

**Requires improvement****North East London NHS Foundation Trust**

# Wards for older people with mental health problems

## Quality Report

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### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RATY1	Sunflowers Court	Cook Ward	IG3 8XJ
RATY1	Sunflowers Court	Stage Ward	IG3 8XJ
RATWD	Woodbury Unit	Woodbury Unit	E11 1NU

This report describes our judgement of the quality of care provided within this core service by North East London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London NHS Foundation Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

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

- The ward environments did not always guarantee the safety of patients. All of the wards contained ligature risks of varying degrees. Work was underway to remove these risks but there was no completion dates set for this work. The layout of the wards we visited did not allow for staff to see directly into the patient bedroom corridors unless a member of staff was placed in this area or just outside. Patient bedrooms and en-suite bathrooms on one ward did not have an alarm system for patients to use to summon help from staff. The ward used a blanket restriction of locking the patient bedrooms during the day.
  - Two days prior to our visit, a patient sustained a fracture during an un-witnessed fall, whilst getting out of bed. The bedroom had no assistive technology such as an alarm or motion sensor pad to alert staff that the patient was getting out of bed, despite the patient being at risk of falls. The wards had implemented a daily ward check to prevent plastic bags and other contraband items being brought on to the ward following a serious incident. However this learning was applied inconsistently across the wards with plastic bags permitted in patient bedrooms in two out of three wards. During our visit the staff did not increase the level of care and intervention in response to one patient's changing presentation during the day. However, the patient records did show that the patient had received regular physical health checks and a recent physiotherapy assessment.
  - The wards did not always support the dignity and privacy of patients and the wards were only partially dementia friendly in appearance. Apart from one, all of the bedrooms we saw were very bare and depersonalised in appearance. Patients were not able to open or close the viewing panel of their bedroom doors from inside, which could impact on their privacy. Each bedroom we looked at contained a safe with keypad access which would require the patient to memorise the keypad pin number. Patients with cognitive impairment or a mental health problem that affected their memory may have found this difficult and staff told us that patients never used the safes.
  - Not all staff had been adequately trained to carry out their responsibilities. Apart from training incorporated into the care certificate, not all of the staff across the three wards were specifically trained in dementia as recommended by National Institute for Health and Care Excellence. Not all healthcare assistants had access to Mental Capacity Act 2005 training. Mental Health Act 1983 training was not compulsory in the trust so there was minimal uptake of this training.
  - There was a lack of psychological review and formulation of patients with dementia following admission and prior to commencement of, or discontinuation of antipsychotic medicine for behavioural symptoms. The wards had limited input from a psychologist because the trust employed only one full time psychologist across the service. Input to the wards ranged from once a week to three times a week. Therapy was offered on an out-patient basis only.
  - The care plans were variable across the wards. The majority of care plans were holistic and personalised, but many lacked patient views and were not recovery focussed.
  - Some of the wards had delayed discharges. The wards told us the delayed discharges were often due to difficulties in finding appropriate supported accommodation and funding issues.
  - The wards used several information technology systems along with hard copies of documents. This meant that key information was stored in different places and could make it difficult for staff to access documents readily.
- However:
- All of the care records we looked at during our visit had robust, thorough risk assessments in place. These were reviewed and updated weekly or fortnightly, and more frequently if necessary. All of the care records we looked at showed good evidence that a physical examination had taken place on admission and that physical health reviews were done monthly, or more frequently if required. There was good assessment and monitoring of patient's nutrition and hygiene needs.
  - Medicine was prescribed within the British National Formulary range.

# Summary of findings

- There were no seclusion rooms on the wards and staff told us that they did not seclude patients. Instead they used de-escalation techniques to manage challenging behaviour. The wards began implementing 'Safewards' in November 2015. Safewards identifies areas where conflict may happen and provides ten interventions which aim to specific tools/behaviours to reduce these. All the wards had a 'safety cross' quality dashboard visible on the wards which displayed performance in key areas of safety and quality in an open and transparent way.
- There was good adherence to both the Mental Health Act 1983, the Code of Practice 2015 and the Mental Capacity 2005. Many improvements had been made on the wards that had previously received a visit from a Mental Health Act reviewer.
- Staff were trained in safeguarding and demonstrated that they had a good, detailed understanding of the safeguarding processes.
- Staff described a friendly and inclusive ward culture and that they enjoyed being part of the team.
- All of the wards adhered to the Butterfly scheme, which was designed to improve patient safety and wellbeing in hospital. Its focus enabled staff to respond appropriately to people with memory impairment or dementia. The wards also offered 'Namaste Care' which is a sensory based programme designed for use with people who have advanced dementia and is a dementia friendly approach to care. On some wards there was an excellent use of both pictorial images and words to help patients with cognitive impairment negotiate the ward. Food menu options were both in written and pictorial versions. We saw that a good variety and choice of food options were offered, including a healthy choice, vegetarian, Halal, Caribbean, pureed and gluten-free. There was a good range of activities provided on each of the wards, seven days a week.
- Patients on all of the wards told us that they were treated with dignity and respect, and that staff assisted them with things like personal care. We observed staff interactions that were patient, person-centred and caring. Carers of patients on the wards told us they were involved in their relative's care and supported when their relative was in hospital.

# 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:

- The layout of each of the three wards we visited did not allow for staff to see directly into any of the patient bedroom corridors unless a staff member was placed in this area or just outside.
- The patient bedrooms and shower/bathrooms on two of the wards were equipped with either alarm buzzers or alarm cords. However, the majority of patient bedrooms and ensuite bath/shower rooms on Cook ward did not have an alarm system for patients to use to summon assistance.
- None of the wards used assistive technology such as motion sensor technology that would alert staff if a patient at risk of falls moved away from their bed or chair.
- Each of the three wards contained ligature points (anything that could be used to attach a cord, rope or other material for the purpose of strangulation). Work was ongoing to remove these risks and many bathrooms had touch sensor taps. However it was not clear when this work would be finished.
- Following a serious incident that involved the use of a plastic bag, the wards carried out daily environmental checks to check whether plastic bags were being brought onto the ward. However, there were plastic bags in patient bins in the bedrooms of two of the three wards.
- During our visit the staff did not increase the level of care in response to one patient's changing presentation of increased drowsiness and lack of balance.
- The majority of toilets we viewed across the wards had an offensive odour. There were cleaning schedules in place on all of the wards but none of the wards had a system to record and evidence what cleaning had actually been done.
- All of the care records we looked at during our visit had robust, thorough risk assessments in place that were reviewed and updated weekly or fortnightly, and more frequently if necessary.
- There was a lack of psychological review and formulation of patients with dementia following admission prior to commencement of, or discontinuation of antipsychotic medicine for behavioural symptoms.

However:

### Requires improvement



# Summary of findings

- All of the clinic rooms were clean and functional, and equipment was well maintained and clean. The clinic rooms were fully equipped with accessible resus equipment/grab bags that were checked daily.
- Medicine was prescribed within the British National Formulary range and pharmacists visited the wards regularly to monitor this.
- Woodbury unit was mixed gender and the ward complied with guidance on mixed -sex accommodation.
- The wards began implementing 'Safewards' in November 2015. Safewards identifies areas where conflict may happen and provides ten interventions which aim to specific tools/ behaviours to reduce these.
- All the wards had a 'safety cross' quality dashboard visible on the wards which displayed performance in key areas of safety and quality in an open and transparent way.
- The ward managers told us that they were able to adjust their staffing level according to the needs of the patients and that they try to use bank or agency staff that are familiar with the ward and the patients.
- Staff were trained in safeguarding and demonstrated that they had a good, detailed understanding of the safeguarding processes.

## Are services effective?

### We rated effective as Requires Improvement because:

- The wards had limited input from a psychologist because the trust employed only one full time psychologist across the service. Input to the wards ranged from once a week to three times a week. Therapy was offered on an out-patient basis only.
- The training completion rate for the 'Mental Capacity & Deprivation of Liberty' training was 100% across the wards. However, not all healthcare assistants had access to this training. Mental Health Act training was not compulsory in the trust and there was minimal uptake of this training.
- Apart from training incorporated into the care certificate not all of the staff across the three wards were specifically trained in dementia as recommended by the National Institute for Health and Care Excellence.
- The quality of care plans were varied across the wards. The majority of care plans were holistic and personalised, but many were not recovery focussed.
- The wards did not follow the National Institute for Health and Care Excellence quality statement that stated that anyone over 65 should automatically be considered at risk of falls.

## Requires improvement



# Summary of findings

- The wards used several information technology systems along with hard copies of documents which meant that key information was stored in different places and could make it difficult for staff to access documents readily.

However:

- We looked at 25 electronic patient notes and all of these showed good evidence that a physical examination had taken place on admission and that physical health reviews were done monthly or more frequently if required thereafter.
- There were regular ward rounds on the wards; two or three a week.
- There was good assessment and monitoring of patients' nutrition and hygiene needs.
- We observed thorough and comprehensive handovers take place on all of the wards. The focus was on the patient's recovery, patient choice and individual goals and strengths.
- All of the wards adhered to the Butterfly scheme, which was designed to improve patient safety and wellbeing in hospital. The wards offered 'Namaste Care' which is a sensory based programme designed for use with people who have advanced dementia. Namaste is a hindu greeting that means 'to honour the spirit within' and is a dementia friendly approach to patient care.
- Staff told us that they felt they had a wide range of opportunities for further development, including internal and external training options. Staff received regular supervision and were up to date with appraisals.
- One nurse consultant was involved in a quality improvement project 'making patients on an older people's mental health ward feel safer'.
- Pharmacists visited the wards daily input from Monday to Friday. A Prescribing Observatory for Mental Health format of screening was followed in the prescribing and use of antipsychotics.

## Are services caring?

### We rated caring as Good because:

- On all three wards, we observed staff interactions with patients that were caring, creative and inclusive.
- Patients on all of the wards told us that they were treated with dignity and respect, and that staff assisted them with things like personal care.

Good





# Summary of findings

- Patients and their carers we spoke with told us they felt able to give feedback on the service. There were posters giving details of how to provide feedback, compliments and complaints on the ward notice boards.
- Carers of patients on the wards told us they were involved in their relative's care and supported when their relative was in hospital.
- Each ward held a weekly patient community meeting. We saw the minutes for these and they showed that patients views were heard and actioned appropriately.

However:

- Many of the care plans lacked patient views and patients told us that they didn't always feel involved in their care.

## Are services responsive to people's needs?

**We rated responsive as Requires Improvement because:**

- There were delayed discharges on some of the wards. The wards told us the delayed discharges were often due to difficulties in finding appropriate supported accommodation if required, and funding issues.
- When we visited Cook ward we saw that patients were sitting in chairs in the day area and that nobody was in their bedroom. It appeared that patients were not always able to spend time in their rooms alone due to the lack of an alarm system in their bedrooms. There was a high level of noise on Cook ward that could have been disturbing for patients with mental health problems.
- The wards were only partially dementia friendly in design. There was a lack of contrasting colours of the walls, skirting boards and light switches that would assist patients with dementia to negotiate the ward.
- Each bedroom we looked at contained a safe with keypad access which would require the patient to memorise the keypad pin number.
- Patients were not able to open or close the viewing panel of their bedroom doors from inside, which could impact on their privacy.
- All of the bedrooms, apart from one, were very bare and depersonalised in appearance, with nothing that could be considered personal to the patient evident on the walls.

**Requires improvement**



# Summary of findings

- Staff had written patients' forenames and the first letter of their surname on boards in communal patient areas on both Cook and Stage wards. This could compromise the patients' right to privacy and confidentiality.
- Patients were not able to make hot drinks 24/7 themselves as the kitchens were locked, but staff told us if a patient requested a hot drink at night, this would be made for them. Water was available 24/7.

However:

- The wards used both pictorial images and words to help patients with cognitive impairment negotiate the ward.
- There was a good range of activities provided on each of the wards, seven days a week.
- On admission each patient was orientated to the ward and given a welcome pack.
- Patients had supervised access to a garden.
- We saw a good variety and choice of food options, including a healthy choice, vegetarian, halal, caribbean, pureed and gluten-free.

## Are services well-led?

**We rated well-led as Requires Improvement because:**

- There was a lack of governance around the anticipation, prevention and management of falls on the wards.
- The trust had risk assessments in place that identified the ligature risks on the wards with clear guidance on what work needed to be done, however there was no completion date for this work.
- Following a serious incident involving the use of a plastic bag, the Trust had implemented daily ward checks. However, the trust had not ensured that learning from this incident was applied consistently across the wards.
- Mental Health Act 1983 training was not mandatory within the trust and many staff had not received training in this.

However,

- Local governance processes were in place, such as regular physical health monitoring taking place, weekly reviews of risk assessments, staffing levels and supervision of staff.
- Staff described a friendly and inclusive ward culture and that they enjoyed being part of the team.

**Requires improvement**



# Summary of findings

- The trust's target for the rates of clinical supervision achieved between April 2014 and March 2015 was 85%. The wards for older people with mental health problems achieved 88% of supervision rates overall.
- The training mandatory compliance for staff on wards for older people with mental health problems was 94%.

# Summary of findings

## Information about the service

North East London NHS Foundation Trust has three wards for older adults with mental health problems.

The wards we visited during the inspection were:

- Cook ward, an older adult acute mental health service that cares for women. The ward is based at Sunflowers Court, Goodmayes Hospital, Essex.
- Stage ward an older adult acute mental health service that cares for men. The ward is also based at Sunflowers Court, Goodmayes Hospital, Essex. Both Stage and Cook wards are five year old purpose built wards which are accessed via a 24 hour manned reception.

- Woodbury unit an older adult acute mental health service that cares for both men and women. The ward is currently based in Leytonstone, London.

All of the wards work with older adults who are deemed to be frail and usually aged 65 years and over, although younger adults may be admitted when appropriate, typically if they suffer from an early onset of dementia. The service works with people who have either organic or functional mental health problems, which are complex enough to require a period of inpatient treatment. Some people who use this service are adults who have been detained under the Mental Health Act 1983 and some may have Deprivation of Liberty safeguards in place under the Mental Capacity Act 2005.

## Our inspection team

The inspection team was led by:

Chair: Helen McKenzie, Executive Director of Nursing, Berkshire Healthcare NHS Foundation Trust.

Head of Inspection: Natasha Sloman, Care Quality Commission (CQC).

Team leader: Louise Phillips, inspection manager, Care Quality Commission.

The inspection team that inspected this core service comprised of: a CQC inspector, a specialist advisor doctor, a specialist advisor nurse, an expert by experience and two Mental Health Act reviewers.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people who use services at focus groups and through comment cards.

During the inspection visit, the inspection team:

- visited three wards for older adults with mental health problems
- spoke with 11 patients, three former patients and viewed 35 comment cards

# Summary of findings

- spoke with seven carers
- spoke with the ward managers for each ward, one assistant ward manager, a director of nursing and a deputy director of older people's services
- spoke with 28 other staff members, including six nurses, one nurse consultant, four healthcare assistants, three consultants, four junior doctors, one visiting geriatrician, three pharmacists, two occupational therapists, two psychologists, one physiotherapist, one domestic assistant
- observed three exercise classes
- observed two ward rounds, two staff handovers and a staff safety huddle group
- looked at a total of 25 electronic patient care records and 16 medicine charts
- carried out a check of the equipment in clinic rooms
- looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the provider's services say

Patients on all of the wards told us that they were treated with dignity and respect, and that staff assisted them with their personal care in a respectful way. Patients told us that they felt the staff were attentive towards them. One told us they were regularly reminded to use their walking aid by staff and another told us that staff rearranged the bedroom to prevent the patient falling.

Some patients felt that there wasn't always enough staff on the wards and they were often busy. They told us that the wards were comfortable but there wasn't a lot of privacy. Many of the patients we spoke to told us that they didn't always feel involved in their care.

We looked at 34 comment cards: patients on Cook ward told us they were treated with dignity and respect, patients on Stage ward told us they didn't always feel listened to and patients on Woodbury unit told us that staff could be rude but overall they felt they were treated with dignity and respect. Some patients commented via the comment cards that the rooms on Woodbury unit could be cold.

Ex-patients told us that they were asked to complete an exit questionnaire after discharge and felt able to feedback their experience to the service.

## Good practice

- On Cook ward the nurse consultant was involved in a quality improvement project 'making patients on an older people's mental health ward feel safer'. The project found that by enhancing the therapeutic environment to make it more dementia friendly, the incidence of physical aggression reduced by 40%, and there was an increase of 64% in the number of patients who stated they felt extremely safe. The nurse consultant had been shortlisted by the Royal College of Nursing for a prestigious award - the Nursing Older People Award.
- All the wards had a 'safety cross' quality dashboard visible on the wards which displayed performance in key areas of safety and quality in an open and transparent way. These included the number of incidents were recorded each month, such as violence and aggression, falls, complaints and how many activities were cancelled on the ward.
- All of the wards took part in the Butterfly scheme, a UK wide hospital scheme designed to improve patient safety and wellbeing in hospital, its focus enables staff to respond appropriately to people with memory impairment or dementia.
- The wards began implementing 'Safewards' in November 2015. Safewards identifies areas where conflict may happen and provides ten interventions which aim to specific tools/ behaviours to reduce these.
- The wards offered 'Namaste Care' which is a sensory based programme designed for use with people who have advanced dementia. Namaste is a hindu greeting that means 'to honour the spirit within'. It is a dementia friendly approach to patient care that

# Summary of findings

combines nursing care with additional sensory experiences like touch and sound to create a soothing peaceful environment for patients who cannot engage in other mainstream activities.

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take to improve

- The trust must improve upon the prevention and management of falls on wards for older people with mental health problems.
- The trust must ensure that patient dignity and privacy are maintained by reviewing the viewing hatches on patient bedroom doors and enable access to their bedrooms in the day.
- The trust must ensure that any changes that are made to ward procedure as a result of learning from a serious incident is applied consistently across the wards.
- The trust must ensure that there is an adequate alarm system in place in all patient bedrooms and en-suite shower rooms so that patients can alert staff in the event of an emergency or urgent need.
- The trust must ensure that the ligature risk assessment clearly specifies when the work to remove ligatures will be completed by.
- The trust must ensure that all staff have Mental Health Act 1983 training.

### Action the provider **SHOULD** take to improve

#### Action the provider **SHOULD** take to improve

- The trust should follow the National Institute for Health and Care Excellence quality statement which recommends that anyone over 65 should automatically be considered at risk of falls.

- The trust should consider the use of assistive technology in the care for patients over the age of 65, such as motion sensor equipment.
- The trust should ensure that all staff that care for people with dementia receive training in dementia, as recommended by the National Institute for Health and Care Excellence.
- The trust should ensure that all staff have access to training in the Mental Capacity Act 2005 and not just the qualified staff.
- The trust should ensure that all approved mental health professionals reports are present in Mental Health Act paperwork.
- The trust should consider making the wards a more dementia friendly environment.
- The trust should ensure that care plans include patient views and that patients are involved in their care.
- The trust should ensure that psychology screening is implemented before commencing or discontinuing pharmacology as a treatment for patients. Patients should also have access to a National Institute for Health and Care Excellence recommended therapy while on the wards.

## North East London NHS Foundation Trust

# Wards for older people with mental health problems

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Cook Ward	Sunflowers Court
Stage Ward	Sunflowers Court
Woodbury Unit	Woodbury Unit

#### Mental Health Act responsibilities

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

MHA 1983 paperwork was in order and completed appropriately.

Consent to treatment paperwork was in place. Section 17 leave forms were appropriate and most of these were signed by the patient.

Patient's rights under the MHA 1983 were read to them on admission and at regular points thereafter.

Staff assisted patients with referrals to Independent mental health advocacy service.

All of the wards had notices near the exit door stating that the door was locked and gave instruction to informal patients on what to do if they wanted to leave the ward.

However original MHA 1983 documents were kept in the main MHA office and not on the ward, however these could be made available to the wards as and when needed.

There were approved mental health professional reports missing in some of the legal documents on both Cook and Stage wards which meant that the documentation required to legally detain a patient under a section of the MHA 1983 was incomplete.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

We saw good evidence that staff adhered to and understood the Mental Capacity Act (2005). Capacity assessments were carried and regularly discussed in ward rounds, with contribution from the patient's next of kin. Staff had a good understanding of the need to seek capacity and the principles of the Mental Capacity Act and that they supported patients to make decisions.

The Deprivation of Liberty Safeguard (DoLS) paperwork we looked at showed that standard authorisation and best

interest assessments were completed. We observed that staff reviewed a patient's DoLS status during handover. Staff demonstrated to us across all wards that they had a good understanding of the DoLS process and we saw that DoLS applications were completed by staff and sent to social services.

Staff assisted patients with referrals to advocacy and the Independent Mental Capacity Advocacy service.



# 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

- The layout of each of the three wards we visited did not allow for staff to see directly into any of the patient bedroom corridors unless a staff member was placed in this area or just outside. The patient bedroom corridors were not observable from the nursing station or office. There was no use of mirrors or CCTV on the ward, although Woodbury unit had CCTV which monitored the outside grounds only.
- The bedrooms and shower/bathrooms on both Stage ward and Woodbury unit were equipped with either alarm buzzers or alarm cords. The patient bedrooms and ensuite bath/shower rooms on Cook ward were not equipped with alarm buzzers or cords of any kind to enable patients to alert staff in the event of an emergency or when they needed urgent support. None of the wards used assistive technology such as motion sensor equipment that would alert staff if a patient at risk of falls moved out of their bed or chair.
- To mitigate these risks Cook ward locked the bedrooms during the day of patients considered frail. At night the ward used a rota system so that a staff member was placed at all times in the corridor where particularly frail patients slept. A member of staff told us they felt anxious about being rostered to be in the corridor at night due to a recent patient fall. The ward had purchased hand held bells for patients to use when in their bedroom to summon help from staff. However these were not in reach if the patient was in their bed and the bells may not have been audible if a staff member was in another patient's bedroom.
- Each of the three wards contained ligature points in patient areas which represented risks to patient safety. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of strangulation. However, the wards mitigated these risks by placing patients at high risk in ligature free rooms, locking doors to rooms that contained ligature risks and reviewing individual patient risk assessments frequently. Staff used the Trust's observational policy to ensure patients at risk were closely monitored and staff were placed where needed. The grab bags in the clinic rooms contained ligature cutters and staff knew where to access these. The environmental risk assessment listed the ligature risks but the associated action plans had no dates by when the work to remove the ligature risk would be completed by.
- All of the the wards looked after patients with both functional and organic illnesses, which meant that patients with mental health problems such as depression or schizophrenia were on the same ward as people with a cognitive impairment such as dementia.
- All of the clinic rooms were clean and functional, and equipment was well maintained and clean. The clinic rooms were fully equipped with accessible resus equipment/grab bags that were checked daily. The grab bags contained ligature cutters. Cook ward and Woodbury unit had a separate room for treatment and one for examination while Stage used one clinic room for both functions. Cook and Stage ward had an Electrocardiogram (ECG) machine and all of the wards had blood pressure machines and weighing scales. The emergency equipment was seen and checked and found to be satisfactory. Fridge temperatures were checked daily and were within the correct range of between 2°C and 8°C, to ensure that medicines kept in the fridge were stored at a correct temperature.
- Overall the wards were clean and well-maintained with good furnishings throughout, but the majority of toilets we viewed across the wards had an offensive odour. There were cleaning schedules in place on all of the wards that showed what should be cleaned when and this was overseen by a domestic supervisor. However, none of the wards had a system to record and evidence what cleaning had actually been done. Patients and their carers told us that they felt the wards were clean but three patients on Woodbury unit told us that the toilets were frequently unclean.
- In the 2015 the Patient-Led Assessment of the Caring Environment, the trust scored 99% for cleanliness (2% higher than the national average for trust sites of 98). Patient-Led Assessment of the Caring Environment assessments are self-assessments undertaken by teams of NHS and private/independent health care providers,

# Are services safe?

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

and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness.

- The only ward which had a mixed gender environment was Woodbury ward. It used a mixture of single bedrooms and bedroom bays of two or four beds. The ward complied with guidance on mixed-sex accommodation and had a female only lounge which was situated in the main ward area.
- All staff members were equipped with a personal alarm (PET). Every ward had a PET team member allocated at the start of the shift to a PET team, and the team responds to an incident if the alarm is pressed.

## Safe staffing

- In the three months between 1 August to 31 October 2015 Stage Ward had the highest number of shifts filled by bank or agency staff at 512, while the Woodbury unit had 295. None of the wards had shifts that were not filled by bank or agency staff.
- Key staffing indicators as at 31 October 2015 showed that establishment levels for qualified nurses stood at 36 whole time equivalent (wte) across all three wards with two wte vacancies. Nursing assistant establishment levels across the wards was 35 wte with 11 wte vacancies. Woodbury unit had the highest number of vacancies overall at 21% while Stage ward had the highest percentage of permanent staff sickness at 12%.
- Cook ward had 15 patients on the ward when we visited and the ward used a seven-six-five shift ratio system (seven staff in the morning, six in the afternoon/evening and five at night). Woodbury unit had 21 patients on the ward when we visited with 15 male beds being used and six female beds. The ward normally worked on a five-five-four shift ratio system. Stage ward had nine patients on the ward when we visited and used a four-four-three staffing ratio.
- Woodbury unit was using a rota system that planned eight weeks ahead while Stage and Cook ward planned their rota four weeks in advance unless patients required increased levels of observation or during a ward round day.
- The ward managers told us that they were able to adjust their staffing level according to the needs of the patients and that they tried to use bank or agency staff that were familiar with the ward and the patients. The ward

managers liaised with the bleep holder and moved staff across wards to assist where needed. Staff could cross over between the three wards if one ward was short staffed.

- Most of the patients told us that staff were generally visible but that they were often very busy and that they felt there should be more staff. Patients told us that there wasn't always staff available to unlock the door to access their bedroom, to escort them into the garden and that groups activities had been cancelled. Half of the carers told us that they there wasn't always enough staff to attend to a change in a patient's need, to escort their relative outside and one carer commented that during the weekend there was less staff. However most patients told us that they were able to go on escorted leave and this was rarely cancelled due to short staffing. Staff told us that the wards were sometimes short staffed due to sickness but that activities were rarely cancelled for this reason. Staff told us that there was always at least one experienced nurse present in the ward area and when we observed this during our visit.
- There was adequate medical cover across the wards and staff and patients told us that there was no difficulty accessing a doctor out of hours.
- The mandatory training compliance for wards for older people with mental health problems was 94%. The teams achieved 100% for the number of staff who have been trained in mental capacity & deprivation of liberty and safeguarding children level one. Safeguarding adults recognition and referral has the lowest compliance score overall for the service with 81%. There was no information for basic life support, safeguarding adults strategic or safeguarding children level three.

## Assessing and managing risk to people who use services and staff

- Two days prior to our visit, a patient sustained an injury during an unwitnessed fall on Cook ward while getting out of bed. We looked at previous records for the patient, which showed that the patient was at risk of falls, however there was no evidence of a falls risk assessment or falls care plan in place prior to the fall. The patient's bedroom did not have an alarm to enable them to summon help from staff. However, staff told us that falls risk assessments were completed on every patient's admission and a falls leaflet given to the patient. If the patient had a history of falls, the ward doctor would examine the patient and refer them to the

# Are services safe?

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

ward physiotherapist or a dietitian. Patients told us that staff reminded them to use their walking aids and one patient told us that staff had rearranged their bedroom to prevent them falling.

- During our visit to Stage ward we observed a patient in the main corridor who appeared extremely drowsy and unsteady on his feet. He was being observed by one staff member within arms length without the use of additional aids. The patient's notes showed that he had received monthly physical health checks and monitoring since his admission, including a physiotherapy assessment, but staff had not reassessed despite a change in his presentation.
- Cook ward did not have bedroom alarms for patients to summon assistance from staff. The Trust did not use assistive technology such as motion sensor technology in the wards for older people with mental health problems. However occupational therapists recommended bed leaving sensor mats for patients with a tendency to get out of bed at night when they were discharged to sheltered accommodation.
- None of the patients had a pressure ulcer on the wards we visited. The wards had good processes in place for assessment and treatment of patients at risk of developing pressure ulcers. Staff completed body maps and wound chart during the admission process and referred patients to physiotherapy for further assessment as appropriate. The wards used the SSKIN bundle tool (SSKIN: Surface, Skin inspection, Keep your patients moving, Incontinence, Nutrition), a five step model for pressure ulcer prevention. The wards also used The Malnutrition Universal Screening Tool, 'MUST', a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obesity. There was input from trust employed tissue viability nurses who visited the wards or offered telephone advice to staff.
- The Trust reported no incidents of seclusion or long-term segregation on the three wards for older adults with mental health problems between April 2015 and October 2015. None of the wards we visited had a seclusion room and staff told us that they did not nurse patients in seclusion. Instead staff used de-escalation techniques, the ward's calming box and sensory rooms. Patients and carers across the wards told us that when

other patients had demonstrated behaviours that challenge, that this was generally well managed by staff. Carers told us they felt their relatives were safe on the ward and staff adjusted the level of care when needed.

- The Trust report also showed that across the three wards during this same period there were 17 uses of restraint on 12 different services users of which four were uses of restraint in the prone position and four also resulted in rapid tranquilisation. The highest number of instances of restraint occurred on Cook ward where there was 11 restraints, three in the prone position and three that resulted in rapid tranquilisation. Staff on Cook ward told us that following rapid tranquilisation the patient's blood pressure would be taken, the incident would be reported on the trust's incident reporting system (DATIX) and a staff debriefing would follow.
- All of the 25 electronic patient records we looked at during our visit had robust, thorough risk assessments in place that were reviewed and updated weekly or fortnightly, and more frequently if necessary. Ward managers audited these weekly to ensure they were completed. Staff used the trust's standardised risk assessment tool via the template on the electronic patient records system (RIO) and they were able to see risk assessments completed by the home treatment team who were the main referrers to the wards.
- All of the wards were locked but there were signs inside the entrances alerting informal patients of what to do if they wanted to leave. Staff and ward managers told us that if an informal patient asked to leave the ward, they would ask them where they planned to go and undertake a risk assessment. If the patient was considered at risk they would be considered for an assessment under the Mental Health Act 1983 (MHA 1983). All the wards had 'at a glance' hard copies of policies in a folder for use by bank or agency staff to easily access. There were policies in place for observation and searching of patients, with a list of banned items near the entrance to the wards.
- Patients and carers across the wards told us that when other patients have demonstrated challenging behaviours, this was generally managed swiftly and efficiently by staff. Carers told us they felt their relatives were safe on the ward and staff adjusted the level of care when needed. Staff attended a yearly five day Prevention and Management of Violence and Aggression (PaMOVA) training as well as regular one day updates.

# Are services safe?

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The PaMOVA training attended by staff included de-escalation techniques and these skills appeared to be utilised to good effect on the ward and staff encouraged patient use of the sensory room and the safewards 'calming' box. The box had a variety of items which staff would go through with patients when they began to feel agitated and patients would choose the items they wanted to use.

- There was one safeguarding concern between January 2015 and February 2016 on Cook ward. Staff were trained in safeguarding and demonstrated that they had a good, detailed understanding of the safeguarding processes. If a patient was admitted with bruising, staff would discuss this and raise a safeguarding alert. Staff had access to two policies on safeguarding: the trust policy and the local authority policy. There was a safeguarding duty desk Monday to Friday 9-5, which offered advice and guidance to clinicians outside hours encouraged staff to dial 999 if patient at immediate risk.
- We observed a staff safety huddle on Cook ward. The safety huddle discussed key risk and safety issues, such as reminders to elevate a patient's legs; continence care, the need to encourage fluids for a patient; or, whether a patient's anxiety had reduced. However, the huddle was held in the main area of the ward, potentially audible to patients. We queried the rationale for the location of this meeting and its potential confidentiality risks, staff told us they would have the meeting in the ward office in future.
- The building in which Stage and Cook are set had a family room that could be used if children wanted to visit their family member. Staff would accompany the patient and stay in the visiting room when necessary.

## Track record on safety

- The wards had seven serious incidents reported between 1 November 2014 and 31 October 2015. None of these were 'never' events. Cook ward had two falls (one suspected), and an unwitnessed fall two days before we visited. Stage ward had one suspected fall and one attempted suicide, Woodbury unit had one suspected fall and one incident of a patient being pushed by another patient.

## Reporting incidents and learning from when things go wrong

- Following a serious incident on another ward involving a plastic bag, all three wards had established a daily checking system to screen for patients or relatives bringing plastic bags on to the ward. The wards risk assessments allowed for an exception for clinical waste bags to be used on main patient areas on the wards for older people with mental health problems. The learning and action from the serious incident appeared to be inconsistently applied across the three wards as Stage ward was the only ward that did not allow the placement of these bags in patient bedrooms.
- Ward managers told us that they discussed incidents and subsequent learning from incidents regularly at fortnightly team meetings and in supervision with their staff. We saw minutes from the previous three team meetings on Woodbury that had a section for discussing serious incidents. Staff demonstrated that they were aware of how to report an incident, using the trust's incident reporting system DATIX and that they would cascade any information to the Manager.
- There was an incident on Woodbury in 2015 where a patient pushed another patient and fell, resulting in a fracture, with only one staff member present at that time. The result was a more robust off-duty system used on the ward which planned eight weeks in advance.
- The wards began implementing 'Safewards' in November 2015. Safewards identifies areas where conflict may happen and provides ten interventions which aim to specific tools/behaviours to reduce these. All the wards had a 'Safety Cross' quality dashboard visible on the wards which displayed performance in key areas of safety and quality in an open and transparent way. These included the number of incidents were recorded each month, such as violence and aggression, falls, complaints and how many activities were cancelled on the ward.

# Are services effective?

Requires improvement 

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

## Our findings

### Assessment of needs and planning of care

- All of the 25 care records we looked at showed good evidence that a physical examination had taken place on admission and that physical health reviews were done on a monthly basis thereafter, or more frequently if required. Doctors felt that the wards had made significant improvements to physical healthcare monitoring, including reviewing early warning scores, weekly weight checks, checking blood results on computer and rationalising physical medicines. A geriatrician visited weekly and assisted with the physical reviews which was a reciprocal arrangement with the acute trust. Patient on all the wards told us that staff offered the opportunity for them to see professionals such as a dentist, chiropodist or optician and that they were taken to an acute hospital for any physical interventions that were required. Staff carried out daily physical observations, such as blood pressure checks.
  - We looked at 25 electronic patient records. The care plans varied in quality. The majority were person-centred and holistic but only about one-half contained the patient voice or their views.
  - There was a lack of psychological review and formulation of patients with dementia following admission prior to commencement of, or discontinuation of antipsychotic medicine for behavioural symptoms. The psychology department had made a presentation to the senior managers on this issue.
  - The wards used several information technology systems along with hard copies of documents which meant that key information was stored in different places and could make it difficult for staff to access documents readily.
- Institute for Health and Care Excellence recommended therapy while on the wards. The psychology department offered training for non-psychology staff and psychology trainees ran groups on the wards.
- Staff were allocated during meal times to supervise, prompt and where required, assist people to eat and staff encouraged family to assist where appropriate. We observed a good level of care and attention from staff during mealtimes, with time taken to encourage patients to take an adequate amount of food and fluids. All wards kept meal times protected with administrative staff answering phones. No meetings or clinics were held during this time.
  - Staff completed food and fluid charts for patients that required them. Every patient on admission was started on a food and fluid chart for 72 hours which would either be stopped or changed to a daily chart, depending on the patient's need. Patients were also referred to the occupational therapist if they required any equipment to assist with drinking or eating.
  - Doctors across the wards used the mini mental state exam and the Montreal cognitive assessment both to assess levels of cognitive impairment, then they would follow prescribing pathway for medicine for dementia. The wards used HONoS (health of the nation outcome scales) to measure the health and social functioning of people with severe mental health problems.
  - All of the wards took part in the Butterfly scheme, a UK wide hospital scheme which was designed to improve patient safety and wellbeing in hospital. Its focus was to enable staff to respond appropriately to people with memory impairment or dementia. Images of butterflies placed on paperwork and on patients' doors acted as a reminder to staff to consider their approach to the patient. The scheme included staff understanding of a patient life history, their individual needs and the use of pictures and a relaxation CD. This was in order to improve the quality of patient and carer understanding the process during the in-patient stay. Cook ward also used 'Barbara's story' an in house training tool for staff which included a DVD and teaching session.
  - A nurse consultant on Cook ward was involved in a quality improvement project 'making patients on an older people's mental health ward feel safer'. The project found that by enhancing the therapeutic

### Best practice in treatment and care

- The wards had limited input from a psychologist because the trust employed only one full time psychologist across the service. Input to the wards ranged from once a week to three times a week. Therapy was offered on an out-patient basis only. This meant that patients did not have access to a National



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environment on Cook ward this had reduced the incidence of physical aggression by 40%, reduced episodes of staff sickness by 64%. Of all the patients who responded, 64% stated they felt extremely safe. This project also included the creation of the 'garden room' – this was a sensory room on Cook ward, established in 2015 and designed with the input of patients. The room effused the smell of lavender and rose which encouraged the stimulation of olfactory senses as well as touch, sight and sound. The nurse consultant has been shortlisted by the Royal College of Nursing for a prestigious award - the Nursing Older People Award.

- Infection control nurses completed infection control audits. Pharmacists undertook medicine management audits and shared the results of this with ward managers who then shared this with their staff.
- The wards offered 'Namaste Care' which is a sensory based programme designed for use with people who have advanced dementia. Namaste is a hindu greeting that means 'to honour the spirit within'. It is a dementia friendly approach to patient care that combines nursing care with additional sensory experiences like touch and sound to create a soothing peaceful environment for patients whose illness makes it difficult for them to engage in other ward activities.
- The wards used a prescribing observatory for mental health (POMH-UK) format of screening in the use of antipsychotics: POMH-UK prescribing practice. This is not an accreditation scheme but a series of audits and quality improvement programmes that trusts can take part in.

## Skilled staff to deliver care

- The percentage of non-medical appraisals completed across the inpatient wards of the trust was 68%. These figures were not specific to wards for older people with mental health wards. However staff told us that they were up to date with their appraisals and received monthly supervision. Staff told us they had received an appropriate induction when they joined the trust.
- Apart from training incorporated into the care certificate, not all of the staff across the three wards were trained in dementia as recommended by the National Institute for Health and Care Excellence.

- Staff told us that they felt they had a wide range of opportunities for further development, including internal and external training options. The trust had links with London Southbank University and staff had accessed courses there such as dementia training, continence care, pressure ulcer care and nutrition and dignity.
- Staff told us they received 'safe ward' training which focussed on using de-escalation techniques to prevent challenging behaviour from escalating as well as Prevention and Management of Violence and Aggression. Some staff nurses were trained in phlebotomy and many of the healthcare assistants on the wards were trained to complete electrocardiogram tests when a patient was admitted and at other times as necessary.
- All three wards employed full time occupational therapists. Physiotherapists visited the wards either weekly or twice weekly. Some staff told us they would like more frequent input from the physiotherapists on the wards. Some of the wards had input from an art therapist half a day a fortnight. There were no nurse prescribers on the ward.

## Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary ward rounds taking place either two or three times a week that included ward doctors, nurses, physiotherapists and occupational therapists. Pharmacists did not attend ward rounds due to resource capacity but they did try to attend handover on ward when possible. Healthcare assistants told us that they were not invited to attend ward rounds. The majority of referrals to the wards were made by the home treatment team (HTT) and a representative from the team attended ward rounds. Care co-ordinators from the community mental health teams (CMHTs) also came to ward rounds but staff told us this was variable. The wards had links to four CMHTs which in turn were linked to four local authorities. The bed manager ran a weekly meeting which was attended by ward managers, the CMHTs and HTT.
- The two ward rounds we observed were very different in style. Cook ward round was predominantly based in the medical model and was observed to be prescriptive in style with minimal patient or carer participation or

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discussion around the prescribed medicine's purpose or the possibility of alternatives. Woodbury unit ward round included two family meetings, was more inclusive and recovery focussed with patients and carers were encouraged to engage in the discussion. The team's approach during both ward rounds was respectful, positive and caring. On Woodbury unit a checklist was given to patients and carers two days before the ward round to encourage them to summarise their issues prior to the ward round.

- We observed a handover meeting on Cook ward and Woodbury unit. The handovers were thorough and encompassed each patient's mental health, social and physical needs, Staff reviewed patient's legal status such as leave and whether a referral to the advocacy service was required. The information was recorded in the handover file and a 'things to do list' was completed. Woodbury unit we saw the standard operating procedure for handovers and saw that the format was followed by staff. On Woodbury there was a strong focus on the patient's recovery, choice as well as their individual goals and strengths.

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

- All of the wards had notices near the exit door stating that the door was locked and gave instruction to informal patients on what to do if they wanted to leave the ward. The wards had an open visiting policy and encouraged relatives to take patients out. The ward occupational therapists also took patients out.
- On Cook ward there was minimal use of Section 5 (2) or 5 (4) under the Mental Health Act (MHA 1983). These are sections used to temporarily hold an informal patient on the ward if staff have increased concern about the deterioration of a patient's mental health. The minimal use of these indicated that the wards had good processes around the rights of informal patients.
- Section 17 of the MHA 1983 allows the Responsible Clinician to grant a detained patient leave of absence from hospital. We saw that section 17 leave forms were appropriate and most of these were signed by the patient.
- Staff assisted patients with referrals to independent mental health advocacy service.

- The original MHA 1983 documents were kept in the main MHA office and not on the wards. The wards own MHA 1983 documents did not always match those in the MHA office and were not always as up to date. However the originals were accessible via the MHA office as and when needed. There were approved mental health professional reports missing in some of the legal documents on both Cook and Stage wards which meant that the documentation required to legally detain a patient under a section of the MHA 1983 was incomplete.
- Training in the MHA 1983 was not mandatory and training figures for the 'Introduction to MHA' was variable across the wards, with three staff members having completing this on Cook ward, six on Stage and 15 on Woodbury. None of the staff on any of the wards had completed 'MHA refresher training'
- At the last MHA 1983 review visit to Stage ward on 16 May 2013, we identified the following concerns:
- Not all patients had had their rights explained on admission or repeated.
- Not all patients had had the reasons for escorted leave explained or been facilitated to take that leave.
- Not all the incidents recorded in the progress notes were separately recorded on the incident reporting system.
- During this visit, of the records we reviewed there was evidence that rights were explained to patients on admission and repeated. There were no observations made nor concerns raised around the issue of patients having escorted leave explained or being facilitated to take that leave. There were no observations made nor concerns raised relating to the issue of incidents not being recorded separately in the incident reporting system.

## Good practice in applying the Mental Capacity Act 2005.

- Concern had been raised during a previous visit to Stage ward that patients were not supported to make advance decisions. On our visit the ward manager said that this was now considered for all patients, however no advance decisions were observed in the care records on Stage ward. (Woodbury unit was the only ward on which a patient had been supported to make an advance

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decision). Concern had also been raised that carers were not routinely involved where patients were deemed to lack capacity. On our visit we saw evidence that carers were involved with care planning and decision making.

- Between June 2015 and November 2015 the trust made 84 mental health deprivation of liberty safeguards (DoLS) applications for this core service: DoLS applications by ward were: Cook: 34, Stage: 20, Woodbury: 30. During our visit the paperwork we looked at for DoLS showed that these standard authorisation and best interest assessments were completed. We observed that staff reviewed a patient's DoLS status during handover.
- Staff assisted patients with referrals to advocacy and the independent mental capacity advocacy service.
- We saw good evidence that capacity assessments were carried and regularly discussed in ward rounds, with

contribution from the patient's next of kin. Staff had a good understanding of the need to seek capacity and of the guiding principles of the Mental Capacity Act (MCA 2005) and they supported patients to make decisions. Staff and ward managers told us that issues around the MCA 2005 were discussed in supervision. Staff demonstrated that they knew how to access further advice regarding MCA 2005 & DoLS within the trust. Woodbury unit used a 15 point progress notes system to check what specific part of the treatment patients had capacity to agree to, with everything documented. This included capacity and consent prior to personal care, medication, feeding and leaving the ward.

- The training completion rate for the 'mental capacity and deprivation of liberty' training was 100% across the three wards, however many healthcare assistants had not received this training.



# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

- The trust's overall score for privacy, dignity and wellbeing in the 2015 Patient-Led Assessment of the Caring Environment score was 86%. This figure was the same as the national average of 86.0%.
- On all three wards, particularly on Woodbury and Stage ward, we observed staff interactions with patients that were caring, creative and inclusive. Time was taken to ensure patients understood and engaged with the process. We observed caring interventions with patients when assisting with eating and when dealing with distress. We observed staff patience and gentle behaviour on all wards, particularly in encouraging fluids and food.
- The majority of patients on all of the wards told us that they were treated with dignity and respect and that staff took care and time when assisting them with personal care. A carer on Woodbury told us that this was the best care their relative had received and they felt listened to. We looked at 34 comment cards: patients on Cook ward told us they were treated with dignity and respect, patients on Stage ward told us they didn't always feel listened to and patients on Woodbury unit told us that staff could be rude but overall they felt they were treated with dignity and respect.
- Staff told us would take the time to find out patient preferences on how they would like to be addressed and when assisting with personal care, they would lock the door and encourage patient choice in what they wanted to wear.
- Many of the patients we spoke to told us that they had received a copy of their care plan but didn't always feel actively involved in their care. Of the 25 care plans we looked at the majority lacked patient views. However it was recorded that copies had been offered to patients and whether they had been accepted, refused or whether the patient was too unwell to engage with the process at the time.
- Carers of patients on the wards told us they felt supported and were involved in their relative's care. They told us that they received copies of the care plans and were invited to ward rounds as well as family meetings. Woodbury unit and Stage ward both ran regular carers groups on the wards. Carer assessments were not completed by ward staff as staff not trained to undertake this, instead staff made a referral for this to be completed by the patient's care co-ordinator in the community. There were photos and names of patient's named nurses on the wardrobe in their room and carers knew the named nurse for their relative. However, some carers told us they were not aware of potential risks and side effects of medicine that was prescribed for their relative.
- Patients and their carers we spoke with told us they felt able to were able to give feedback on the service. There were posters giving details of how to provide feedback, compliments and complaints on the ward notice boards.
- At the time of discharge, patients and carers were asked to give their feedback on the service provided by the ward, in the form of an exit questionnaire.
- Each ward held a weekly patient community meeting, we saw the minutes for these and they showed that patients views were heard and actioned appropriately.

### The involvement of people in the care they receive

# 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 number of delayed discharges was a key concern on some of the wards. Staff on the wards told us the delayed discharges were often due to difficulties in finding appropriate supported accommodation. There were delays with funding from social services for high cost packages of care, such as 24 hour nursing home care. Managers told us that they tried to strike a balance between whether to discharge a patient to a care home that was unsuitable to meet the patient's individual needs (with the possibility that the patient will be readmitted to the ward), or to keep the patient on the ward until they are in the most suitable accommodation.

Between 1 May 2015 and 31 October 2015 delayed discharges and re-admissions for each ward rates were:

- Cook ward, 18 delayed discharges, 4 readmissions within 90 days
- Stage ward, 0 delayed discharges, 2 readmissions within 90 days
- Woodbury unit, 17 delayed discharges, 5 readmissions within 90 days
- The Average percentage bed occupancy across the wards between 1 May 2015 and 31 October 2015 was 81%. The individual ward bed occupancy rates for the six month period were: Cook: 78%, Stage: 92% and Woodbury unit: 72%.
- Average length of stay for patients as at 10 December 2015 for patients on the ward at that time, was: Cook: 35 days, Stage 44. days, Woodbury 33 days.
- We did not have referral to assessment and treatment times specifically for this core service.
- If a patient required admission but either Stage or Cook wards were full then the patient might go instead to the Woodbury unit. If there were no available beds there then the patient would be transferred back to the home treatment team.
- There were no out of area placements in this core service between July 2015 and December 2015.

### The facilities promote recovery, comfort, dignity and confidentiality

- When we visited Cook ward we saw that patients were sitting in chairs in the day area and that nobody was in

their bedroom. It appeared that patients were not always able to spend time in their rooms alone due to the lack of an alarm system in their bedrooms. There was a high level of noise on Cook ward that could have been disturbing for patients with mental health problems. Patients commented about the noise and we heard banging doors frequently during our visit. This would impact negatively on patients' privacy and dignity.

- All of the bedrooms, apart from one, were very bare and depersonalised in appearance, with nothing that could be considered personal to the patient evident on the walls. However, ward managers across all wards told us that patients were able to personalise their rooms. Items would be risk assessed before being brought onto the ward. Some patients told us that the bedrooms on Woodbury unit were sometimes cold.
- Patients were not able to open or close the viewing panel of their bedroom doors from inside which could impact on their privacy. Patients told us that the wards were comfortable but there wasn't a lot of privacy. Staff told us that when patients wanted some quiet and privacy they were able to use the ward's sensory room.
- Staff had written patients' forenames and the first letter of their surname on boards in communal patient areas on both Cook and Stage wards. This could compromise the patients' right to privacy and confidentiality.
- Each bedroom we looked at contained a safe with keypad access which would require the patient to memorise the keypad pin number. We had concerns that patients with a cognitive impairment or another type of mental health problem may not have found this easy to do. Staff told us that patients did not use these but were able to leave their personal belongings securely in the staff office. Patients told us that their valuables were kept either at home or in the staff office. Carers told us that the bedrooms on Cook ward were locked during the day so nobody had access to any belongings kept in them. There was also a welfare department within the trust which was able to look after people's money.
- Each ward had a good range of activities provided seven days a week. The activity schedule on one ward was on an A4 piece of paper on the wall which may not have been easy for patients on the ward to see. The activities

# Are services responsive to people's needs?

Requires improvement 

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

were run by both qualified and unqualified staff.

Patients told us they engaged in activities such as scrabble, dominoes, bingo, singing, healthy eating cooking group and exercise classes.

- We observed an exercise class on each ward, a quiz and a word game. We saw that staff were inclusive and communicated well with patients, taking more time where this was needed. Staff made the sessions fun and used creative ways to engage patients. We also saw that staff respected patient's decisions not to participate and offered them 1:1 time instead. We saw staff demonstrate to patients how to use a mobile phone.
- On Woodbury unit in particular we saw good combined use of pictorial images and words to help patient's with dementia negotiate the wards. Food options were both in written and pictorial versions across all of the wards. There was a sensory room on each ward with varying types of sensory stimuli, using sight, sound, touch and smell to varying degrees. However, the wards were only partially dementia friendly in design. There was a lack of contrasting colours of the walls, skirting boards and light switches. On some ward areas these were the same colour completely which could be disorientating for a patient with dementia.
- Patients were not able to make hot drinks 24/7 themselves as the kitchens were locked, but staff told us if a patient requested a hot drink at night, this would be made for them. Water was available on the ward 24/7. Patients told us that they have access to drinks when they request them and were offered a snack at night such as toast or a sandwich.
- There was a good variety of food choices on offer and patients told us that the food quality and portions were good. However some patients told us that if they needed assistance such as help to butter their toast, they sometimes had to wait as the staff were busy doing other things.
- All patients had supervised access to a garden area. The door to the garden would be locked if it was raining.
- Patients were not permitted to bring mobile phones on to the ward that had camera functions. However the wards told us they had a stock of mobile phones for patients to use and they could insert their own SIM card into these.

- Stage ward had a computer with internet access for patient use in one of the main lounges. Woodbury had a virtual shop by reception which displayed classic posters and items such as soaps and biscuit tins from the 1940s and 1950s that helped patients reminisce.

## Meeting the needs of all people who use the service

- On admission patients were assisted to complete a 'this is me' form stating their individual food likes and dislikes, as well as whether they used dentures or had any nutritional requirements. They would then be assessed for their dietary needs and if a patient was diabetic, they would be referred to a dietitian.
- On admission each patient was given a welcome pack which included the menu for the day, times of meals, relative and carers information, how to complain, the advocacy service, side effects of common medicines, information on the Mental Health Act, dates of ward round/care programme approach meetings, the meanings of observation levels, the chaplaincy service, info on referrals to optician, dentist, chiropody as well as how to access information in other languages.
- We saw a good variety and choice of food options, including a healthy choice, vegetarian, halal, caribbean, pureed and gluten-free food. Patients told us that it was easy to request and access these options. This was written on a board in the dining area with accompanying pictorial images.
- Both Stage and Cook wards were in a purpose built complex that opened approximately five years ago. Access for people with disability was factored into the design of the building. Woodbury unit was housed in a much older building but it was on ground floor and had good access for people with disabilities.
- Staff on the wards told us that it was easy to access an interpreter when necessary but there were not many multi-language leaflets on view on the wards. Staff told us that a patient's rights under the Mental Health Act 1983 could be downloaded from the intranet in most languages.
- Staff supported patients based on Woodbury unit to attend their own local place of worship.

## Listening to and learning from concerns and complaints

# Are services responsive to people's needs?

Requires improvement 

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

- There was one complaint from May 2014 to December 2015 for Cook ward which was partially upheld. The complaint related to a patient who broke their hip while on the ward and found that staff had not undertaken a revised risk assessment.
- Patients told us that they didn't have a reason to complain but if they wanted to complain the

information on how to do this was in their induction pack and they would speak to staff or put it in writing. Patients and carers were told about the complaints process upon admission and supported to make complaints if they wished. Carers told us they were sent information in the post about how to complain. We saw leaflets about how to complain across the wards.

# Are services well-led?

Requires improvement 

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

## Our findings

### Vision and values

- Staff were aware of the trust's vision and values. We saw vision and values statement posters displayed on the wards.
- The trust had a positive strategy in place for the recruitment and retention of black and minority ethnic staff and staff described a friendly and inclusive ward culture with good morale.

### Good governance

- There was a lack of governance around the anticipation, prevention and management of falls on the wards. This included the lack of a patient alarm system on Cook ward, (a ward with previous incidents of falls) and the lack of a falls risk assessment or care plan prior to a patient fall and lack of assistive technology.
- There was adequate trust guidance in place which the staff on the wards used appropriately to mitigate the remaining ligature risks, such as individual risk assessments of patients, placement of high risk patients in ligature free rooms and use of the trust's observational policy. The trust's risk assessments identified the ligature risks on the wards with clear guidance on what work needed to be done, however there was no completion date for this work. The trust had implemented daily ward checks in response to a serious incident involving a plastic bag. However, the trust had not ensured that the changes put in place as a result of this incident, such as the removal of plastic bags from bins in patient bedrooms, was applied consistently across the wards.
- The layout of each of the three wards we visited did not allow for staff to see directly into any of the patient bedroom corridors and there were no mirrors on CCTV to improve the line of sight.
- Local governance processes were in place, such as regular physical health monitoring taking place, weekly reviews of risk assessments, staffing levels and supervision of staff.
- The staff on the wards were required to use several information technology systems along with hard copies of documents which meant that key information was

stored in different places and could make it difficult for staff to access documents readily. The trust had highlighted that inadequacies in information systems was an area for improvement.

- Staff told us that they felt they had a wide range of opportunities for further development, including internal and external training options.
- The training compliance for wards for older people with mental health problems was 94%. However Mental Health Act training was not mandatory within the trust and many staff had not received training in this.
- The ward managers used the 'Safety Cross' quality dashboard to monitor performance in key areas of safety and quality in an open and transparent way.

### Leadership, morale and staff engagement

- There have been no qualified whistleblower reports received by the Care Quality Commission in the last two years up to February 2016 relating to the three wards. Staff told us they knew how to use the whistleblowing process.
- Staff told us that they had a supportive team and that morale was generally good. They felt the care they gave was excellent. Staff described a friendly and inclusive ward culture and that they enjoyed being part of the team.
- On Stage ward the domestic assistant describing joint working with healthcare assistants and on Woodbury unit domestic assistants were invited to team meetings. The ward manager of Woodbury unit was recognised as he took us around the ward and seemed well known to all staff and patients as well as visiting carers/family.

### Commitment to quality improvement and innovation

- There was a lack of provision of National Institute of Health and Care Excellence recommended therapies for older people with mental health problems or psychology screening prior to pharmacology being continued or commenced. This was recognised as an area for improvement by the trust.
- The trust participated in the 'Safe prescribing of anti-psychotics in dementia' clinical audit in July 2015.
- The wards began implementing 'Safewards' in November 2015. Safewards identifies areas where conflict may happen and provides ten interventions which aim to specific tools/behaviours to reduce these.

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- A nurse consultant led research project began in February 2016 to be completed in June 2016. This is a pilot study to establish the psychometric properties of a newly developed tool measuring therapeutic engagement from the perspectives of both registered mental health nurses and service users.
- Infection control nurses completed infection control audits. Pharmacists undertook medicine management audits and shared the results of this with ward managers who then shared this with their staff. Ward managers audited risk assessments weekly.
- The wards used the Prescribing Observatory for Mental Health (POMH-UK) format of screening in the use of antipsychotics. This is not an accreditation scheme but a series of audits and quality improvement programmes that trusts can take part in.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect
Treatment of disease, disorder or injury	Regulation 10: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect. <ul style="list-style-type: none"><li>· Patient bedrooms on Cook ward were locked during the day and patients were not able to easily access their rooms to obtain peace and quiet.</li><li>· Patients' bedrooms on all wards were very bare and unpersonalised. Ward Managers told us that patient's were allowed to personalise their bedrooms however we saw only one bedroom (on Woodbury unit) that had anything that could be considered personal in it.</li><li>· Each patient had a safe in their bedroom that was accessed by a numbered keypad which were not being used by patients. It is likely that people with a cognitive impairment may not be able to memorise the numbers to access the safe. This compromises patient's dignity and independence.</li><li>· Patients were not able to open or close the viewing panel on their bedroom door, which could impact on their privacy and dignity.</li></ul>



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## Requirement notices

- Staff had written patients' forenames and the first letter of their surname on boards in communal patient areas on both Cook and Stage wards. This could compromise the patients' right to privacy and confidentiality.

This is a breach of Regulation 10(2)(a)(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 18 HSCA (RA) Regulations 2014 Staffing  
Regulation 18 HSCA (RA) Regulations 2014

Staffing

Regulation 18: Health and Social Care Act 2008  
(Regulated Activities) Regulations 2014.

Staffing

- Mental Health Act training was not mandatory for staff. There was poor staff uptake for Mental Health Act Introduction training and no staff had completed the refresher course.

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



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	<b>Section 29 A of the Health and Social Care Act 2014</b>
Treatment of disease, disorder or injury	<ul style="list-style-type: none"><li>· Taking into account the number of incidents involving falls on the Cook ward and our observations and interviews during the inspection, there were not adequate measures in place to anticipate or mitigate the risks to patients who might have been at risk of falls.</li><li>· There were no call bells or pull cords in 18 of the 20 bedrooms and ensuite shower rooms on Cook ward. This meant that patients were unable to call staff in an emergency, or when necessary in order to meet their needs such as food and nutrition, toilet, personal care and emotional care if they became distressed.</li><li>· Staff on Cook ward had placed a hand held bell in each patient bedroom for patients to use to summon staff. However, it is possible that these would not be sufficiently audible to staff if the level of noise was high elsewhere. The bells were placed on shelves on the wall opposite to the patient's bed which could mean they were out of the patient's reach.</li><li>· Between 1 November 2014 and 31 October 2015 Cook ward recorded that there were two falls (one suspected). Two days prior to our visit there was another fall; staff told us that a patient sustained a fracture during an unwitnessed fall when the patient slipped on their incontinence while getting out of bed. We looked at previous records concerning the patient which showed</li></ul>

This section is primarily information for the provider

## Enforcement actions

that they was known to be at risk of falls, however there was no evidence of a specific falls risk assessment or falls care plan in place prior to the fall. These were completed post-fall.