Good

Plymouth Community Healthcare CIC

Wards for older people with mental health problems

Quality Report

Local Care Centre
Mount Gould Hospital
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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)
1-297622270	Plymouth Community Healthcare CIC	Cotehele Unit	PL4 7QD
1-297622270	Plymouth Community Healthcare CIC	Edgcumbe Unit	PL4 7QD

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC.

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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

Contents

Summary of findings

Overall summary

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

- Patients on Cothele ward had limited access throughout the day to their bedrooms except for an hour at lunch time. Patients also had to comply with agreed times to get up and go to bed. This was agreed to enable staff to safely monitor the wards which were on two different levels in the building.
- Wards did not have access to doctors employed on the ward outside the hours of 9am to 5pm from Monday to Friday. The wards also did not have access to the provider's junior doctor rota.
- Not all staff had completed basic life support mandatory training.
- Staff did not initial and date when they made changes to the the frequency of modified early warning scores on Edgcumbe ward.
- Staff did not always update care plans following incidents with patients.
- On Cothele ward, doors on patients' bedrooms were not fitted to open in both directions.
- Staff did not monitor the clinic room temperature on Edgcumbe ward to ensure that medicines stored there were kept below the manufacturer's required maximum temperature.
- The wards' ligature assessments did not list dates when work was to be completed to remove risks.
- Staff on Cothele ward had not escalated health findings for two patients to doctors for action, even though the escalation treatment protocol indicated they should.

However:

- The wards were clean, bright and well furnished.
- Staff delivered care and treatment to patients in a kind, caring manner that respected their dignity.
- Staff developed care plans for patients. These included outcomes from assessments for anxiety and memory issues.
- Staff adhered to strong infection control principles and equipment across the wards was well maintained.
- Patients and their families told us they felt safe and cared for on the wards.
- We saw good evidence of clear leadership on both wards. Managers were visible and supported staff when required.
- Staff had received training and had a good understanding of safeguarding on the wards.
- There was a wide range of activities on the wards throughout the week.
- Patients told us that food was good and there was a wide choice.
- Staff worked with patients and their families to deliver individualised care.
- There was a wide range of professionals in the multidisciplinary team providing treatment and care to patients.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There was restrictive practice on Cothele ward with regard to patients' waking and sleeping times. Patients got up at 8am and had breakfast upstairs at 8.30am. They were allowed access to their bedrooms from 1pm to 2pm if they wished. In the evening they went downstairs to sleep after having their evening medicine between 10pm and 10.30pm.
- Wards did not have access to doctors employed on the wards outside the hours of 9am to 5pm from Monday to Friday. The wards also did not have access to the provider's junior doctor rota.
- Not all staff had completed basic life support mandatory training.
- Staff did not monitor the clinic room temperature on Edgcumbe ward to ensure that medicines stored there were kept below the manufacturer's required maximum temperature.
- The wards' ligature assessments did not list dates when work was to be completed to remove risks.

However:

- Wards were clean and well laid out.
- Both wards had separate male and female sleeping and bathing areas and female only lounge areas.
- Staff adhered to strong infection control principles and equipment across the wards was well maintained.
- There were sufficient staff on the wards to care for patients safely.
- Both wards had enough staff so that patients had one to one time with their named nurse.
- There were good observation policies and procedures.
- Staff had good knowledge of safeguarding and safeguarding procedures.
- Medicines were managed safely.
- Patients used pressure relieving mattresses and cushions to reduce the risk of developing pressure ulcers.

Are services effective?

Good

We rated effective as good because:

- Care plans were up to date and recovery oriented.
- Staff recorded patients' physical and mental health.

Summary of findings

- Patients had full, comprehensive assessments on admission.
- Patients' nutrition and hydration needs were assessed and met daily.
- Staff completed malnutrition universal screening tools for patients who were at nutritional risk.
- The wards followed best practice when prescribing medicines.
- The wards had good access to physical healthcare specialists, for example there were strong links with the diabetes specialist.
- The wards had a wide range of experienced and registered mental health staff providing input to the wards.
- Staff received specialist training for their role such as dementia awareness.
- Staff had good knowledge of the Mental Health Act 1983 and its code of practice.
- Staff had good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

However:

- Staff on Cothele ward had not escalated health findings for two patients to doctors for action, even though the escalation treatment protocol indicated they should.
- Staff did not initial and date when they made changes to the the frequency of modified early warning scores on Edgcumbe ward.
- Staff did not always update care plans following incidents with patients.
- On Cothele ward, doors on patients' bedrooms were not fitted to open in both directions.

Are services caring?

Good

We rated caring as good because:

- We observed staff treating patients with care, patience, respect and dignity.
- We spoke with seven patients who all told us that staff cared for them and treated them with respect.
- Staff had a good understanding of patients' needs.
- Staff encouraged and supported patients with specialist eating needs.
- Admission processes helped patients to orientate themselves to the ward.
- Patients were involved in their care planning.
- Families and carers were involved in patients' care.
- Patients were able to give feedback about the care they received

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There were a good range of rooms including activity rooms for patients to use on both wards.
- Both wards had mattresses and chairs to offer pressure relief to patients at risk of developing skin ulcers.
- Both wards had a range of equipment to support patients who were at risk of falls including handling bars and walking frames.
- Both wards had quiet rooms for patients to use and where they could meet their visitors.
- Patients could make phone calls in private.
- Patients on both wards had access to outside gardens which were well kept.
- Patients told us that the food available on the wards was good and varied.
- Patients could store valuables in the office safe.
- Photographs were displayed on the outside of doors and in non patient areas to show patients what was behind the doors.
- Patients on both wards had access to activities seven days per week, for example reminiscence groups, gardening, breakfast and lunch clubs, and crafts.
- Leaflets were available explaining patients' rights, local services, treatments, and how they could complain.
- Patients had access to a range of food on the wards, for example vegetarian and gluten free.
- A chaplain and lay preacher visited the wards each week for patients who wanted to meet them. Staff told us they sometimes escorted patients to attend church on Sundays.

Are services well-led?

Good

We rated well led as good because:

- Staff we spoke to were aware of and understood the provider's vision and values.
- Managers on both wards said they felt supported by senior management.
- All staff we spoke to had received mandatory training.
- Staff were supervised and appraised in line with the provider's supervision policy.
- Staff knew how to raise safeguarding issues within the organisation.
- We saw good evidence of clear leadership on both wards. Managers were visible and supported staff when required.
- Staff told us that team morale was good and there was strong team work.

Summary of findings

- Both wards were AIMS (accreditation for inpatient mental health services) accredited. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided.

Summary of findings

Information about the service

The wards offer support to older people over the age of 65 with mental health support needs.

- Cothele ward has 15 beds and admits older men and women with functional ill health. On the day we visited there were 15 patients on the ward.
- Edgcumbe ward is a 10 bed ward for older men and women with severe organic mental ill-health and challenging behaviour. There were 10 patients on the ward on the day of our visit.

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, executive director of nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection manager: Nigel Timmins, Care Quality Commission

The team that inspected this core service comprised one CQC inspector, two specialist advisors with experience in mental health, and a pharmacist inspector. The specialist advisors included a psychologist and a mental health service manager. The inspection team also included an expert by experience. This is someone who has used, or cared for someone, using a similar service.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

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 visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited two hospital sites and looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with seven patients;
- spoke with seven family members of people who were using the service;
- spoke with the managers for each of the wards;
- spoke with 20 other staff members; including psychiatrists, doctors, nurses, the chief pharmacist, an occupational therapist and a social worker;
- observed two patient business meetings;
- looked at 13 care records of patients;
- carried out a specific check of the medicine management on both wards;
- looked at a range of policies, procedures and other documents relating to the running of the wards;
- looked at supervision and appraisal records for 11 staff members;
- carried out structured observations of interactions between patients and staff.

Summary of findings

What people who use the provider's services say

We spoke with seven patients. They said staff were kind, caring and considerate. Patients told us they felt safe and thought the food was very good. They told us that staff explained why they took medicine and made sure there were lots of activities on the wards for them to join.

We spoke with seven family members of patients on the wards. They said the staff were very caring and professional and involved them when planning care for their family members.

Good practice

Photographs were displayed on the outside of doors and non patient areas on Edgcumbe ward to show patients what was behind the doors.

Cothele ward had talking books and wind up radios for patients to use if they became unsettled at night time. This was used as a distraction technique and staff reported that patients became settled quickly when they listened to the talking books.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients can wake up and go to bed when they want to and have access to their bedrooms during the day.
- The provider must ensure that the wards have doctors employed on site 24 hours daily and access to the junior doctor rota.

Action the provider SHOULD take to improve

- The provider should ensure that all staff complete basic life support mandatory training.
- The provider should ensure that changes in the frequency of modified early warning score should be initialled and dated by staff making the changes to ensure that risk is calculated in relation to patients' physical health.
- The provider should ensure that rationale is documented when staff assess patients' capacity.
- The provider should ensure that care plans are updated following incidents with patients.
- The provider should ensure that staff monitor the clinic room temperature on Edgcumbe ward to ensure that medicines stored there are kept below the manufacturer's required maximum temperature.
- The provider should ensure that ligature assessments list dates when work is to be completed to remove risks.

Plymouth Community Healthcare CIC

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
Cotehele Unit	Plymouth Community Healthcare CIC
Edgcumbe Unit	Plymouth Community Healthcare CIC

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.

- All staff on the wards had training in and had a good understanding of the Mental Health Act 1983 (MHA) and its code of practice.
- Consent to treatment and capacity assessments were adhered to on the wards.
- Staff explained patients' rights to them on admission and routinely throughout their admission. This was documented on their treatment records. Staff told patients their rights again in the presence of their relatives.
- The provider's central MHA team offered administrative support and legal advice to the wards with regards to the MHA and its code of practice. The team carried out regular audits to ensure the MHA was applied correctly.
- Notices were displayed on the locked ward entrance doors explaining the rights of informal patients to leave the ward.
- Detention paperwork was up to date and signed appropriately.
- Patients had access to independent mental health advocacy (IMHA) support through an organisation called Support, Empower, Advocate and Promote. IMHA leaflets were displayed in the reception area of both wards.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff were trained in and had good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff recorded mental capacity for all patients on admission but did not record rationale for how they reached their decisions.
- There was a policy for the MCA and deprivation of liberty safeguards (DoLS) on the organisation's intranet.
- Staff supported patients to make decisions where they had capacity. If a patient lacked capacity other teams and family members were involved to make decisions in the patient's best interest. For example, the occupational therapist and family members were involved in a patient's discharge assessment. We reviewed documentation of best interest meetings for patients. For example, there was evidence of documentation agreeing best interest decisions around covert medication for some patients including pharmacy input on how best to administer the medicine.
- Staff got advice including support around DoLS from the organisation's MCA office. Six patients were subject to DoLS at the time of our visit. Patient paperwork was completed and up to date which ensured appropriate safeguards were in place.

Requires improvement

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

- Both ward areas were clean, appropriately furnished and well maintained. Patients told us that the wards were always clean. Cleaning rotas were visible throughout the wards indicating that cleaning was up to date.
- Layouts of both wards did not allow staff to observe all parts of the wards. However during our inspection, staff were always visible in areas where patients were present. Staffing levels meant that the ward manager always ensured there were enough staff to observe patients at all times.
- The wards had current ligature risk assessments. However, the assessments listed the risks but they did not list dates when the work was to be undertaken to remove the risks. There were some ligature points on the wards and these were managed by staff observation and were noted in the ward ligature audits. Staff had access to ligature cutters on the wards.
- Both wards had separate male and female sleeping and bathing areas. They also had separate female lounges. This meant the wards were compliant with the Department of Health's guidance on mixed sex accommodation.
- Both wards had fully equipped clinic rooms with emergency equipment which was accessed by staff in emergencies. Records showed that the emergency equipment was regularly checked and maintained by staff. The clinic room on Edgcumbe ward was warm and staff did not monitor the temperature. This meant that staff did not ensure that medicines stored there are kept below the manufacturer's required maximum temperature
- Emergency medicine was checked regularly by the pharmacist who visited the wards weekly. All stored medicine we checked was in date.
- Staff adhered to infection control principles. This included ensuring that all visitors washed their hands before entering the ward areas and cleaning ward areas daily. The manager told us that patients had virus checks using urine samples, including a check for MRSA, on admission which meant staff identified infection risk quickly. On one ward a patient was being barrier nursed to protect the rest of the ward from infection risk while they were unwell. The patient was nursed in their room until they were well enough to join the rest of the patients in the communal ward area without risk of spreading infection to staff and patients.
- Equipment across the wards was well maintained. Electrical equipment had electrical testing stickers on them which were in date. Clinical equipment, such as blood pressure monitors and suction devices had cleaning stickers on them which were in date on both wards. Cothele ward used a cleaning rota schedule and Edgcumbe used green stickers to identify when equipment was cleaned. Cleaning was up to date at the time of our visit.
- Cleaning records for the wards were up to date. Cleaning was undertaken by the housekeeping teams during our visits.
- The wards had environmental risk assessments. They included issues such as the garden in Cothele ward and a section of the sensory corridor, which had a small patch of bristles on a wall, in Edgcumbe ward. These issues were managed by ensuring that all patients were observed from a safe distance or accompanied as they moved around the ward which we observed during our inspection.
- All staff carried personal alarms. There were security alarms throughout the wards and in all bedrooms. The ward's alarm system allowed staff to carry alarms throughout the ward and call for assistance if needed. Other staff could find the location of the caller via a display in the main reception office.
- Staff in Edgcumbe ward had access to personal alarms if they were lone working. If staff required assistance, the alarms indicated the staff member's precise location via a global positioning system to the central security office.
- There were nurse call systems across all wards for staff and patients to use if they needed immediate assistance.

Safe staffing

- Staff received mandatory training. The average mandatory training completion rate for staff was 83% which was above the minimum provider level of 80%. Topics such as manual handling, safeguarding children

Requires improvement

Are services safe?

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and safeguarding adults, were included in the mandatory training. The training completion rate for basic life support was 43% which fell below the provider's minimum training completion rate.

- There were sufficient staff on the wards to care for patients' safely. Safe staffing levels were agreed at monthly meetings with the matron, locality managers and finance staff to ensure levels met patient need on the wards. Each ward had a minimum of two registered nurses and three non registered nurses on each morning shift, two registered and two non registered staff on afternoon shifts, and two registered and two non registered nurses on night shifts.
- Safe staffing levels were displayed in the reception area of Edgcumbe ward. Ward managers were able to bring in additional staff if patients' needs changed. We observed that when patients with challenging behaviour were admitted to Cothele, the ward manager brought in additional health care assistants to ensure there was safe staffing to meet the additional patient need.
- The manager at Edgcumbe brought in one additional member of staff for a twilight shift which started at 4pm and ended at 11pm. Staff identified that some patients with advanced dementia became increasingly agitated during these hours and the extra member of staff helped meet additional patient need during these hours.
- The wards used agency and bank staff appropriately, all bank and agency staff used were familiar with the wards and needs of this patient group. All agency staff read the observation and organisation policies before working on the wards.
- Both wards had enough staff so that patients had one to one time with nurses who were allocated to them at the beginning of each day.
- There were enough staff to carry out physical interventions with patients, such as personal care and escorting through the ward environment.
- There was adequate medical cover during the day. This meant that a junior doctor and consultant were available onsite from Monday to Friday (9am until 5pm) but not outside of these hours. The wards were allocated three junior doctors and at the time of our visit they had had only one junior doctor for two months. The matron dealt with recruitment to hire more. Both wards did not have access to the provider's junior doctor rota. An out of hours on call doctor system was available to staff. This meant that staff could phone a medical doctor or psychiatrist if they needed verbal medical support. We saw evidence that an on call doctor attended one evening to carry out a physical health check on a new admission. Doctors were not based nearby and were unavailable to attend in person in an emergency.
- In urgent cases staff called the emergency services. If staff needed advice regarding medicines, the on call doctor gave verbal medicine orders over the telephone. Staff told us they would like to have a doctor available on the ward at night time to address emergencies.

Assessing and managing risk to patients and staff

- There was restrictive practice on Cothele ward with regard to patients' waking and sleeping times. The ward was built on two floors (ground floor and lower ground floor) and the sleeping areas were situated on the lower ground floor. Due to the difficulty of staffing for patients on two floors at the same time, there was a timetable for getting up in the morning and going to bed at night so that staff concentrated their work together on one floor of the ward. Patients got up at 8am and had breakfast upstairs at 8.30am. They were allowed access to their bedrooms from 1pm to 2pm if they wished. In the evening they went downstairs after evening medication between 10pm and 10.30pm to sleep. This practice meant that patients did not have free access to their rooms throughout the day and did not have the choice to sleep into the morning or go to bed earlier if they wished. The manager told us staff were as flexible as possible and risk assessed staffing levels if a patient requested to go to their room at a time outside the timetable. Two patients told us they were frustrated with this practice as they preferred to get up and go to sleep when they wanted.
- For the period August 2015 to January 2016 Cothele ward reported 13 incidents of restraint on five different patients and Edgcumbe reported 46 incidents on 10 different patients. Staff told us that they had restrained a small number of patients who were new to the ward and had challenging behaviour. These restraints were carried out to help administer medicine. Restraints were carried out using approved techniques and body mapping to show where patients had been held.
- We reviewed 13 care records and each had up to date risk assessments. Staff assessed risk of aggression, medicine compliance, self neglect and falls.

Requires improvement

Are services safe?

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

- Staff assessed patients' risk of suicide using a risk management tool.
- Doors to the wards were locked. There was information on the doors for informal patients telling them about their right to leave if they wished.
- There were good policies and procedures for use of observation. Staff adjusted observation check levels depending on patients' needs. Both wards had clear ligature risk assessments which outlined how staff used observation to manage risks on the wards. Staff searched patients' belongings when they first were admitted to the wards and when they returned from leave. Searches did not include body searches. Staff did this to ensure patients were not carrying any banned articles, such as scissors or knives. When staff found banned articles, they locked them away safely and gave them to patients' relatives for safe keeping when they visited. Information was given to patients when they were admitted listing items which should not be brought onto the wards, for example sharp objects such as nail scissors, knitting needles, tweezers, and electrical items which had not had appropriate tests.
- Staff on both wards carried out intentional rounding. This was when staff carried out regular checks with individual patients at set intervals, typically hourly. During these checks, staff carried out scheduled or required tasks. This approach meant that all patients received attention on a regular basis. These checks were carried out in addition to ongoing individual observation and monitoring of patient's safety and wellbeing.
- The wards had a protocol for responding to challenging behaviour in older patients. Restraint was only used after de-escalation techniques had failed. Staff were trained in restraint techniques specific to older people who were frail. These included use of distraction (for example with music or by leading the patient away to a quieter part of the ward) and safe holding of patients.
- When staff used rapid tranquilisation they followed national institute of health and care excellence guidance. Staff carried out physical health observations routinely afterwards to monitor patients' wellbeing. Rapid tranquilisation was used once in the last six months on Edgcumbe ward and almost twice monthly over the last six months on Cothele ward.
- Staff knew how to safeguard patients from potential abuse. Staff we spoke to all received safeguarding adults training and knew how to recognise a safeguarding issue. Teams had strong links with local safeguarding teams.
- Staff managed medicines safely. A pharmacist checked medicines weekly and ward staff trained in medicines management checked them daily. Each patient had a medicine administration record which included their photograph to support identification. Three patients were prescribed covert medicine and this was clearly assessed and planned.
- Patients used pressure relieving mattresses and cushions to reduce the risk of developing pressure ulcers. Staff supported patients who were at risk of falls. They did this by use of observation and assisting patients when moving around the ward.
- Sometimes family members brought children to visit patients. This was done in agreement with staff so they could ensure it was a safe environment for children. There were separate family visiting rooms on both wards. The family visiting room on Edgcumbe had a range of toys and colouring books for children to play with while visiting.

Track record on safety

- A patient death in 2014 led to a change in practice. Now junior doctors are expected to work with consultants in geriatric medicine to improve health care with older patients.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and did this via an internal electronic reporting system. There was evidence of reporting on falls, safeguarding issues and patient aggression. Incidents were discussed at weekly ward meetings. Staff we spoke to told us they were de briefed after incidents. Staff were updated on learning from incidents and complaints in weekly team meetings, immediately after incidents and by email
- As a result of an incident 12 months ago, the provider was going to fit bedroom doors which opened in both directions so that staff could gain access if the door was blocked from the inside. They were also going to fit

Requires improvement

Are services safe?

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bedroom lights which could be switched on from outside of the bedrooms for emergency use. This incident happened 12 months ago and the adaptations had still not been made at the time of our inspection.

Are services effective?

Good

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

- There were care plans on all 13 patient files we reviewed which were recovery oriented. However, care plans for some patients on Cothele ward had not been updated following a number of incidents. Staff had not updated care plans when a patient fell, when a patient had low blood pressure which preceded a fall, and when a patient received an updated dementia diagnosis.
- Staff recorded patients' physical health observations using modified early warning score charts (MEWS). MEWS charts are a tool for nurses to help monitor their patients' health and improve how quickly a patient experiencing a sudden decline receives clinical care. The scores measure vital signs including temperature, respiration and blood pressure.
- Evidence on the nine treatment records we reviewed on Cothele ward indicated health monitoring was inconsistent. One out of nine MEWS charts had calculated scores. Two out of nine MEWS charts had scores which were not calculated and required escalation treatment plans but these were not done. This meant that staff did not fully calculate risk relating to patients' physical health. We informed a member of nursing staff of our findings at the time. This meant there was little evidence that the ward's escalation protocol for elevated scores was followed.
- Staff calculated MEWS for patients on Edgcumbe ward and followed the ward's treatment escalation protocol if the score required this. The frequency of physical observations was handwritten on the top of the MEWS charts. However, when frequency changed, staff crossed it out and replaced with a new frequency. Staff who made the changes did not sign, date or initial them. This meant there was no evidence of who made the changes and when they were made.
- Staff assessed patients' needs regarding anxiety and depression using hospital anxiety and depression scales. Staff also assessed patients' memory problems using the Addenbrookes Cognitive Examination 3 (ACE III). Findings from these assessments were included in patients' care plans to ensure their needs were met.
- All 13 care records we reviewed indicated that all patients had a physical examination on admission. This included a blood test, an electrocardiogram and a urine test.
- Staff completed comprehensive assessments for all patients on admission. Assessments covered areas such as mental and physical health, involvement of other agencies, and patient capacity.
- Staff ensured patients' nutrition and hydration needs were assessed and met daily. Staff recorded patients' fluid and nutrition intakes on each patient's file so they could monitor progress or need.
- Staff completed malnutrition universal screening tools for patients who were at nutritional risk.
- Nursing teams developed care plans for patients who were unable to feed themselves which included input from the speech and language team and a dietician.
- Staff completed targeted examinations with patients if their physical presentation required this or if a need was identified at admission. Blood sugars were routinely monitored for patients with diabetes.
- The wards had a resuscitation policy which contained specific guidelines including treatment escalation plans relating to do not resuscitate orders. Staff recorded resuscitation decisions for all patients and included relatives' views.
- Staff used an electronic recording system called System One to record patient data. All staff who needed to have access to the recording system had passwords to use it. Paper records were also kept for daily recording such as medicine and MEWS charts. All patient data we reviewed was up to date.

Best practice in treatment and care

- Staff on the wards followed best practice when prescribing medicines. For example, patients were prescribed anti-psychotic medicine for challenging behaviour which was in accordance with the national institute for health and care excellence guidance. Doctors reviewed patients' medicine and symptoms weekly to review the need for a change in dosage to meet patients' needs. Doctors prescribed medicine which had the least side effects for patients.
- Staff on Cothele ward monitored levels of schizophrenia in patients using a commissioning for quality and innovation framework to improve the quality of care provided to mental health patients. This was in accordance with NHS professional guidance.
- Patients were offered psychosocial interventions, such as mindfulness as appropriate to their level of capacity.
- The wards had good access to physical healthcare specialists, including the diabetes specialist.

Are services effective?

Good

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.

- The wards used health of the nation outcome scales (HONOS) to assess health outcomes for all patients. This meant staff measured the health and social functioning of patients on the wards in order to improve it. The use of HONOS is recommended by the English national service framework for mental health.
- Staff on the wards engaged in clinical audits. For example, they undertook a monthly safety thermometer audit which included monitoring of the occurrence of pressure ulcers and falls amongst patients. This is an NHS audit which allows staff to survey patient harm and analyse results so that they can measure and monitor local improvement over time.
- Staff on Edgcumbe undertook an audit over a six month period prior to our visit to assess how many patients they had assessed for capacity. The audit indicated that 92% of patients had been assessed for capacity. They also carried out an audit in the use of anti-psychotics in dementia patients in September 2015.

Skilled staff to deliver care

- The wards had a wide range of experienced and registered mental health staff providing input to the wards such as psychiatrists, doctors, nurses, health care assistants, an occupational therapist, recovery workers, a physiotherapist, a psychologist and pharmacists.
- All staff received regular supervision and annual appraisals in accordance with the provider's supervision policy.
- Staff received specialist training for their role such as dementia awareness. Staff also received suicide prevention and self harm mitigation training.

Multi-disciplinary and inter-agency team work

- Staff attended weekly multi-disciplinary team meetings.
- Teams had effective handovers at the end of each shift. Cothele ward was piloting the use of an electronic white board which meant that staff could look at updates on patient wellbeing from handover notes on a screen displayed on a screen on the office wall rather than look up each file separately. The screen only displayed data when it was activated by a member of staff. This meant that data remained private unless a member of staff wanted to view information.
- Both wards had good working relationships with external teams such as care co-ordinators, social services and community mental health teams. Teams also had good links with local GPs.

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

- All staff on the wards had received training in and had a good understanding of the Mental Health Act 1983 (MHA) and its code of practice.
- Consent to treatment and capacity requirements were adhered to on the wards.
- Staff explained patients' rights to them on admission and routinely throughout their admission. This was documented on their treatment records. Staff told patients their rights again in the presence of their relatives.
- The provider's central MHA team offered administrative support and legal advice to the wards with regards to the MHA and its code of practice. The team carried out regular audits to ensure the MHA was applied correctly.
- Notices were displayed on the locked ward entrance doors explaining the rights of informal patients to leave the ward.
- Detention paperwork was up to date and signed appropriately.
- Patients had access to independent mental health advocacy (IMHA) support through an organisation called SEAP. IMHA leaflets were displayed in the reception area of both wards.

Good practice in applying the Mental Capacity Act

- All staff were trained in and had good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff recorded mental capacity for all patients on admission but did not record rationale for how they reached their decisions.
- There was a policy for the MCA and deprivation of liberty safeguards (DoLS) which staff accessed on the organisation's intranet.
- Staff supported patients to make decisions where they had capacity. If patients lacked capacity other teams and family members were involved to make decisions in the patient's best interest. For example, the occupational therapist and family members were involved in a patient's discharge assessment. We reviewed documentation of best interest meetings for patients. For example, there was evidence of documentation agreeing best interest decisions around covert medication for some patients including pharmacy input on how best to administer the medicine.

Are services effective?

Good

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 got advice including support around DoLS from the organisation's MCA office.
- Six patients were subject to DoLS at the time of our visit. Patient paperwork was completed and up to date which ensured appropriate safeguards were in place.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff treating patients with care, patience, respect and dignity.
- Staff maintained patients' dignity when bathing them and sometimes offered bed baths to offer more privacy to patients who required more support. There were curtains in front of toilets to ensure that patients had privacy when using the toilet when staff needed to be close by to support them.
- We spoke with seven patients who all told us that staff cared for them and treated them with respect. Patients told us that staff knocked before entering their rooms.
- Staff had good understanding of patients' needs. They treated each patient as an individual and worked with patients and family members to find out more about them. Each patient had a 'This Is Me' document on their treatment record which listed their likes and dislikes regarding activities such as pastimes and food.
- We observed staff assisting patients to eat. The staff encouraged and supported patients with specialist eating needs. Staff were calm and gave time to each patient during mealtimes.

The involvement of people in the care that they receive

- Admission processes helped patients to orientate themselves to the ward. Patients on Cothele ward received a welcome pack when they were admitted to the ward. The pack included information about having a named nurse, safekeeping of patients' property while on the ward, laundry, washroom facilities, and meal times.
- Patients were involved in their care planning. Staff also included family members when planning care for patients where it was appropriate to do so. Care plans were developed to help patients develop independence while on the ward. On Cothele ward the occupational therapist ran breakfast and lunch clubs where patients developed food preparation and kitchen skills for returning to the community.
- Families and carers were involved in patients' care. During our visit we observed staff making visitors very welcome. A weekly carers group was available on Edgcumbe ward. Visitors told us that staff always asked for their views regarding their family members' care. There was evidence of carers involvement in patients' care in the treatment records we reviewed.
- Patients were able to give feedback about the care they received. On Cothele ward patients attended a weekly business meeting where they gave feedback on ward issues. All patients received a discharge questionnaire when leaving the ward and gave feedback on their experience where possible. On Cothele ward staff looked into feedback they received about the sinks which patients said were too shallow. The matron worked with the properties team to look at alternative types of sink the ward could use safely and informed the patients of progress.

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

- Bed occupancy for the six months between August 2015 and January 2016 was 65% for Cotehele ward and 94% for Edgcumbe ward.
- Cotehele ward had four delayed discharges for an average of 19 days and Edgcumbe ward had 12 delayed discharges for an average of 66 days for the period August 2015 to January 2016. Staff told us this was due to a lack of community placements for patients with dementia. All delayed discharges were listed on the risk register including details of why they occurred. The ward managers discussed delayed discharges in weekly meetings with business intelligence staff and locality management. Delays were also addressed at the monthly ward performance review meetings with all our locality managers. Both wards had daily whiteboard meetings with staff members and then weekly with the broader multidisciplinary team where delays were escalated to explore if there was anything staff could do to avoid or minimise the delays.Staff did not refer patients with dementia from Edgcumbe ward to interim placements when waiting for a bed in a nursing home. The team felt it was not in their patients' best interests to disorientate them unnecessarily with an additional care setting while waiting for a longer term placement. This unfortunately caused delays to discharge some patients.
- Staff reported social care funding challenges when finding appropriate placements. Cothele had a dedicated discharge co-ordinator who linked in with the integrated social services team to follow up on these issues.

The facilities promote recovery, comfort, dignity and confidentiality

- There were a good range of rooms including activity rooms for patients to use on both wards.
- Both wards had mattresses and chairs to offer pressure relief to patients at risk of developing skin ulcers forming. Staff had a range of equipment in patients' rooms and in the ward toilets and bathrooms to manage continence support needs. Staff were competent in providing necessary care to patients who used urinary catheters and colostomy bags on the wards.
- Both wards had a range of equipment to support patients who were at risk of falls including handling bars and walking frames. Staff on Edgcumbe ward also used hip belts for patients which were fastened around a patient's waist. Staff held onto the belt to support the patient while they walked without causing potential distress by physically holding onto the patient.
- Both wards had quiet rooms for patients to use and where they could meet their visitors.
- Patients could make phone calls in private.
- Patients on both wards had access to outside gardens which were well kept.
- Patients told us that the food available on the wards was good and varied. Patients could make hot drinks throughout the day and night if they wanted.
- On Cothele ward patients were risk assessed before they could personalise their bedrooms. On Edgcumbe ward all patients' rooms were personalised with their photographs and belongings. Patients on Edgcumbe ward also had pictures and photographs which were personal to them displayed outside their bedroom doors. This was done to assist patients with dementia to identify their room.
- Patients could store valuables in the office safe. When patients were admitted their valuables were signed over to the safe keeping of the ward manager. Staff explained that they did not accept responsibility for loss or damage to items which were not handed in for safe keeping. However, if a patient wanted to keep their valuables then they and their family, where appropriate, could agree to this.
- Patients on both wards had access to activities seven days per week for example reminiscence groups, gardening, breakfast and lunch clubs, and crafts.

Meeting the needs of all people who use the service

- Both wards were accessible. Cothele ward was a two storey building and had a lift to enable patients to access both floors. There were hoists and disability aids in the bathrooms and toilets for staff to use when assisting patients with personal care and any mobility needs.

Are services responsive to people's needs?

Good

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

- Photographs were displayed on the outside of doors and in non patient areas to show patients what was behind the doors.
- Leaflets were available explaining patients' rights, local services, treatments, and how they could complain.
- Both wards had access to interpreters.
- Patients had access to a range of food on the wards, for example vegetarian and gluten free. All meal plans were developed individually in line with patients' likes and dislikes. Menus were displayed in the dining areas so patients could see what was on the main menu.
- A chaplain and lay preacher visited the wards each week for patients who wanted to meet them. Staff told us they sometimes escorted patients to attend church on Sundays.

Listening to and learning from concerns and complaints

- Patients we spoke to told us they knew how to complain and had confidence that the managers listened and responded appropriately. Ward managers told us they provided feedback to all patients and staff on the learning from complaints.
- Staff told us that ward managers gave them feedback following investigations and that they felt well informed.

Are services well-led?

Good

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 to were aware of and understood the provider's vision and values.
- Managers on both wards said they felt supported by senior management.

Good governance

- The members of staff we spoke to had received mandatory training, however overall mandatory training completion levels were at 83%.
- Staff were supervised and appraised in line with the provider's supervision policy.
- Ward managers and staff told us that shifts were always covered and we saw evidence of staff rotas which confirmed this. Safe staffing levels were reviewed at regular meetings with finance team members and the locality manager.
- Staff were updated on learning from incidents and complaints in weekly team meetings, immediately after incidents and by email.
- Ward managers had access to administrative support. This was helpful to staff as they had access to someone who could handle administrative tasks such as ordering and monitoring incoming paperwork which freed nursing staff up to carry out their nursing activities.
- All staff had the ability to add items to the provider's risk register. For example, Cothele ward had added access to the garden and lone working as risks and Edgcumbe ward had added falls and part of the sensory corridor as risks.
- Staff knew how to raise safeguarding issues within the organisation. Staff had a good understanding of the deprivation of liberty safeguards and the referral process to the social work team.

Leadership, morale and staff engagement

- We saw good evidence of clear leadership on both wards. Managers were visible and supported staff when required.
- Staff knew how to use the provider's whistle blowing procedure and felt able to raise concerns without fear of victimisation.
- Staff told us that team morale was good and there was strong team work.

Commitment to quality improvement and innovation

- Both wards were AIMS (accreditation for inpatient mental health services) accredited. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. AIMS is an initiative of the College Centre for Quality Improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care All patients on Cothele ward were requested to go to bed and rise at a set time each day as staff had to work between the sleeping area and the day ward. Patients had access to their rooms during the day from 1pm to 2pm. This is a breach of regulation 9(1)(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The wards did not have access to doctors employed on the wards outside of the hours 9am to 5pm from Monday to Friday. The wards did not have access to the junior doctor rota. This is a breach of regulation 18(1)