

Inadequate

Coventry and Warwickshire Partnership NHS 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)
RYG79	St Michael's Hospital	Ferndale Ward	CV34 5QW
RYGCW	Manor Hospital	Pembleton Ward	CV11 5HX
RYGCW	Manor Hospital	Stanley Ward	CV11 5HX
RYG 81	Woodloes Avenue	Woodloes Ward	CV34 5XN

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service

Inadequate



Are services safe?

Requires improvement



Are services effective?

Inadequate



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Inadequate



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 changed the rating from requires improvement to inadequate because:

- We issued the trust with a warning notice under Section 29a of the Health and Social Care Act 2008 because we found that staff did not monitor physical health effectively. Care records showed that staff did not use the early warning scoring tool accurately. Audits had failed to identify any issues. There was no oversight of the competency of staff after initial training. Staff did not follow care plans to manage known physical health problems, such as diabetes. For example, staff recorded observations intermittently rather than as planned and took no action if they found adverse results. This placed patients at risk.
- The service had low training rates for core clinical skills such as the use of restraint and manual handling of people. The trust made dementia training mandatory in April 2017, eight years after NICE guidance and the national dementia strategy recommended its introduction.
- The trust had failed to implement two recommendations made at our last inspection to improve person-centred care on the wards. We recommended the trust should ensure care plans are personalised and holistic and that staff give copies to patients, where appropriate. Records showed little evidence of patient involvement in discussions about care plans and that staff were inconsistent in offering copies to patients. Nursing care plans remained generic with little evidence of personalisation.
- The CQC had requested that the trust should ensure that all care plans record capacity assessments, where

relevant. We found that three best interests decisions about discharge plans lacked a decision-specific assessment of mental capacity. This meant they fell short of the requirements set out in the Mental Capacity Act Code of Practice to demonstrate that all reasonable efforts had been made to support the individual patients to make their own decisions and that they lacked mental capacity for that decision at that time. These omissions significantly infringed a person's rights.

However:

- The trust had addressed all of the requirements and most of the recommendations from the last CQC inspection. The trust made all wards single sex, which fully met the guidance on eliminating mixed-sex accommodation. The trust had addressed environmental issues including poor lines of sight and ligature risks in patient areas with new equipment and risk assessments to mitigate risks. Staff referred all qualifying patients to independent mental health advocacy services, in line with Mental Health Act Code of Practice. Staff recorded who they gave section 17 leave forms to in addition to the patient. The trust provided training for staff on the use of seclusion that was in line with the standards outlined in the Mental Health Act Code of Practice. The trust fitted vision panels in bedroom doors to help staff observe patients discreetly, while maintaining their privacy.
- Wards maintained their planned staffing levels and ward staff were able to request extra staff in response to changes in patients' needs.

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:

- Following incidents, staff did not routinely update mental health and physical risk assessments and risk management plans.
- We found out-of-date emergency equipment on Pembleton ward.
- The trust did not have safe and effective plans to manage high clinic room temperatures to ensure safe storage of medicines.
- The inspection team found that staff on Pembleton ward left doors and windows open in the clinic room and left medicines unlocked. We reported this security breach to the matron and the trust pharmacy during our inspection.
- Wards had low training rates for moving and handling people and the use of restraint, which potentially affected staff's ability to respond to an emergency.
- The physical complexity wards had restrictions in place but no record of individual risk assessments that justified them. Patients were restricted in their movement around the ward on Ferndale ward by locked internal doors.

However:

- Following the last CQC inspection, all wards met the requirement to eliminate mixed sex accommodation and each ward had clinic rooms fully equipped for resuscitation. Staff checked all emergency equipment regularly except on Pembleton ward where we found some out-of-date equipment.
- Managers had completed a ligature risk assessment on all four wards in May 2017. Woodloes had made significant improvements in addressing its ligature risks. The remaining wards had ligature risk reduction plans to mitigate risks that included individual patient risk assessments.
- All wards were clean and well maintained. Cleaning schedules and audits showed that staff cleaned them on a daily basis. Managers monitored compliance with infection control procedures, including handwashing, through monthly audits.
- Staffing levels on the wards met the minimum standards for the required numbers of qualified and unqualified staff. Managers used bank staff to cover vacancies.
- All wards had access to medical cover during the day. There was an on-call system for out-of-hours cover.

Requires improvement



Summary of findings

Are services effective?

We rated effective as inadequate because:

- Staff did not monitor patients' physical health care consistently and did not address any health problems identified in line with the local guidance.
- Care plans were not up-to-date or personalised, and did not reflect progress towards recovery and discharge.
- Staff did not keep care notes in good order, which made it difficult to find key information quickly.
- Managers could not show that they followed the National Institute of Health and Care Excellence (NICE) quality standards on dementia and falls. Psychological therapies recommended by NICE were not available to the majority of patients on the wards.
- Staff referred patients to the local acute hospital if they needed specialist physical healthcare assessments, for example, swallowing assessments.
- Staff lacked specialist training in physical healthcare and managers did not evaluate clinical skills or provide refresher training.
- Staff on the two specialist dementia wards had not received mandatory training in dementia care and they had received very limited dementia-awareness training previously.
- Some best interests decisions about future care arrangements lacked decision-specific assessments of capacity.
- The core service had low staff supervisions rates, and few opportunities to meet as a group to reflect on practice and discuss lessons learnt.

However:

- The trust had significantly improved the rates of referral to the independent mental health advocate for qualifying patients.
- All patients who received covert medicines had best interests decisions with specific assessments of capacity.

Inadequate



Are services caring?

We rated caring as good because:

- Staff reacted quickly to patients in distress.
- On Stanley and Pembleton wards, we observed the interactions between staff and patients using the short observational framework for inspections. In both sets of observations, we found staff engaged warmly with patients and provided reassurance through speech and touch.

Good



Summary of findings

- All patients received an information pack on admission.
- Staff on the dementia wards used 'this is me' forms to capture patients' personal preferences and history.
- Staff noted when they offered patients a copy of their care plan.
- The carers and relatives we spoke with made positive comments about the standard of care and staff's communication with them.

However:

- Community meetings on three of the wards focused on activities only. We saw broader discussions that included care and environmental issues on Ferndale ward only
- There were no mechanisms in place for patients to be involved in decisions about the development of their service.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- All of the four wards had average bed occupancies of 100% and above including leave. The wards with the highest average bed occupancies were Pembleton ward (108%) and Ferndale ward (107%). This meant that, when patients went on leave, staff used their beds for new admissions, if needed. High rates of delayed discharge of patients were a major contributor to these high levels of bed occupancy. Discharge care plans did not refer to the entitlement to aftercare under section 117 of the Mental Health Act.
- All wards had a limited number of rooms available to accommodate a full range of activities. Therapy activities took place in the lounges and small meeting rooms meant for clinical meetings and visitors.
- Each ward had only limited space to accommodate visitors.
- There were no dedicated clinic rooms to allow for the physical examination of patients, staff used patients' bedrooms instead.

However:

- Activity workers on Pembleton and Stanley wards provided appropriate activities to patients with dementia. They used equipment specifically tailored for the use of people with dementia.
- The patient-led assessment of care environments scores for the ability of the wards to meet the needs of people with dementia

Requires improvement



Summary of findings

or a disability were all higher than the national average. The wards for people with dementia on the Manor hospital site rated above the national average for supporting the needs of people with dementia.

- Only three complaints were reported by the four wards in the year to 30 April 2017. The wards received 14 compliments during the same period.
- Information on making complaints and the patient advice and liaison service (PALS) was available on all the wards.

Are services well-led?

We rated well led as inadequate because:

- Senior clinicians on the wards did not clearly understand the physical complexity pathway. This meant there was no agreed admission criteria between the ward team and referrers which had led to patients being inappropriately placed.
- There were no service development plans in place or analysis of development needs of staff completed.
- Governance systems had not alerted managers to the concerns we found with regard to physical health monitoring.
- Staff reported low morale caused by work pressures and continuous changes to the service. Staff felt that managers did not consult them about changes to ward locations or care pathways.

However:

- Staff told us they felt well supported by other members of their team and that ward teams worked well together.
- Staff felt confident to raise concerns without fear of victimisation and understood the whistleblowing procedures.
- Managers shared information about the performance of the wards with staff, patients and visitors.

Inadequate



Summary of findings

Information about the service

Coventry and Warwickshire Partnership NHS Trust has four wards that provide care to older people with mental health problems.

Two wards, Stanley and Pembleton, are based at the Manor hospital site in Nuneaton.

Stanley ward has 12 beds for male patients, and provides assessment and treatment for men and women with dementia-related illness. In December 2015, managers relocated the ward from the Caludon Centre in Coventry to the Manor site owing to health and safety concerns about the building. In October 2016, managers changed the ward from mixed sex to one for men only. In April 2017, managers made a decision to keep the ward on the Manor site permanently.

Pembleton ward has 12 beds for female patients, and provides assessment and treatment for women with

dementia-related illness. On our last inspection, the ward was a psychiatric physical complexity unit with 12 beds for both male and female patients. It became a ward for the care of women living with dementia in October 2016.

There are a further two wards based in Warwick. Ferndale ward is a psychiatric physical complexity unit with 21 beds for male patients based at St. Michael's Hospital in Warwick. Managers relocated the ward from the Caludon Centre in Coventry in February 2016 due to health and safety concerns at the time. Woodloes ward is standalone psychiatric physical complexity unit based at Woodloes Avenue on the St. Michael's Hospital site. It has 15 beds for female patients. These wards are age independent and are for those who present with physical health complexities alongside mental health problems.

At the time of the inspection, all wards were full apart from Ferndale ward, which had three vacant beds.

At our last inspection in April 2016, we did not inspect Woodloes ward.

Our inspection team

The Coventry and Warwickshire Partnership NHS Trust comprehensive inspection was led by:

Head of Inspection: James Mullins, Head of Hospitals (Mental Health), CQC

Team Leader: Paul Bingham, Inspection Manager (Mental Health), CQC

The team that inspected wards for older people with mental health problems comprised one CQC mental health inspector, three specialist advisers (a consultant

psychiatrist, a mental health nurse and a clinical psychologist) all with experience working with older people with mental health problems. A CQC inspector from the acute hospital directorate joined the team for two days to review physical health records with another mental health nurse specialist adviser. A CQC specialist pharmacy inspector joined the team for one day. A representative of the National Institute for Health and Care Excellence (NICE) joined our inspection to observe how the CQC inspects a service.

Why we carried out this inspection

We undertook this inspection to find out whether Coventry and Warwickshire Partnership NHS Trust had made improvements to their inpatient mental health services for older people since our last comprehensive inspection of the trust in April 2016.

When we last inspected the trust in April 2016, we rated wards for older people with mental health problems as **requires improvement** overall. We rated the core service as requires improvement for safe, effective, responsive and well led. We rated caring as good.

Summary of findings

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

- The trust must ensure adherence to the guidance on eliminating mixed-sex accommodation.
- The trust must address environmental issues including poor lines of sight and ligature risks in patient areas.
- The trust must ensure that qualifying patients are referred for support from an independent mental health advocate, in line with Mental Health Act (MHA) Code of Practice.
- Section 17 forms must indicate who they are given to in addition to the patient.
- The trust must ensure that seclusion is carried out in line with the MHA Code of Practice.

We also told the trust it should take the following actions to improve wards for older people with mental health problems:

- The trust should ensure that all care plans record capacity assessments, where relevant.
- The trust should ensure that care plans are personalised and holistic and that a copy is given to the patient, where appropriate.
- The trust should ensure patient confidentiality when putting names on patients' bedroom doors.
- The trust should consider providing privacy panels in bedroom doors for staff to observe patients when required.

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.

During the inspection visit, the inspection team:

- visited all four of the wards at the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service

- spoke with five relatives of patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with forty other staff members including doctors, nurses and social workers
- interviewed the pathway leaders with responsibility for these services
- attended and observed one hand-over meeting, one positive behaviour support planning meeting and one multidisciplinary meeting
- looked at 48 medication treatment records of patients
- looked at 22 patient care records
- carried out two observations of interactions between patients and staff using the short observational framework for inspections (known as SOFI)
- 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 heard positive feedback from patients and carers about the caring nature of staff. Patients described staff as caring and respectful, and patients felt listened to. However, patients expressed concerns about the food, both the quality and the taste. Patients on Ferndale raised concerns about the restrictions they faced on the

ward. For example, staff asked informal patients to seek medical consent to leave in advance, and patients found doors on the ward locked without clear explanation. This left the patients dependent on nursing staff who were not always available immediately to open the doors.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

Action the provider **MUST** take to improve

- The trust must ensure that there is consistency in the ongoing monitoring and mitigation of identified physical and mental health care risks.
- The trust must ensure that care plans are up-to-date, person-centred kept, and reflect changes in patients' wellbeing and behaviours.
- The trust must ensure there are effective contingency plans to respond to high clinic room temperatures that affect medicines.
- The trust must ensure that staff are up-to-date with their mandatory training and receive the specialist training required for their roles.
- The trust must ensure that sufficient staff are trained in critical clinical skills such as physical intervention, and moving and handling people, to handle emergencies appropriately.
- The trust must ensure that staff in the wards for older people receive up to date Mental Health Act training to equip them for their current roles.

- The trust must ensure that staff's clinical risk management clinical skills are evaluated regularly and that staff are offered refresher training, where necessary.
- The trust must ensure that staff skills in monitoring and managing common physical health conditions and crises are kept up-to-date.
- The trust must ensure staff receive ongoing supervision and access to staff meetings to maintain their professional competencies, and to reflect and share experiences and lessons learnt.
- The trust must ensure that records show an initial decision-specific assessment of mental capacity linked to all decisions in the patients' best interests.
- The trust must be able to demonstrate that it reviews and considers for implementation the National Institute for Health and Care Excellence, NHS England and the Royal College's guidance relevant to this core service.

Action the provider **SHOULD** take to improve

- The trust should ensure that staff inform all patients detained under the Mental Health Act of their rights on an ongoing basis, in line with local policy, and after any change in their status.

Coventry and Warwickshire Partnership NHS 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
Ferndale Ward	St Michael's Hospital
Pembleton Ward	Manor Hospital
Stanley Ward	Manor Hospital
Woodloes Ward	Woodloes Avenue

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings to help reach an overall judgement about the provider.

An average of 46% of staff in this core service had received training in the Mental Health Act between 1 May 2016 and 30 April 2017. Staff on Pembleton ward had the highest training rate of 71%, and Stanley ward, the lowest at 15%. We found that there were patients detained under the Mental Health Act on all four wards with a higher proportion on the two wards for people living with dementia.

We found that staff adhered to consent to treatment and capacity requirements. Copies of consent to treatment forms were attached to medication charts, where required.

Staff recorded that they informed patients of their rights at the point of their admission or when a change to their detention status occurred. On Stanley and Pembleton wards, staff informed patients of their rights at regular intervals. However, on Woodloes and Ferndale wards, staff did not inform patients of their rights after admission.

A central trust team supported the wards in the administration of the Mental Health Act.

Staff held Mental Health Act paperwork in a separate folder from the main care notes. The paperwork was in good order, up-to-date and accurate.

On the last CQC inspection of the service, we found that staff had not referred all detained patients to an independent mental health advocate (IMHA). At this inspection, staff had recorded making referrals to the IMHA

Detailed findings

for 24 of the 26 patients under detention. The two omissions were both patients on Ferndale ward. This was a significant improvement overall. Staff told us that IMHAs visited all the wards and staff discussed and referred any new admissions.

Mental Capacity Act and Deprivation of Liberty Safeguards

In the year to 30 April 2017, 92% of clinical staff across the services had received training in the Mental Capacity Act.

The trust had made 80 Deprivation of Liberty Safeguards (DoLS) applications between 1 April 2016 and 31 March 2017, of which the local authority approved 45. The trust had informed the CQC of 71 of these DoLS applications.

Staff on the two wards for people with dementia had a good understanding of the deprivation of liberty safeguards. They monitored review dates and kept in touch with the relevant local authority about progress on applications. They gave early notice of any planned discharge to allow for the next placement to prepare relevant documentation.

The trust had a policy in place to inform staff of their responsibilities under the Mental Capacity Act and provide essential information about its use and application. The policy included information on the DoLS.

Staff supported patients to make decisions and worked on the basis that any assessments should be decision specific. In one set of case notes, we saw that staff had provided a patient with written information because their visual comprehension was better than their ability to interpret speech.

In all the cases we reviewed of the use of covert medications, we found staff were following proper procedures in line with the Mental Capacity Act and National Institute for Health and Care Excellence (NICE) guidance on managing medicines in care homes. Staff involved families, carers and pharmacy staff in discussions about the use of covert medicines in the best interests of patients who lacked mental capacity.

We reviewed six best interests decisions made to support the discharge of patients to a community placement. We found no decision-specific mental capacity assessments in three of the decisions. Without evidence of an original decision-specific assessment of mental capacity, the decision reached would be invalid.

Staff understood the Mental Capacity Act's definition of restraint and the principle of least restrictive interventions about physical restraint.

Staff knew that the trust's Mental Health Act office was also responsible for the Mental Capacity Act. Trust staff completed audits of each ward's compliance with the Mental Capacity Act and left feedback for staff on areas of 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

- In our last inspection, we raised concerns about poor lines of sight on the wards. The trust had addressed these concerns by carrying out an assessment with the estates department. It had introduced mirrors and other fittings to improve the lines of sight. The trust had included Woodloes ward in this review although we did not inspect it in our last inspection. Stanley and Pembleton wards had the same layout and clear lines of sight or fittings to aid observation. Ferndale ward had some limited lines of sight because staff locked corridor doors, which meant they could not see into the next patient area. Woodloes ward was set around a central garden area. It had open lines of sight from the main entrance across the garden to all points on the ward.
- Staff had assessed and identified potential ligature points on each ward in May 2017. In the public areas of the ward, the constant presence of staff risks mitigated the risks. On Woodloes ward, patients' bathrooms had anti-ligature fittings. The trust had a policy to address ligature risks through annual audits and action plans. In addition, staff completed 'ligature walk arounds' on the wards to inform them of risks. Staff assessed patients' risk of potential use of ligature and used individualised risk management plans and clinical observations to manage the risks. If a patient's risk history included ligature use, the bed management team considered their suitability for the four wards. The trust had considered the needs of the patient group to identify and address the risks on the wards. For example, the wards had a range of equipment and disability aids such as hand and grab rails. These are reasonable adjustments in line with the Equality Act requirements to meet the needs of the patient group.
- Following our last inspection, the trust re-organised the mixed-sex wards and created single-sex wards. Pembleton ward became a ward for women with dementia. Stanley ward became a ward for men with dementia.
- Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that nurses checked weekly. Records showed that staff on the wards checked emergency equipment and drugs on a daily basis. Ligature cutters were available in the main emergency bags. These are hooked knives designed to allow staff to remove any material tied to a patient without harming the person. Staff completed daily checks on the ligature cutters on all wards. However, on Pembleton ward we found an oxygen cylinder that had passed its expiry date of August 2016, and still had a mask attached to it. We also found a smaller oxygen cylinder that was empty and had expired in December 2016. Two other oxygen cylinders were in date. Staff had not labelled the out-of-date and empty bottles to prevent use in an emergency, or arranged for their collection.
- None of the four wards had access to a seclusion room.
- The wards were clean and well maintained, and corridors were free from clutter. Each ward had allocated domestic staff that cleaned their wards on a daily basis. Cleaning schedules were available on each ward. We reviewed cleaning checklists and audits and found they were completed and up-to-date. The domestic staff knew the risks associated with the cleaning products they used and stored them securely when not in use. Managers displayed the outcomes of monthly audits of cleanliness, hand hygiene, mattress checks and food safety in the public areas of all the wards. This was part of their matron's dashboard initiative to keep staff, patients and visitors informed about the performance of the wards.
- Patient-led assessment of care environments (PLACE) assessments are self-assessments undertaken by teams of NHS and private/independent health care providers and include at least 50% members of the public (known as patient assessors). The assessments focus on different aspects of care environments. In relation to cleanliness, the 2016 PLACE score was 98.4% for Manor Hospital (comprising Stanley and Pembleton wards), 98.8% for St. Michael's Hospital (including Ferndale ward) and 100% for the standalone Woodloes ward. The overall score for the trust was 97% just below the England average of 97.8%. For condition, appearance and maintenance Manor Hospital scored 95.1%, St. Michael's Hospital scored 92.4%, and Woodloes Avenue scored 100% against a national average of 94.5%.

Are services safe?

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

- Managers monitored ongoing compliance with infection control procedures, including handwashing through monthly audits.
 - Equipment in clinical rooms was clean and well maintained. However, on Woodloes ward, we found out-of-date dressings in the clinical store.
 - The clinic room on Pembleton ward had a glass-paned door that opened onto a publicly accessible car park. Staff opened the door at times to allow the room to cool to protect the integrity of the medicines. Managers told us that this happened only when staff were present. However, on our second visit to the unit, we found that staff had left a window open and the drugs trolley unlocked and unsecured to the wall, creating a risk of theft. We informed the pharmacy department and matron of our concerns.
 - There were two alarm systems in operation on the wards. Pembleton and Stanley wards had nurse call alarms operated from fixed points on the walls of bedrooms, communal areas, bathrooms and toilets. Patients used this system for non-urgent calls for nursing aid and urgent calls for assistance in emergencies. Woodloes ward had nurse call alarms in the bathrooms and toilets but not in bedrooms. There was no nurse call system available on Ferndale ward. Nursing staff on all the wards carried personal alarms that linked to a hospital-wide system and pinpointed the location of the alarm when activated. The response team was made up of members of staff from other wards in the hospital. However, Woodloes ward was a stand-alone unit and relied wholly on its own staff to attend to any emergency.
- Safe staffing**
- Ferndale and Woodloes wards had 14.2 whole time equivalent (WTE) qualified nurses, a ward manager, two deputy ward managers and 11.2 WTE staff nurses. Pembleton and Stanley wards had 13 qualified nurses, a ward manager, a deputy ward manager and 10 staff nurses. Ferndale had 23.75 WTE nursing assistants. Woodloes ward had 12.5 WTE nursing assistants, and both Pembleton and Stanley wards had 20 WTE nursing assistants.
 - Ferndale ward had vacancies for three registered nurses and five nursing assistants. Woodloes ward had vacancies for one registered nurse and three nursing assistants. Pembleton ward had vacancies for one registered nurse vacancy and four nursing assistants, and Stanley ward had vacancies for 1.8 WTE registered nurse and two nursing assistant. The wards had an overall vacancy rate of 16%.
 - Bank and agency staff had filled 1712 qualified nurse shifts and 3391 nursing assistant shifts in the year to 31 January 2017. The trust had not been able to fill 251 qualified nurse shifts and 606 nursing assistant shifts in the year to 31 January 2017.
 - The average sickness rate for this core service was 10.6% between 1 February 2016 and 31 January 2017, which was above the trust's target of 4.65%, and the trust's overall sickness rate of 5.4%. Ferndale ward had the highest average sickness rate of 12.8%. Pembleton ward had the second highest rate of 10.5%. Woodloes ward had an average sickness rate of 9.8%, and Stanley ward had the lowest sickness rate of 9.6%.
 - Older people's wards had 16.6 (14%) staff leave between 1 February 2016 and 31 January 2017, which was in line with the trust average. All four wards had staff leave during this period. Ferndale ward had the highest leaver rate; with 5.6 staff leaving during that 12-month period. Ward managers told us that further staff had indicated they wished to leave since the decision to keep the relocated wards in Nuneaton and Warwick.
 - Each ward had a minimum complement of staff assigned to day and night shifts, and additional staff worked the twilight (evening) shift. Woodloes ward had some staff work an early morning shift to support patients to get ready for the day. The planned level of staffing allowed for one patient to receive one-to-one clinical observations. Managers requested additional staff if there was more than one patient who needed one-to-one observation. If clinical needs increased, the nurse-in-charge used the safe care tool to request extra staff from the trust's staff bank. This electronic staffing tool allowed staff to rate the dependency of each individual patient routinely twice a day, and at other times if a patient's needs changed significantly. The tool calculated the number of staff required to provide safe care on the ward based on the assessed level of need. If extra staff were required, the system programme automatically contacted the trust's bank staffing team to fill the vacancy.

Are services safe?

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

- On all wards, we observed that a qualified nurse was not always present in the communal areas of the ward because of other duties in the office, clinic or meeting rooms.
- The ward managers told us they rarely cancelled escorted leave or ward activities because there were too few staff. However, staff expressed concern that they could not always maintain the safety of the ward in an emergency because other staff were occupied with observations and other duties.
- Managers block-booked agency or bank staff where possible so that they became familiar with the patients and ward systems, and so that patients received continuity of care.
- Each ward had access to medical cover from their regular medical team from Monday to Friday, during the daytime. The wards had an on-call system for out-of-hours medical support, and medical staff could attend Pembleton, Stanley and Woodloes wards quickly if needed. A member of the out-of-hours medical team was based at St. Michael's hospital, which meant they could attend Ferndale ward quickly, if needed. Consultant psychiatrists were available by phone at all times. In cases of physical health emergencies, ward staff contacted the emergency ambulance service.
- As at 31 January 2017, the average compliance rate for mandatory training for staff on the older people's wards was 86%. In 11 of the 16 training courses that the trust provided information on, the service did not meet the trust compliance target of 95%. Infection prevention (level 1 and 2) had the highest compliance rate of 98% while manual handling people had the lowest compliance rate of 24%. Seventy-two per cent of qualified staff had received training in resuscitation and 86% of staff were up-to-date with basic life support skills training. Staff received mandatory training in the use of restraint and were required to maintain their skills through annual updates. As of July 2017, 65% of staff on Ferndale ward, 71% of staff on Pembleton ward, 70% of staff on Woodloes ward and 87% of staff on Stanley ward were up-to-date with their refresher training in this key clinical skill. Staff were also required to complete a foundation course to introduce them to the principles of a least restrictive model and essential practice to perform a restraint safely. The training compliance rate for the course was 81% on Ferndale ward, 89% on Woodloes ward, 87% on Stanley ward and 94% on Pembleton ward.
- Staff not up-to-date with training or untrained in restraint posed a risk to the safety of any restraint and increased the risk of harm to the patient and staff involved. Although Woodloes ward reported low rates of restraint, it was a stand-alone unit with no support available from other wards. Yet 30% of permanent staff were not adequately trained to respond to an incident of aggression safely. Training figures were similar on Pembleton ward but staff had access to help from Stanley ward, which reduced the overall risk.

Assessing and managing risk to patients and staff

- In the six months up to 30 April 2017, there were no recorded episodes of seclusion or long-term segregation on the four wards.
- There were 73 episodes of restraint recorded in the six months to the 30 April 2017. These were highest on Stanley ward with 35, and Pembleton wards with 29 episodes. There were no episodes of prone restraint recorded.
- Stanley ward recorded four episodes of the use of rapid tranquillisation using intra-muscular injection in the six months to 30 April 2017. The trust had based its policy on rapid tranquillisation on the current National Institute of Clinical Excellence (NICE) guidance dated February 2015. The policy provided a clear explanation of the safeguards required to ensure that staff monitored a patient's wellbeing after administration. There were separate protocols to guide doctors on prescribing for older people.
- We examined 22 clinical care records across the four wards. Every patient had a risk assessment completed on admission to the service. The risk assessments were comprehensive and took account of mental health, physical health and social risks. For each identified risk, staff completed management plans, which identified how they planned to support patients. Staff recorded the risk assessment and plan on paper-based care records. However, we found that staff did not review risk assessments regularly. We tracked two cases in detail on Stanley ward. In one case, staff had completed two reviews since March 2017, both in the week prior to this inspection. In the other case, staff had not completed any reviews between January 2017 and 31 May 2017.
- Staff did not routinely update risk assessments and associated management plans after an incident. On Pembleton ward, we found that staff did not update a risk assessment to record multiple assaults on staff until

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20 days after the incident. The corresponding incident report stated that care plans “be reviewed and the risk assessment updated and a positive behavioural support plan developed.” We searched the patient’s notes and found one care plan related to the management of physical aggression that commenced on 22 June 2017, several months after the incident of assault. On the day of the assault, staff had removed furniture from the patient’s room to reduce risk. However, there was no plan associated with this action. Staff had started a positive behavioural support plan, but it remained incomplete and undated. Following another incident of an assault on staff, staff reviewed the care plan within 48 hours. However, they did not complete the action to develop a detailed positive behavioural support plan until seven weeks later.

- Staff on Ferndale ward had reacted to antagonism between two patients by separating them on the ward and locking a connecting door. There were no records in the patients’ risk assessments or care plans to explain these actions, justify the impact on other patients. There was no evidence that staff had considered less restrictive strategies to manage the underlying challenging behaviours.
- Staff used Steve Morgan’s ‘working with risks’ clinical risk management tool to assess risks. This is one of the tools included in the Department of Health (2007) guidance on best practice in managing risk. The tool comprised a structured template checklist of relevant risk and contextual factors. The tool included a structured assessment of suicide, neglect, violence and other risks (rated as ‘present’ or ‘absent’). There was space to describe the context of risk factors, positive resources, opportunities for risk prevention and risk management options (short and long-term), with an emphasis on positive risk management.
- Ferndale and Woodloes wards had a number of restrictions in place in response to some patient risks. Staff locked the doors on the wards, which restricted patients’ movements on the ward. This also meant that patients had to ask staff for drinks and snacks. Staff also locked the bathroom doors so patients had to ask staff for access. On Ferndale ward, staff had locked a corridor door to divide the ward into two sections to separate two patients. On Woodloes ward, staff had locked bathrooms following a number of incidents where a patient had attempted to harm herself. Although this measure disadvantaged other patients, staff ensured

they responded to any requests to use the bathrooms immediately. Ward policies imposed reasonable restrictions on patients to manage identified risks. Staff did not allow patients to hold restricted items such as cigarette lighters. However, staff provided a light and support to patients who wished to smoke.

- On all wards, there was a notice at the exit that advised informal patients they were free to leave but asked them to inform staff if they wished to do so. Staff gave informal patients an information leaflet regarding their rights on admission. This gave a clear summary of a patient’s rights and made a reasonable request that the patient should inform staff of any leave they planned to take and when they expected to return. However, three informal patients expressed their dissatisfaction with the locked doors on Ferndale ward. One patient informed us that staff told him he needed a doctor’s permission before he could leave the ward.
- Staff were aware of the trust’s policy on supportive clinical observations. They kept records of their observations of and activities with patients during periods of close (one-to-one) care.
- The trust was rolling out training in positive behavioural support to help manage challenging behaviour. The trust hoped to increase its staff’s skills and confidence in de-escalation and distraction techniques. At the time of our inspection, only staff on Pembleton ward had received training on this approach. We found few examples of individualised approaches that emphasised de-escalation to reduce a patient’s distress. We found only one fully completed positive behavioural support plan.
- As of the 31 January 2017, 97% of staff in this core service had received for training in safeguarding adults and children. The staff we interviewed knew how to recognise and report safeguarding concerns, and gave examples of the types of issues they encountered. Staff made safeguarding referrals in cases of any allegations of abuse between patients. The trust’s data showed that inpatient wards had made 106 referrals between 1 April 2016 and 30 March 2017. However, the trust did not have disaggregated data that showed the number of referrals made by the older people’s wards.
- In total, we looked at 48 prescription charts. On all wards, we saw that staff completed medicine reconciliation on all prescription charts and recorded when patients had allergies to any medicines.

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Prescription charts had pharmacist interventions documented on them, and where appropriate, staff reported medicine errors using the incident reporting system.

- During the six-month period prior to our inspection, the medicines management team had audited controlled drugs, and undertaken 'snap-shot' audits on the safe and secure handling of medicines. However, we found that medicines were not always stored within safe temperature ranges. The trust had an approved standard operating procedure, 'Temperature Monitoring in Rooms Storing Stock Medication'. This was to ensure that medicinal products (medicines and medicated dressings) that required storage at 25°C or less were stored correctly. Medicines stored out of their temperature range maybe ineffective or have a shortened shelf life. The trust's pharmacy department carried out a snapshot review of the temperatures recorded for April 2017 by all acute inpatient and rehabilitation wards. All four wards in this core service had recorded temperatures over 25°C during that month. Woodloes ward recorded the highest incidence of 21 days out of a possible 30 days. The trust had since installed air conditioning to the clinic room and temperatures had remained within the recommended ranges. On the other three wards, staff tried to reduce temperatures in the clinic rooms by opening windows and doors, and turning off heating. However, on Pembleton ward, there was an additional medicine store holding medicine stocks for both Pembleton and Stanley wards. The trust's audit found there were no temperature readings for this room, which meant there was no assurance that the medicines were safe to use.
- Staff took into account common issues associated with their patient group such as pressure ulcers, osteoporosis, continence problems, and the risk of falls. Staff supported some patients with a known history of falls with a preventative package of care that included, for example, a review by a physiotherapist, provision of non-slip footwear and other measures to reduce the risks. The trust's policy required staff to complete a screening assessment for preventing falls within 24 hours of admission for all patients admitted to the four wards. It required that staff develop a care plan where they identified a risk of falls. However, in four out of five case records we reviewed, staff had not met this requirement.

- Incident reports showed that staff responded appropriately to falls. Patients received a medical review and staff carried out neurological observations if there was a suspected head injury. However, staff did not review or update care plans or record progress on them. We found that staff had not routinely updated falls risk assessments after an incident in six out of seven cases on Stanley ward and seven out of 13 cases on Pembleton ward to capture any new risks. This showed a difference in practice between the two wards despite their being a common trust-wide policy. The trust's falls policy stated that staff should complete new falls risk assessments if there was a change in the patient's condition, if they experienced a fall or near miss, or if deemed appropriate by a healthcare professional. The trust told us that there was no specialist training to support staff to do this effectively. However, the falls policy stated that all staff should receive one-to-one training in falls risk assessment on their local ward induction.
- Staff on all four wards supported children visiting the ward if they received advanced notice. They allocated meeting rooms away from the main social areas of the ward to facilitate the visits.

Track record on safety

- There were no serious incidents reported for this core service in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and used the trust's electronic incident recording system to report them. Ward managers and service leads received and reviewed copies of all incident reports, and gave feedback, including any actions, to the reporter.
- Staff reported incidents appropriately. Incident reports reflected the detail of the incident and any urgent action taken.
- All the senior nursing staff we interviewed knew of their duty to be open and transparent with patients when things went wrong.
- Managers did not organise staff meetings regularly on any of the wards to feedback lessons learnt from incidents to the staff as a group. However, the incident reporting system allowed managers to give feedback to the individual reporter. Managers recorded the percentage of incidents in which they gave individual

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feedback on the matron's monthly dashboard. For May 2017, the performance rate was 98% for Pembleton ward, 82% for Stanley ward, 50% for Woodloes ward and 7% for Ferndale ward.

- Each ward held a monthly governance meeting to discuss incidents and share lessons learnt across the clinical team. We requested copies of the minutes of these meetings. However, the trust provided one set of minutes from one ward for April 2017.
- There were opportunities for staff to receive support after serious incidents on both wards. Senior nursing staff supported individual staff.

Are services effective?

Inadequate 

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 looked at 22 care records. Staff completed initial assessments of mental and physical health status at the point of admission.
- Medical staff carried out a physical examination of patients at the point of admission. Through their assessment and review of past medical history, the ward doctors highlighted areas of physical health that required ongoing monitoring and review. All patients had their vital signs (blood pressure, pulse, temperature, respiratory rate and temperature) monitored at least daily. However, we found that ongoing monitoring and responses to changes in condition were not carried out consistently and when observations indicated staff take action it had not always been done. None of the wards routinely monitored pain or used a delirium-screening tool to allow early identification of two physical health problems that have a strong relationship with behaviours that challenge. These concerns were included in the warning notice issued to the trust.
- Staff had not always personalised and rarely updated care plans. In several care plans, there was no evidence of any updates or reviews following of the initial plans put in place upon admission; this was despite staff having noted changes in the patient's condition in incident reports and in the daily evaluation sheets. We saw in all case notes that staff used generic care plans for discharge and the involvement of carers and families. These model care plans, started around the time of admission, were not updated or personalised to the circumstances of the individual patients. For instance, in two cases on Stanley ward we heard very positive descriptions of staff offering support to relatives they were not reflected in the care plans.
- We found that the care records were not always available in an accessible form with multiple elements being misfiled in the wrong section and sections not being arranged in any chronological order. Case notes were held in paper files and comprised several volumes often relating to the same admission to hospital. Only limited information was available to ward staff on the electronic patient record used in other areas of the trust. The paper records were securely stored but as they often comprised of multiple volumes only the most recent was immediately available for inspection.

Best practice in treatment and care

- Prescribing for the use of antipsychotics for people with dementia fell in line with the National Institute for Health and Care Excellence (NICE) guidance. We found that some prescriptions included additional information on the rationale for prescribing an antipsychotic for a person with dementia, outlining the maximum dosages and cautions for staff to considered in their use. There was also space to allow the prescribing doctor to explain their choice of medication if not using risperidone, which is the only drug, licensed for the treatment of behavioural disturbance in dementia.
- Patients did not have access to therapies recommended by NICE for people with dementia and other mental health problems, for example, cognitive behavioural therapy for anxiety and depression, cognitive behavioural therapy for psychosis, and family therapy. These were not available because the service had a gap in psychology provision.
- Staff accessed specialist physical healthcare for their patients by referring them to the local acute hospital trust.
- Staff assessed the nutritional and hydration needs of all patients on admission. Staff used the malnutrition universal screening tool to identify particular risk of being malnourished. Ward staff requested support from a dietician when they needed to develop individual care plans for nutritional needs.
- Clinical outcome scales to measure the severity of mental health problems were not in regular use on the wards. Staff completed the health of the nation outcome scales for older adults (HoNOS-65+) on admission as part of the care cluster allocation tool. However, they did not repeat this assessment at discharge or at any points during the stay to demonstrate any change in the psychological and social needs of the patients. Staff were required to monitor all patients for changes in their physical well-being using the modified early warning scores (MEWS) and other condition specific measures such as a pressure ulcer risk rating scale. In four out of five MEWS records we reviewed in depth at Manor hospital, scores were either omitted or wrongly calculated and if a response was triggered, then no action was recorded. The most recent trust audit on Pembleton ward (5 July 2017), staff had incorrectly calculated MEWS four out of twelve patients scores in that day.

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- We found further evidence that where a doctor had indicated a known physical health condition be regularly monitored there had been a failure to do so regularly or effectively. Staff on two wards had been requested to closely monitor the fluid intake of two patients and maintain a basic level of hydration. In both cases, when daily totals had fallen below the goal there was no evidence of staff escalating the shortfall as a concern to qualified nursing or medical staff.
- Clinical staff managed audits to assess local compliance with trust standards for aspects of care. Each ward was conducting a local audit of the completeness of MEWS scoring. However, there was no consistency with Stanley ward and Woodloes auditing weekly and the other two wards, monthly. Staff were also following two different methodologies, with two wards taking a sample of just five patients records, the others completing a review of all patients on the ward. Woodloes only submitted five weekly audit sheets from the current year (2017) - 19% of the expected total and Stanley only nine submissions in 2017 - 35% of the expected total. On the monthly audits submitted by Pembleton ward, staff had only recorded a sample of five patients between June 2016 and July 2017. For Ferndale ward, the frequency changed in one month to fortnightly. Overall, Pembleton has completed an audit each month in 2017 until July and Ferndale four out of the six months until June. Staff had never noted any errors in any of the audits of MEWS scores before our inspection. Our findings of multiple omissions and errors suggest that these audits have been ineffective in identifying concerns and areas for improvement. These concerns about the lack of consistency in applying and monitoring physical health were included in the warning notice issued to the trust.

Skilled staff to deliver care

- Ward teams included occupational therapists, a psychologist and physiotherapist as well as nursing and medical staff. There were vacancies for psychologists on three of the four wards and the psychologist on Woodloes ward was due to leave the service. The immediate impact of these vacancies had been delays in rolling out and implementing positive behavioural support plans and only limited opportunity for individual psychological therapy. The lead psychologist was providing some support to all wards whilst recruitment went ahead to fill the posts. Only one physiotherapist was available to support all the inpatient services at the time of inspection. This limited their ability to provide support to only the most urgent needs. The speech and language therapist post was vacant and staff were making urgent referrals to their local acute hospitals for any swallowing assessments.
- Agency and bank nurses completed an induction to orientate them to the ward and an introduction to patients. Eleven nursing assistants (five on both Stanley and Ferndale ward and one at Woodloes) had completed the care certificate that includes physical health skills components. New starters to the trust commence the care certificate on induction. Pembleton had not recruited any new nursing assistants since the introduction of the care certificate.
- The local trust policy stated that staff should attend clinical supervision at least once every two months. Compliance with the policy for supervision as of 31st May 2017 were Pembleton ward 9%; Ferndale ward 18%; Woodloes 8% and Stanley ward 58%. Only Ferndale ward was able to provide evidence of regular monthly team meetings. In the minutes, staff were recorded as raising concerns about a shortage of staffing and a lack of equipment. Stanley ward had only one team meeting in the previous three months that focused on the decision made by managers not to return the ward team to their original base in Coventry. Woodloes ward also provided evidence of only one team meeting in the three months prior to our inspection. The manager on Pembleton ward confirmed that there had been no regular team meetings on the ward and none in the previous three months.
- All four wards had regular development days to which all staff were invited. We saw evidence from Woodloes ward of a development day in June 2017 that saw staff discussed issues around the MCA and MHA.
- The trust's target rate for appraisal compliance was 95%. As of 31 January 2017, the overall appraisal rates for non-medical staff within older people wards was 85%. Of the four wards, none had 100% overall compliance. The lowest compliance rate was for Stanley ward with 77%.
- There were no medical staff due for revalidation for this core service at the time of the inspection. The service had achieved 100% revalidation rate for nursing staff with none deferred or overdue.
- All four wards admitted patients with physical health problems. The trust provided specialist training to staff on these wards to support them in meeting these needs.

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The trust provided evidence that 100 staff had attended a physical health care skills training day since they introduced the training in 2012. The training records showed that only four staff had ever attended an update session. Following the classroom training, staff were expected to practice the skills and complete a competency workbook to evidence this. However, the trust told us that this did not happen. This meant the trust did not have any evidence that staff put training effectively into practice by any ongoing assessment of competency in physical health care skills

- The trust also reported training rates in other areas of physical health assessment and management:
 - Thirty (25%) out of an eligible 120 staff had completed training in use of the malnutrition universal screening tool (MUST).
 - Twenty-seven (54%) out of an eligible 50 staff have completed training in the management of diabetes. Twenty-four staff received training in 2014 with no evidence of any updates.
 - Ten staff had received training in the management of anaphylaxis.
 - Only seven nurses were trained in tissue viability.
- None of the training around physical health care was categorised as requiring any update and some training dates for physical health skills date back as far as 2012 without any evidence of renewal. Overall, the training rates are low representing a potential risk of common physical problems not being effectively managed with a negative impact on patients wellbeing.
- We asked the trust how it ensured staff were appropriately trained in the care of people with dementia, in line with the National Institute of Health and Care Excellence (NICE) quality standard one (June 2010). This standard linked to the earlier objective in the national dementia strategy (2009) to provide an informed and effective workforce for people with dementia. This set out a goal for "all health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work to be achieved by effective basic training and continuous professional and vocational development in dementia." The trust made dementia training mandatory in April 2017, and aimed to deliver training to all appropriate staff before the end of 2018. At the time of our inspection, seven staff across the service had

completed dementia awareness training in 2010, and Pembleton ward staff had received a psychology-led training session on therapeutic conversations with people with dementia.

Multi-disciplinary and inter-agency team work

- Each ward held weekly multidisciplinary team meetings. We observed a ward review meeting on Ferndale ward attended by doctors, nursing staff and a pharmacist. The team discussed a new admission that had arrived the night before and their suitability for the ward. We heard concerns that ward meetings were not representative of all disciplines working on the wards due to resource issues where allied health professionals were not available to contribute. There were weekly consultant led multi-disciplinary meetings on each ward. All professional disciplines, based on the ward, were invited to the ward reviews. Patients and family members, alongside community-based professionals were also included in the meetings.
- Nursing staff had a limited period of time (15 minutes) to handover between the two long shifts operated on the ward. Staff told us that there was a proposal to limit the time to ten minutes. They felt this would affect their usefulness because there would be no time to properly discuss any incidents or introduce new patients to the team. The allied health professionals attending the wards reported that they regularly received a handover from nursing staff about any developments. .
- We found on all wards that the clinical pharmacists were involved in patients' individual medicine requirements, and in multidisciplinary meetings. This was good practice and in line with NICE guidance on medicines optimisation that a pharmacist regularly attend these meetings given the complications of long-term physical health conditions and polypharmacy in the patient group.
- Staff from community mental health teams and the pharmacy department regularly visited the wards. Staff could request further specialist support from a dietician who could attend the ward and supported patients about their dietary needs
- Staff relayed concerns about the lack of other specialist services. The lack of any collaboration with a geriatrician was highlighted as was concerns about access to tissue viability services.

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- Ward staff worked closely with the next care placement, for example, a nursing home, to share their knowledge of the patient and their preferences before any planned discharge.

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

- Upon admission, a competent staff member made an initial examination of detention paperwork. They used a checklist to ensure the completeness of the applications and their compliance with the standards required.
- A central trust team supported the wards in the administration of the Mental Health Act. The Mental Health Act team could provide information to ward staff and managed the timetables for reviews, hearings and tribunals on the wards. Staff on the wards knew how to contact the Mental Health Act team.
- Staff maintained a record of leave granted to detained patients and shared copies of the authorisation with patients and carers as required.
- Overall, 46% of staff in this core service had training in the Mental Health Act between 1 May 2016 and 30 April 2017. Staff on Pembleton ward had the highest uptake at 71%, with Ferndale 50%, Woodloes 46% and Stanley only 15%. We found that there were patients detained under the mental health act on all four wards with a higher proportion on the two wards for people with dementia. Staff lacked knowledge in the detail of the mental health act code of practice and its principle to follow the least restrictive when caring for patients. The impact of this was that staff failed to recognise the restrictive nature of blanket restrictions in place on all the wards.
- We scrutinised 48 prescription charts for patients detained under the Mental Health Act. We found that staff adhered to consent to treatment, capacity requirements and had attached copies of consent to treatment forms to medication charts where applicable.
- Staff recorded that they had informed patients of their rights at the point of admission or a change in their section status. The trust's recommendation was that as a minimum there should be a new form for the first week, at two weeks, one month and then three months, or following any substantial changes to the patient's treatment or if they moved from one area to another. Therefore, if a patient was detained under the Mental Health Act in the hospital for three months, managers expected that staff would have completed a minimum

of four attempts to inform patients of their rights. We found that on Stanley ward and Pembleton ward, staff informed patients of their rights at the intervals recommended. On Woodloes and Ferndale ward, staff had not informed patients of their rights after the initial attempt when the section started.

- Staff kept Mental Health Act paperwork in a separate folder from the main care notes. Staff maintained these records in good order, the records were well ordered, complete, and stored securely.
- On each ward, managers were able to demonstrate that there were regular quarterly audits of the Mental Health Act records including the authorisations for medical treatment. A common theme across all the wards had been the completion of Section 132 paperwork to evidence that staff regularly informed patients of their rights. The auditor left clear information for staff to follow on correcting and updating any information found be wrong or missing. Staff on Stanley and Pembleton wards as reported above had implemented the actions.
- On our last inspection of the service, we found that staff had not referred all detained patients to the independent mental health advocate (IMHA). We told the trust that they must ensure that staff referred detained patients to an Independent Mental Health Act Advocate, in line with Mental Health Act Code of Practice. At this inspection, staff had recorded making referrals to the IMHA for 24 of the 26 patients under detention. The two omissions were both patients on Ferndale ward. In the case of one of the two omissions, staff had apparently confused an independent mental health advocate referral for one made to the independent mental capacity advocate. This error reflected some of the misunderstanding we found about the Mental Health Act and its relationship to the mental capacity act linked to the low levels of training. However, this was a significant improvement overall and we were told of regular visits to all wards by the IMHAs where staff discuss and refer any new admissions.

Good practice in applying the Mental Capacity Act

- Ninety-two per cent of clinical staff across the services had received training in the Mental Capacity Act.
- The trust provided information around the Deprivation of Liberty Safeguards applications they had made between 1 April 2016 and 31 March 2017. Between these dates, the trust had made 80 Deprivation of Liberty

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Safeguards (DoLS) applications with local authorities approving 45. The trust is required to inform the CQC of all DoLS referrals and they had reported 71 of the 80 in this period.

- The trust had a policy in place to inform staff of their responsibilities under the Mental Capacity Act and provide essential information about its use and application. The policy included information on the deprivation of liberty safeguards (DoLS). Managers had updated this policy to include the Cheshire West decision of the supreme court and their definition that a deprivation of liberty occurs where the person is under continuous control and supervision, they would not be free to leave and they lack the capacity to consent to these arrangements.
- Staff on the two wards for people with dementia, were very competent in their understanding of the application of the deprivation of liberty safeguards. They monitored review dates and kept in touch with the relevant local authority about progress. They gave early notice of any planned discharge to the next placement to allow them to prepare a application for a new authorisation if appropriate.
- Staff supported patients to make decisions and worked on the basis that any assessments should be decision specific. In one set of case notes, we saw staff had given the patient written information, as their visual comprehension was better than their ability to interpret speech.
- Staff on Pembleton and Stanley wards gave patients covert medicine (this is medicine given to a patient in a hidden way without the knowledge or consent, for example in food or drink). In all four cases reviewed, we found staff were following proper procedures with regard to the Mental Capacity Act and NICE guidance on managing medicines in care homes. Families, carers and pharmacy staff had all been involved in discussion around making a best interests decision to allow nursing staff to administer medicines to patients lacking mental capacity without their knowledge.
- We reviewed best interests decisions made to support the discharge of patients to a community placement.

The Mental Capacity Act's Code of Practice requires that for significant decisions about a person's care and treatment staff must take into account everything that staff know about the person's preferences and consult with all interested parties. This means that family, carers and professionals with particular knowledge who may be able to inform the decision should be invited and involved. In the three cases we reviewed on Pembleton ward, staff had not referred to the need for best interests' decision-making in discharge care plans. One discharge care plan was incomplete with the second part missing. In all three cases, we could not find a specific assessment of mental capacity around accommodation that would have been the trigger for a best interests' decision. However, in two cases, we found very detailed notes of discussions that involved relatives and considered the benefits of particular placements. We also saw that staff took account of the least restrictive principle in their considerations. However, without evidence of an original decision specific assessment of mental capacity, the decisions reached would be invalid. On Stanley ward, we reviewed three cases where staff were making discharge plans in a patient's best interests because they lacked mental capacity to make that decision. Staff did not record the need for a best interests decision or record the views and preferences of the patients in discharge care plans. However, there were clear decision specific assessments of mental capacity in each case and evidence of best interests decision making meetings. In one case where family were not available, an independent mental capacity advocate had joined the meeting as recommended in the code of practice.

- Staff understood the Mental Capacity Act's definition of restraint and the principle of least restrictive interventions about the use of physical restraint.
- Staff knew that the trust Mental Health Act office was also responsible for the mental capacity act.
- We saw evidence that members of the Mental Health Act team had completed audits of each ward's compliance with the Mental Capacity Act and had left feedback left for staff on areas of improvement.

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

- The patient-led assessment of care environment (PLACE) survey scored Manor Hospital 77.7%, St. Michael's Hospital 90.2%, and Woodloes Avenue 93.8% for privacy, dignity and wellbeing. The national average for mental health and learning disability hospitals was 89.7%.
- We observed staff react quickly to patients in distress or to help restore their dignity or privacy. At mealtimes, we saw staff offer patients support to eat independently rather than do it for them. Staff were attentive to the wishes and preferences of patients, for example, staff on Woodloes ward accommodated the choice of some patients to eat in their rooms.
- On Stanley and Pembleton wards, we observed the interactions between staff and patients using the short observational framework for inspections. This tool helps collect evidence on interactions between staff and patients especially where patients have cognitive problems. In both sets of observations, we found staff engaged warmly with patients and provided reassurance through speech and touch. We saw staff respond promptly to any sign of distress. In one case when a patient fell asleep during their meal, staff provided a fresh meal when they awoke and encouraged the patient to eat and drink.
- In a ward review meeting, we saw that staff listened to family members and offered information and support from the team. The ward managers offered to meet with carers to discuss any questions around diagnosis, treatment and discharge planning. Where patients lacked family support, the team invited an appropriate advocate to meetings to represent the patient's interests and support decision-making.
- On Stanley and Pembleton wards, community meetings focused only on activities. Staff asked individual patients what activities they enjoyed and what they would like to do in the week ahead. The trust told us that only two sets of minutes were available for these meetings on Stanley ward. They explained that a recent shortage of activity co-ordinators (due to recruitment and retention issues, and sickness) had meant that some meetings did not take place. Woodloes ward had weekly meetings for patients but again the focus was limited to feedback on activities and suggestions for the week ahead. However, on Ferndale ward, there were broader discussions about care and environmental issues. Staff on Ferndale ward gave feedback on previous discussions and actions taken in light of patients' comments. For example, staff had listened to feedback from patients about meal times. This had led them to change the day's main meal to lunchtime from the evening.
- There were no mechanisms in place for patients to be involved in decisions about the development of their service

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

- At the time of our inspection, none of the patients had advance decisions in place. These are decisions made beforehand to refuse a specific type of treatment at some time in the future.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

- The trust provided details of bed occupancy rates for the four wards between 1 March 2016 and 28 February 2017. All of the four wards had average bed occupancies of 100% and above which included leave and were within commissioned targets. The wards with the highest average bed occupancies were Pembleton ward (108%) and Ferndale ward (107%).
- There was one out of area placement between 1 March 2016 and 28 February 2017 relating to this core service.
- The high occupancy rates meant that staff could not always provide a bed for patients returning from leave as they had used their room for a new admission. One staff member told us that they had to ask relatives to support patients on home leave longer than planned and sometimes without a fixed time to return. Patients on Ferndale ward also raised these concerns. One reported having moved rooms three times during his stay as staff had used his previous room for new admissions. One nurse felt that these problems were in part due to a lack of written admission criteria for the physical complexity wards that led to inappropriate admissions.
- Staff took account of the interests of patients before arranging any movement between wards during an admission.
- Clinical staff tried to plan discharges in advance and at an appropriate time of day when community based professional and carers could support patients.
- 23% of all discharges from this service had been reported as delayed by the trust between 1 March 2016 and 28 February 2017. This meant that the person was considered well enough to leave the ward but there was a problem in securing their next placement or care package to return home. Pembleton ward had the highest number of delayed discharges between 1 March 2016 and 29 February 2017 with 28 out of 43 discharges (65%). Stanley was the only ward with no delayed discharges across the 12 months. Reasons given for delayed discharges were disputes about funding and difficulties in identifying community placements. Staff told us that delays in discharge were often because of a lack of availability of community staff to become care co-ordinators and facilitate arrangements for aftercare.

- Discharge care plans did not refer to the entitlement to aftercare under section 117 of the mental health act.

The facilities promote recovery, comfort and dignity and confidentiality

- There were a limited number of rooms available to accommodate a full range of activities at Manor hospital. There was no dedicated clinic room to allow for the physical examination of patients, staff used patient bedrooms instead. Therapy activities took place in the lounges and small meeting rooms that were used for clinical meetings and visitors. There were plans to increase the amount of rooms available for patient care through redeveloping the connecting corridor between the two wards.
- Each ward had only limited space to accommodate patients meeting their visitors. At Manor hospital, there were plans to develop a connecting corridor between the wards as a space for visitors. At Woodloes Avenue, there were a variety of rooms off the ward within the building, which staff could use for meetings, and Ferndale ward had access to additional space within St. Michael's hospital.
- Patients had to ask staff for access to a phone and office space to make any private phone calls.
- At Manor hospital, the two wards shared an outside space that lay between the wards. On our visits, we saw staff and patients from both wards using this space to sit, play games and receive visitors. Woodloes ward and Ferndale ward had more limited access to outside space from the ward but staff encouraged patients to make use of local community resources.
- All four patients we spoke with on Ferndale ward said they did not enjoy the food and reported access to hot drinks were very limited. One complained that he was not able to follow his normal diet, as he could not regularly order Indian food on the ward. At Manor hospital, each ward held a monthly meeting attended by the dietician, housekeeper, hotel supervisor and nurse for the ward to review food service and feedback from patients.
- Food quality scored 91.7% for Manor hospital, 97.6% at St. Michael's Hospital and 100% at Woodloes in the 2016 patient-led assessment of the care environment (PLACE). The national average for mental health service across England was 91.9%.

Are services responsive to people's needs?

Requires improvement 

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

- Access to hot drinks was dependent on requests to staff on all wards. Across all wards, staff provided a regular drink service every two hours throughout the day. Squash and water were available on request all day.
- Patients had the ability to personalise their bedrooms with their own belongings and decorations.
- Each ward had arrangements in place to care for patient valuables using a safe or locked cupboard. Although staff advice to patients was to ask relatives and carers to take home any valuables.
- Activity workers on Pembleton and Stanley wards led on delivering activities to patients to support mental and physical wellbeing. They organised activities for groups of patients and supported individual activities. They provided table-top activities to help engage patients not directly interacting with staff. Some of the equipment was specifically tailored for the use of people with dementia and included fidget muffs (to keep hands busy), rummage boxes to provide a distraction and with some female patients the therapeutic use of dolls to provide a focus to their attention. Physiotherapy and occupational therapy staff also ran regular groups on the wards. The physiotherapist assistants had a programme of exercise groups as part of the falls prevention strategy.
- Staff also told us about the use of dementia pods which were being introduced to Pembleton and Stanley wards. These screens would allow patients to view a personalised set of images and listen to music and sound choices that might help distract and engage them in positive memories of their life and families.
- Unfilled vacancies had reduced the amount of activity workers who felt this had affected their ability to offer consistent input to individuals as they managers had asked them to provide cover across all four wards as required.
- Activity timetables for all wards showed group activities led by activity workers and other therapy staff available most weekday morning and evenings. The exception was Ferndale ward where in the weeks prior to our inspection staff had only been able to offer three or four days a week. The lack of activities available on Ferndale was a concern for the four patients and three carers we spoke to on the ward.
- There were no formal activities planned at weekends and in the evenings.
- Each ward had level access from the main hospital entrance. Handrails were available on the main corridors to assist patients and visitors with mobility problems. There was equipment available for patients with mobility difficulties to allow bathing, showering and safe transfers between areas of the wards. Occupational therapists carried out assessments for those patients requiring such aids during their admission.
- Dementia friendly signage was in use at Manor hospital and staff had clearly identified the purpose of rooms with words and symbols. Staff had made use of high colour contrast in providing equipment to improve identification by patients with dementia.
- The patient-led assessment of care environments scores for the ability of the wards to meet the need of people with dementia or a disability were higher than the national average of 82.9% (Manor Hospital scored 87.5%, St. Michael's 89.4%) apart from Woodloes ward at 77.6%. The suitability of the ward environments to support people with a disability was rated at Manor Hospital 88.3%, St. Michael's 79.6% and Woodloes ward 84.8%. The national average score was 84.5% in 2016..
- Each ward had very wide range of information leaflets available for patients and visitors. In addition, there were numerous notice boards and display cases presenting information on patients' rights, treatments and the performance of the wards
- Information immediately available on the wards was mainly presented in English only. Staff could, on request, source copies of the information in a range of other languages. There was a lot of information available about local support services in the voluntary sector and from community based health services.
- Staff on all wards could access signing and interpreting services on the assessment of patient need. Staff told us they prioritise language support around legal issues such as informing detained patients of their rights
- The variety of choice in menus was limited; staff could order additional choices to meet the dietary requirements of religious and ethnic groups on request.
- Patients on the wards could have access to the chaplaincy service on request. There was no dedicated multi faith room available on the wards. We saw plans to allocate a multi faith room in plans to develop the units at the Manor hospital.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

Requires improvement



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

Listening to and learning from concerns and complaints

- Managers reported receiving three complaints for this core service between 1 May 2016 and 30 April 2017. Stanley, Pembleton and Woodloes wards all received one complaint each with a focus on communication and quality of care. The wards for older people with mental health problems had also received 14 compliments during the same twelve months.
- Information on making complaints and use of the patient advice and liaison service (PALS) was available on all the wards. Patients and carers we spoke with were all aware of the process and felt confident in raising concerns informally with staff.
- Staff on all of the wards had knowledge of the complaints process. They emphasised that they would try to resolve any issues informally and immediately and when that was not possible enable a referral to the patient advice and liaison service.
- There was no evidence that managers routinely gave feedback to staff on the outcome of investigation of complaints and the findings.

Are services well-led?

Inadequate 

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 were aware of the trust's values and objectives. We saw posters displaying these on the wards.
- The four ward teams lacked any clear objectives for service development. The two pathway leaders were looking to start a review of the service's aims and objectives and develop a mission statement in line with the trust's values.
- Ward staff we spoke with felt senior management, at board level could do more to visit wards to involve and listen to staff. Most wards reported that the chief executive had visited and was known to them.

Good governance

- Managers expected staff to undertake mandatory training. Shortfalls identified in training had not been addressed by managers. There were low rates of training in Mental Health Act training the use of restraint and moving and handling people.
- Staff received regular appraisals. However, supervision rates were low across the service, and debriefings infrequent.
- Following the requirements of NHS England in implementing recommendation in the Francis Report, the trust managers had committed to ongoing reviews of staffing levels every six months, monthly discussions at board meetings and publication of safe staffing data on the trust's website. There were sufficient numbers of staff of the right grades and experience to cover shifts. However, managers relied on regular bank staff to ensure they maintained staffing levels safely on some of the wards.
- There was only limited evidence that the service learnt from incidents and service user feedback. Managers told us that each ward team held governance meetings each month to discuss clinical issues and lessons learnt. The trust could only provide minutes of one meeting on Stanley ward in April 2017 to evidence that these meetings occurred. The two pathway leaders told they met with ward managers monthly to discuss concerns and lessons across the service. However, the trust presented the CQC with a flowchart illustrating the governance structure for the wards that stated that the

frequency of ward based governance meetings should be weekly. This was a further inconsistency between the report of senior management and the ward based teams.

- Staff participated in clinical audits. However, the different approaches to the audit of modified early warning scores (MEWS) also illustrates this disconnect with senior management providing assurance that there has been a common approach across all wards around a monthly cycle whilst two wards continue with weekly audits. Also, these were not effective in identifying areas for action.
- Staff followed safeguarding, and mental health act procedures. There was good evidence of staff understanding procedures around the deprivation of liberty safeguards. However, staff had not always followed the requirement for recording decision specific mental capacity assessments before making decisions about a patient's future care.
- Each ward displayed a copy of their latest 'matron's dashboard' which presented data showing how well they were doing against trust targets such as staff appraisals, sickness, bed occupancy, and length of stay. These enabled managers and staff to identify then concentrate on issues that were outliers. We investigated use of the National Institute of Health and Care Excellence (NICE) quality standards with the trust in regard dementia care and falls prevention both relevant to this service. The trust had decided in 2010 that they had met quality standard one on dementia care as part of a local Commissioning for Quality and Innovation (CQUIN) target and had not revisited that decision to ensure ongoing compliance.. They had decided it was not applicable to their inpatient dementia services despite the introduction to the quality standard (p5) is clear about its application to wards, "This quality standard covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings." In relation to falls, managers had completed a benchmarking exercise in April 2017. The trust told us that this demonstrated that all NICE recommendations were met and no further action was required. However, the trust had not followed the methodology set out by NICE in their guidance to measure compliance and the main source of evidence was an internal audit completed in 2012.

Are services well-led?

Inadequate 

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.

NICE provides evidence and guidance on the most effective forms of treatment available to NHS organisations. Although trusts are not required to follow the advice of NICE, they should be able to demonstrate they take account of it in developing clinical policies and assessing their own effectiveness. In relation to falls and dementia care, the trust could not evidence that they had met this expectation.

- The ward managers felt they had sufficient authority and administrative support to run the wards.
- Staff were able to submit items to the trust risk register. There were no clinical issues relating to this core service on the risk register at the time of our inspection.

Leadership, morale and staff engagement

- The CQC had been alerted prior to the inspection to a high level of staff sickness on Pembleton ward because of workplace injuries since March 2017. We discussed these concerns with the ward manager and pathway co-ordinator. Staff had been injured in three incidents of restraint and whilst supporting a patient to use the toilet. We found that all staff involved had been up to date in the relevant training, MAPA and moving and handling patients, at the time of the incident. Managers had referred all cases to the occupational health team for an opinion and completed the relevant notifications about an accident at work. Managers had provided ongoing support to all staff affected in line with local trust policy. Our outstanding concern, as discussed above, was the follow up to the incidents in updating care plans and risk assessments in order to mitigate future risks.
- We were not made aware of any cases of bullying and harassment within the service.
- Staff were aware of whistle blowing procedures and the role of the CQC in supporting staff who wish to raise concerns.

- All staff we interviewed during the inspection felt confident in being able to raise concerns with their local managers without fear of victimisation.
- Staff told us that morale reflected the challenges posed by the patients on the ward and at high levels of activity would fall. We also heard from staff of low morale because of the wards moving and at Manor hospital the change of function of Pembleton ward had been difficult for staff to adjust. There was also uncertainty about the future of the service and at Woodloes when managers would move the wards again.
- The trust offered staff the opportunity to take part in an internal leadership programme with the support of the local university. No staff from this service were taking this course at the time we visited.
- Within each staff team, we heard positive comments about team working. Staff reported examples of team working well together across professional boundaries and the support they had received from other team members.
- Staff understood their duty of candour and were open and transparent in explaining to patients when something went wrong. Staff could seek support from the patient advice and liaison service in how to make a disclosure.
- Staff believed that managers had not discussed decisions about the future of the service, recent changes to single sex wards and relocation of wards with them in a meaningful way. In only one record of a ward meeting is any discussion noted of the impact of changes to the service.

Commitment to quality improvement and innovation

- The trust was involved in a project to trial the remote monitoring of patients vital signs through ceiling mounted monitors in a selection of the bedrooms at Manor hospital. The sensors had been fitted but were not operational at the time of our inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Not all staff were up-to-date with their mandatory training. Training rates were low for manual handling, Mental Health Act and physical intervention.
- Staff lacked specialist training in physical healthcare and dementia care.
- Staff did not have regular access to one-to-one supervision sessions and team meetings.

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

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Safe care and treatment

- Staff did not re-assess patients' risks as required or keep risk assessments up-to-date.

This was a breach of regulation 12 (2) (a) and (b)

- Pembleton ward had out-of-date and/or empty oxygen cylinders.

This was a breach of regulation 12 (2)(f)

This section is primarily information for the provider

Requirement notices

- There was no room temperature monitoring of a room on Pembleton ward that held stocks of medicines.
- There were insufficient contingency plans to respond to high clinic room temperatures that affect medicines.

This was a breach of regulation 12 (2)(g)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

- Care plans were not up-to-date or personalised, and did not reflect progress towards recovery and discharge.

This was a breach of regulation 9 (3)(b)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

- Some best interests decisions lacked decision-specific assessments of capacity.

This was a breach of regulation 11(1)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Staff did not keep care notes in good order, which made it difficult to find key information quickly.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17 (2)(c)

This section is primarily information for the provider

Enforcement actions

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	Section 29A HSCA Warning notice: quality of health care
Diagnostic and screening procedures	Warning Notice
Treatment of disease, disorder or injury	We required the trust to make the significant improvements in the areas identified below regarding the quality of healthcare by 4 September 2017.
	The trust's systems and processes do not effectively monitor the physical healthcare of patients and reduce identified risks.
	This was breach of Regulation 12 Safe care and Treatment (1) (2) (a) and (b).
	There is insufficient management oversight and governance to ensure the effective management of the physical healthcare needs of patients. This means patients are potentially placed at unnecessary risk.
	This was breach of Regulation 17 Good governance (1) (2) (a) (b) and (c).