

Good 

South West Yorkshire Partnership NHS Foundation
Trust

Wards for older people with mental health problems

Quality Report

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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)
RXG10	Fieldhead	Chantry Unit	WF1 3SP
RXGDD	Priestly Unit	Ward 19	WF13 4HS
RXG31	Poplars Community Unit For The Elderly	The Poplars	WF9 4LX
RXGCC	The Dales	Beechdale Ward	HX3 0PW
RXG82	Kendray	Willows Ward	S70 3RD

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire Partnership NHS Foundation 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.

Summary of findings

Where applicable, we have reported on each core service provided by South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation 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

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

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Summary of findings

Overall summary

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

- All wards were clean, tidy, and well maintained. The clinic rooms were fully equipped and emergency equipment was checked regularly. Staff were aware of how to report incidents and did so via the online incident reporting system. The ward complied with guidance on same sex accommodation by having single en-suite bedrooms and a designated female lounge area. There were good medicines management procedures for recording, dispensing and storing of medication. Staff were aware of the duty of candour and their responsibilities surrounding this.
- All patients had a physical health check on admission and there was evidence of ongoing physical health monitoring. There was evidence that National Institute for Health and Care Excellence guidance was being followed in relation to prescribing of medication and there was a range of psychological therapies on offer to patients. Clinical staff participated in a wide range of clinical audit, including medications, mental health act and care records. Eighty seven percent of staff had received an appraisal in the last twelve months. Mandatory training was at 89% for the core service. This was above both the national average and the trust target of 80%.
- We saw positive interactions between staff and patients. All patients we spoke with told us they were treated in a dignified, respectful and caring manner. The staff we spoke with knew the patients well and this was reflected in the care plans of the patients. Patients all had a copy of their care plan if they wanted one and they were fully involved in developing them. There were weekly community meetings where patients were given the opportunity to give feedback on the ward. Patients told us they were encouraged to join in with activities that were available.
- Discharge was always well planned and happened at an appropriate time for that person. There was a full range of rooms to support care and treatment of the

patients. Patients had the facilities to make a phone call in private. There was a lot of emphasis on patients accessing local groups for activities. However, there was also a wide range of activities available on the ward seven days a week, including evenings. Staff and patients were able to discuss any issues in community meetings and staff meetings. Information leaflets were available in a range of languages if required. Patients had access to an independent mental health advocate who visited the ward on a weekly basis. Staff were aware of the organisation's vision and values and used them as a basis for their work with patients'. These were displayed in the communal areas.

- The clinical leadership on the ward was clear and all staff said that they felt supported and listened to. Staff were aware of the trust vision and values and were committed to providing good care in line with this.

However:

- On The Poplars, Ward 19 and Chantry Unit the ward layout did not allow staff to observe all parts of the ward. This was not mitigated by the use of mirrors on Chantry Unit or Ward 19. The use of observations did not include staff being present in those areas on a routine basis and on the day of our inspection staff were not present in those areas. Risk assessments of patients did not refer to the blind spots within the wards when considering the risks to and from that patient. This meant that the ward was not doing all that was practicably possible to reduce the risk of harm to patients and staff.
- The bedrooms door handles at Ward 19 were a ligature risk. Although this was identified on the annual ligature risk assessment to be managed locally there were no bedrooms without these door handles. This meant that if patients were a high risk of self harm they would need to be nursed on close observations which was not the least restrictive option.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- On The Poplars, Ward 19 and Chantry Unit the ward layout did not allow staff to observe all parts of the ward. This was not mitigated by the use of mirrors on Chantry Unit or Ward 19. The use of observations did not include staff being present in those areas on a routine basis and on the day of our inspection staff were not present in those areas. Risk assessments of patients did not refer to the blind spots within the wards when considering the risks to and from that patient. This meant that the ward was not doing all that was practicably possible to reduce the risk of harm to patients and staff.
- The bedrooms door handles at Ward 19 were a ligature risk. Although this was identified on the annual ligature risk assessment to be managed locally there were no bedrooms without these door handles. There were no plans to remove the door handles at the time of our inspection. This meant that if patients were a high risk of self-harm they would need to be nursed on close observations which was not the least restrictive option.

However:

- There was a fully equipped clinic room on each ward which had accessible resus equipment and emergency drugs which were checked regularly.
- All wards were clean, well maintained and had a good standard of furnishings.
- Cleaning records were regularly filled in and were up to date.
- There were nurse call buttons in all patient bedrooms.
- The trust had low levels of vacancies and the number of nurses required matched the number of nurses on all shifts.
- Every patient had a risk assessment that was up to date and reviewed regularly.
- Staff were aware of the trust safeguarding procedures and used them appropriately. They had good links with the local safeguarding teams and could ring them for advice.
- All falls were incident reported and any fall resulting in harm to a patient was investigated by the trust. On Willows Ward a falls audit was undertaken by the ward manager. This identified that higher levels of falls happened in patient bed areas and bathrooms. It was also identified that nearly all patients who

Requires improvement



Summary of findings

had fallen were found by staff and not by use of nurse call buttons. Following this nurse call strips were installed in each bedroom and bathroom at floor level so patients could alert staff if they had fallen.

- Mandatory training was at 89% for the core service. This was above both the national average and the trust target of 80%.

Are services effective?

We rated effective as good because:

- All patients had a full assessment on admission including physical health checks that were on going throughout admission.
- Care plans were person centred and holistic and were regularly reviewed in collaboration with the patient and their carers if the patient wished them to be included.
- There were good links with physical healthcare teams, and on each ward there was a dedicated physiotherapy and occupational therapy team that worked as part of the multi-disciplinary team (MDT). This included a dietician team on Chantry unit who attended patient meetings with catering department.
- Staff were involved in clinical audit. These included audit of care records, medication charts and mental health act (MHA) and mental capacity act (MCA), amongst others. These were done by the relevant member of the MDT and fed back to the team via individual supervision and team meetings.
- Appraisal rates were 87% across the core service and these were at 100% for Ward 19 and the Poplars.
- Staff received specialist training relevant to their role. For example, staff at Willows Ward were trained to carry out ECGs and Venepuncture.
- Each ward had weekly MDT meetings for patients and family/ carers were encouraged to attend these if the patient consented. These included all members of the MDT including physiotherapists, occupational therapists, doctors, nurses and pharmacists.
- There were good links across the core service with outside agencies. This included the local authority providing a flex and stretch group facilitator for Ward 19, a dance therapist that visited all of the wards at least weekly. The trust employs a team of Admiral Nurses that as part of their role provide support to ward 19.
- Staff had a good understanding of the MHA and all relevant documentation was filled in correctly and up to date. Staff at The Poplars had developed an easy read rights leaflet for

Good



Summary of findings

dementia patients, which was simplified using short direct sentences with the addition of pictures to clarify key points. There was access to MHA admin support for all wards and they provided receipt and scrutiny training for all qualified staff.

- Staff had a good understanding of the MCA and receive training in this area. We saw evidence of best interest decisions being made appropriately following capacity assessments.

Are services caring?

We rated caring as good because:

- We observed many interactions between patient s and staff. All of these were done in a respectful way to ensure the needs of the patient were met whilst maintaining dignity and providing emotional support.
- All patients told us that staff were kind and came to help when they needed them.
- Staff we interviewed had a very good understanding of the patients they were looking after and were able to tell us lots of detail about the person. This was not only about the persons mental illness but their family, past jobs hobbies and interests.
- There was access to advocacy on each ward. The advocates visited regularly and on Beechdale and Willows ward they operated an opt out service so patients were referred on admission and the advocate would visit. If the patient did not want to engage at this point then this was respected.
- Patients were involved in their care plans on all wards. We saw evidence of patients signing care plans and their views being included in the form.
- Each ward had a detailed information booklet, which was given out on admission and displayed on the ward for people to read. This included activities happening on the ward, information about laundry, advocacy services and mealtimes.
- On each ward there was a board with all staff members' photographs and their roles within the team.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- Beds were available for people when they needed them in their catchment area. There had been two out of area placements in the last six months.

Good



Summary of findings

- Leave beds could be protected if there was a clinical indication. For example if someone was going to a care home with particularly challenging behaviour the wards would support the care homes with the transfer and keep the leave bed open for a short time to ensure the patient had settled in.
- Discharges were always planned and happened at an appropriate time of the day. This was planned in collaboration with family. In the six months prior to inspection, there had been 26 delayed discharges for this core service. The highest numbers of delayed discharges was from Ward 19 ward with eight. We reviewed care records of patients that were a delayed discharges, the delay was mainly due to awaiting an appropriate placement for patients with higher levels of need.
- There was access to psychiatric intensive care unit (PICU) if the wards needed to use it. However, this was rarely used.
- All wards had a full range of rooms that supported the care and treatment of patients. This included activity rooms, quiet lounges and private space for visitors.
- There were facilities on each ward for patients to make a call in private. This was either in the form of a phone booth or a ward mobile phone that patients could use in the privacy of their own bedrooms.
- There was outside space for each ward that was well maintained with sensory aspects such as wind chimes for patients with cognitive impairment. There were birdfeeders in some areas for patients to sit and watch, which patients reported they enjoyed.
- There was a good choice of food for patients and alternatives should the patients not like what was on offer for that day. This included sandwiches, jacket potatoes or soup as well as a full hot meal. As the food was managed on the wards by housekeepers they were able to order food for any speciality diets, for example, vegetarian or food to meet the needs of different religious groups.
- There was information about complaints clearly displayed on each ward but this was also in all of the ward information booklets. Patients we spoke to told us they knew how to complain and would feel comfortable speaking with staff for support.

Are services well-led?

We rated well led as good because:

- All staff were aware of the trust vision and values and used these as part of the appraisal process to reflect upon them.

Good



Summary of findings

- Staff we spoke to told us that their immediate managers were visible on the wards and approachable.
- Staff were able to name the most senior managers in the organisation.
- Ward managers were able to manage their team and felt they had enough authority to do so. They got regular updates via the intranet about their teams performance in training and were able to address this appropriately through supervision and appraisal.
- Morale in the teams we visited was good despite changes happening within the service. Staff told us they felt managers had supported them throughout the changes and kept them up to date with information when they could.

Summary of findings

Information about the service

South West Yorkshire NHS Partnership Foundation Trust had five wards for older people with mental health problems, spread across five hospital sites. These wards provided care for patients aged 65 and upwards who required hospital admission for their mental health problems. This also included people under the age of 65 who had a diagnosis of dementia.

Ward 19 was based at The Priestley unit. It admitted people with functional mental disorders or dementia. The unit was split into two wards one for men and one for women, with 15 beds on each ward. The unit was based at Dewsbury District Hospital, Dewsbury.

Chantry unit was a unit for people with functional mental disorders or dementia based at Fieldhead Hospital, Wakefield. The ward had 16 beds and accommodated both men and women.

Willow Ward was a ward with 10 beds for people with functional mental disorders. It was located at Kendray Hospital, Barnsley and accommodated both men and women.

The Poplars was a ward for people with a diagnosis of dementia based within its own grounds in Pontefract. The ward had 15 beds and accommodated both men and women.

Beechdale Ward was for older people with mental health conditions based at The Dales within Calderdale Royal hospital. The ward had 16 beds and accommodated men and women.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leaders: Chris Watson, Inspection Manager, mental health services, CQC

Berry Rose, Inspection Manager, community health services, CQC

The team that inspected this core service comprised: a CQC inspector, three specialist advisors, one was a mental health nurse, one was an occupational therapist and the other was a consultant psychiatrist who specialised in older adults mental health. On one day of the inspection, there was a pharmacist with the team.

Why we carried out this inspection

We inspected this core service as part of our on going 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?

Summary of findings

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 all five of the wards and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 16 patients who were using the service and eight carers and collected feedback from patients using comment cards.
- Spoke with the managers or acting managers for each of the wards.
- Spoke with 53 other staff members, including doctors, nurses and therapy staff.
- Attended and observed activities and a multi-disciplinary meeting.
- Looked at 44 care records of patients.
- Carried out a specific check of the medication management on all 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

We spoke with 16 patients across the five wards and eight carers.

All the patients we spoke to told us that they felt safe. They told us that they had good relationships with the staff on the wards. Patients told us that if they needed to speak with a member of staff, they would make time to talk to them, or if they were busy, they would explain this and arrange a more convenient time and stick to it. Both patients and carers told us that the environment of their ward was always kept clean and that the domestic staff did a good job. Patients told us that they enjoyed the food and that they could make a choice each day of what

they wanted to eat. If they did not want anything on the menu, there was also a range of other options which included sandwiches and jacket potatoes. Patients told us that they enjoyed the activities that were available on the ward each day.

Carers of patients told us they felt that staff also supported them as well as their relative. They explained to us that staff always made time to talk to them either in person or when they telephoned the wards. Carers all felt that they could speak to the ward staff if they had a problem or any concerns about their relatives care and that they would be listened to.

Good practice

The ward manager on Willows Ward had undertaken a falls audit. This identified that higher levels of falls happened in patient bed areas and bathrooms. It also found that nearly all patients who had fallen were found by staff and not by use of nurse call buttons. Following this audit, the trust installed nurse call strips in each bedroom and bathroom at floor level so that patients could alert staff if they had fallen without having to attempt to stand with a potential injury.

Staff at The Poplars had developed an easy read rights leaflet for dementia patients which was simplified using short direct sentences with the addition of pictures to clarify key points.

On all wards, there was dementia friendly improvements that had been made. This included dementia friendly signage and use of colours identified as easy to see for people with cognitive impairment. On Beechdale ward the trust had secured funding from the Kings Fund to significantly improve the environment for people with dementia. This included a “rempod” which is a pop up reminiscence room that works by turning any care space into a therapeutic & calming environment.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that there are clear lines of sight on (The Poplars, Ward 19 and Chantry Unit).
- The trust must review the door handles on ward 19 to ensure the safety of the patients.

South West Yorkshire Partnership 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
Chantry Unit	Fieldhead
Ward 19	Priestly Unit
The Poplars	The Poplars Community Unit for The Elderly
Beechdale Ward	The Dales
Willows Ward	Kendray

Mental Health Act responsibilities

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

At the time of our inspection the trust did not routinely capture compliance information around MHA training, as this was not identified as mandatory training. However, despite this the staff had a good understanding of the Act relevant to their role.

During our inspection, we reviewed 44 care records. All patient files included a record of the responsible clinicians' assessment of capacity and their discussions with the patient.

There was good evidence of patient rights being recorded and reviewed at the correct intervals. All wards had copies of the patient rights leaflet with their admissions pack if the patient was detained. At The Poplars the staff had devised an easy read patients' rights leaflet for those who had dementia.

Patients'; risk assessments were reviewed and updated prior to and following leave. This showed a clear link between the consultant's decision to allow or stop leave dependent on the patients' current risks.

Detailed findings

There was a good MHA administration system. This ensured that MHA documentation was receipted and scrutinised in accordance with the MHA code of practice.

There was an independent mental health advocate (IMHA) that was available for each ward. The wards used different advocacy services based on their location.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection the trust did not routinely capture compliance information around mental capacity act (MCA) training, as it was not identified as mandatory training.

We reviewed 44 care records as part of our inspection. MCA was considered where there was concern a patient lacked capacity. Staff were able to give us examples of when a patient's capacity had been assessed and decisions made in their best interest. Examples of this included do not attempt resuscitation status and issues around medication being given covertly. We spoke to carers and they confirmed that they had been involved in these decisions and invited to meetings regarding their relatives' care.

Staff were able to talk us through the key principles of the MCA in a way that was relevant to their role. Similar to MHA training, managers had arranged for their staff to attend this training despite the fact it was not mandatory. It was clear from our observations and reviewing care records that patients' were deemed to have capacity unless it was decided otherwise. Patients were encouraged to make as many decisions as they could for themselves no matter how small. For example choosing items of clothing to wear that day or picking food choices off an easy read menu with pictorial aids if required.

No deprivation of liberty safeguards applications had been made for the wards between 1 November 2015 and 31 January 2016.

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

All wards were clean and tidy at the time of our inspection. There were cleaning schedules that were up to date and filled in by the domestic staff. The furnishings were in a good state of repair and there was artwork on the walls. All wards had access to an outdoor space.

None of the wards had a layout which allowed staff to see every part of the ward. On The Poplars, Ward 19 and Chantry Unit the ward layout did not allow staff to observe all parts of the ward. This was not mitigated by the use of mirrors on Chantry Unit or Ward 19. The use of observations did not include staff being present in those areas on a routine basis and on the day of our inspection staff were not present in those areas. Risk assessments of patients did not refer to the blind spots within the wards when considering the risks to and from that patient. However, on Beechdale Ward and Willows this was mitigated and we saw evidence of this in observation charts and patient risk assessments.

Ligature audits were in place on each ward and were completed annually. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. All wards had ligature points which were referenced on the ligature audits. On all wards, except Ward 19, mitigations were in place to manage these risks which included locking rooms where ligatures existed, for example, some bathrooms, observations of staff and individual patient risk assessments. However, on Ward 19 the bedroom door handles both inside and out were a ligature risk. This meant that patients who were at risk of self harm would need to be nursed on close observations to mitigate this risk and this was not the least restrictive option for those patients.

Apart from Ward 19, all of the wards provided care and treatment for both male and female patients. On all wards this met Department of Health's guidance on eliminating mixed sex accommodation.

All wards had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. There was appropriate equipment in the clinic rooms for monitoring

of medical observations, this included a blood pressure machine and weighing scales. Temperature checks of drug cupboards were carried out by staff daily and showed they were within the required range. Weekly cleaning of medical equipment took place and there were checklists and labels that showed these were completed and up to date.

There were no seclusion facilities on any of the wards we visited. On ward 19 there had been nine episodes of seclusion in the six months leading up to our inspection. This had related to two patients who were particularly unwell, both of whom were later transferred to the psychiatric intensive care unit (PICU). As there were no seclusion facilities on the ward, they would access the seclusion room on the adult acute ward across the corridor. We visited the seclusion room and found it met the required standards for seclusion rooms. We also found that the situation, when it arose, was dealt with in a sensitive manner ensuring that staff from Ward 19 managed the patient and stayed with them throughout the seclusion period. Their privacy and dignity was maintained during the transfer with staff ensuring that other patients and visitors were asked to move to another area prior to moving the patient. When the seclusion facility had been used this was for appropriate reasons and was for very short periods of one to two hours. If a patient required a higher level of nursing they would have accessed one of the PICU beds within the trust.

On every ward there was a nurse call alarm system in place in all patient bedrooms and bathrooms. Staff carried emergency alarms when working on the wards. On Willows ward there were call strips in place round the bottom of walls so if a patient had fallen they could alert staff without having to locate the nurse call button higher up on the wall. There was also a system in place where the lights in a bedroom came on when a patient who was at risk of falls put their feet out of bed, in order to try and reduce falls. Patients could also wear a personal alarm around their wrist to alert staff before they got out of bed and that they needed help. At The Poplars there were bed sensors in place that sounded an alarm to staff when patients who were at risk of falls put their feet out of bed so they could assist them.

Are services safe?

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

Infection control principles were adhered to throughout the inspection. This included handwashing, where appropriate, for example after direct patient care. There were also gel handwashing stations at the entrance to each ward for visitors and staff to use when entering and leaving the wards. We saw staff using these and encouraging others entering and leaving the ward to do the same.

Safe staffing

The staffing establishment for the five wards was 80 (WTE) for qualified staff and 77 (WTE) for unqualified staff. At the time of our inspection there were two vacancies for qualified staff and no vacancies for unqualified staff. There were 3,841 shifts filled by bank and agency to cover sickness, absence or vacancies in the 12 months leading up to our inspection and 288 shifts that were not filled. The staff sickness rate in the 12 months leading up to our inspection was 7.5% and the turnover was 11%.

In order to establish the number of staff required on each shift the trust had carried out a safer staffing review in 2015. This included a monthly report by wards on different issues that affected staffing including acuity, needs of the patient group and staff sickness. Following this review the trust had implemented minimum staffing levels of qualified and unqualified staff for each of the older adult wards across the trust. This information had also been used to inform skill mix. During our inspection we reviewed the staffing rotas across all wards. They confirmed that managers adjusted staffing levels to take into account patient mix; for example, at times when increased observations were needed or days when there were appointments requiring escorts off the wards. The numbers of staff on duty on each shift matched that of the establishment set for each ward.

All the wards were using bank and agency staff. This was highest at The Poplars at 1,017 shifts. We saw evidence that where possible bank and agency staff knew the ward well and worked on a regular basis. Many staff that were working on the bank at the time of our inspection were staff that had retired and wanted to continue to work a few shifts per week. There was a ward level induction for bank and agency staff if it was the first time they were working on a particular ward and this was completed by the nurse in charge. The ward manager was supernumerary on each of the wards. This allowed for the ward manager to be able to cover the shift for short periods if someone rang in sick

whilst a member of staff was found to cover without the ward being short staffed in the meantime. All of the ward managers were clear that they had authority to increase their staffing levels if there was a need.

On all of the wards there were sufficient staff on duty to assist patients with activities of daily living. We saw staff sat in communal areas with patients, spending one to one time with them. Patients we spoke to told us that staff always made time for them and records showed that staff regularly documented one to one time with the patients.

There was enough staff to carry out physical interventions if required and all staff were trained in management of violence and aggression for older adults. There was a response team at all wards based at a main hospital site who would assist the ward if they sounded their alarms.

Every ward had a doctor based with them Monday to Friday; this was usually a junior doctor. The consultant for each ward visited a minimum of twice weekly but staff reported that they could call the consultant at any time for advice. Out of hours all wards (evenings, nights and weekends) had access to the on call junior doctor and consultant system for the trust. If there was a medical emergency then the wards would access the crash team at the acute hospital on the same site by dialling 2222 on the ward telephone. For the Poplars that was located off the main hospital site they would dial 999 in an emergency.

The average mandatory training rate for staff across the core service was 89%. All wards were above 75% in all courses that were mandatory.

Assessing and managing risk to patients and staff

In the six months leading up to our inspection there were nine episodes of seclusion. These were all on ward 19 and related to two patients who required a more intensive level of nursing care and were later transferred to the psychiatric intensive care unit. Between 1 May 2015 and 31 January 2016, there were 301 incidents of use of restraint, 126 (42%) of which occurred on Ward 19 and involved 22 different service users, 99 (33%) incidents occurred on Beechdale and involved 13 different service users. There were eleven incidents of prone restraint being used and this was highest on Ward 19 at seven episodes. National institute for health and care excellence guidance NG10: Violence and aggression, recommends avoiding prone restraint, and only using it for the shortest possible time if needed. During our inspection we reviewed records and spoke to staff

Are services safe?

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

regarding the episodes of prone restraint. Where patients had placed themselves down on their front during restraint the staff had quickly turned them, or if patients were turned to administer medication this was documented as prone restraint. This was despite the prone position being for the shortest possible time as per NICE guidance.

We reviewed 44 care records during our inspection. All patients had an up to date risk assessment that was reviewed weekly by the named nurse. We also saw evidence of risk assessments being reviewed following incidents and periods of leave from the ward. The trust used the Sainsbury's level 1 risk assessment tool.

We did not find any evidence of blanket restrictions on any of the wards. All of the wards we visited were locked. However, we saw clear signage for informal patients informing them of their right to leave at any time. The trust had an observation policy for observations of patients and staff were able to talk to us about this and the different levels of observations. Searching of patients did not happen, however, there was a trust policy for search of patients and their belongings. Staff were able to show us where this was located on the trust intranet.

On all of the wards we visited we found evidence that National Institute for Health and Care Excellence (NICE) guidance was being followed in relation to rapid tranquilisation. This was rarely used and staff showed good use of de-escalation techniques during our inspection.

The trust had a medication management policy and there were effective medicine management procedures in place. There was a pharmacist allocated to each ward and they visited most days each week. Staff also told us that the pharmacist was available on the telephone should they have any queries outside of these times. The pharmacist would carry out reconciliation of medications on admission to the ward and they all had access to the GP records system so this could be checked quickly. There was a trust NICE steering and overview group who met three monthly to discuss NICE guidance that has been issued each month. Each of the older people's services had a representative that attends and feedback any guidance relevant to the service to ward managers. This was then in turn passed on to staff via staff meetings and supervision.

On admission all patients were checked for any pressure areas. This was documented using a body map and any pressure areas were incident reported and a safeguarding

referral made. There were good links with the tissue viability team and access to pressure relieving equipment such as pressure cushions and mattresses that were hired when required. All falls were incident reported and any fall that resulted in harm was investigated by the trust at a senior level. There was a falls and bone health meeting where participants included physiotherapists and health and safety staff as well as doctors and nurses. This meeting occurred monthly and discussed any issues arising around falls. For example the falls policy, any training that was available relating to falls and the trust falls strategy for the year. The trust also used a falls risk assessment tool (FRAT) for each patient which highlighted people who were at risk of falls and put measures in place to reduce this risk. We saw evidence of people who were given personal alarms or wrist alarms who were identified as a higher risk of falls on the wards.

Staff we spoke to had a sound understanding of the local safeguarding procedure they used. They were able to explain this to us and show us the forms they would fill in to make a referral and where they would send them to. Safeguarding training was provided by the trust in relation to adults and children and this training was mandatory. Incidents were reported via the electronic notes system and staff were able to show us where this was. Staff knew the name of the trust safeguarding leads and also the lead within the local authority for the area they worked. They told us they could ring them for advice around safeguarding if they needed it.

Track record on safety

There were three serious incidents in the 12 months leading up to our inspection. Two of these related to patient falls and the other an assault patient on patient.

The trust had a clear system for investigating serious incidents. Initially an incident form was completed and this was reviewed by the ward manager. There was then an initial three day investigation at ward level to fact find and gather information. Following on from this a root cause analysis would be carried out to identify any causal factors and identify learning. A learning event would be held where staff involved could attend and discuss learning from the incident and changes that could be made to prevent the same incident occurring in the future.

Are services safe?

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

Reporting incidents and learning from when things go wrong

The trust had an electronic incident reporting system called datix. We spoke to staff and they were able to tell us how they would access the system and what kind of incidents would need to be reported. Staff were aware of duty of candour and the need to be apologise and be open and transparent when an incident occurred.

Staff we spoke to told us that they learnt from incidents through a number of ways. This included team meetings, supervision, via email from the manager and by updates on the trust intranet. Following any serious incident the team and patient would be debriefed. This was in order to give support around the incident to all those involved. Staff felt that they were supported following incident and that they did not feel there was a blame culture in the trust but one of support and sharing learning.

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

We reviewed 44 sets of care records during our inspection. They all contained a comprehensive care plan and risk assessment of the patient that had been formulated on the day of admission. All the records showed evidence of physical health checks on admission. This included a physical examination and baseline observations such as blood pressure, pulse and temperature. It was also evident that this was ongoing throughout the admission with regular bloods being taken, weight monitored and regular blood pressure checks being undertaken.

Care plans were patient centred and holistic and included the views of the patients where possible. If this was not possible, for example, the patient had severe levels of cognitive impairment, then the family or carers were included in this and their views were taken into account. We saw evidence of patients being offered a copy of their care plan and patients had signed for these where possible. If patients could not sign or refused to sign this was clearly documented and repeated attempts were made to engage the patient in the process.

Around three months before our inspection the trust had upgraded their electronic recording system (RIO) and this had caused some initial problems. This included some periods where the system was down for a few hours at a time. However, the trust had contingency plans in place for this and the wards reverted to paper notes and scanned these in when the systems went down. Staff on the inpatient wards did not report any major problems with the system apart from it being a little slow at times.

Best practice in treatment and care

The Royal College of Psychiatrists provided best practice guidance for older adult mental health wards. This included recommending the joint working between the multidisciplinary team (MDT) in relation to physical healthcare and mental healthcare. This also included the community services working in partnership with the inpatient staff to ensure continuity of care when patients were discharged. At the time of our inspection the inpatient wards were doing good work in these areas. This included the physiotherapists and occupational therapists being integrated into the teams and working on the wards as part of the MDT, taking part in ward rounds and handovers and

completing care plans for patients. This joint working included outside organisations too, such as local authority staff who came in to the wards to do exercise groups and dance therapy.

Each ward was able to refer patients for psychological therapies as recommended by the national institute for health and care excellence. This differed in each location but all wards had a clear process for referring into the service. Services available from psychological therapy teams for inpatients included individual psychological assessment and psychological therapy, family therapy and working with ward staff to provide formulation sessions. Ward staff were supervised to deliver psychological interventions with individual cases. There was also a dance and movement psychotherapist who ran a group on each of the wards weekly.

On each of the wards there was good access available to physical healthcare including specialists if necessary. The wards had access to a geriatrician who visited once per week to discuss patient needs. There was evidence of good links with dieticians and at Chantry the dietician team was based on the ward and had good input into MDT meetings. They also attended the patient meetings to discuss the food and relay any issues to the catering department.

During our inspection we saw staff encouraging patients to eat and drink on a regular basis. Following admission patients would be placed on a diet and fluid chart for three days in order for staff to monitor the patients' nutritional intake. If there were any issues identified in that time then the patient would remain on the diet and fluid chart until a specialist such as a dietician had seen the patient and completed a care plan. Patients were weighed each week and their weight was recorded so staff could identify those who were losing or gaining weight.

Clinical staff participated in clinical audit and we saw evidence of this during our inspection. These included medication audits, mental health act audits and care record audits. Staff were able to tell us that the outcome of these audits was discussed in team meetings and individual supervision to improve practice.

Skilled staff to deliver care

Each of the wards was staffed by a multidisciplinary team (MDT). This included a dedicated consultant psychiatrist who specialised in older adults with mental health problems. Other members of the teams included nurses,

Are services effective?

Good 

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physiotherapists, dieticians, occupational therapists, student nurses and student occupational therapists. The teams also included domestic and administrative staff. There was a pharmacist allocated to each ward who visited most days but at a minimum of weekly.

New starters to the trust received a robust induction which included some of the mandatory training required. Most of the staff we met during our inspection had worked at the trust for some time and had lots of experience in working with older adults with mental health problems.

At the time of our inspection the trust did not collect figures for the supervision of staff. However, we looked at staff files during the inspection week and found that staff received supervision six weekly as per the trust policy. Appraisal figures were 97% for the service at the time of inspection and this was at 100% Beechdale, Ward 19 and The Poplars. Staff reported that they found the appraisal process helpful and that this was used to inform their work for the following 12 months.

Ward managers were confident to manage performance issues within their teams. The manager and senior staff were confident in the way they would approach this. They could explain how this had been done and could give examples around staff sickness levels and managing these in accordance with the trust policy. We reviewed staff files and found evidence to support appropriate actions being taken when necessary.

Multi-disciplinary and inter-agency team work

There were regular and effective multidisciplinary team meetings on each ward. Members of the community mental health teams were heavily involved in these meetings and were always updated afterwards by staff if they could not attend. Staff on the wards reported good working relationships with the community teams especially in relation to discharge planning.

There was a handover at each shift change. The trust had implemented 12-hour shifts across all wards. This meant that there was a handover in the morning and one at night. However, during the day if extra staff were coming on shift or for example if the manager started at 09:00 then the staff would hand over relevant information to them when they commenced work.

The wards also reported good working relationships with outside agencies such as the local council. This included their staff coming in to the wards to run some of the exercise groups that were on the activity planner.

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

The trust do not routinely capture compliance information around Mental Health Act (MHA) training, as it was not identified as mandatory training. However, the trust did provide MHA training for all staff. This included scrutiny and receipt training for qualified staff in order to show them how to ensure MHA documentation was completed correctly. The trust also provided training throughout 2015 on the implementation of the new code of practice. The staff had a good understanding of the MHA and that ward managers took responsibility to ensure staff attended this training despite the fact it was not mandatory.

During our inspection we reviewed the care records of patients who were detained under the MHA. In total, we reviewed 44 records. Patients' files included a record of the responsible clinician's discussions with the patient around capacity and a record of the capacity.

Patient rights were recorded and reviewed at the correct time intervals. All wards had copies of the patient rights leaflet with their admissions pack if the patient was detained. At The Poplars the staff had devised an easy read patient rights leaflet for those who had dementia. This incorporated pictures with shorter sentences to explain the patients' rights while detained under the MHA. Information was displayed on the notice boards and in the patient information racks on the wards. Patient risk assessments were reviewed and updated prior to and following leave. This showed a clear link between the consultant's decision to allow leave and the patients' current risks. Patients and carers views on the outcome of leave was recorded in patients' notes and used to decide on increased or decreased leave for that patient.

There was a good MHA administration system. This ensured that MHA documentation was received and scrutinised in accordance with the MHA code of practice. Patients' detention papers were held at a central office but copies were kept in the patient's file.

There was an independent mental health advocate (IMHA) that was available for each ward. The wards used different advocacy services based on their location. The wards had

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.

an opt out referral service whereby patients who were detained were referred on admission to the IMHA and they could decide when they visited if they wanted to speak with them or not.

Good practice in applying the Mental Capacity Act

South West Yorkshire Partnership do not routinely capture compliance information around mental capacity act (MCA) training, as it was not identified as mandatory training. However, the trust do provide a range of training around the MCA and deprivation of liberty safeguards (DoLS) for staff. This includes DoLS in hospitals, safeguarding and consent. Staff were able to talk us through the key principles of the MCA in a way that was relevant to their role. Similar to MHA training managers had arranged for their staff to attend this training despite the fact it was not mandatory. It was clear from our observations and reviewing care records that patients' were deemed to have capacity unless it was decided otherwise. Patients were

encouraged to make as many decisions as they could for themselves no matter how small. For example choosing items of clothing to wear that day or picking food choices off an easy read menu with pictorial aids if required.

We reviewed 44 care records as part of our inspection. There was good evidence of MCA being considered where there was concern a patient lacked capacity. Staff were able to give us examples of when a patients capacity had been assessed and decisions made in their best interest. Examples of this included do not attempt resuscitation status and issues around medication being given covertly. We spoke to carers and they confirmed that they had been involved in these decisions and invited to meetings regarding their relatives' care.

No deprivation of liberty safeguards applications had been made for the wards between 1 November 2015 and 31 January 2016.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

During our inspection we spent time observing interactions between the staff and patients. We observed a kind and caring approach used by the staff at all times. Patients were treated with dignity and respect and staff always maintained confidentiality when speaking to them about their care and treatment by taking patients to a private area. Some of the patients we observed had severe levels of cognitive impairment and became agitated or aggressive at times. When this happened, we saw staff respond to patients in a calm and reassuring manner and allow patients time to calm down using de-escalation techniques. It was clear that staff knew patients well as they discussed their hobbies and interests with them whilst trying to help them relax.

Patient care plans reflected their individual preferences. This included things such as patients preferred bedtimes and food choices. These were often displayed in the patients' bedroom or in regards to food choices on a board in the kitchen area so staff serving meals could see the information. We saw staff assisting patients' with their personal hygiene. When this was the case, the staff always ensured that patient privacy and dignity was maintained by closing privacy screens on doors and ensuring that curtains were pulled around in bathrooms so if the patient was able to wash themselves they could do so in private.

We spoke to 16 patients during our inspection. Those patients told us that staff were kind and looked after them well. They told us that staff always had time to help them, but if they were busy they would explain and always come back when they said they would. Patients all told us they felt safe on the wards and that staff supported them if they were feeling unwell or upset.

The involvement of people in the care that they receive

On admission, patients were orientated to the ward by the staff on duty. They were shown their bedroom, where bathrooms were and where they could get a drink or something to eat. They were introduced to the staff on duty and to the other patients. For patients with cognitive impairment staff would do this as many times as was needed to reassure the patient and their rooms were made recognisable by having their names or photograph on the doors. On Willows Ward, there were signs on all doors in braille so that patients who had impaired vision could find their way around.

We reviewed 44 care records during the inspection. We saw evidence of patients' involvement in their care. This included patients attending meetings regarding their care and their views being clearly documented in the notes. Patients had signed to say they had been given a copy of their care plan and where they could not sign or refused a copy this was documented in the care records and more attempts to get the patient to engage could be seen throughout the care record.

All the wards had open visiting times. This meant that relatives were welcome to visit at any time and remain involved in the care of the patient. Mealtimes were protected meaning that all staff went to the dining room to assist and did not take calls unless urgent at these times. However, relatives were encouraged to come at mealtimes if this meant that the patient felt more comfortable to eat and when this happened, it was reflected in the patient care plan.

All wards had access to an advocacy service. This varied depending on the location but all ward staff reported they had good links with their chosen advocacy service. Patients we spoke to were able to tell us what the advocacy service was and if they had met with that person. Staff told us that the advocates usually responded to referrals within 24 hours.

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

Average bed occupancy over the six months prior to inspection was 91% including leave and 83% excluding leave. All of the older adult wards were above the national average of 85% for bed occupancy. In the 6 months prior to our inspection there were four out of area placements for the service.

Staff told us that leave beds would be used. However, this would be risk assessed dependent on whether the patient was likely to return. For example, if a patient was placed in a care home where they would have a high level of support and input from a community team a leave bed might be used. If a patient had failed leave or was a complex case then staff were clear they could protect that leave bed in case the patient needed to return.

In the six months prior to inspection, there had been 26 delayed discharges for the core service. The highest number of delayed discharges were from Ward 19 with eight. We reviewed care records of patients that were delayed discharges, the delay was mainly due to awaiting an appropriate placement for patients with higher levels of need.

If patients required a higher level of nursing care there was access to a psychiatric intensive care unit. This was always in the same locality as the ward the patient was on in order to allow family and friends to visit regularly.

When patients were discharged this was always planned in collaboration with the patient. This was always done during the day at an appropriate time for the patient and their relatives or the care provider they were going to. Staff would facilitate discharge to care homes so that the patient went with a familiar person and their family would meet them there to help patients settle in.

The facilities promote recovery, comfort, dignity and confidentiality

On each of the wards there was a full range of rooms to support treatment and care. This included clinic rooms to examine patients, activity rooms and rooms where patients could meet with staff for one to one time. All of the wards had a minimum of two lounge areas so that patients could choose to go to another area if they wanted to. On all of the wards where there were patients with a diagnosis of dementia, there was dementia friendly signage which

incorporated words and pictures at a visible height so that patients could find their way around more easily. On Willow Ward, there were signs in braille on all the doors so that patients who were visually impaired could find their way round the ward.

Patients were encouraged to personalise their bedrooms and we saw examples of this. Some patients had pictures of their family or pets and others had artwork they had done during arts and crafts groups on the wards.

The patients we spoke with told us that the food was of good quality and there was plenty of choice. The dining room on each of the wards was spacious and allowed staff to engage with patients during mealtimes. This meant that if patients needed help with eating staff had room to do this without imposing on other patients. There were facilities on each of the wards so that patients could make a hot drink. For patients who were unable to do this for themselves staff would offer drinks on a regular basis and assist them to drink, we saw this happening during the inspection. All the wards had access to implements to assist patients to maintain their independence when eating for example plate guards and non slip mats for tables. There was access to specialist diets for patients who may have swallowing difficulties which included thickener for drinks and different consistencies of food that were easier to swallow.

Each ward had access to an outdoor area. There was access to these at all times although this was risk assessed as some patients needed assistance due to poor mobility.

There was access to a telephone to make a private phone call on each of the wards. For some wards this was a ward mobile phone that patients could use and on others there was a private booth where patients could sit and make a call.

On all of the wards there was an activity planner. This was displayed clearly on the wall somewhere on the ward and staff gave patients a copy of this on admission. On every ward we were told this was flexible so if patients wanted to do something else during that time staff would try to facilitate this. For example if it was nice weather they may choose to go for a walk rather than do a quiz indoors. This was led on most of the wards by the occupational therapist or their assistant and they worked Monday to Friday. At weekends and in the evenings there were activities

Are services responsive to people's needs?

Good 

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

available and these would be led by the ward staff. At weekends more people had visitors or went out with family so the activity plans were more relaxed for example board games and DVD nights.

Meeting the needs of all people who use the service

All of the wards we visited were on the ground floor and had full disabled access. They all had an assisted bathroom that was a wet room design to allow wheelchair users to gain access easily. These bathrooms all contained an assisted bath where the seat could be moved up and into the bath for people who found it difficult to step in.

There were information leaflets on each ward which contained information about the ward, treatments and different illnesses. There was information about how to complain and patients' rights when they were detained. There were also leaflets about local groups and activities that people could attend. If required these leaflets could be obtained in different languages. There was access to interpreters via an online booking system and staff reported they were quick to respond when they needed them. There was access to specialist diets from the catering department for example kosher or halal food for patients that required them.

Staff told us that patients were encouraged to continue to attend their own religious meetings as much as possible. However, if patients could not go out for any reason then the trust had access to religious leaders of different denominations who were able to attend the ward to see patients. We spoke to the priest who was visiting Beechdale Ward whilst we were there and patients reported they appreciated their input. There was going to be a church service at The Poplars for Easter Sunday where there would be communion for patients who wanted it. There was also a multi faith room at each site where patients could have access to religious books and materials required to pray for all denominations.

Listening to and learning from concerns and complaints

Ten complaints were received in the 12 months prior to inspection regarding the service and of these, all were upheld. No complaints were referred to the Ombudsmen. Chantry Unit, Wakefield had the highest number of complaints with five and had the highest number of upheld complaints with five.

Thirty-two compliments were received in the 12 months prior to inspection, with Ward 19 receiving the most with 11.

We spoke to 16 patients' during our inspection and they all told us that on admission they were given details of how to complain about the service. Some had an information pack which contained these details that were kept in their bedroom. All patients told us that they were confident if they spoke to staff about an issue they would listen and do their best to sort it out. They all felt they could approach staff without any problems. Patients told us about the ward community meetings where they could discuss any issues they had on the ward for example food, activities, and the environment. During this time staff would try and answer their queries but there was also a record of these meetings in a file or on the wall for all patients to access should they want to. Staff could also refer back to this if the same issues kept coming up so that this could then be passed to a more senior member of staff.

Staff we spoke to were able to explain the complaints procedure appropriate for their level. For example support staff knew where the complaints leaflets were and how to access them. The senior staff including qualified nurses and ward managers were able to tell us the process in more detail. Staff told us that learning from complaints was shared in team meetings or if they related to an individual this would be discussed between that member of staff and the ward manager.

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

The trust values were “honest, open and transparent, respectful, person first and in the centre, improve and be outstanding, relevant today, ready for tomorrow, families and carers matter”. During the inspection we spoke to staff and asked them about the values. Staff told us that the values were identified through a series of sessions for staff and patients where they could give their ideas on what they thought was important to them, these were then developed into the trust values.

The trust values were reflected in individual teams. Staff were able to tell us what these were and how they were used during their supervision and appraisal process in order to reflect on their practice.

We asked staff about the most senior managers in the organisation. Staff told us that they knew who they were and that they have seen some of them on the wards or at meetings. Staff felt if they needed to speak with someone more senior they would feel comfortable doing so.

Good governance

There were systems in place for managers to be able to oversee performance of their team in training, both mandatory and non mandatory. This meant that managers were able to identify what training their staff required it also see when training was due so that they could plan for this and book staff on in advance. This was reflected in the training figures for the core service where 89% of staff had completed mandatory training. During our inspection we reviewed staff training and could see that managers had pre booked staff on courses the month before training expired so there was no gap in compliance.

The appraisal process for the trust was called a “season”, this meant there was a set time of year for appraisals to be done and this would begin with the most senior managers in the trust. This meant that identified needs across the service filtered down to ward level and all staff knew what their own plan was for the year. This was reviewed every three months so managers and staff had an opportunity to sit down together and see where the plan was up to and any areas that were difficult to achieve that needed to be reviewed.

The trust had carried out a safer staffing review in 2015. This included a monthly report by wards on different issues

that affected staffing including acuity, needs of the patient group and staff sickness. Following this review the trust had implemented minimum staffing levels of qualified and unqualified staff for each of the older adult wards across the trust. This information had also been used to inform skill mix. During our inspection we saw managers working with this to ensure that wards were staffed to the minimum staffing levels set by the trust. However, it was also clear that should managers feel the need to increase staffing for any reason they felt confident to do so to ensure the staff and patients were safe.

There were many examples of clinical audits happening across the service. These included medication audits, care records audits and mental health act audit amongst others. Staff were involved in these audits at all levels and information was fed back to the appropriate people at meetings, in supervision and via email from the ward manager.

We spoke to staff and asked them about the incident reporting process. Staff were able to tell us how this worked and when and how to report incidents. We saw evidence of learning from incidents and changes made following this learning.

All ward managers felt that had sufficient authority to run their ward. They were confident that they could approach their immediate managers for extra support if they needed it. Managers also told us that they felt they would not have a problem going to more senior members of the leadership team if their immediate manager was off work or unavailable. They felt their opinions were valued and they were listened to.

Leadership, morale and staff engagement

The sickness level across the service was 7.5%. This was highest at Beechdale Ward at 5.3%. During our inspection we reviewed staff files and found that managers were managing any sickness absence according to the trust policy. There was support available for staff who were off with work related stress this included access to counselling and phased returns back to work.

At the time of our inspection there were no ongoing cases of bullying or harassment. Staff were however, aware of the trust whistleblowing policy and how this should be used. Staff were all confident they could approach their immediate managers for support if they needed it.

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.

Commitment to quality improvement and innovation

Staff we spoke to told us that they were encouraged to improve their practice by taking courses at University. The trust had good links with the local universities. Examples of courses taken by the staff were mentorship module to assist student nurses in their learning, cognitive behavioural therapy and counselling courses. Junior staff also felt they were encouraged to improve their skills, for example some healthcare assistants were able to take blood samples following a venepuncture training course.

The older adult wards were just beginning the process of rolling out the safeguards model of care. This is about

reducing restrictive practices in mental health and learning disability settings by using positive language to reduce conflict in mental health settings, in particular the use of restrictive practices such as restraint

All wards had been involved in a project to reduce length of stay. This was done by an outside agency to look at barriers to discharge in the older adult wards and how to reduce length of stay.

The trust was not engaging in any national accreditation schemes for older adult inpatient wards.

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 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users</p> <p>How the regulation was not being met</p> <p>On The Poplars, Ward 19 and Chantry Unit the ward layout did not allow staff to observe all parts of the ward. This was not mitigated by the use of mirrors on Chantry Unit or Ward 19. The use of observations did not include staff being present in those areas on a routine basis and on the day of our inspection staff were not present in those areas. Risk assessments of patients did not refer to the blind spots within the wards when considering the risks to and from that patient. This meant that the ward was not doing all that was practicably possible to reduce the risk of harm to patient s and staff.</p> <p>This was a breach of regulation 12(2)(b)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>How the regulation was not being met</p> <p>On Ward 19 the bedrooms door handles were a ligature risk. Although this was identified on the annual ligature risk assessment to be managed locally there were no bedrooms without these door handles. This meant that if patients were a high risk of self harm they would need to be nursed on close observations which was not the least restrictive option. Furthermore this meant that patients</p>

This section is primarily information for the provider

Requirement notices

who had no previously identified risk of self harm were not routinely risk assessed for the ligature risk inside their bedroom leaving them with easy access to ligature points.

This was a breach of regulation 15(1)(C)