Requires improvement

Cumbria 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) |
|---|---|---|---|
| RNNBJ | The Carleton clinic | Oakwood Unit | CA1 3SX |
| RNNBJ | The Carleton clinic | Ruskin Unit | CA1 3SX |
| RNNY2 | Ramsey Unit | Ramsey Unit | LA14 4LF |

This report describes our judgement of the quality of care provided within this core service by Cumbria 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 Cumbria Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cumbria 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 | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Requires improvement |
| Are services caring? | Good |
| Are services responsive? | Good |
| 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

## Contents

# Summary of findings

## Overall summary

**We rated Cumbria Partnership NHS Foundation Trust as requires improvement because:**

- The trust did not have robust arrangements for psychiatric medical cover out of hours.
- Staff had a varied understanding of the Mental Capacity Act. Patient records did not always show that staff sought consent for treatment or completed required capacity assessments.
- Dormitory-style bedrooms on Oakwood unit did not promote patient privacy and dignity.
- Staff appraisal rates were low. Only 34% of staff on Ramsey unit had completed appraisals, 5.13% on Ruskin and 12% on Oakwood unit.
- Mandatory training rates among staff were below trust requirements.

However

- The wards were clean, spacious, safe and secure. They were also patient and age friendly and offered pleasant outdoor areas as well as various rooms and activities.
- Staff used evidence-based tools to assess, monitor, and manage individual patient needs and risks. Staff also used outcome measures to assess treatment effectiveness.
- The trust provided staff with access to specialist training for their roles. It also supported clinicians to attend further training for career progression and to improve their clinical effectiveness.
- Staff treated patients and carers with dignity and respect. They gave patients time as necessary, were enthusiastic and positive, and had a good understanding of patients' needs and how to meet them.
- All patients and carers we spoke with were positive about the service's care and treatment, and patients said they felt well supported. The service had a carers' support group.
- The wards participated in an innovative pathway-wide project called '#seethe person'. The project moves the focus of care away from a patient's diagnosis or symptoms and onto their individual needs. Staff had a commitment to quality improvement and innovation. Clinicians took part in audits to improve the quality of care.

# Summary of findings

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

### Are services safe?

**Requires improvement**

**We rated safe as requires improvement because:**

- after midnight psychiatric medical cover was provided by two on call consultant psychiatrists across Cumbria, although supported by general practitioners from Cumbria health on call, we considered this to be insufficient
- the average uptake of mandatory training were below trust requirements
- difficulty accessing bank or agency cover at short notice meant that some shifts did not meet agreed staffing levels
- Ramsey and Ruskin units operated a blanket restriction on locked bedroom doors. This was not individually care planned
- no permanent doctor input on Ruskin unit to assist with the complex physical health care needs.

However:

- the wards were clean and well maintained with visible good hygiene and infection control
- the wards had safe spaces for patients and were meeting the Department of Health same sex guidance
- staff used appropriate screening assessment and monitoring tools to ensure patient well-being and safety
- the wards had up-to-date environmental risk assessment and management plans
- management could adjust staffing levels to reflect and meet current patient needs
- staff effectively monitored and guarded against risks associated with older patients such as pressure sores and falls
- trust pharmacists supported staff to safely manage medication
- staff had a good understanding of safeguarding processes and knew their responsibilities to protect patients from harm and abuse
- staff reported incidents and management ensured that learning from incidents helped to improve patient safety.

### Are services effective?

**Requires improvement**

We rated effective as requires improvement because:

- staff had a varied understanding of the Mental Capacity Act (MCA)
- patient records did not always show that staff sought consent for treatment or completed required capacity assessments
- a lack of permanent doctor cover on the nurse-led Ruskin unit raised anxieties among junior doctors

# Summary of findings

- Oakwood had no dedicated occupational therapy and there was limited access to psychology across all wards
- electroconvulsive therapy was not available on any ward; patients had to travel out of Cumbria for this treatment.

However:

- nursing and medical staff completed comprehensive patient assessments on admission that included patients' mental and physical health as well as nutritional and hydration needs
- patient care plans were person centred
- the trust provided nursing staff with training to monitor and treat patients' physical health
- clinical staff regularly completed clinical audits and amended practice accordingly
- clinic staff received regular supervision, and management monitored and recorded this supervision
- handovers and multidisciplinary team meetings were effective in that they focused on individual patients needs.

**Are services caring?**

Good

We rated caring as good because:

- staff were warm and positive in the support and treatment they provided
- staff showed a good understanding of patients' individual needs
- patients and relatives gave very positive feedback about staff
- carers and patients felt involved in the care provided
- the trust offered support groups for carers
- staff used various approaches to promote engagement and communication among patients with limited cognitive capacities.

However:

- staff did not always fully involve patients in the care planning process.

**Are services responsive to people's needs?**

Good

We rated responsive as good because:

- Ruskin and Ramsey units had dementia-friendly features and sufficient rooms to give patients privacy when they wished
- all wards had various rooms to support a range of activities
- the trust provided leaflets and other information sources about wards, treatments and other relevant patient care and well-being topics

# Summary of findings

- staff responded to complaints and general comments from patients and relatives and used these insights to inform service improvements
- a good range of equipment was available to meet the needs of patients with physical disabilities, and wards could access this equipment in a timely manner.

However:

- Oakwood unit was set up in a dormitory style that compromised patient privacy and dignity.

**Are services well-led?**

**Requires improvement**

We rated well-led as requires improvement because:

- management had not ensured the trust had robust arrangements for psychiatric medical cover out of hours
- completed staff appraisal rates were lower than trust expectations
- the uptake of mandatory training was lower than the trust average.

However:

- regular team meetings and other opportunities allowed staff to receive debriefings and share feedback and lessons learnt
- staff felt supported by their managers
- management shared governance systems with staff, and staff understood these systems
- management shared good practices among wards and implemented practice changes to improve patient care and experience
- regular cross-ward management meetings ensured good practice and skills were shared
- the trust supported staff to access further education and training to advance clinical practice.

# Summary of findings

## Information about the service

Cumbria Partnership NHS Foundation Trust provides inpatient services for people aged 65 and above with mental health conditions. The services cover patients who are admitted informally as well as patients who are detained under the Mental Health Act 1983 (MHA).

The trust has three older people's inpatient wards:

At Furness General Hospital, based in the south of Cumbria

- Ramsey unit, a 15-bed mixed-gender assessment ward for patients with organic mental health problems.

At Carleton Clinic, based in the north of Cumbria

- Ruskin unit, a 15-bed mixed-gender assessment ward for patients with organic mental health problems. This is a nurse-led ward with a nurse consultant as the responsible clinician.
- Oakwood unit, a 12-bed mixed-gender assessment ward for patients with functional mental health problems. Oakwood serves older adults who have additional fragility needs, for example poor mobility. Oakwood also admits younger adults with significant physical healthcare needs.

In 2014, the trust's inpatient mental health services moved from a locality model to a care pathway model. The care pathway is called 'Memory matters and later life'. It aims to provide specialisms for older people as well as a consistent approach across services.

The CQC inspected Ramsey unit in November 2013 and issued three warning notices. A follow-up inspection took place in February 2014. The unit realised significant improvements between November 2013 and February 2014 and met the required standards during the follow-up inspection.

Ruskin unit had a CQC MHA review in October 2015.

During this inspection, an unannounced MHA review was completed on Oakwood unit. This was part of the CQC's MHA monitoring schedule.

## Our inspection team

Our inspection team was led by:

**Chair:** Paddy Cooney, Chief Executive (retired)

**Head of Inspection:** Jenny Wilkes, Care Quality Commission

**Team Leaders:** Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Sarah Dronsfield, Inspection Manager (Acute) Care Quality Commission

A seven-person team inspected the wards for older adults with mental health problems at Cumbria Partnership NHS Foundation Trust. The team included two CQC inspectors, one Mental Health Act (MHA) reviewer, one Expert by Experience, two nurses, and one psychiatrist.

Two CQC inspectors and one specialist advisor general nurse conducted an unannounced inspection that followed the announced inspection.

## Why we carried out this inspection

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

# Summary of findings

## 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 focus groups.

We completed an announced inspection of each of the service's three wards. We also completed a further unannounced inspection of Ruskin unit after the initial inspection. This unannounced inspection took place on 17 November 2015.

During the inspection visit, the inspection team:

- visited all three wards at the two hospital sites and looked at the quality of the ward environments
- observed how staff cared for patients
- checked all clinic rooms
- spoke with 12 patients as well as five carers whose relatives or friends used the service
- interviewed the ward managers
- spoke with the older adults inpatient services manager
- spoke with 23 other staff members including doctors, nurses, occupational therapists, healthcare assistants, nurse consultants/responsible clinicians and pharmacists
- attended and observed three handover meetings and one multidisciplinary meeting
- observed a staff reflective practice group
- looked at 25 care records, including risk assessments
- reviewed 31 medication charts
- completed a short observational framework inspection (SOFI) on Ruskin unit
- observed interactions between patients and staff
- observed interactions between staff
- joined and observed a Remembrance Day afternoon tea for patients and carers
- looked at a range of policies, procedures and other documents relating to the running of the service

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

We spoke with 12 patients and five carers. The feedback we received was all positive. Patients told us that they felt safe and that staff were good and caring.

Carers reported that they felt staff looked after and kept patients safe; they were satisfied overall with the care given.

## Good practice

The memory matters and later life services designed and implemented the '#seethePERSON' model of care. This model moves the focus of care away from a patient's diagnosis or symptoms and onto their needs. It puts focus on staff and aims to: raise their competencies in person-centred recovery practice; empower their innovation and creativity; and support their well-being. Managers complete all staff appraisals within the service in line with the model. The National Patient Safety Congress and Safety Awards 2015 shortlisted the services '#seethePERSON'model and awarded it a 'highly commended' rating.

# Summary of findings

## Areas for improvement

**Action the provider MUST take to improve**

Action the provider MUST take to improve

- The provider must ensure all staff understand the application of the Mental Capacity Act (MCA). MCA documentation should record evidence of patients' informed consent to treatment as well as any decisions made about a patient's capacity.
- The trust must review the out-of-hours medical cover available across the wards to ensure there is adequate psychiatric medical cover.

**Action the provider SHOULD take to improve**

Action the provider SHOULD take to improve

- The provider should ensure it promotes patient privacy and dignity on all wards.
- The provider should ensure there are enough staff to meet staffing requirements.
- The provider should continue to monitor the requirements of patients with physical healthcare needs and ensure it fully supports and trains all staff to complete the associated tasks.
- The provider should consider how the blanket restriction of locked bedroom doors impacts upon patients with limited verbal communication. It should ensure there are systems to review the restriction for each patient.
- The provider should consider whether better access to psychology could benefit the recovery of individual patients.

Cumbria 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 |
|---|---|
| Oakwood Unit | Carleton clinic |
| Ruskin Unit | Carleton clinic |
| Ramsey Unit | Furness General Hopsital |

## 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.

- As of October 2015, 33% of staff across the wards had attended Mental Health Act (MHA) legislation updates.
- On Ramsey unit consent to treatment cards were attached to medication cards.
- Staff demonstrated their knowledge of the different MHA sections.
- Staff told us they explained to detained patients their rights under the mental health act on a weekly basis. We could see in patient notes that this had been documented.
- MHA administration systems were in place ensuring that required documents were received and scrutinised in accordance with the MHA and Code of Practice (CoP).
- All staff we spoke with knew whom to contact within the trust for further advice and support regarding the MHA and MHA CoP.
- Staff we spoke to on Oakwood reported that it could prove difficult to access the advocacy service due to work and travel pressures for advocates.
- Each ward had a checklist in place to review MHA documents on admission.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

- As at October 2015, 65% of staff in the older adults inpatient services had received training in the MCA.
- Ten Deprivation of Liberty Safeguards (DoLS) applications had been made in the last six months by the trust. Seven were related to Ruskin Unit and were all granted. The other three DoLS applications related to older adult general units.
- Ruskin unit staff had an understanding of the MCA, in particular the five statutory principles. We listened to many discussions in hand overs and a reflective practice group that demonstrated their knowledge and understanding. One such discussion was around a patient's refusal to have a chest x ray. The staff had assessed the patient's capacity to make this decision and concluded they had capacity.
- On Ramsey and Oakwood units, nursing staff demonstrated an understanding of the MCA in practice. However, they felt that it was the doctors' role to complete any formal assessment and paperwork. The ward managers had identified that staff did not feel confident completing mental capacity assessments or using the documentation.
- On Ramsey unit, we found there was a lack of consistency in applying the MCA. We found that assessments of capacity to consent were generalised. This is was not in line with MCA code of practice, which states that assessments must be specific to particular decisions. Patients' capacity assessments covered general areas around admission and treatment plan. There was a lack of specific decision capacity assessments, such as a patient's capacity to consent to medication or delivery of personal care.
- Independent mental health advocates were available and staff knew how to make referrals.
- Ward staff were not aware of any arrangements in place to monitor adherence to the MCA.

Requires improvement

# Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Our findings

### Safe and clean environment

- All ward and office areas were clean and well maintained. Each ward had housekeeping staff and up to date cleaning schedules.
- Wards complied with Department of Health same sex guidance and each had a designated female only lounge.
- None of the wards had clear lines of vision. The layout of the wards meant that there were blind spots. Staff reported they managed this by actively deploying staff in these areas and by carrying out observation of all patients. We observed this practice and reviewed up to date records of observation checks completed by staff. During inspection, we observed that staff were visible on wards.
- There were up to date environmental risk assessments in place for all wards. These identified ligature risks and considered fixtures, fittings and ward layout. Risk management plans were in place to mitigate against risks.
- Wards had ligature cutters kept in an accessible place. All staff we spoke to knew where to access them.
- All clinic rooms were clean, tidy, and well organised. All were fully equipped with accessible resuscitation equipment and emergency drugs. We reviewed documents, which confirmed daily equipment checks were carried out. Temperature logs for fridges showed that minimum and maximum temperatures were recorded on a daily basis. All clinical observation equipment was present with evidence of regular calibration and maintenance.
- We observed good hand hygiene and infection control practices across the wards.
- All staff wore mobile alarms. These alarms also alerted staff to any movement sensors that were in place such as bed and chair sensors.
- Nurse call buttons were in all patient bedrooms and bathrooms for patients to use when needed.
- We noted that cleaning cupboards were secure and there was correct storage of cleaning products.
- The wards did not have seclusion rooms.
- Patient led assessments of care environment scores (PLACE) - the scores for the locations for this core service were above the trust average for cleanliness, food, and dementia friendly environment.

### Safe staffing

- Ruskin and Ramsey units estimated staffing levels using Stirling University guidelines. Oakwood staffing levels had been set using Royal College of Nursing guidance. Recruitment is a particular difficulty for the trust and there have been 8.5 whole time equivalent (wte) vacant posts within older adult in patient services over the last 12 months.
- Ramsey unit had 33.65 wte substantive staff with 14.34% vacancies. Bank staff filled these vacancies. Staff we spoke to said staffing levels had increased since the last CQC inspection and that the unit used less agency staff. Carers and patients we spoke with had no concerns regarding staffing levels.
- Ruskin unit had 34.96 wte substantive staff with 7.42% vacancies. A new well-being practitioner post had been established and appointed to.
- Oakwood unit had 23.40 wte substantive posts with 13.77% vacancies. The ward manager post was vacant and the inpatient older adult's services manager was covering two days a week. The trust had advertised the post. Staff we spoke to on Oakwood said they meet the required number of staff of per shift, but occasionally a shift will only have one qualified nurse. The ward manager confirmed that this happened at times when they had been unable to get bank or agency staff in to cover shifts at the last minute. Rotas we reviewed confirmed this was correct. The ward recently recruited qualified nursing staff and were awaiting staff start dates. The ward manager said this would bring them up to agreed staffing levels.
- We reviewed rotas across all wards. They confirmed managers adjusted staffing levels to take into account patient mix. For example, at times when increased observations were needed or days when there were team meetings.
- All staff we spoke with confirmed there was enough staff on shifts to carry out any physical interventions. If needed they were able to access support as and when from other wards.

Requires improvement

# Are services safe?

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

- Junior doctors and consultants provided Oakwood and Ramsey units with medical cover during the day. Ruskin unit is a nurse led and the nurse consultant is the responsible clinician, however, junior doctors from Oakwood provided some medical cover for physically unwell patients.
- Two on call consultant psychiatrists provided psychiatric medical cover out of hours. Cumbria had two consultants to cover the north and south of the county. CHOC also provided out of hours medical cover for physical healthcare needs. Doctors working for CHOC had access to psychiatry training supervision and support from Cumbria Partnership NHS Foundation Trust. CHOC doctors also had access to the consultant psychiatrist on call for advice and support. The ward manager said this could cause difficulties for out of hours admissions. For example, CHOC doctors were reluctant to write up the medication charts for new admissions. In this situation, the nurse would request a verbal order from the consultant on call.
- The trust ran a mandatory training programme across Cumbria. The average mandatory training uptake for the older adults in patient staff as at October 2015 was 57%. During inspection, we reviewed documents, which confirmed that staff had been booked on for future mandatory training. Ward managers said that distance to travel for training, releasing staff from ward duties and course being cancelled all affected negatively upon the compliance rates.
- Prevention and management of violence and aggression training (PMVA) and manual handling training had taken place on the wards. This had made the training more assessable to staff and tailored to the specific needs of the patient group they worked with.

### Assessing and managing risk to patients and staff

- No seclusion or long-term segregation had been reported in the last 12 months.
- During January – June 2015 there were five incidents of restraint on Oakwood unit, 57 on Ramsey unit, and 21 on Ruskin unit. One restraint was prone, which resulted in rapid tranquilisation.
- Staff explained different types of de -escalation techniques they employed to reduce any need for restraint. These included distraction, engaging in activities, and identifying risks and triggers of individuals. During inspection, we observed staff diffusing a potentially challenging situation without the need for physical intervention. There were care plans in place, which showed individual's triggers, and how staff could manage them, noting physical issues such as arthritis or issues with previous restraints.
- Staff carried out risk assessments of every patient on admission using the Galatean Risk and Safety Tool (GRIST). Of the 25 care records we reviewed, all had a risk assessment completed and up to date.
- Ramsey and Ruskin units had self-locking bedroom doors. These meant patients could not access their bedroom once they had left it. Staff told us the locked rooms ensured patients' possessions were safe and reduced the risk of patients wandering into others bedrooms. Staff said they would always open patient bedrooms doors on request. If the patient had limited communication, they would offer bedroom access throughout the day and gauge from carers/ relatives what the patients' routines were. However, we found no evidence of this blanket restriction recorded in individual patient notes.
- Both Ruskin and Ramsey units had a locked door entrance. Informal patients asked the staff to open the door if they needed to leave. During inspection, all patients on Ruskin and Ramsey were subject to detention under the MHA. Staff said if an informal patient wanted to leave and staff felt that this would put the patient at risk, they would seek a Deprivation of Liberty Authorisation and document any decisions made at the time.
- On Oakwood, there were both informal and detained patients. Inspectors observed the entrance door to be both locked and unlocked at different times throughout the visit. Staff said informal patients could leave at will and that they would open the door if it were found to be locked.
- Observation policies were in place and staff understood them. We observed staff discussing observation levels of all patients in handovers. We saw observations taking place in line with assessed and recorded risks on all wards.
- Trust data showed that rapid tranquilisation had occurred once in the last 12 months on Oakwood unit. Staff we spoke to confirmed that it was rarely used but were able to explain the procedure and how it should be recorded and monitored, adhering to NICE guidelines and trust policies.

Requires improvement

# Are services safe?

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

- All staff we spoke with was able to identify what would constitute a safeguarding concern and knew how to alert the local authority or trust safeguarding team.
- Prescription charts were clear and well documented. Pharmacists and technicians regularly visited the wards. We met with the pharmacist on Ramsey unit who was able to tell us about a recent medication error and how lessons were learnt resulting in reminders being sent to prescribing staff.
- Nursing staff and junior doctors ensured patients prescribed medicines were correct on admission.
- Patients vulnerable to falls had a falls assessment and management plan in place. We noted they were up to date and amended as necessary. Hip protectors were available if needed. Bed and chair sensors enabled staff to be aware when patients were potentially at risk and in need of support.
- Visitor rooms were available across the locations on or off the wards.
- All staff we spoke to were clear about the covert medication policy and what procedures they would have to go through in order to administer medication covertly.

### Track record on safety

- There were no Serious Incidents (SIRIs) reported in the last 12 months.
- Trust data showed there had been 15 safeguarding alerts made to the local authority, but they had not met the threshold for further investigation.
- There were 201 incidents recorded between 1st July – 31st October 2015. Oakwood reported 64, Ramsey 39 and 98 for Ruskin. 83 of the 201 incidents were for aggression / violence and 76 for falls. Ruskin unit had the highest amount for falls and violence. Staff said and a recent report written by the senior clinical services manager confirmed that this was due to the complex physical and mental health needs of the patient group.

### Reporting incidents and learning from when things go wrong

- Staff reported incidents using the trusts incident reporting system. The data was accessible via the intranet to all staff. Incidents were analysed and reported to staff via the ward dashboards.
- Staff shared examples of learning from when things go wrong. For example, following an incident on Oakwood, changes to locks were made and a modification to the alarm system.
- Staff received debriefs after incidents and were able to request this as and when needed. Ruskin unit used a reflective moments form to audit debriefs and document the process. From a review of these we could see that the forms encompassed a description of the incident, captured how people felt, documented what went well and what did not. They considered alternative actions and actions to take. The forms evidenced good debrief processes and staff we spoke to confirmed that it was a supportive process and that it had a positive impact on patient and staff wellbeing.
- Staff we spoke to were aware of Duty of Candour and the need to be open and transparent.

# 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

- We reviewed 25 care records. They confirmed that patients had a comprehensive assessment on admission, which included mental and physical health, nutritional and hydration needs. On-going assessment was evident. All patients had food and fluid charts started on admission and malnutrition universal screening tools (MUST) were completed.
- Care records showed that staff documented actions such as recording medical early warning scores and acting appropriately when the scores were rising, for example, monitoring observations, calling the doctor or ambulance as appropriate.
- Physical health checks took place within 24 hours of admission. There was evidence of on-going assessments of mental state, risks, physical health needs along with food, and hydration needs.
- Care plans were recovery focused where possible, holistic, and personalised and where views of the patient could not be ascertained views, of relatives or carers were sought.
- Care records were paper based and when not in use they were stored securely in a locked mobile trolley. The care records were neat and tidy and divided into sections. They were legible and key documents signed. The trust had plans to implement an electronic system in the future.

### Best practice in treatment and care

- Ruskin unit is a nurse led unit with no dedicated full time doctor. Junior doctors from Oakwood unit provided support with physical health care needs during the week. A general practitioner also worked on the ward for two sessions a week.
- Junior doctors had expressed concerns that the physical health needs of patients on Ruskin unit were complex and that they felt under supported and lacked training to deal with them, particularly when they were not allocated to the ward on a day to day basis. A document entitled 'Ruskin unit physical health care needs' written by the clinical services manager acknowledged the increasingly complex physical presentations of many of the patients and inherent risks faced. The trust had responded to this by organising a future meeting to discuss the issues further and supported initiatives at ward level to manage these risks in the meantime. As such, nursing staff had received training in taking bloods, performing electrocardiograms, and insulin titration. Nurses told us this was useful due to the nature of dementia, in that the staff are always on the ward and can complete these at times when the patient is relaxed, in an environment they know.
- On a further unannounced inspection to Ruskin unit, we focused on inspecting the management of physical health care needs. We observed staff managing the complex needs of patients in a confident and competent manner. Evidence for this came from the thorough comprehensive physical care plans, documents confirming use of medical early warning scores and acting upon them appropriately. We found no evidence to suggest patient's physical needs were not being met. During the inspection, we observed staff having training on wound care. The ward had plans for a full time junior doctor to be allocated to Ruskin unit within two weeks of inspection, as well as increasing general practitioner input.
- All wards had good links with the pharmacy teams who help maintain medication in clinics, attend ward reviews and multidisciplinary team reviews. On Ramsey unit, we observed a ward round in which the pharmacist was actively involved in discussing the effect of medications on individual patients and gave clinical advice on the use of medications.
- We saw many examples in patients' notes of referrals to podiatry, dieticians and physiotherapy and the staff report and records confirmed referrals completed and responded to in a timely manner. We observed thorough and detailed discussions of patients' physical health care needs taking place on ward rounds. Health care professionals shared information within the on-going care records to ensure continuity and clear plans of care.
- Cumbria did not provide electro convulsive therapy (ECT). If prescribed a patient would have to travel outside of Cumbria to receive ECT. Cumbria Partnership Foundation Trust (CPFT) and University Hospitals

# 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.

Morecambe Bay Trust (UHMBT) had agreed a contract for an ECT suite at the Dane Garth site (run by CPFT). This suite will provide ECT for both adults and older people. The service is projected to open in 2016/17.

- Prescription cards showed that staff followed NICE guidance when prescribing medication for Alzheimer's and low mood.
- Ruskin unit had a nurse consultant who is approved as a responsible clinician (RC); they have responsibility for MHA reviews, diagnosis, supervision, and support of staff with a particular focus on dementia care. Ramsey unit had also appointed a nurse consultant and they were currently undertaking non-medical prescribing training.
- We observed staff to be following patients' nutrition and hydration charts. Areas of concern were monitored and actions taken for example encouraging fluid intake, taking blood sugars or making a referral to a dietician or member of the speech and language team if there were particular concerns. One patient had lost weight whilst on the ward so staff referred to the dietician. The dietician prescribed supplement drinks and continued to monitor the patients' weight.
- We reviewed clinical audits that had been completed by clinical staff. Many had resulted in action plans of proposed or actual change. On Ruskin unit, staff had completed a mealtime audit. This resulted in allocating the task of serving food to the housekeeper. This meant clinical staff spent increased amount of time supporting and engaging with patients during mealtimes. Case record and hand washing audits were also regularly completed.
- Wards used a variety of recognised rating scales such as the Addenbrookes cognitive assessment, MRSA screening and health of the nation outcome scales (HoNos) to assess and record severity outcomes.

### Skilled staff to deliver care

- Occupational therapy was only available on Ruskin unit. Ramsey had an occupational therapist but they were on maternity leave and had not been able to recruit a locum cover. Oakwood had no occupational therapist, as they had been unsuccessful in recruitment despite many attempts. Oakwood and Ramsey made referrals to the community occupational therapist, but they were only able to provide limited input to the wards. This meant occupational therapy assessments were delayed and there was less provision of meaningful activities.
- None of the wards had dedicated psychology input. Staff made referrals to psychology but staff reported this would take two to three weeks to process and psychologists had limited availability. This meant that older people had less choice about treatment options such as talking therapies. Oakwood were able to refer to a dedicated cognitive behavioural therapist who had a three to four week waiting list.
- Health care workers worked alongside mental health nurses on all the wards. Although there were no general nurses, some of the mental health nurses had undertaken further clinical training in physical healthcare to increase physical health care skills knowledge and practise base.
- All new staff completed an induction to the trust and their local area of work. Each of the wards had their own induction checklists. A newly qualified nurse we spoke to confirmed they had been on induction and were on a preceptorship programme.
- Supervision structures were in place across the wards for both clinical and managerial supervision. Staff reported they received supervision and we reviewed documentation that confirmed this was taking place on a regular basis.
- Staff appraisal levels across the inpatient units varied. 34% of staff on Ramsey had an appraisal in the last 12 months, 5% on Ruskin, and 12% on Oakwood. On inspection, we could see that the ward managers had introduced a scheme to ensure staff would be completing appraisals within the next few months. This included a redesigned appraisal form, which reflected a recovery focused approach. Ward managers followed human resources guidance to address staff performance issues.

### Multi-disciplinary and inter-agency team work

- All three wards had multi-disciplinary team meetings (MDT). These involved a range of clinicians and staff. Ruskin unit had no set times for MDTS as they were booked in as and when needed for the patient and at flexible times to enable attendance of relatives / carers.

# 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.

- We observed a ward review on Ramsey unit. It had whole system approach, all the team contributed and were sensitive to patients' needs.
- We observed handovers on all wards to be comprehensive. Staff discussed all of the patients' needs, including MHA status, physical and dietary needs, resuscitation status, and risks. Staff tasks were allocated, such as, one to ones with patients. This meant staff knew what they were doing and when.
- We reviewed minutes from staff meetings that confirmed they took place monthly. Minutes were dated and identified any actions agreed.

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

- As of October 2015, 34% of staff across the wards had attended MHA legislation updates.
- On Ramsey unit all consent to treatment forms for people detained under the MHA had been attached to medication charts.
- Staff told us they explained to detained patients their rights under the mental health act on a weekly basis. This was recorded in the care records of the patients concerned.
- MHA administration systems were in place ensuring that required documents were received and scrutinised in accordance with the MHA and Code of Practice (CoP).
- All staff we spoke with knew whom to contact within the trust for further advice and support regarding the MHA and MHA CoP.
- Staff we spoke to on Oakwood reported it could prove difficult to access the advocacy service due to work and travel pressures for advocates.
- Each ward had a checklist in place to review MHA documents on admission.

### Good practice in applying the Mental Capacity Act

- 64.7% of staff across older adults' inpatient services had training in the Mental Capacity Act as at October 2015.
- Ten DoLS applications had been made in the last six months. Seven were related to Ruskin Unit and were all granted. The other three DoLS applications related to older adult general wards.
- Ruskin ward staff had an understanding of the MCA 2005, in particular the five statutory principles. We listened to many discussions in hand overs and a reflective practice group that demonstrated their knowledge and understanding. One such discussion was around a patient's refusal to have a chest x ray. The staff had assessed his capacity to make this decision and concluded he had capacity.
- On Ramsey and Oakwood units, the ward managers had identified that staff did not feel confident completing assessments or using the documentation. All staff we spoke to felt that it was not within their remit and that a doctor should assess, record and document assessments around capacity.
- On Ramsey, we found that they were not applying the MCA consistently. We found assessments of capacity to consent were generalised. This is not in line with MCA code of practice, which states that assessments must be specific to particular decisions. Patients' capacity assessments covered general areas around admission and treatment plan. There was a lack of specific decision capacity assessments, such as a patient's capacity to consent to medication or delivery of personal care.
- Independent mental health advocates were available and staff knew how to make referrals.
- Ward staff were not aware of any arrangements in place to monitor adherence to the MCA.

Good

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- We observed staff to treat and support patients in warm, positive, and respectful ways. We observed privacy and dignity supported in many ways across the wards, for example, patients had choice different environments to eat their meals, and medicines given in the patient's bedroom or clinic.
- Staff promoted peoples dignity in managing incidents in a timely and discreet manner. We observed a patient shouting out in a communal area, the nurse swiftly distracted the patient and took them out for a walk outside.
- Relatives and carers were welcomed and supported in continuing with providing assistance with patient's personal care and activities of daily living if appropriate. For example, a wife continuing to shave her husband.
- Some elderly relatives would have had long journeys across Cumbria to visit. Staff adapted visiting times to individuals and at times provided warm meals.
- Staff we spoke with had a good knowledge of the patients' individual needs. Staff were able to relate behaviours, patient preferences and histories, where known.
- We carried recorded observations of staff interactions with the patients. They showed positive and empowering engagements and interactions by staff with patients.
- We saw staff knock on bedroom doors before entering.

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

- The admission process informed and orientated the patient to the ward. Information leaflets were available for patients and carers.
- Staff we spoke with on the dementia care units said that involving some patients in their care could be challenging due to the patients cognitive levels. However, staff said they worked with relatives and carers where applicable to develop care plans and would attempt to care plan with the patients where appropriate.
- Ruskin and Ramsey units used 'My life' software with patients to promote engagement and conversation to develop life stories and get to know the patients in more detail.
- Oakwood staff said they talked with the patient and then incorporated the patients in the care plan.
- Ruskin unit had a carers' link nurse who completed carers' assessments.
- Ruskin unit had a carers support group.
- Oakwood unit had a fortnightly patients' community meeting. We reviewed minutes but noted they were not on display for the patients to access.
- All carers told us they were fully involved with patients care and the ward staff were very good in letting them know

# Are services responsive to people's needs?

Good

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

## Our findings

### Access and discharge

- Average bed occupancy over the last six months was 87%. Oakwood and Ruskin Unit had bed occupancy of more than 85% at 97% and 91% respectively. This showed that the wards were managing beds without patients having to wait for beds to become available in order for admission.
- Three patients had been placed out of area in the last six months due to beds being closed. Beds were closed to admissions due to high levels of patient acuity and low staffing levels.
- Records and discussion with staff showed that beds remained available for patients to return to after leave.
- Staff said it was very rare for patients to be moved from their wards to another unless it was justified on clinical grounds or at the request of the patient. An example given was of a patient being transferred to a ward, which was more geographically local to the patient's home.
- The core service had two care pathway coordinators who managed referrals and assisted with discharges. They attended MDTs, ward rounds, and liaised with CMHTS. This provided continuity and ensured consistent communication when planning admissions and discharges.
- Between April – September 2015 there had been six delayed discharges. All had been on Ruskin unit. Delays were due to a lack of suitable nursing homes to meet the patients' needs.
- The highest number of readmissions within 28 days was Oakwood with five within the last six months between May – September 2015.
- There was no psychiatric intensive care unit available specifically for older adults inpatients within Cumbria, but if needed and appropriate could access the working age adults PICU.

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

- Ramsey and Ruskin ward had single ensuite bedrooms along with a good range of communal and gender specific rooms. This enabled patients to mix with each other, partake in different activities, or spend time in quiet areas. Both wards were age and dementia friendly, decorated with pictures, photographs, wardrobes with 'see through' doors and sensory items. Rooms had bold clear signage with contrasting colours. All toilet/shower seats, flush handles, and rails contrasted to the sanitary ware, floor, and walls. Reminiscence props were placed around the wards such as a hat stand and hats, sensory boxes and books. The corridors enabled the patient to walk around without coming to a dead end, minimising any frustration they might feel at doing so. Bedrooms had memory boxes outside the doors, which were filled with an individual patient's memorabilia to promote independence and offer familiarity. Bedroom doors had adjustable viewing panels; this made night observations more discreet as to not disturb patients sleep.
- Ramsey and Ruskin units both had bedrooms for higher dependency care such as end of life care.
- There was blue film over bedroom windows that overlooked public areas. This ensured extra privacy and dignity for patients.
- Oakwood unit had seven single bedrooms, which were ensuite. There were also two shared dormitories with ensuite bathroom facilities. The doors to the dormitories had viewing panels, which had curtains on the inside of the door. Staff reported they would draw back the curtains to make night observations less disturbing to the patients as they would not have to open the door. However, we felt that this could compromise the privacy and dignity of patients within the dormitories.
- The beds in the dormitories had curtains to pull around the bed space. Patients each had a wardrobe in this area but the wardrobes did not have doors. This provided little privacy for patients' belongings and personal space within a dormitory that already compromised their privacy.
- Each ward had an activity room equipped with various activities such as crafts, games, jigsaws and activities of daily living kitchen. On Ramsey, patients could independently access this to make snacks and drinks.
- There were facilities on all wards for patients to make a private telephone call if needed or they could use their own mobile phone.

# Are services responsive to people's needs?

Good

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

- All wards had access to well-maintained garden space that was also was equipped with appropriate handrails and seating areas.
- Snack and finger food was available throughout the day.
- We saw that patients were able to personalise their bedrooms and bring in items from home.
- Provision of activities varied across all three wards. We did not see an activities programme in place. However, we observed a group activity session taking place and staff engaging in positive and meaningful ways with patients. Patients said that activities did happen but they were limited in variety. One patient said they preferred to watch TV and read the daily papers, one patient said they did not like the quizzes but did gardening; another patient said they thought that there was enough activities to do. Staff said that they had been limited in what they could offer recently due to low staffing levels and would like to offer more. Oakwood had recently recruited a well-being practitioner whose role will be to develop activities offered to patients.
- There was no timetable of activities on Ruskin. The occupational therapist described this as being something they want to move away from, promoting a person centred approach. The occupational therapist had piloted "wellbeing diaries. One of the diaries we reviewed was pictorial, describing what the person enjoyed, what they needed help with and what to do if the person appeared anxious or upset. They were completed with the patient and their carers.
- Ruskin unit ran a daily breakfast club for patients. They could assist with cooking a breakfast.
- Staff used touch therapy for patients with severe dementia who not communicate.
- On Ramsey unit health care assistants engaged in individual activities with the patients these varied in type from Jigsaws, fish and chip suppers, quizzes, singing, nail painting, dominoes, and looking through papers.
- PLACE 2015 - the Trust's overall score for privacy, dignity and wellbeing is 83.2% which is below the MH/CHS trust average of 87.5%.The scores for the locations for this core service were above the MH/CHS trust average and above the trust overall score for privacy, dignity and wellbeing. Carleton Clinic location and Ramsey scored 88.5% and 97.7% respectively.
- Patients had access to anti-slip mats, plate guards, and adapted cutlery when necessary to promote independence.

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

- There were facilities for people requiring additional support, including hoists and good wheelchair access. This meant the staff could effectively manage patients with physical needs well as mental health needs.
- There were information leaflets in different languages at the main receptions and numerous notice boards around wards sharing information to patients and carers. Examples of these were patient advice liaison services, independent mental health, advocacy, and other support groups, detained patients' rights and how to complain.
- Information about physical and mental health treatments, as well as detained patients' rights were on notice boards.
- Wards were able to access specialist equipment when needed in a timely manner, one example we noted was of patient with spina bifida who needed personalised specialist seating. Staff arranged for the seating to be delivered to the ward in a timely manner
- All wards had access to variety of dietary requirements from finger food, soft, low potassium or culturally specific.

### Listening to and learning from concerns and complaints

- Data from the trust showed that in the past 12 months there had been seven complaints received, none had been upheld or referred on to the health services ombudsman. We reviewed one complaint, which was responded to in writing by the ward manager. It was professional and the issue dealt with in a timely manner.
- Carers we spoke with said they felt confident in speaking with any of the staff about concerns they had.

# Are services responsive to people's needs?

Good

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

- Staff we spoke with was able to explain the complaints procedure clearly.
- Staff received feedback from the outcome of investigation of complaints via the dashboard or governance report.

# 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 on wards were aware of the trust's values. It was evident that their approach to their work, and their responses to patients and relatives, demonstrated their agreement with these values. Staff spoke positively about their work, about their role within the trust and were proud of the job they did.
- Ramsey unit staff said that they received an apology from trust management following the CQC inspection in 2013 and since then have visits from senior management to support changes in service provision and management structure. One member of staff said that it is now a more honest and open service. Another said that the culture had changed and that they felt far more supported by the trusts senior management.

### Good governance

- Management had not ensured the trust had robust arrangements for psychiatric medical cover out of hours. Two on call consultant psychiatrists provided psychiatric medical cover out of hours. Cumbria had two consultants to cover the north and south of the county. CHOC also provided out of hours medical cover for physical healthcare needs. Doctors working for CHOC had access to psychiatry training supervision and support from Cumbria Partnership NHS Foundation Trust. CHOC doctors also had access to the consultant psychiatrist on call for advice and support. This could cause difficulties for out of hours admissions.
- Managers monitored mandatory training and were aware that uptake in some areas was low. The reasons given for this being that some staff were on sick or annual leave when training was offered: training days had been booked on to, but then cancelled by the trust. Ward managers on the older adult wards had responded to low uptake by arranging for some of the mandatory training to take place on the wards which then were tailor made for the needs of patient group.
- Staff received formal supervision on average every six - eight weeks.
- There were regular and recorded monthly staff meetings with action plans identified. These were accessible to all staff and stored on the shared drive.
- Staff reported incidents. Ward managers analysed these and shared themes with staff. We reviewed copies of a monthly governance report for Ruskin unit. It included an analysis of data, themes and variance, safety data, patient feedback, lessons learnt. Each report documented progress, risks, and action plans.
- Wards had dashboards, which enabled staff to monitor bed status, incidents, and lessons learnt. Staff were aware of these and knew how to use them
- Junior doctors reported that they had supervision weekly.
- Consultants said they had regular supervision and time for teaching and study days.
- The wards used Key performance indicators (KPI) that had been developed when the wards were locality based. The ward managers did not feel they related well to the Memory matters and later life pathway and were in the process of developing service specific KPIS
- Ward managers felt they had sufficient authority and administrative support.
- Unit managers had access to a risk register and placed items on it. Trust data showed eight risks logged for the core services. We found that some of the risks had been logged since 2013. The log that they had been reviewed but it was not clear if the risk remained or had been mitigated against. We could see that the dormitory style bedroom had been logged for issues around dignity and privacy; however, there were no clear plans in place to address this.
- Managers from all wards met regularly at operational managers meetings for the memory matters and later life services. We reviewed the last three sets of minutes. They were structured with a standing agenda and had agreed action plans. Some very practical issues could be seen to be resolved in the minutes, for example, patients and staff experienced glare from the sun in the dining room – so it was agreed that blinds could be ordered and fitted. Other more complex issues were highlighted for example shared dormitory rooms on Oakwood, which could not be resolved so easily. This showed that staff were considering and keeping in mind on-going issues.

### Leadership, morale and staff engagement

# 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.

- Sickness and absence across the three wards over the last 12 months was 7.4%.
- Staff across all wards consistently told us that they felt able to raise concerns without fear of victimisation. They said they were clear regarding whistleblowing procedures and felt confident raising issues with managers. No concerns were raised regarding bullying or harassment.
- Three staff we spoke with told us how the trust was supporting them with personal development. One health care assistant with a degree in psychology had taken on the role of assistant practitioner was being supported by the trust at university to develop therapy skills. An occupational therapist was sponsored by the trust to complete masters in dementia studies. They had also supported a nurse in developing nurse consultant skills and becoming an approved clinician.
- Staff spoke of job satisfaction and sense of empowerment. Staff consistently praised the local management of the wards.
- Staff felt they were part of a team and they worked well together.
- Staff told us ward managers listened to them and respected staff views and opinions. Business meeting minutes, debriefing documents and observations of discussions between staff and managers confirmed this.

### Commitment to quality improvement and innovation

- Following warning notices given by the CQC in 2013 improvements were made to Ramsey unit to ensure compliance and improve patient care. Since moving to clinical pathways from locality pathways staff report that improvements in consistency across the wards have been made. Ramsey and Ruskin wards have started to streamline admission, assessment and monitoring tools and share practices to promote positive dementia care and nursing practices for example Reflective moments debriefing, re-structuring of clinical nursing and managerial roles
- The memory matters and later life service are implementing #seethePERSON. It is a model of care to ensure services are based on the values of person centred recovery. It aims to move the focus of care away from concentrating on a person's diagnosis or symptoms by instead focussing on all the persons' needs. This also includes enriching the involvement of carer's and families where appropriate. It focusses on staff, aiming to raise their competencies in person centred recovery practice, empower their innovation and creativity, and support their well-being. All staff appraisals are completed in line with the model. The project was shortlisted in the national patient safety congress and safety awards 2015 and was highly commended.
- All wards participated in the mental health patient experience audits and aimed to use data to improve the service they offer.

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<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>Need for consent<br><br>Patient's capacity and ability to consent to be involved in the planning, management and review of their care and treatment was not routinely documented.<br><br>This was a breach of Regulation 11(1) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Staffing<br><br>The trust did not have robust arrangements for psychiatric medical cover out of hours<br><br>This was a breach of Regulation 18(1) |