

Good

5 Boroughs Partnership NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTV06	Warrington	Kingsley Ward	WA2 8WA
RTV03	Halton	Grange Ward	WA7 2DA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Good



Are services safe?

Requires improvement



Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	7
What people who use the provider's services say	7
Good practice	7
Areas for improvement	8

Detailed findings from this inspection

Locations inspected	9
Mental Health Act responsibilities	9
Mental Capacity Act and Deprivation of Liberty Safeguards	9
Findings by our five questions	10
Action we have told the provider to take	20

Summary of findings

Overall summary

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

- Following the inspection in July 2015, we rated the core service as good for the key questions of

effective, caring, responsive and well-led. We did not inspect these key questions during the most recent inspection in July 2016 and we have not changed these ratings.

- Following the inspection in July 2015, we rated safe as requires improvement. As a result of this most recent inspection, we have not revised this rating.

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:

- Bedroom doors had window viewing-panes that could be fully opened to enable staff to have an unobtrusive view into each bedroom. Staff left these open as a default position, apart from when they were assisting patients with their personal care needs.
- A female patient on Kingsley ward had to pass a male patient's bedroom to access toilet and bathroom facilities. However, this was an emergency situation and staff thoroughly understood the risk this posed and put plans in place to mitigate it where possible.
- On Kingsley, we found gaps on medication cards where staff had not signed to indicate if a medication had been administered.

However:

- Both wards had identified female only lounge areas.
- The trust had refurbished a new clinic room on Grange ward. This had access to good ventilation which ensured medicines were stored within an adequate temperature range.
- Staff produced robust risk assessments for all patients and updated these regularly.
- Staff knew what constituted a safeguarding concern and reported safeguarding concerns promptly.

Requires improvement



Are services effective?

Are services caring?

Are services responsive to people's needs?

Are services well-led?

Summary of findings

Information about the service

The wards for older people with mental health problems were located at four bases across 5 Borough's Partnership NHS Foundation Trust. Each of the wards was located within a specialist mental health unit based within the grounds of an acute general hospital. There were corresponding community mental health teams at the same locations, which were combined with wards as part of the later life and memory services. During this inspection we visited two of the wards, Grange ward based at the Brooker Centre and Kingsley ward based at Hollins Park.

Grange ward was an eight bedroom mixed sexed unit that admitted patients with an organic illness, most commonly dementia. Kingsley ward had 18 bedrooms and admitted men and women. Eight bedrooms were single rooms with en suite shower rooms and one was a double room able to accommodate couples. Nine were

single rooms without en suite facilities. Patients admitted to the ward had an organic illness, most commonly dementia. Patients had usually been admitted from a nursing or residential facility because they were unable to provide the level of required support and specialised interventions to meet the needs of people in crisis. The purpose of admission to both wards was to reduce the crisis and to have a period of reassessment to determine where the patient's needs could be best met when their presentation had been stabilised.

The Care Quality Commission last inspected the trust in July 2015 and there were five requirement notices issued following the inspection, of which only one specifically related to wards for older people with mental health problems. This was in relation to Regulation 10 of the Health and Social Care (Regulated Activities) Regulations 2014, Dignity and respect

Our inspection team

Our inspection team was led by:

Team Leader: Sarah Dunnett, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised one Care Quality Commission inspector.

Why we carried out this inspection

We undertook this inspection to find out whether 5 Boroughs Partnership NHS Foundation Trust had made improvements to their wards for older people with mental health problems since our last inspection of the trust July 2015.

When we last inspected the trust in July 2015, we rated wards for older people with mental health problems as good overall. We rated the core service as requires improvement for safe, and good for effective, caring, responsive and well led.

Following this inspection we told the trust that it must take the following actions to improve wards for older people with mental health problems.

We also told the trust that it should take the following actions to improve:

- The trust must ensure that female only lounge areas are available and clearly identified for patients on all of the wards.

We also told the trust that it should take the following actions to improve:

- The trust should review the practice of leaving open door observation windows into patients' bedrooms.
- The trust should continue the work addressing the temperature of the clinic room on Grange ward.
- The trust should ensure the use of the Careflex Smart seat is recognised as a potential mechanical restraint and is included in an associated policy.

Summary of findings

- The trust should ensure that it maintains the recent improvement in staff receiving line management supervision.

Following our inspection of the service in July 2015, we issued the trust with one requirement notice that affected wards for older people with mental health problems. This related to:

- Regulation 10 Dignity and respect

We inspected this service as a focused inspection of wards for older people with mental health problems. This

was to review one requirement notice from the last inspection in July 2015; this related to wards for older people with mental health problems. When we last visited, we found that people who used the service and others may be placed at risk. This was because on two wards there were no identified female only lounges which is not in line with best practice (Department of Health 2014).

At this inspection, we were assured that this requirement notice had been met.

How we carried out this inspection

We asked the following question of the service:

- Is it safe?

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent to us by the trust. A notification is information about important events which the trust is required to send to us.

During the inspection visit the inspection team:

- visited two wards for older people with mental health problems; Kingsley ward at Hollins Park and Grange ward at the Brooker Centre and looked at the quality of the environment
- spoke with the managers of both wards
- spoke with five other staff members, including nurses, a pharmacist and a modern matron

- attended and observed one handover meeting
- observed staff undertaking their work
- looked at eight treatment records, which included care plans and risk assessments
- looked at 19 medications cards
- looked at safeguarding referrals
- looked at mandatory training records
- reviewed a seclusion log at one location and one episode of seclusion in detail
- reviewed five incident reports at one location on the trust's electronic incident reporting system
- reviewed medication management and a range of other policies and procedures on the wards.

What people who use the provider's services say

Due to the severity of their dementia, we were not able to meaningfully speak to any patients using the service during this inspection. However, we observed how staff were interacting with patients and found that staff were respectful, kind and had a good knowledge of individual patient's needs.

Care plans and risk assessments demonstrated that staff tried to involve patients and their relatives, where possible, in the planning and delivery of their care.

Good practice

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

- The trust must review the practice of leaving open door observation windows in patients' bedrooms

Action the provider **SHOULD** take to improve

- The trust should ensure that no patient has to pass bedrooms occupied by members of the opposite sex to reach toilet and bathroom facilities.
- On Kingsley ward, the trust should continue to address staff's failure to indicate when a medication has or has not been administered on patients' medication cards.
- The trust should ensure that eligible staff are compliant with mandatory training.

5 Boroughs Partnership NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Grange Ward	Halton
Kingsley Ward	Warrington

Mental Health Act responsibilities

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

We did not look at Mental Health Act responsibilities during this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not look at Mental Capacity Act and Deprivation of Liberty Safeguards during this inspection.

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 ward layout on Kingsley ward did not allow staff to observe all parts of the ward. However, blind spots on Kingsley ward were adequately mitigated by staffing presence across different areas of the ward. This included areas that were accessible to patients during the day, for example, patient lounges and activity rooms. At night, staff situated themselves at a nursing station based on two adjoining bedroom corridors. During the day nursing staff on Kingsley ward locked the doors leading to the bedroom corridors. Staff also told us that there was an increased falls risk where patients were not supervised. This claim was supported by incident reports that confirmed the majority of the patient falls occurred in areas of the ward that were not supervised by staff. Staff also told us that this reduced the risk of patients wandering into other patients' bedrooms which may result in avoidable incidents and altercations. However staff told us, and we observed that patients were allowed to access bedroom corridors and bedrooms during the day under staff supervision. Activities, meetings and family visits took place in communal areas of the ward, such as the patient lounge and conservatory, so this is where patients generally preferred to spend their time during the day.

The ward layout on Grange ward was t-shaped and allowed staff a clearer view of all areas of the ward. The wards nursing station was based at the cross junction between the adjoining corridors.

We reviewed the environmental and ligature risk assessment folders for both wards. A ligature risk assessment identified points that patients intent on self-harm may use to strangle themselves. These were up to date and clearly identified all the potential ligature points throughout the wards. This included ligature points in patients' en suite and communal bathrooms, such as handrails and profiling shower chairs. The folders also contained photographs of the key ward ligature risks which were shown to staff new to the ward. Ligature and environmental risk assessments also identified that the risk of patients ligaturing on both wards was low. This was due to the nature of the patient group that was commonly

admitted to the wards. Most patients were diagnosed with an organic illness such as dementia and generally did not present at risk of deliberate self-harm. This, in part, mitigated the risk of patients using ligature points to deliberately injure themselves. The main risk posed by ligature points on the wards was therefore accidental self-injury. Staff we spoke with were aware of all the identified ligature points and told us that they screened all patients for potential risk of ligaturing on admission to the ward. Patient risk assessments we reviewed confirmed staff were routinely completing this. If staff identified a patient to be at risk of ligaturing, staff would implement a personal safety plan and review that patient's unsupervised access to rooms that contained ligature points. This may include increasing patient observation levels to ensure adequate staff supervision.

Since our last inspection, both wards had designated and clearly sign posted a female only lounge. This met the requirement notice following our last inspection that identified both wards must provide female patients access to a single sex lounge area.

On Grange ward, all patients were allocated a bedroom with en suite toilet and shower facilities. However, on Kingsley ward, only eight of the 18 bedrooms had en-suite facilities. To ensure patients' privacy and dignity was maintained, staff on Kingsley ward had tried to allocate male and female patients bedrooms on separate bedroom corridors to ensure those without en suite facilities would not have to pass a bedroom of the opposite sex to reach toilet and bathroom facilities. It was also clear that staff had considered other important factors, such as falls risk and the level of nursing support individual patients may require in the night when allocating bedrooms. In one instance we did find that a female patient was allocated a bedroom that was not en suite next to a male patient's bedroom. This meant that the female patient had to cross the male patient's bedroom to access toilet and bathroom facilities. However, we found that due to 17 of the 18 beds being occupied at the time of our inspection, there was no other way in which staff could have allocated individual patients bedrooms in order to reduce this risk. Staff were aware that this allocation could potentially compromise the female patient's dignity and had placed a commode in their bedroom to reduce the need of having to access the

Are services safe?

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

communal toilet during the night. Because staff restricted bedroom access during the day due to risk of patient falls, most patients would generally use the communal single sex toilets and bathroom facilities during the day.

On both wards, bedroom doors had window viewing-panes that could be fully opened to enable staff to have an unobtrusive view into each bedroom. These could not be closed from within the bedrooms. This meant that patients would have to ask staff to close these should they want full privacy within their bedroom. Although we saw that staff closed the window viewing panes when assisting patients with their personal care needs, ward managers told us that window viewing panes were otherwise left open as a default position. This meant that other patients could look into other patients' bedrooms which could effect their privacy and dignity. This had been raised as a concern during our last inspection in July 2015, but the trust had not addressed this by July 2016.

Both wards were clean and domestic staff completed cleaning schedules each day. Both wards had a fully equipped clinic room and audits confirmed that staff completed daily checks that resuscitation equipment and emergency drugs were available, in date and suitable for use. During our last inspection in July 2015, we found that the temperature in the clinic room on Grange ward was noted to be excessive and at times the temperature was between 25 and 30 degrees. This was a risk because some medicines will be affected if stored at temperatures consistently above 25 degrees. During this inspection, we found that the trust had moved the clinic room to another area of the ward. In comparison to the previous clinic room, the new clinic was well ventilated as there was a window. Daily temperature recording for the past three months confirmed that medicines were being safely stored within a clinic room temperature below 25 degrees.

The modern matrons for both hospital sites had completed an audit schedule to monitor and improve infection control within the clinical environment. The last audit was undertaken in May 2016 and identified that Grange ward scored 80% for staff adhering to bare below the elbow dress code which fell below the trust target of 85%. Kingsley scored 100% for adhering to this practice. The audit further indicated that whilst Grange ward had scored 100% in hand hygiene, Kingsley scored 57%. The audit further indicated the general cleanliness of the ward environments were very good, each ward scoring above the

trust target of 85% at 98% respectively. There were clear protocols in place for infection prevention and these were well-communicated across the staff teams. The housekeeping staff on the wards were informed of the clinical indications of bacterial infections, such as methicillin resistant staphylococcus aureus (MRSA) and were able to undertake appropriate cleaning and safe disposal. The housekeeping staff had effective systems in place for communicating and maintaining a safe environment on the wards. There was an action plan in place to address staff adherence to good hand hygiene practice on Kingsley ward.

Safe staffing

Senior management on both wards told us that recently they had used more bank and agency staff to cover shifts. This was due to the long-term sickness of some substantive staff and staffing vacancies. Senior management were recruiting into vacancies. Vacancies had either been advertised or staff had been appointed and were awaiting standard occupational health screening checks and starts dates. To cover staffing shortfalls, ward managers booked bank and agency staff in advance, where possible, to cover periods between three and six months. This ensured continuity of care and familiarity for patients. Agency staff we spoke with during inspection demonstrated a thorough understanding of the needs of the patients.

Staff told us that they felt safe working on the wards and that other wards within the units would provide additional staffing to support patient escorts off the unit. This could include escorts to other routine health appointments within a general hospital, such as x-rays and specialist outpatient appointments. Care records we reviewed confirmed that patients and carers were regularly meeting with their named nurse to review their care and to adapt their care plans and risk assessments accordingly. Staff were consistently reviewing patients' physical health needs, which included monitoring and recording their baseline physical observations. During inspection we saw that although Kingsley ward in particular was busy due to 17 out of the 18 beds being occupied, staff were able to meet with relatives to discuss patient care.

On both wards there were two shifts during the day; morning and afternoon. There were usually two qualified nursing staff on each shift and three nursing assistants. There was also a twilight shift that was generally covered by one nursing assistant. Ward managers told us that this was

Are services safe?

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effective because patients with dementia generally became more unsettled in the evening time due to the sun-downing effect. The sun-downing effect is where patients with dementia can become more confused, agitated and restless in the late afternoon and early evening time. Ward managers identified that patients required more staff presence and a higher level of support during this time in order to maintain their safety and ensure their additional needs were met. At night there was usually one qualified nursing staff and three nursing assistants.

Additional staff would generally be sought from bank or agency to cover any additional staffing needs due to higher level patient observations. An activity co-ordinator worked between 8am and 5pm to ensure patients' recreational needs were met. This included scheduling and facilitating ward based activities such as cooking, art work and pampering sessions.

The trust provided the following information about staffing:

Staffing establishment (WTE):

Kingsley ward - qualified nurses 12 nursing assistants 18

Grange ward - qualified nurses 9 nursing assistants 13

Staffing vacancies (WTE):

Kingsley ward - all professions 13%

Grange ward - all professions 13%

Staffing sickness (June 2015 - July 2016):

Kingsley ward - 5%

Grange ward - 8%

Staff turnover rate (June 2015- July 2016):

Kingsley ward - 9%

Grange ward - 9%

Staff accessed the majority of mandatory training through the trust's electronic system. The trust's compliance target was set at 85%. We reviewed mandatory training figures for all four older people's wards within the trust.

Overall training figures for mandatory training on was:

Grange ward

- Statutory - 87%
- Core - 91%

- Clinical Statutory - 81%
- Specialist (mandatory) - 96%

Kingsley ward

- Statutory - 73%
- Core - 79%
- Clinical Statutory - 65%
- Specialist (mandatory) - 82%

Rydal unit

- Statutory - 79%
- Core - 79%
- Clinical Statutory - 81%
- Specialist (mandatory) - 81%

Sephton unit

- Statutory - 86%
- Core - 90%
- Clinical Statutory - 88%
- Specialist (mandatory) - 92%

Kingsley ward had the lowest level of compliance with mandatory training of all the wards; compliance low in medicines management training with 55% of staff having completed it, dual diagnosis at 17%, immediate life support at 55%, information governance 61%, infection control at 52% and breakaway training (conflict resolution) at 59%.

Across all four wards, lower compliance rates was mostly accounted for by staff that had not been able to complete the required training due to long-term sickness or absence. This included staff who were currently on maternity leave. We saw that where staff had not completed the required training or it was due to expire, senior management had booked them on the relevant course within the next two months.

Assessing and managing risk to patients and staff

We reviewed eight patient risk assessments. We found that staff completed these on admission and updated as a standard once a month or more regularly if a patients level of risk had changed, for example, following an incident. Staff were aware of the trust's observation policy and any

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patient observations were undertaken and recorded as per trust policy. A shift co-ordinator, usually the most experienced staff member on shift, allocated staff members to undertake set observations for each shift. When necessary, the shift co-ordinator allocated observations on the basis of staff gender and familiarity with the patient.

We reviewed the local ligature risk audit for both wards. This was an assessment undertaken annually by the ward manager and a member of the trust's maintenance and facilities department to ensure staff were made aware of any facility from which ligatures could be created. This provided staff with a clear picture of the potential environmental risks associated with patients who might self-harm to assist in managing and minimising those risks. We saw that all ward ligature risks had been identified within the audits, action plans were developed to mitigate the identified ligature risks. On both wards this included ligature risk points within communal and en suite bathrooms, for example grab rails, that were designed to assist patients who required additional support to mobilise safely. Staff mitigated this risk by locking communal and en-suite bathrooms only allowing patients access under staff supervision. We observed that staff promptly unlocked the doors if a patient wanted to go to the toilet and would immediately lock the door once the patient had left.

The trust used an electronic risk reporting system and staff we spoke with knew what types of actual incidents and near-miss incidents should be recorded. Staff of all grades and professions were able to complete and submit incident reports. The trust provided the following details of incidents of restraint, seclusion and the use of rapid tranquilisation. The following data cover the time period between 1 April 2016 and 30 June 2016.

Incidents of seclusion:

Kingsley ward 0

Grange ward 3

During the same period of time there were no incidents of long-term segregation.

Incidents of restraint:

Kingsley ward restraint 23 rapid tranquilisation 0

Grange ward restraint 42 rapid tranquilisation 4

Wards for older people did not use the practice of prone restraint (restraining patients in a face down position).

The highest number of restraints occurred on Grange ward. Patients admitted to Grange ward could display challenging behaviours due to the severity of their illness. This meant that in some circumstances staff had to physically intervene to maintain the patients safety and that of other people. The number of restraints used within this time period were in part related to two patients who subsequently required the use of the seclusion facility on a neighbouring ward due to their level of distress. The trust had a policy in place that promoted least restrictive practice and directed staff to only use restraint as a last resort when patients became physically aggressive. We saw that staff were skilled in de-escalation techniques, such as encouraging patients to move to a low stimulus area of the ward, providing verbal reassurance or utilising distraction techniques when they saw an individual patient was becoming distressed or agitated. Staff we spoke with knew that restraint should only be used as a last resort and that this practice was reflected in the incidents reports we reviewed during inspection.

During our inspection in July 2015, we found that Rydal ward, an older peoples assessment ward based at Knowsley Resource and Recovery Centre, occasionally used a specialised posture support chair, which included a lap belt. Posture support chairs are used to provide comfortable pressure relief whilst sitting and are specifically for patients with poor mobility who present as a high risk of falls. We raised concerns because care plans and risk assessments that were reviewed did not clearly detail when the chair should be used as a clinical intervention. When we raised this with the trust, they took immediate action and developed a new protocol detailing specifically when the chair could be used. Care plans and risk assessments were also updated to reflect the new protocol. During this inspection, we found that Kingsley and Grange wards had a clear protocol in place detailing specifically when the chair could be used. This was displayed in the ward office on both wards. Both wards had a posture support chair, however these were not in use at the time of our inspection. Ward managers could explain when the chair would be appropriately used and we found that this was captured in one patient's care plan and risk assessment that had previously required the use of the posture support chair. A physiotherapist would also provide guidance to staff on how to appropriately use the chair.

Are services safe?

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

Kingsley ward and Grange ward did not have a seclusion room. However, both wards were able to access a seclusion room on other wards within their unit when required. Between April 2016 and June 2016, no patients on Kingsley ward had required seclusion whilst two patients on Grange ward had been secluded. We reviewed the respective patients' care records and found that seclusion had been used as a last resort following a series of unsuccessful attempts to maintain the patients' safety on the ward. We also found that seclusion was ended at the earliest opportunity. Grange ward used their own staff to complete the required observations of the patient during seclusion. This ensured continuity of care and familiarity with the patient and their needs. Episodes of seclusion were thoroughly recorded in the patients' care records and in a seclusion log book that was kept in the ward manager's office. We checked and found that patients in seclusion were being reviewed by medical, nursing and allied health professionals within the appropriate timescales as identified in the Mental Health Act code of practice. Members of the trust's governance team completed a seclusion audit tool every three months. This was to ensure staff were utilising and documenting episodes of seclusion in line with trust policy and the code of practice.

Staff we spoke with were able to identify the different types of abuse and what would constitute a safeguarding concern. Records we reviewed identified that staff made prompt safeguarding referrals where appropriate. Staff knew who the safeguarding lead for their service was and contacted them regularly to discuss any concerns relating to patients on their wards. Staff completed training in safeguarding children and vulnerable adults as part of the trust's mandatory training for clinical staff. These were two separate courses and compliance rates were as follows:

Grange ward

Safeguarding vulnerable adults – 90%

Safeguarding children – 96%

Kingsley ward

Safeguarding vulnerable adults – 79%

Safeguarding children – 90%

Both wards were supported by a clinical pharmacy team, including a pharmacist and pharmacy technician. The pharmacist attended the wards approximately once a week whilst the pharmacy technician could attend up to once a

day to complete audits relating to medication administration and safe prescribing of medicines. We found that where audits identified shortcomings in good medicines management practices, action plans were developed to address the areas of need. On Kingsley ward we reviewed prescription cards for 11 patients. In seven of these, we found gaps where staff had not signed to identify whether a patient had been administered a specific medicine at an identified time. However, we found that the clinical pharmacy team had already raised this concern with the ward's senior management team prior to our inspection. This meant that the problem was being addressed within an adequate time frame. On Grange ward we reviewed eight prescription cards. All were completed to indicate where staff had administered medication. On both wards, medicines were stored appropriately and the clinical pharmacy team completed medicines reconciliations promptly for all patients on admission to the ward. Nursing staff on both wards wore tabards to indicate when they were engaged in administering medicines to patients. This meant that other staff and visitors were aware that the nurse involved should not be disturbed to prevent administration errors and delays from occurring due to distraction.

Nurses on both wards used a colour coded system to identify when a patient had been administered a medicine but staff had then witnessed the patient secreting some of it. This most commonly occurred with patients who lacked the capacity to understand what their medication was for and were therefore unsure about taking it. This system made staff aware of when a patient may not have taken all their prescribed medicines so that staff could monitor them more closely for any impact this may have on their recovery.

Staff monitored and managed areas of risk more common to patients diagnosed with an organic illness. This included supporting patients who had been identified as at risk of falling or developing pressure sores. The trust employed its own tissue viability specialist nurse for mental health inpatient services. The tissue viability nurse attended the wards regularly to provide specialist advice around individual patients' wound care and pressure sore management. Ward managers were able to order specialist equipment, such as pressure relieving cushions and air flow mattresses, for patients who were at risk of developing pressure sores.

Are services safe?

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

Due to the design of Kingsley ward, which included blind spots, staff locked the doors leading to the bedroom corridors to ensure all patients could be monitored for risk of falls during the day. However, staff opened and escorted patients to their bedrooms during the day if and when required and we saw this happening during our inspection. Both wards used large signs with pictures to sign post key ward areas such as patient bedrooms, toilets and lounges. This helped orientate patients to their environment and therefore reduced the risk of falls that may be caused by disorientation. Grab rails were also situated throughout communal areas of the wards. This also assisted patients to mobilise safely around the ward.

Track record on safety

Between 1 April 2016 and 30 June 2016, Kingsley ward and Grange ward submitted a total of 234 incident reports. The highest reported incident type on both wards related to patient violence and aggression towards staff, another patient or visitor; Grange ward 46 and Kingsley ward 76. This was followed by incidents relating to patient falls; Grange ward seven and Kingsley ward 36. The majority of patients admitted to both wards could not be safely cared for within a community residential or nursing facility due to their level of the agitation or distress. This accounted for the higher number of incidents caused by violence or aggression towards staff. However, these incidents reduced as the patient progressed in their treatment during inpatient admission. This was reflected in patient care plans that identified how individual patients were to be supported when they became distressed. Staff identified what triggered individual patient's distress that informed effective intervention strategies to support them without having to use restraint.

Between 1 April 2016 and 30 June 2016, the service reported no serious incidents that required investigation.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew what incidents required reporting and we found that staff of all grades and professions reported incidents as appropriate on the trust's electronic incident reporting system. We reviewed eight incident reports completed by staff on Grange ward. We found that these were comprehensive and ward management were reviewing all submitted reports to identify what could be done differently to prevent the incident from re-occurring.

Staff knew about their responsibilities under the Duty of Candour, including notifying patients and their nearest relative when there had been an incident and offering an apology.

Senior management on both wards held a monthly staff meeting where a review of incidents and investigations both internal and external to the wards was a standing agenda item. Staff also received feedback and had an opportunity to discuss incidents within monthly supervision with their line manager. Patient safety alerts, produced by the trust's senior governance team, were also displayed within the ward's offices and staff areas. This also raised staff awareness of incidents that had occurred external to the service so that staff could address these potential areas of concern within their own ward environment

Are services effective?

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

<Enter findings here>

Best practice in treatment and care

<Enter findings here>

Skilled staff to deliver care

<Enter findings here>

Multi-disciplinary and inter-agency team work

<Enter findings here>

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

<Enter findings here>

Good practice in applying the Mental Capacity Act

<Enter findings here>

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

<Enter findings here>

The involvement of people in the care that they receive

<Enter findings here>

Are services responsive to people's needs?

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

Our findings

Access and discharge

<Enter findings here>

The facilities promote recovery, comfort, dignity and confidentiality

<Enter findings here>

Meeting the needs of all people who use the service

<Enter findings here>

Listening to and learning from concerns and complaints

<Enter findings here>

Are services well-led?

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

<Enter findings here>

Good governance

<Enter findings here>

Leadership, morale and staff engagement

<Enter findings here>

Commitment to quality improvement and innovation

<Enter findings here>

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>Staff left open door observations windows into patients bedrooms as a default position. We raised this concern during our last inspection of wards for older people with mental health problems in July 2015, but the provider had not addressed this at the time of this inspection.</p> <p>This was a breach of regulation 10(2)(a).</p>