Requires improvement

Central and North West London NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Trust Headquarters
Stephenson House
75 Hampstead Road
London NW1 2PL
Tel: 020 3214 5700
Website: www.feedback.cnwl@nhs.net

Date of inspection visit: 23 – 27 February 2015
Date of publication: 19/06/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV329	Beatrice Place	3 Beatrice Place	W8 5LW
RV3AN	Hillingdon Hospital Mental Health Centre	Oak Tree Ward	UB8 3NN
RV383	Northwick Park Mental Health Centre	Ellington Ward	HA1 3UJ
RV320	St Charles Mental Health Centre	Kershaw Ward Redwood Ward	W10 6DZ
RV3Y2	TOPAS Waterhall Care Centre	TOPAS	MK2 3QH
RV391	Butterworth Centre	Butterworth Centre	NW8 9SE

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

Summary of findings

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 Central and North West London NHS Foundation Trust and these are brought together to inform our overall judgement of Central and North West London NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Requires improvement** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We gave an overall rating for wards for older people with mental health problems of **requires improvement** because:

- Oak Tree ward and TOPAS did not comply with the guidance on same sex accommodation.
- On Redwood ward at St Charles the medication trolley was not locked when left at the nurse's station. We saw medication had been left where it could have been picked up by patients which meant that they may not have been protected from avoidable harm.
- On Redwood ward the drugs to be used for emergency resuscitation were not stored together which could make them harder to locate in an emergency.
- At the TOPAS centre there was no record so staff knew about current safeguarding alerts and any actions that needed to take place to keep people safe.
- On Redwood ward ongoing physical health checks were not always taking place which meant people's physical health care needs might not be met.
- On Redwood ward we saw that a number of the female patients attend the mealtime in their nightwear with no dressing gown and this did not preserve their dignity.
- Patients were not always involved in their care planning across the wards nor did they have a copy of their care plans where appropriate.
- On several wards patients did not have access to a lockable space in their rooms and were not able to lock their own bedroom doors.
- People could not close their observation panel from inside their room to have privacy.
- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. Some of these patients were not clinically appropriate for the ward environment.
- Most wards admitted patients to the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

This inspection highlighted that Redwood ward at St Charles had a number of areas for improvement. This was in contrast to many of the other services for older people which were providing a high standard of care. The improvements which had taken place at Beatrice Place were particularly positive. It was also good to see that the Butterworth centre was maintaining high standards of care even though the service was transferring to a new provider. This good practice needs to happen consistently across the services.

The commitment and care displayed by many of the staff was observed throughout the inspection. Most wards were well led and on Redwood ward alternative management arrangements had been implemented to start improving the service. Progress had been made in the management of falls and pressure ulcers. Risks were also being well managed.

Relatives and carers were mainly positive about being informed and involved in care decisions. Progress had been made in the use of the Mental Capacity Act.

There were many examples of good multi-disciplinary working and work between agencies to facilitate people being discharges.

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:

- Oak Tree ward and TOPAS did not comply with the guidance on same sex accommodation.
- On Redwood ward the medication trolley was not locked when left at the nurse's station. We saw medication had been left where it could have been picked up by patients which meant that they may not have been protected from avoidable harm.
- On Redwood ward the drugs to be used for emergency resuscitation were not stored together which could make them harder to locate in an emergency.
- At the TOPAS centre there was no record so staff knew about current safeguarding alerts and any actions that needed to take place to keep people safe.

There were sufficient staff to meet the needs of people using the service and where bank or agency staff were used they generally knew the ward. The management of the risk of falls and of developing pressure ulcers was being managed well. Individual risk assessments were in place and in most wards were being updated regularly.

Are services effective?

Requires improvement

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

- On Redwood ward at St Charles ongoing physical health checks were not always taking place which meant people's physical health care needs might not be met.

Good multi-disciplinary team working was taking place and staff were working in line with recognised good practice. Staff had a good understanding of the Mental Health Act and Mental Capacity Act although further work is needed to ensure all the correct documentation is maintained to ensure peoples rights are protected at all times.

Are services caring?

Requires improvement

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

- On Redwood ward we saw that a number of the female patients attended the mealtime in their nightwear with no dressing gown and this did not preserve their dignity.
- Patients were not always involved in their care planning across the wards nor did they have a copy of their care plans where appropriate.

Summary of findings

- On several wards patients did not have access to a lockable space in their rooms and were not able to lock their own bedroom doors.
- People could not close their observation panel from inside their room to have privacy.

We received mostly good feedback from the relatives and carers about the care provided and their level of involvement in care and decision making.

Are services responsive to people's needs?

Requires improvement

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

- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. Some of these patients were not clinically appropriate for the ward environment.
- Most wards admitted patients to the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

Patient's cultural and religious needs were met. Information was provided in a number of different languages and a varied choice of meals meeting peoples differing dietary needs was available. Patients were well informed on how to complain and concerns were addressed as needed.

Are services well-led?

Good

We rated well-led as **good** because:

The staff we spoke to across all wards felt connected to the trust and knew of its visions and values. They felt well led by their immediate line managers.

Most wards were operating the trust wide audit schedule which was was used to quality assure services.

Summary of findings

Information about the service

3 Beatrice Place is based in Kensington and Chelsea and is a 24 bedded continuing care service. The service accommodates both men and women and provides care to older adults with functional and organic mental health problems. This service had been inspected in May 2014 and as a result of this inspection there was one outstanding compliance action relating to regulation 9 (Care and Welfare of People who use Services). At this inspection we found that the compliance actions had been met.

Oak Tree ward based at Hillingdon Hospital is a 25 bed assessment service. The service accommodates both men and women and provides care to older adults with functional and organic mental health problems.

Ellington Ward is based at Northwick Park Hospital. The service is a 24 bedded ward that accommodates both men and women and it provides care to older adults with mental health needs, both functional and organic.

Redwood ward and Kershaw ward are both based at St Charles Hospital. Redwood Ward is a 17 bedded ward that accommodates both men and women. It provides care to older adults with mental health needs, both functional and organic. Kershaw ward is a 14 bedded unit for both men and women, providing care to older adults with both functional and organic mental health problems. St Charles Hospital had been inspected in November 2014 and was found to be non-compliant with 3 regulations. However these did not relate to Redwood ward or Kershaw ward.

The older persons assessment service (TOPAS) is a 20 bedded assessment and treatment service for predominately older people who have complex or acute mental health needs both functional and organic. The service is based at the Waterhall Centre in Milton Keynes. The service provides care for both men and women.

The Butterworth Centre is a continuing care service based at the Hospital of St John and St Elizabeth. The service is a 45 bedded centre that accommodates both men and women. The centre provides continuing care services for older people who have advanced cognitive impairment or severe and enduring mental health needs.

Our inspection team

The team that inspected the wards for older people with mental health problems consisted of 15 people: two experts by experience, four inspectors, two Mental Health Act reviewers, two nurses, two psychiatrists, one occupational therapist, one dietician and one pharmacist. A further team of two inspectors, one nurse, one Mental Health Act Reviewer and one expert by experience visited the TOPAS Waterhall centre in Milton Keynes.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

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

During the inspection visit, the inspection team:

- visited seven of the wards at the five hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 34 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 29 other staff members; including doctors, nurses and social workers
- attended and observed six hand-over meetings and four multi-disciplinary meetings.

We also:

- collected feedback from 5 family member using comment cards.
- looked at 47 treatment records of patients.
- carried out a specific check of the medication management on five wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with patients and their relatives. Most were positive about their experience of care on the wards. They told us that they found staff to be very caring and supportive, and most people were involved in decisions about their care.

Good practice

At Beatrice Place the team was pioneering a new sensory activity programme designed for adults in the advanced stages of dementia called Namaste. This evidence based programme focused on meeting the physical and emotional needs pf patients through meaningful activity which in turn decreases distress and resulting behavioural problems. The activity used music, fragrance, plants, sensory stimulation, massage and food treats to improve the comfort and pleasure of the patient's experience. It had just started running but Beatrice Place was the first NHS service to pilot the programme. Staff reported that a couple of their higher risk patients had improved communication and demonstrated less agitation and distress since they started attending the programme.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve the wards for older people with mental health problems

- Oak Tree ward and TOPAS must comply with same sex accommodation guidelines to promote peoples safety, privacy and dignity.
- On Redwood ward at St Charles medication must not be left unsupervised in reach of patients.
- On Redwood ward at St Charles medication used for emergency resuscitation must be kept in one place so it is easily accessible in an emergency.
- At the TOPAS centre in Milton Keynes staff must have access to a record of safeguarding alerts so they can know what action to take to keep people safe and learn from previous events.
- On Redwood ward peoples physical healthcare checks must take place as regularly as each person needs to ensure their health is monitored.

Summary of findings

- On Redwood ward primarily but also on other wards for older people, patients must be supported to be dressed in a manner that preserves their dignity, have access to a lockable space to protect their possessions preferably their bedroom, be able to close their observation panels in their door from inside their room and participate in the preparation of their care plan and have a copy where appropriate.
- Redwood ward must not provide beds for working age adults who are not clinically appropriate for a service for older people.
- A bed must be available for patients who are on leave incase they need to return to the ward.

Action the provider SHOULD take to improve

- The trust should ensure staff working on wards for older people can clearly articulate how they are supporting patients to keep safe in terms of the ligature risks on the ward.
- At St Charles chairs with split covers should be repaired or replaced and enough chairs should be available so people can eat together.
- Where actions are needed following environmental risk assessments, these should be followed through.
- The trust should review the layout at Beatrice Place to try and provide gender separation in terms of bathroom facilities.
- On Redwood ward risk assessments should be updated following incidents.
- The trust should ensure staff have opportunities to discuss and learn from incidents across the trust and not just their site.
- The trust should ensure that Mental Health Act documentation is completed correctly for patients on TOPAS, Redwood ward and the Butterworth Centre to ensure people are being supported to understand their rights, their medication is authorized and their leave is approved.
- The trust should ensure that staff have been supported to have the training needed to support patients with their physical healthcare in line with the training provided at Beatrice Place.
- The trust should ensure that where patients are subject to a deprivation of liberty safeguard that the authorisations are kept under review and updated as needed.

Central and North West London NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
3 Beatrice Place	Beatrice Place
Oak Tree Ward	Hillingden Hospital
Ellington Ward	Northwick Park Mental Health Centre
Kershaw Ward, Redwood Ward	St Charles Mental Health Centre
TOPAS	Waterhall Care Centre
Butterworth Centre	Butterworth Centre

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.

On Ellington ward we saw staff showed a good understanding of the Mental Health Act, code of practice and guiding principles. Consent to treatment and capacity requirements were met and treatment forms were attached to medication charts where applicable. Staff informed us people had their rights explained to them on admission and staff demonstrated good understand of how to work with older people to ensure they understood their rights. The records we looked at indicated this had taken place and been properly recorded.

At the TOPAS centre two out of four patients records we reviewed we were unable to locate evidence of the treating clinicians' assessment of the patients' capacity to consent to treatment, or a discussion of consent since their admission to the ward and before the first administration of medication following their detention under the Mental

Health Act (MHA). We found in three of the sets of records that when staff had been unable to explain patients' rights under the MHA to them successfully there was no record that there had been further attempts made.

On Redwood ward we found that for one detained patient they had been administered a medicine for 6 days which had not been authorised. This had not been recorded as a medicines incident.

At The Butterworth centre we found an unlawful detention due to an error in recording on the MHA documentation. Two patients section 17 leave forms to authorise leave into the community had expired which meant they were going out into the community without the recorded consent of the responsible clinician.

On Redwood ward we found that not all capacity and consent to medication assessments were being carried out on admission and one patient had not had their rights read under section 132 for nearly two months following detention under Section 3 of the MHA.

It was reported that regular audits of the MHA documentation were happening across all sites however the issues found would indicate that these audits were not effective in highlighting errors.

Staff received training and had a good understanding of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff training on the Mental Capacity Act (MCA) is mandatory and records we looked at showed all staff had either completed or were booked to attend the training. All wards work closely with the bank service to ensure all bank staff have the necessary training in the MCA to work on the wards.

We found that people were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

We found that staff had a good understanding of the MCA and best interest meetings took place as needed. We received good feedback from families and carers they felt they were appropriately involved in decisions about care and mental capacity.

We found evidence of good practice in the implementation of Deprivation of Liberty Safeguards (DoLS) in Ellington ward, Kershaw ward, Beatrice Place, Butterworth centre and Oak Tree ward. However at Redwood ward we were told that there were two patients subject to a DoLS authorisation. On reviewing their files we found that they had been assessed as lacking capacity to consent to their admission in December 2014 and beginning of January 2015 respectively. The DoLS authorisation requests had not been made until February 2015 and they had yet to be seen by the supervisory body. The urgent authorisations had expired and there was no evidence that permission to grant a further seven day urgent authorisation had been sought. It was therefore unclear under what legal authority these patients were being kept on the ward.

At the TOPAS centre we observed good compliance with the MCA. However we found one DoLS authorisation which had expired the previous day which had not been flagged up or identified prior to that day. This was identified immediately to the ward manager who liaised with the local authority to address. There was a risk that without the correct checks in place this would continue to happen.

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

Summary of findings

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

- Oak Tree ward and TOPAS did not comply with the guidance on same sex accommodation.
- On Redwood ward the medication trolley was not locked when left at the nurse's station. We saw medication had been left where it could have been picked up by patients which meant that they may not have been protected from avoidable harm.
- On Redwood ward the drugs to be used for emergency resuscitation were not stored together which could make them harder to locate in an emergency.
- At the TOPAS centre there was no record so staff knew about current safeguarding alerts and any actions that needed to take place to keep people safe.

There were sufficient staff to meet the needs of people using the service and where bank or agency staff were used they generally knew the ward. The management of the risk of falls and of developing pressure ulcers was being managed well. Individual risk assessments were in place and in most wards were being updated regularly.

Our findings

Safe and clean environment

- On most of the wards there were not clear lines of sight for observing patients. There were many blind spots across all the wards. We did not see consistent use of convex mirrors in areas on the wards where you couldn't clearly see. However, staff said that they regularly checked corridors and would discretely follow a patient if they moved out of view.
- We saw all the wards had up to date ligature audits that had been completed by the trust central safety team. However, a large number of the identified ligature points had been identified across the wards as 'to be managed locally'. Most of the staff on the wards for older people reported that they were managing ligature risks based on the needs of the individuals. On Redwood ward we were told by staff that they were managing the ligature risk in the telephone room by keeping the room locked. During our inspection we found this room to be unlocked. Staff were not able to consistently articulate on wards how they were managing this risk.
- Two out of the seven wards visited did not comply with the guidance on same sex accommodation. At Oak Tree ward we found the communal bathrooms and toilets were mixed gender. On Oak Tree ward a female patient with complex needs resided in a single room on a corridor with male patients and had to walk past male bedrooms in order to access the toilet. The bathroom directly outside the female patient's room was locked at night as there was a hoist stored in the room which was deemed a risk to the patient. This was raised with the manager who was trying to find an alternative storage space for the hoist. A female patient told us that a male patient wanders into their bedroom, which they find frightening. This was raised immediately with the manager.
- At The TOPAS Centre we found the ward was mixed gender and mixed diagnoses of people with dementia and mental illness. We were told that staff try to segregate the genders but this had been unsuccessful. There was no separate female lounge area on the TOPAS centre. Although bedrooms were individual and en suite, female patients had to pass by male patients bedrooms regularly to access the assisted bathrooms. Ellington, Redwood and Kershaw wards had separate bedroom corridors and female lounges. However, we were told these lounges were not regularly used as there was no television available for the female patients. At Beatrice Place we did find some mixed gender use of a bathroom, but this is a smaller community based service where people using the service receive continuing care and staff risk assess and manage this situation. However the trust should review the layout of the building to try and provide gender separation in terms of bathroom facilities.
- Most of the clinic rooms were found to be clean and tidy with accessible equipment and medications which had been regularly monitored and checked. The medicine

fridge temperature was being checked daily. We noted end of the month medication expiry checks were being carried out by the pharmacist. In most of the clinic rooms we saw guidance for the management of controlled drugs and the covert medication policy was clearly displayed on the wall. On Redwood Ward the medication room was located off the ward as it had recently been identified that the old room was too warm for the medication to be stored safely. This meant that medication was dispensed from a trolley that was taken to the nursing station. We observed that the medication trolley was not locked in situe at the nurse's station. We observed a medication round on Redwood ward and saw medication to be left unobserved at the nurse's station which meant that patients may not have been protected from avoidable harm.

- Most of the wards had accessible resuscitation equipment which was checked daily and emergency medication was in place and in date. On Redwood ward a tray containing a supply of emergency resuscitation medication was kept in the medication trolley. However, the medicines kept did not correspond to the list of medicines required. Staff told us that the correct medicines were available but were stored elsewhere on the ward as the tray was too small. Therefore in an emergency, this may have caused a delay in locating emergency medicines.
- All wards visited were clean and had visible cleaning schedules which were being regularly completed. Most of the bedrooms we looked at were not personalised by the patient groups and felt sterile and institutional.
- The furnishings we saw were mostly clean and in good order. However at the St Charles Centre some of the chairs in the communal areas had split covers which may pose an infection control risk. We observed that there were not enough chairs for all the patients and staff to sit at to enable them to eat at the same time.
- We found that the trust had environmental risk assessments. Most of the wards reported having a weekly or bi weekly 'walk around'. However, it was not clear what happened with any actions that were identified from this reporting process. On two of the wards we identified a significant risk relating to the patient beds which had not been identified during any 'walk around' risk assessments. These both had protruding metal parts that could have hurt a patient. This risk was immediately rectified when discussed with the managers of the two wards.

Safe staffing

- The trust regularly reviewed the staffing levels on all the wards we visited. We looked at staff rotas and saw the amount of staff on duty usually reflected the staff detailed on the rota.
- On most wards we saw that the ward had a board up which clearly identified the numbers of staff that should be on duty compared to the number of staff that were actually on duty This showed patients and visitors clearly the staffing numbers for the ward for that day.
- The staffing levels were maintained using bank and agency staff. The same agency staff were used where possible to promote continuity of care. The trust had a robust workforce strategy in place looking at recruitment. The ward managers we spoke to worked closely with the trust bank staff to ensure bank staff members had the appropriate training to work on the ward.
- We were told that ward managers had autonomy to be flexible with the staffing numbers when required and this helped to maintain the safety of the ward.
- There was always at least one registered nurse on duty on the wards at all times. However, staff told us that nurses were very busy and only out on the ward when dispensing medication or when specifically requested for a nursing task.
- We saw no examples of escorted leave or ward activities being cancelled because there were too few staff.
- Across most of the sites we were told by staff that medical cover and support was available. There were junior doctors on site during the day and on call at night. A consultant was present for weekly ward rounds. However, on Redwood ward patients were not routinely having effective and timely medical assessment upon admission and we saw one patient who had not had a medical assessment until one week after admission. Staff told us this was due to lack of medical cover.
- All staff had to complete training on physical interventions which is refreshed on an annual basis. We

Requires improvement

Are services safe?

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

saw evidence that staff had either completed the trusts breakaway training or were booked to attend. Staff described how they would try and manage peoples care without the use of physical interventions. There was an occasion when planned restraint had been used because a patient refused medication following admission. They said only experienced trained staff completing the restraint. Staff also spoke of a debrief session to discuss what went well and what might be improved on. Prone restraint had been used on one occasion in the six months prior to the inspection.

Assessing and managing risk to patients and staff

- Across the wards we saw that patients had up-to-date risk assessments in place which were regularly reviewed and updated reflecting any change in risk level or after incidents. However, on Redwood ward we found that there was not always an effective process followed for ensuring that risk assessments were updated following an incident.
- Across the wards we saw few blanket rules being used and when they were applied it was used proportionately to maintain patient safety. We saw signs up next to ward exits indicating that informal patients were able to leave when they wished. At Beatrice Place we observed the front door had a keypad and informal patients were given the code so they could leave without asking staff, although they were encouraged to tell staff if they were leaving the ward.
- Staff across all wards received mandatory safeguarding training and most were able to tell us how to identify and report a safeguarding incident. However, on Oak Tree ward we were told of one example of an incident not being reported as a safeguarding as the staff member felt that because the police had been called no further action was required to be taken. We reported this to the manager who took appropriate action and referred the safeguarding incident to the local authority safeguarding team on the day of the inspection. At the TOPAS Centre we found there was a lack of clarity among staff as to who the safeguarding lead was. There was no centralised log of safeguarding incidents in place. The local authority received the safeguarding alerts from the ward manager but the ward manager or the matron had no clear overview of all of the safeguarding incidents for their wards.
- Staff were aware of the risk of falls and pressure ulcers within the patient group and managed risks accordingly. There was evidence in the care plans of assessing for physical health needs on admission and regular reviews taking place. There was evidence of discussion in the multi-disciplinary team about both physical and mental health needs for all the patients. A compliance action around the identification and treatment of pressure sores was served as a result of the last inspection in May 2014 at Beatrice Place. At this inspection we found that improved practices had been put in place, including improved assessment of patient's physical health upon admission.

Reporting incidents and learning from when things go wrong

- Most of the staff we spoke with were aware of what do when reporting incidents through the electronic reporting system. We discussed examples of recent incidents with staff. They told us how they had debriefings following incidents and how risk assessments and management plans were amended. We saw most notably how observations were adjusted in response to incidents.
- Most staff we spoke with showed a good awareness of patient's individual risks and how these were managed. However we found examples of incidents having taken place on the ward which were not identified as incidents and so we cannot be confident that all incidents that should be reported are being reported.

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.

Summary of findings

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

- On Redwood ward at St Charles ongoing physical health checks were not always taking place which meant people's physical health care needs might not be met.

Good multi-disciplinary team working was taking place and staff were working in line with recognised good practice. Staff had a good understanding of the Mental Health Act and Mental Capacity Act although further work is needed to ensure all the correct documentation is maintained to ensure peoples rights are protected at all times.

Our findings

Assessment of needs and planning of care

- We looked at samples of care plans on all the wards. Mostly records were regularly reviewed, personalised and orientated towards recovery or management of conditions. There was evidence that the multi-disciplinary team (MDT) knew the patients well and considered all their needs, including social care needs before and after discharge.
- Most care records we looked at showed that physical health checks were completed upon admission. Patient records at Beatrice Place, Oak Tree, Butterworth and TOPAS showed that there was robust ongoing monitoring of physical health issues. On Oak Tree ward there were some good examples of ongoing physical healthcare monitoring. However there were some patient care plans which had limited physical healthcare information around diet and nutrition. Information around pressure sores and falls was thorough and up-to-date.
- At Redwood ward we saw examples of daily temperature, pulse and respiration charts (TPR) not completed for periods up to seven days. This meant that patient's physical health needs were not being properly monitored. We found several examples of physical health care needs not being met specifically around the monitoring of dwelling catheter usage. We observed a lack of care planning around frequency of changing of catheters and no recording of batch numbers. It was reported in a patients' clinical note, that there was no syringe available on the ward to wash out a blocked catheter, which should be standard equipment.
- Patient information was stored electronically and was password protected.

Best practice in treatment and care

- We saw evidence that staff followed NICE guidelines when prescribing medication. For example, the consultants rarely prescribed anti-psychotic medication for patients with dementia, and would try to find an alternative prescription if a new patient was already being prescribed anti- psychotic medication.
- Individual ongoing psychological therapy was not regularly available due to lack of psychology staffing across a number of the wards. However the psychologists on site provided psychological input to teams and met with individual patients on a short term basis when necessary.
- Across most sites we observed access to art therapy, music therapy and drama therapy. At Ellington ward we were told that the trust is supporting a member of the team to undertake cognitive stimulation therapy.
- A wide range of clinical audits involving clinical staff took place including care plans and risk assessments, medication, safeguarding reporting, infection control, ligature risk and staffing audits including training and supervision.

Skilled staff to deliver care

- We saw there was a good range of staff available which included qualified occupational therapists (OT's) and activity co-ordinators to ensure a wide range of individual and group activities were available across the wards.
- Staff received supervision, mandatory training and appraisals. However supervision did not always happen monthly; more often than not it would occur every 6-8 weeks.
- Staff received some specialist training. For example at 3 Beatrice Place staff received specialist physical

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.

healthcare training and medication training. However, this was inconsistent across all wards. On Oak Tree Ward staff identified the need for physical healthcare training but this was not yet in place.

- All the services we visited had a range of skilled specialists working either on the ward or in the community linking in to the ward, including OT's, clinical psychologists, pharmacists and activity coordinators. None of the wards had a social worker on site although there were improved links to a named social worker in the community teams.
- There were vacancies for a dietician, speech and language therapist and a physiotherapist across Oak Tree ward and Beatrice Place. We were told that service managers were able to recruit agency staff for these posts on a temporary basis.

Multi-disciplinary and inter-agency team work

- All the services hold regular multi-disciplinary teams (MDT) meetings ranging from a daily basis on Ellington ward to a weekly basis across the rest of the wards. We observed several ward rounds led by the consultants and attended by members of the MDT. The ward rounds were well organised and well led. There was clear demonstration of thorough decision making and recording. Staff present were respectful of all contributions and the meetings had a holistic patient centred focus.
- Regular handovers took place between shifts enabling the sharing of essential information. We observed handovers from the morning to afternoon shifts and most wards had good structures in place to ensure information was passed over. We noted a particularly effective recorded handover system being used on Kershaw ward incorporating staff allocation of individual roles and responsibilities ensuring staff were aware of their duties during the course of the shift. This was not however evident on Redwood ward. Although the handover incorporated clinical issues, there was no specific planning of duties and responsibilities observed during the handover and there was no system to indicate that tasks had been appropriately allocated.
- Three of the wards told us they were located next door to the community mental health team (CMHT) which enabled close liaison between the services. This meant that care coordinators were able to visit the ward easily to attend meetings and Care Programme Approach (CPA) reviews when required.
- There was evidence from the MDT meetings we observed of strong working relationships with a range of outside professionals and agencies. They were invited and welcomed to join the MDT meetings and needs were discussed holistically. We received good feedback from local CMHT services about the communication from the wards and in particular the consultant psychiatrist on Ellington ward who provided weekly updates via email on the patients known to the CMHT.

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

- On Ellington ward we saw staff showed a good understanding of the Mental Health Act, code of practice and guiding principles. Consent to treatment and capacity requirements were met and treatment forms were attached to medication charts where applicable. Staff informed us people had their rights explained to them on admission and staff demonstrated good understand of how to work with older people to ensure they understood their rights. The records we looked at indicated this had taken place and been properly recorded.
- At the TOPAS centre two out of four patients records we reviewed we were unable to locate evidence of the treating clinicians' assessment of the patients' capacity to consent to treatment, or a discussion of consent since their admission to the ward and before the first administration of medication following their detention under the Mental Health Act (MHA). We found in three of the sets of records that when staff had been unable to explain patients' rights under the MHA to them successfully there was no record that there had been further attempts made.
- On Redwood ward we found that for one detained patient they had been administered a medicine for 6 days which had not been authorised. This had not been recorded as a medicines incident.
- At The Butterworth centre we found an unlawful detention due to an error in recording on the MHA

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.

documentation. Two patients section 17 leave forms to authorise leave into the community had expired which meant they were going out into the community without the recorded consent of the responsible clinician.

- On Redwood ward we found that not all capacity and consent to medication assessments were being carried out on admission and one patient had not had their rights read under section 132 for nearly two months following detention under Section 3 of the MHA.
- It was reported that regular audits of the MHA documentation were happening across all sites however the issues found would indicate that these audits were not effective in highlighting errors.

Good practice in applying the Mental Capacity Act

- Staff training on the Mental Capacity Act (MCA) is mandatory and records we looked at showed all staff had either completed or were booked to attend the training. All wards work closely with the bank service to ensure all bank staff have the necessary training in the MCA to work on the wards.
- We found that people were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- We found that staff had a good understanding of the MCA and best interest meetings took place as needed. We received good feedback from families and carers they felt they were appropriately involved in decisions about care and mental capacity.
- We found evidence of good practice in the implementation of Deprivation of Liberty Safeguards (DoLS) in Ellington ward, Kershaw ward, Beatrice Place, Butterworth centre and Oak Tree ward. However at Redwood ward we were told that there were two patients subject to a DoLS authorisation. On reviewing their files we found that they had been assessed as lacking capacity to consent to their admission in December 2014 and beginning of January 2015 respectively. The DoLS authorisation requests had not been made until February 2015 and they had yet to be seen by the supervisory body. The urgent authorisations had expired and there was no evidence that permission to grant a further seven day urgent authorisation had been sought. It was therefore unclear under what legal authority these patients were being kept on the ward.

At the TOPAS centre we observed good compliance with the MCA. However we found one DoLS authorisation which had expired the previous day which had not been flagged up or identified prior to that day. This was identified immediately to the ward manager who liaised with the local authority to address. There was a risk that without the correct checks in place this would continue to happen.

Requires improvement

Are services caring?

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

Summary of findings

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

- On Redwood ward we saw that a number of the female patients attend the mealtime in their nightwear with no dressing gown and this did not preserve their dignity.
- Patients were not always involved in their care planning across the wards nor did they have a copy of their care plans where appropriate.
- On several wards patients did not have access to a lockable space in their rooms and were not able to lock their own bedroom doors.
- People could not close their observation panel from inside their room to have privacy.

We received mostly good feedback from the relatives and carers about the care provided and their level of involvement in care and decision making.

Our findings

Kindness, dignity, respect and support

- Overall across all wards we observed a number of caring and respectful interactions between staff and patients. Staff members were mostly very respectful, for example knocking on doors before entering bedrooms.
- Staff demonstrated an understanding of the individual needs of patients. Across most of the wards we observed staff laughing and joking appropriately with patients in a manner which suggested familiarity and mutual fondness.
- Patients we spoke to were positive about their ward and the care they received, but on Ellington ward a patient stated at night they were woken every fifteen minutes by staff knocking on their door to complete observations. This matter was raised with the ward manager who explained that it was a bank member of staff who had done this. They said there were notice boards to show how often people needed to be observed and staff would be reminded at the team meeting to observe people in line with their individual needs.
- We observed mealtimes on two of the wards. On Redwood ward we saw that a number of the female patients were supported to attend the mealtime in their nightwear with no dressing gown. The patients were wearing nightwear with "hospital" printed as a pattern across it, which although may be necessary did not preserve the patients dignity.
- On Redwood ward we observed a distressed patient in the female lounge whilst a member of staff was observing a patient 1:1 in their room with the door open. The staff member did not to attempt to engage with the distressed patient, call for help or turn around to ensure that the patient was safe. This displayed a lack of appropriate practical and emotional support for the distressed patient at this time.
- On several wards we inspected patients did not have access to a lockable space in their rooms and were not able to lock their own bedroom doors. Patients on Redwood ward told us that they had some of their possessions stolen from their bedroom. We saw from meeting minutes that this issue had been raised in the community meeting in October 2014. However there were no actions to ensure it did not happen again.
- On Redwood ward we noted that the shutters on viewing panels on bedroom doors were in the open position, therefore not maintaining patient's privacy and dignity. Patients were not able to close the shutters from the inside of their rooms. This was also the case on other wards.

The involvement of people in the care that they receive

- All staff we spoke to described how new patients were carefully introduced to the different ward environments. This often had to take place gradually as people may be very unwell on their arrival. This included showing patients around and introducing them to staff and other patients.
- Patients were not always involved in their care planning across the wards. Where patients told us they did not have a copy of their care plan it was evident on most wards in their records why this was the case or if a care plan had been given but the patient could not retain the information.
- We saw care plans were mainly written in clear and accessible language. However on Redwood ward the care plans showed minimal involvement of the patients. No patient views were meaningfully incorporated and

Requires improvement

Are services caring?

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

patients told us they did not have copies of their care plans. When we looked at the patient bedrooms we did not find evidence that copies of care plans had been given to patients or put in people's rooms so they could easily access them.

- There was evidence of family involvement in care. We were told that relatives and carers were routinely invited to review meetings. Relatives and carers had access to courses at the recovery college.
- We received mostly good feedback from the relatives and carers we spoke with about the care provided and their level of involvement in care and decision, making. However some relatives and carers told us that they were unhappy about specific issues around the care and treatment their family members were receiving.
- Patients had access to advocacy services. On several of the wards the advocate runs the weekly community meetings. We saw most wards had information freely available to support patients and relatives and carers to access advocacy services and information about drop in groups for them to be able to discuss their concerns with the ward managers. We were told that the carers group was not currently running on Redwood ward

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

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

- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. Some of these patients were not clinically appropriate for the ward environment.
- Most wards admitted patients into the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

Patient's cultural and religious needs were met. Information was provided in a number of different languages and a varied choice of meals meeting peoples differing dietary needs was available. Patients were well informed on how to complain and concerns were addressed as needed.

Our findings

Access and discharge

- We were told that none of the wards operated a waiting list and there were always beds available for people in their catchment areas. The reported issues around bed management were related to discharging patients to suitable accommodation in the community. At several of the wards the links with the local community mental health team (CMHT) were strong and conducive to ensuring patients were moved into suitable accommodation as soon as clinically appropriate. We were told that there was a bed management system within the trust that supports this process and co-ordinates with the local commissioning teams to help arrange for patients to be discharged. Staff reported that this was helpful.
- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. There were 3 patients of working adult age on the ward on the day we inspected. Some of these patients were not clinically appropriate for the ward environment and told us they did not feel the ward was appropriate for them. The staff reported that they found managing these patients challenging and they had no specific training to deal with their presenting problems. This meant that patients may not be receiving the most suitable care and treatment for their needs.
- Most wards admitted patients to the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

The facilities promote recovery, comfort, dignity and confidentiality

- The TOPAS Centre, Ellington ward and the Butterworth Centre were conducive to patient's individual well-being, dignity and comfort. Redwood ward was cramped and cluttered. We found that these wards lacked a choice of rooms for visitors, and for quiet times.
- Most wards had open access to an outdoor space either a garden or a secure balcony. However at Redwood ward patients had to use a lift or staircase down to the ward below to access a designated garden area. On the day of the inspection the lift was not working. We were told that if patients had mobility issues they would have to use the lift into the Electroconvulsive Therapy (ECT) suite and then access the garden by travelling the length of the ward below. This meant patients with mobility issues that were informal were not able to freely access an outside space. This was not a suitable adjustment for a person requiring disabled access to and from the ward.
- Patient's bedrooms were not personalised for their individual comfort with most of the fixtures fittings and linen being hospital issue. However at the Butterworth centre we saw that lots of care and attention had been paid to ensure that patients had their personal belongings with them.
- Weekly activity programmes for patients were advertised on all wards. Patients had access to occupational therapy and dedicated activity workers. There was mixed views across the wards about the programme of activities. At Beatrice Place the feedback was overall positive and people were accessing culturally and age appropriate activity both during the day and in the evening. At the weekends we were told that the majority of the wards had activities carried out by the ward staff. The feedback received was that this

Are services responsive to people's needs?

Requires improvement

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

was dependent on who was on duty as to whether it happened. Staff told us that planned activities were sometimes cancelled at busy times or if there weren't staff available to run them.

- The food available across most of the wards was cooked from chilled and we had mixed feedback on whether there was enough and if the choices were acceptable. Food was regularly identified in community meetings as an ongoing issue with varying comments. Hot drinks and snacks were regularly available outside of meal times across all wards but on most wards the patients were not able to freely make themselves a hot drink or snack and had to request staff prepare it for them.

Meeting the needs of all people who use the service

- Across the wards we saw that attempts were made to meet patient's cultural and religious needs and information in the reception areas was provided in a number of different languages.
- All wards we inspected had access to local interpreting services. Many of the wards had a culturally diverse staffing team so staff could help provide interpreting on a day to day non clinical basis. We witnessed this on Redwood ward during the mealtime. We observed staff members speaking in French to support a patient's choice of food items. We were told that interpreters would be booked for formal reviews and ward rounds.
- A varied choice of meals meeting peoples differing dietary needs was available so that patients with requirements associated with their religion or beliefs were able to access appropriate meals.

Listening to and learning from concerns and complaints

- Patients we spoke to across all wards told us they would complain to staff if they were unhappy with any aspect of the service they were receiving. There were complaint leaflets and posters displayed in all wards in a range of different languages and styles that were easy to understand. Patients told us they would be able to raise complaints in the community meetings or with the advocates if they felt they were not being listened to.
- Staff and managers told us they would always attempt to resolve the complaint at a local level in the first instance by dealing with the issue straight away. Staff said they would inform their manager of any patient complaints. We saw an example of a complaint from a relative concerning a number of issues including poor communication from staff, agency nurses texting on duty etc. The manager responded to the complainant in writing detailing the investigation which had taken place, the findings and the changes implemented as a result.
- Patients on some of the wards were actively involved in the running of the ward through a weekly community meeting which was minuted and the minutes were produced as a newsletter.

Are services well-led?

Good

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

Summary of findings

We rated well-led as **good** because:

The staff we spoke to across all wards felt connected to the trust and knew of its visions and values. They felt well led by their immediate line managers.

Most wards were operating the trust wide audit schedule which was used to quality assure services.

Our findings

Vision and values

- The staff we spoke to across all wards felt connected to the trust and knew of its visions and values.
- Most of the staff we spoke to were able to identify who the directors of the trust were and spoke positively about the culture of board to ward communication. We were told by some staff that the Chief Executive for the trust visited the wards over the Christmas holidays and they reported this as being positive for team moral.

Good governance

- The wards all had access to information to monitor and audit quality through data extracted from the electronic record system. We saw this being put to good effect on Kershaw ward. However this was not used consistently across all wards.
- Most wards were operating the trust wide audit schedule and we observed excellent input from the specialist registered general nurse (RGN) who completed a lot of the infection control audits for the wards.
- The managers we spoke to had sufficient time and autonomy to manage their wards and reported that their local management structures supported them to be able to raise concerns and escalate them to the trust risk register when appropriate.

Leadership, morale and staff engagement

- Some of the staff we spoke to told us that at times the trust felt too big and not as focussed as it had done previously.
- The majority of the wards were reported to be well managed by their staff teams and the managers were visible on the wards on a day to day basis. Managers had an open door culture and the teams said they could suggest ideas to improve the quality of care. On Redwood ward which was clearly an outlier in terms of its performance; an interim manager had recently come in to post three months prior to the inspection.
- Sickness and absence rates were reported to be running at 3.2% across older person mental health services and none of the services had significantly high levels of sickness absence.
- At the time of the inspection there were no grievance processes reported or grievance processes being followed. However data provided by the trust indicated the 30% of the staff in older person mental health services had experienced bullying or harassment in the previous 12 months. We were not told about any examples of bullying or harassment during our inspection.
- All the staff said they felt passionate about the patients and their teams. They told us they felt well supported and enjoyed their jobs. Some staff told us they struggled with the high use of agency staff and the management issues surrounding the mix of functional and organic patients across all inpatient wards.

Commitment to quality improvement and innovation

- At Beatrice Place the MDT was pioneering a new sensory activity programme designed for adults in the advanced stages of dementia called Namaste. This evidence based programme focused on meeting the physical and emotional needs of patients through meaningful activity which in turn decreases distress and resulting behavioural problems. The activity used music, fragrance, plants, sensory stimulation, massage and food treats to improve the comfort and pleasure of the patient's experience. It had just started running but Beatrice Place were the first NHS service to pilot the programme. Staff reported that a couple of their higher risk patients had improved communication and demonstrated less agitation and distress since they started attending the programme.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure the service user is protected against the risk of receiving care and treatment that is inappropriate or unsafe by planning and delivering care to ensure the welfare and safety of the service user. On Redwood ward patients were not having ongoing physical health checks. On Redwood ward female patients were wearing clothing that did not preserve their dignity. Patients from adult wards were receiving care and treatment on the older people's wards when this was not always clinically appropriate. Patients were admitted to the beds of patients who were on leave but not discharged. This meant they may not be able to return to the ward if they needed to. This was in breach of regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9,10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout.

This section is primarily information for the provider

Requirement notices

Oak Tree ward and TOPAS did not comply with guidance on same sex accommodation and compromised patients safety, privacy and dignity.

On several wards patients did not have access to a lockable space to safely store their personal possessions which should ideally have been provided through a key to their bedroom door.

Patients could not close their observation panel from inside their room to have privacy.

This was in breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9,10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider did not protect patients against the risks associated with the unsafe handling of medicines. On Redwood ward medication was left in an unlocked medication trolley where patients could have picked it up. On Redwood ward the drugs used for emergency resuscitation were not stored together which could make them harder to locate in an emergency. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider had not made suitable arrangements to ensure that patients are safeguarded from the risk of abuse by responding appropriately to an allegation of abuse. At the TOPAS centre there was no record so that staff would know about current safeguarding alerts and any actions that needed to take place to keep people safe. This was a breach of regulation 11(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	The provider was not making suitable arrangements to ensure that patients could participate in making decisions relating to their care. Patients were not always involved in their care planning or have a copy of their care plan where appropriate. This was a breach of regulation 17(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.