that there was good teamwork and mutual support.
- A relative told us that staff were open and transparent and explained to patients if something went wrong.

Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Managers offered staff the opportunity to give feedback on services and input into service development.

Commitment to quality improvement and innovation

- The trust participated in national and Midland initiatives, by implementing improvement plans for pressure ulcers in Cubley and London road. The NHS safety thermometer scores were positive for older people's wards. The NHS safety thermometer is a

programme of work to monitor staff performance in delivering harm free care, which includes pressure ulcers, falls, urinary tract infections in catheters and new venous thromboembolisms.

- The staff team participated in the National Institute for Health Research's Health Technology Assessment programme regarding antipsychotic treatment of very late onset schizophrenia-like psychosis.
- Staff participated in the national evaluation of the Dementia Rapid Response Service called "Achieving Quality and Effectiveness in Dementia Using Crisis Teams - a systems support to providing care at home or in a care home.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
How the regulation was not being met:

Staff did not receive the necessary specialist training for their role so they could safely meet all patients' needs.

Staff had not received regular supervision with their manager.

This was a breach of Regulation 18 (2) (a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

How the regulation was not being met:

Staff had not fully completed Mental Capacity Act documentation and assessments at London Road.

Some staff did not apply the Mental Capacity Act correctly or fully understand how it related to the patient group that they cared for.

This was a breach of Regulation 11(1) (3)