Good

North Staffordshire Combined Healthcare NHS Trust

Wards for older people with mental health problems

Quality Report

Tel:
Website:

Date of inspection visit: 8th – 9th September 2015
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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)
RLY88	Harplands Hospital	Ward 4	ST4 6TH
RLY88	Harplands Hospital	Ward 6	ST4 6TH
RLY88	Harplands Hospital	Ward 7	ST4 6TH

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
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

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Summary of findings

Overall summary

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

- The wards were clean, spacious, and safe. They were secure, whilst being patient and age friendly, with pleasant outdoor areas and a variety of rooms and activities. They were grouped together on the same site, so that they could benefit from each other's support and facilities, as well as support and facilities from the rest of the hospital.
- Risks to patients were individually assessed, monitored and managed effectively.
- Patients' physical health, as well as their mental health, was monitored and treated effectively with a clear focus on recovery and discharge in a timely manner. Joint working between the mental health & acute trusts on ward 4 was working particularly well in speeding and enhancing patients' recovery.
- There was a good mix of well-trained, motivated, professional and caring staff to help patients. Staff were enthusiastic, positive and had a good understanding of the needs of all patients and how to meet them.
- Wards worked well with other agencies and kept carers and patients informed about and involved in individual needs and progress. They were able to treat and discharge patients within reasonable time limits.
- Patients and relatives were overwhelmingly positive about the staff, the food, the service and the care and treatment offered.
- There was a good range of activities available to aid patients' well-being and recovery.

However,

- There was no evidence of any psychology input that might benefit particular patients.
- Not all staff working with dementia patients had received in depth dementia training.
- Although they felt well supported and supervised, staff did not have regular recorded supervision.
- Not all medication given was properly recorded.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Wards were clean with safe spaces for patients. There was visible good hygiene and infection control in place. Wards were designed, laid out, maintained and decorated with patient well-being and safety in mind.
- Risks to patients, both individually and collectively, were assessed and managed. Wards used appropriate screening assessment and monitoring tools to ensure the well-being and safety of patients.
- Staff were properly trained in de-escalation and restraint if patients became at risk of harming themselves or others.
- Physical health needs were provided for with additional medical support available if required.
- Patients were properly observed and kept safe by sufficient numbers of suitably trained and supportive staff. Staffing levels could be adjusted to reflect and meet the needs of patients currently on wards. Patients consistently told us that they felt safe on wards.
- Risks generally associated with older patients such as falls and pressure sores were monitored and guarded against with effective support.
- Incidents were reported and referred to safeguarding as required.
- The service learned from incidents to help improve safety

However:

- Three of the thirteen patient medication records looked at had entries missing. This meant, in these instances, it was not clear if the patients concerned had received their prescribed medication.

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Are services effective?

Good

We rated effective as good because:

- Care plans were personalised, focused on recovery and included the views of patients and carers.

Summary of findings

- There was good monitoring and treatment of physical health as well as mental health needs. Fluid and nutrition charts were in evidence. Staff were aware of individual diets and other health needs.
- Suitable assessment, screening and monitoring tools supported staff in improving the health and well-being of patients.
- Physiotherapy was available on the wards. There was suitable equipment, aids and adaptations available to support people's health needs and especially their mobility.
- Medication management followed best practice guidelines and was supported and monitored by the trust pharmacists.
- There was a good mix of staff on wards, with support from a range of clinicians and health professionals.
- Staff received mandatory training that was up to date and met trust targets.
- There were regular and effective multi-disciplinary meetings with all health professionals contributing as required. These, along with reviews and handovers, were focussed on patients, their recovery and effective and timely discharge.
- The service worked well with other agencies to secure timely patient discharge.
- Mental capacity and Mental Health Act documentation was in good order.

However,

- There was no evidence of direct input by psychologists.
- Not all staff working with dementia patients had received in depth dementia training.
- Although staff felt supported and supervised, they did not all receive regular and recorded supervisions
- Patients or relatives did not have copies of care plans.

Are services caring?
We rated caring as good because:

Good

Summary of findings

- Staff were warm, positive and caring in the support and treatment they gave to patients. They showed a good understanding of the individual needs of patients. Privacy and dignity was respected.
- Responses from patients and relatives about staff were very positive.
- Patients and relatives were kept informed about treatment and developments, including discharge plans.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Beds were available for patients who needed them. Discharges were made within target times, unless there were clinical reasons for delays.
- The ward environments promoted well-being and recovery, with dementia-friendly features and sufficient rooms to enable patients to have privacy when they wished. There were a variety of rooms supporting an appropriate range of activities.
- Patients were very positive about the food and choices available
- There were leaflets and other information available about the wards, treatments and all relevant areas to do with patient care and well-being.
- Complaints and general comments of patients and relatives were responded to and helped inform improvements in the service.

However:

- We observed that was limited personalisation of patients bedrooms

Are services well-led?

Good

We rated well-led as good because:

- Staff demonstrated the trust's values in their work.
- Staff training was effectively monitored so that any shortfalls were identified and were addressed promptly.
- Staff received regular appraisals, had regular staff meetings and opportunities for feedback and debriefings when needed . Staff felt well supported by managers.

Summary of findings

- Staff morale was high. Staff felt empowered and expressed high levels of job satisfaction. Staff were supported in their personal career development.

However:

- Although supervision was offered, there was no formal process in place
- At least one manager felt that having that being on a rota as senior nurse within the hospital took them away from the ward too frequently.

Summary of findings

Information about the service

The service provides treatment and short term inpatient care for older people with mental health problems in order to discharge them to suitable community settings. This could be to their own homes, supported living or residential or nursing care. Ward 7 is primarily for older people with fiunctional mental illnesses, whilst ward 6 is primarily for older people with organic mental disorders, such as dementia. Ward 4 is a 'Shared Care' ward jointly run with the University Hospital of North Staffordshire NHS trust. This ward is for older patients with physical health problems and dementia needs who were treated at that hospital and need additional support prior to 'stepping down' to community, nursing or residential settings. Ward 6 has 15 beds in use, ward 7 has 20 beds and ward 4 has 15 beds.

Our inspection team

The comprehensive inspection was led by:

Chair: Paul Lelliot, Deputy Chief Inspector (Mental Health), Care Quality Commission.Head of Inspection: James Mullins, Care Quality Commission.Team Leader: Kenrick Jackson, inspection manager, Care Quality Commission.

The team that inspected wards for older people with mental health problems consisted of

two CQC inspectors, a nurse, a social worker, an MHA reviewer and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients, families & carers

During the inspection visit, the inspection team:

- Visited the three wards that provided treatment and care for older people with mental health problems at Harplands hospital. We looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 20 patients and carers who were using the service.
- Spoke with the managers or acting managers for each of the wards.
- Spoke with 12 other staff members; including doctors, nurses and social workers.
- Interviewed the divisional director with responsibility for these services.
- Spoke with the modern matron with responsibility for the three wards
- Attended and observed three hand-over meetings, a ward round and a patient review.

Summary of findings

We also:

- Collected feedback from 12 patients on wards 6 and 7 using comment cards.
- Looked at 31 treatment records of patients.
- Received feedback from our pharmacy inspectors who had inspected medication management on two of the three 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

Patients and relatives were overwhelmingly positive about the wards we visited. We had no negative comments on the day of our visit from the twenty patients and carers we spoke with. Of the twelve comment cards we got back, only one was negative. Very few formal complaints were received about the service. Minor concerns raised in the past included such issues as missing laundry items.

Patients and relatives enthused about the cleanliness of the wards, the food and the helpfulness and responsiveness of the staff. Patients told us they felt safe on the wards and that staff were quick to respond to any problems. Relatives told us they were kept informed and their views were sought regarding treatment recovery and discharge plans.

Good practice

Ward 4 had been re-opened as a shared care ward and demonstrated how good joint working between acute and mental health services could bring great benefits and improve outcomes for patients.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider whether better access to psychology by wards could benefit the recovery of particular patients.
- The provider should make copies of treatment and care plans available to patients and/or relatives.
- The provider should ensure all trust staff working with dementia patients are fully equipped for the role by having undertaken appropriate dementia training.
- The provider should ensure any prescribed medication that is given, ommitted or refused is always recorded.

North Staffordshire Combined Healthcare NHS Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 4	Harplands Hospital
Ward 6	Harplands Hospital
Ward 7	Harplands Hospital

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 ward 4, all of the registered mental health nurses employed by the trust had training in the Mental Health Act. Registered general nurses employed by the partner trust did not however.There were sufficient mental health nurses on this ward to be able to offer advice to the general nurses when required. There was one detained patient on ward 4. They were supported by a general nurse with additional support by a mental health nurse. On wards 6 and 7,all nurses had training in the Mental Health Act. There were seven detained patients on ward 7 and five detained patients on ward 6. Figures confirmed by the modern matron showed that all staff employed directly by the trust had training in the Mental Health Act and the Mental Capacity Act.
- There was evidence of assessments of mental capacity on all but 2 of the 31 care records looked at. There was evidence of informed consent being obtained on all records on wards 6 and 7. On ward 4 it had been recorded on 9 of the 13 looked at.
- Staff told us they explained the rights to detained patients under the mental health act on a weekly basis. This was recorded in the care records of the patients concerned.
- Staff consistently praised the support of the trust's mental health act team. "Brilliant" said one ward manager of their support on issues relating to deprivation of liberty safeguards.
- Each ward had a mental health checklist to ensure all the documentation was recorded. This was checked by the manager, the deputy or a designated link person.

Detailed findings

Wards did peer reviews of each other's documentation. The manager on ward 7 advised that these peer audits identified minor issues to address, such as ensuring relevant documentation was filed with medication records.

- Independent mental health advocates were available. However, they did not come on the ward to raise awareness of the service.There were posters and information concerning the advocacy service available on the wards. We were not made aware of patients wishing to raise advocacy issues whilst on the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The service applied for Deprivation of Liberty Safeguards as appropriate. There had been 32 applications in the past six months; 17 from ward 4, 14 from ward 6 and one from ward 7. This showed staff were alert to the need for ensuring patients were not being deprived of liberty for unlawful or unjustified reasons.
- Capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions. Patients were given help to make specific decisions for themselves before they are assumed to lack the mental capacity to make it. We consistently saw patients being offered choices, whether this concerned, food, activities or where they wanted to sit or move to.
- When patients lacked the capacity to make decisions, best interests assessments were undertaken. We saw evidence of the recognition of the importance of the person's wishes, feelings, culture and history. Best interest decisions were made with the recorded involvement of appropriate people. A covert medication agreement that we viewed for one patient was signed by doctor, family member and pharmacist.
- Staff said they were well supported by the trust Mental Health Act department in the event of any queries or uncertainties. One ward manager said that the team were "brilliant" when referring to their support on Deprivation of Liberty Safeguards issues.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- The wards enabled staff placed at strategic points to view corridors to ensure patients were safe. Wards 4 and 7 were laid out in a crucifix shape, which enabled male and female corridors to run from a central point and as such were entirely separate. Ward 6, which was a dementia care ward, was laid out as a quadrant. This enabled patients to walk around it safely, minimising any frustration they might feel at coming to 'a dead end'. Any exit doors were made to look like book shelves, again minimising any distress and frustration at seeing an exit door they were unable to exit through. This helped to make the ward safer for the patients.The ward as a whole was laid out and furnished in ways that gave it a 'homely' feel that was dementia friendly.
- The ward complied with guidance on same-sex accommodation. The wards were mixed, but separation was maintained by separate corridors. The arrangements for gender separation meant that no-one had to walk through an area of the opposite gender to gain access to their room. There were rooms designated as female-only lounges.
- There were ligature risks assessments which either ensured there were no ligature risks or that these were monitored to ensure minimal risks. Individual risk was assessed and monitored. All staff were trained in the use of ligature cutters. There had been no self-harming or suicide attempts in this service in the past twelve months. Staff we spoke with could not recall any at all.
- Clinic rooms were clean, tidy and well-organised. Resuscitation and blood pressure monitoring equipment was checked daily. We saw records confirming this, with fridge and room temperatures recorded and 'clean stickers' on cupboards. Medication was stored appropriately.
- There were no seclusion rooms on any of the wards. There was a break out area on ward 6. This allowed one person who was currently being treated privacy and dignity when their behaviours, such as removing all their clothes, became potentially upsetting to others.
- All ward areas were clean, had good furnishings and were well-maintained. We pointed out one patient toilet that did not lock. It was repaired and worked properly within an hour.
- Staff adhered to infection control principles including handwashing. Each bedroom and bathroom had its own store of gloves and aprons and all staff carried anti-bacterial hand gel. There had been one case of flu and one of 'C Diff' (clostridium difficile). These had originated elsewhere and had presented only when the patients had been on the older person's wards for a short while. The patients concerned had been effectively barrier nursed.
- Equipment was well maintained and clean. 'Clean' stickers were visible and in date. Hoists and other mobility equipment were clean, properly checked and maintained.
- Cleaning records were up to date and demonstrated that the environment was regularly cleaned. We had only complimentary comments from patients and relatives about the cleanliness of the ward. One relative visiting ward 4 told us, "It's beautiful here. This is the cleanest hospital we've been in". Domestic staff we spoke with were highly motivated, proud of their work and felt an integral part of the teams.
- For the purposes of safety, each patient's bed on ward 4 had an alarm which alerted staff to any significant movement in beds. Alarms were available for patient beds on other wards on a risk assessed basis. Staff had personal alarms. Support could be sought across wards in the event of emergencies. A 'pinpoint' alarm went off at least twice during our two day visit, indicating an issue on another ward. A designated nurse was able to check to see if support was needed at the ward sounding the alarm. A patient told us a nurse always came promptly when they pressed their call alarm.

Safe staffing

- Wards were staffed according to an assessment of need agreed with the local clinical commissioning group. Extra staff were able to be brought in to meet any increased needs amongst individual patients. Patient bed numbers were restricted according to how needs

Good

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could be managed safely and effectively by staff. Ward 4, which was a shared care ward, was restricted to fifteen beds, of which twelve were in use at the time of our visit. Staff ratios were seven in the morning, seven in the afternoon and five at night. Ward 4 had a mix of two general nurses (RGNs) and four mental health nurses (RMNs) o the establishment figures. There were four nursing assistants. There were vacancies for three nurses and three nursing assistants. These vacancies were covered by agency and bank staff in the interim. The ward used, as far as possible, agency and bank staff who were familiar with the ward. This was the case on the day of our visit.

- Rotas showed that shifts on ward 4 generally had seven staff on duty, and sometimes six. Numbers did not go below six, which the ward manager acknowledged was the safe limit. When there was a shortfall, this was caused by an agency or bank nurse cancelling a shift at short notice. This was the concern in the use of agency staff for the manager. There were a lot of bank and agency staff being used, particularly on ward 4. As this ward had been re-opened on a shared care basis in response to a bed crisis its future was not yet guaranteed. This meant there was a shortage of permanent staff and a high use of agency staff. Ward 4 routinely used bank or agency staff. On average, eight out of the nineteen on a full twenty-four hour shift were bank staff. The service predominantly used bank staff who were familiar with the ward and the needs of the patients. The other wards also used bank staff to a lesser degree; ward 6 averaged fourteen shifts in a week covered by bank staff.
- Ward 6 was staffed by six staff in the morning, six in the afternoon, and four at night. It had one nurse vacancy which had just been appointed to, and three staff seconded to other wards or the community mental health team.
- Ward 7 was fully staffed with maternity cover arranged to cover maternity leave, and with one new nurse due to start. Staffing on this ward was five in the morning, five in the afternoon, and three at night. Bank staff picked up any shortfall. Agency staff were not used on this ward. Five shifts a week on average had been covered by bank staff over the past three months.
- Ward managers were able to adjust staffing levels daily to take account of the fluctuating needs of patients. Staffing levels were exceeded at times because of additional patient need.
- There was a mix of qualified nurses and support workers of approximately 50/50. Where wards had several communal areas, there would be a qualified nurse present in at least one area.
- Ward 4 had implemented a named nurse system two weeks before our visit. It was too early to evaluate the effectiveness of this. The manager believed it would improve individual patient safety and well-being by having one nurse responsible for over seeing this in each instance.
- There were sufficient staff to ensure activities took place regularly throughout the week. An activities organiser worked four days a week, and staff led more small-scale activities. At weekends, family visits became the major source of activity. We had favourable responses from the majority of patients we spoke with concerning the types and regularity of activities offered.

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- There were enough staff to safely carry out physical interventions. A relative we spoke with had observed a patient being aggressive the previous week on ward 4 and that staff “handled it quickly and calmly. They used ‘minor restraint’ and walked them down the corridor”. Patients on all wards consistently told us they felt safe and that there were always staff around to help.
- There was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency. On call doctors based on the hospital site were available during the 24 hour period.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident. Risk reviews took place after any incident and care plans updated accordingly. Of the 31 records we looked at, all had initial risk assessments and all but one of these were fully up to date.

Good

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- The wards used the trust's integrated care pathway which included recognised screening and assessment tools to assess relevant risks such as falls, pressure areas and nutrition and hydration risks.
- We saw no evidence of blanket restrictions. Patients' bedrooms were generally locked once patients were up, but could be unlocked if they needed or wanted their rooms. Rooms were generally locked to help patients be active, ensure they were safe and that any possessions were safe. Where patients required bedrest or expressed a wish to be in their rooms, this was facilitated.
- Informal patients were able to leave at will although we were not aware of this happening on the day of our visit. Where risk assessments showed this was a risk in non-detained patients, Deprivation of Liberty safeguards (DoLS) were applied for. We discussed with managers examples of previous patients who, as part of their recovery plan prior to discharge, were able to leave the wards whenever they wished. .
- Observations took place dependent upon individual risks. On ward 4 observations had until recently been every 15 minutes for patients in bed. This had been reduced to hourly after bed alarms had been installed. Thisnabled staff to be alerted to significant movement. Further observations were individually risk assessed. We saw observations taking place in line with assessed and recorded risks on all wards.
- All trust staff were trained in management of actual or potential aggression (MAPA), de-escalation and restraint. Registered general nurses employed by the acute trust on ward 4 had not yet received this training. Low level restraint was recorded on patient notes but was not reported. This had been discussed by the ward with the head of health and safety. They were advised to record only 'significant' restraint involving holds of more than a minute. Data supplied by the trust showed that in the six months from October 2014 to March 2015 restraint had been used once on ward 4, twenty times on ward 6, and six times on ward 7, with one occasion involving the use of prone restraint. Since then there had been two incidents on ward 4 of floor restraints where the patient had put themselves on the floor. There had been rapid tranquilisation used in this case. There was a plan in place for covert medication for this patient. During our visit, we observed staff effectively de-escalating patients when they became agitated.
- An agency nurse that we spoke with was clear on restraint procedures. They had been received the appropriate restraint and de-escalation training and were able to outline the ward guidelines on de-escalation and restraint. This showed that the wards used, wherever possible, a percentage of agency staff who were able to use approved restraint techniques.
- Where rapid tranquilisation was used, nurses and managers were able to detail how this adhered with NICE guidelines in terms of procedure and recording. Our pharmacy inspector had noted how, on ward 6, rapid tranquillisation incidents were reviewed by the team every week during the ward round. In particular, when a patient had regular rapid tranquillisation a themed meeting was held to review treatment options.
- There was no seclusion room. A 'breakout' area was being used on ward 6 for one patient at the time of our visit to support their dignity and avoid upset to other patients when this patient removed clothes. This was a spacious, airy communal area with a corridor and room which was open to all but which could be made private for short periods by closing the corridor double doors. We saw this patient being observed and supported by staff at various intervals in the day, either in this area, on other parts of the corridor, or in their room. During our visit the doors were open, except when the patient undressed or required additional support because of incontinence.
- Staff were trained in safeguarding and knew how and when to make a safeguarding alert. They were able to discuss safeguarding concerns they had raised and how they had done this. Pressure sores of grade 3 and above were raised as safeguarding alerts.
- An example of a safeguarding issue concerned a patient who had locked themselves in a quiet room for 45 minutes. This was raised as an environmental issue to ensure doors could not be accidentally locked in future. The patient later said they had 'enjoyed the peace and quiet'. Staff had learned from this and had repositioned the chair in the quiet room to ensure any patient sitting in there was more visible in future.
- Our pharmacy inspectors visited wards 6 and 7. Their observations were generally positive. They noted medicines were stored securely and within safe temperature ranges, that there was good access to

Good

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medicines and that medicines for discharge were available. They also found clinical pharmacists were actively involved in all aspects of a person's individual medicine requirements. The pharmacy team were part of the daily ward round which helped identify medicine issues and therefore they could be dealt with immediately. Prescription charts were clear and well documented with pharmacist interventions documented on the front of the chart. Medicine errors were reported using the incident reporting system. Information was cascaded to the nursing staff team via e-mail and weekly team meetings. They were also told about a recent medicine incident that had occurred on the ward and where lessons had been learnt. However, they also looked at 13 patients' prescription charts and found three patients with missed administration medicine recording. There was no signature for administration or reason documented to explain why the medicine had not been given in each case. This did not indicate a widespread problem but showed that recording should be more robust to ensure that all medicines given were properly recorded.

- The wards adhered to trust falls policy using the 'frequent fallers' model, whereby anyone with more than one fall in the past 12 months was risk assessed accordingly. For example, one patient now had one to one support to mobilise because of their falls risk. This showed the service was responding to risks in order to improve safety.
- There were pressure sensors on beds in ward 4 to make staff aware if someone got out of bed or moved significantly in bed. This enabled staff to be aware when patients were potentially at risk and in need of support. This meant that patients were protected without being restricted. One relative told us "they had a rail on the bed, but now they have pressure sensors". This helped keep patients safe without intruding on their privacy with excessive observation checks.
- The wards would make families aware of any specific risks if applicable in order to ensure children could visit safely.

Track record on safety

- The manager on Ward 4 informed us of a fall where a patient had sustained a fracture the previous week. This had been referred as a serious incident and was in the early stages of investigation. Trust data showed there had been 23 safeguarding alerts from the three wards to the local authority. The majority concerned events in the hospital, others related to concerns in the community, home, or care home prior to admission. None were recorded as meeting the threshold for investigation.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were aware of what to report and how to report it. Ward 4 reception had a large, well thought out display about incidents with clear details about what and how to report. It also detailed when the next learning lessons session was scheduled for.
- Staff were open and transparent and explained to patients if and when things went wrong, demonstrating duty of candour. There was an issue following the expected death of a patient on the shared care ward, where different protocols between the two trusts resulted in misunderstandings and delays. A joint protocol was then established to prevent any such problems recurring. The patient's family were made aware of the issue. We saw the response from the family. Although they had been upset by the misunderstandings following the death, they were so full of praise for the excellence of the palliative care provided on the ward, they were prepared to overlook the issues following the death.
- Staff received feedback from the investigations of incidents both internal and external to the service. There was an example of shared learning where a patient on one ward had swallowed a false teeth sterilising tablet. This had been shared with other wards to ensure they all took sufficient precautions against such an eventuality reoccuring.
- Staff received debriefs after incidents. They gave examples of how they were able to get feedback and support, individually and collectively following challenging incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We looked at a total of 31 care records; thirteen on ward 4, seven on ward 6 and eleven on ward 7. All showed a full physical health check took place on admission. Care plans were recovery-focused, holistic and personalised, and included the views of the patient and/or carer. It was clear both from records and discussions with patients and carers that care and treatment was discussed with them and that they were kept informed. However, patients or their relatives did not have copies of their care and treatment plans.
- Care records showed that a full physical examination was undertaken upon admission and that there was ongoing monitoring of physical health problems. All 31 records we looked at showed assessments of physical health, using recognised screening and monitoring tools for areas such as continence, tissue viability and swallowing.
- Care records were recorded and stored on paper. This meant they were accessible to staff on wards but that information then had to be copied or sent when a patient was transferred to another care setting. This was not raised as an issue by managers or staff and there was no evidence that this was a concern with other agencies. The trust planned to introduce electronic records for care and treatment plans, although staff in this service were not clear on when this was to happen.

Best practice in treatment and care

- The pharmacy inspectors visited the wards for this service and found them to be compliant and following best practice and guidance with regards to medicines management. A well-established pharmacy team provided good clinical services to ensure people's medicines were handled safely. The pharmacy team were actively involved in all aspects of a person's individual medicine requirements from the point of admission through to discharge. Pharmacists visited wards to check people's medicine records and were also involved in multidisciplinary team meetings to discuss people's medicine requirements. Any concerns or advice about medicines were written directly onto the person's medicine records. Nursing staff confirmed that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times.
- There was no evidence of psychology input onto the wards. The ward manager on ward 7 said that patients could be signposted to Cognitive Behaviour Therapy but that patients generally were not inpatients long enough to benefit from sessions. We observed a patient on ward 6 whose dementia-related behaviour may have benefitted from short-term input from a psychologist. Staff we spoke with agreed that support from a psychologist might help in understanding and managing particular behaviours.
- There was good access to physical healthcare, including access to other health professionls, such as the speech and language team, when needed. We observed thorough and detailed discussions of patients' physical health care needs taking place on ward rounds, and actions being taken as necessary. One carer told us their relative received regular physiotherapy to aid recovery. Physiotherapy support was present three days a week, most notably on ward 4, as this was where there was likely to be the highest demand for it. There was a strong emphasis on helping people regain mobility. There were examples of patients coming on to this ward confined to bed, regaining mobility and moving on to residential care, rather than nursing care.
- There was suitable equipment available to support people's health and mobility needs. Hoists were available as needed. Pressure relieving equipment was available when required. Handrails and grips were in toilets, bathrooms and corridors.
- There were fluid and nutrition charts in place for all patients assessed as requiring these. These were regularly updated throughout shifts and checked by nurses on each shift in order to note any areas of concern and take necessary actions. A dietician or member of the speech and language team was called if there were particular concerns. Kitchen and care staff were aware of individual needs regarding matters such as swallowing difficulties and diabetes. There were clear instructions and guidelines regarding these.
- Staff used recognised rating scales such as the Montreal cognitive assessment to assess and record severity and

Are services effective?

Good

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.

outcomes. These formed part of the integrated care pathway. This pathway also included screening assessment and monitoring tools, risk assessments for falls, osteoporosis, manual handling, pressure areas, continence, capacity, alcohol, nutrition, hygiene, blood tests, along with a discharge checklist. Checks such as modified early warning score were done daily to ensure any physical or other health issues were picked up promptly.

- Clinical staff participated in clinically based audits. There had been hand wash audits as part of barrier nursing. There were monthly nutrition, fluid and diet chart checks. All nutrition, fluid and diet charts we looked at were properly filled in and up to date. This reflected our observations and feedback of patients being well fed and hydrated.

Skilled staff to deliver care

- Wards were supported by occupational therapists, pharmacists and social workers to support patients in regaining skills, achieving optimal medication, and finding suitable discharge placements. However, there was no evidence of direct input into the ward by psychologists.
- There was a good mix of registered nurses and support workers on all wards. Ward 4 had both general and mental health nurses working together, sharing knowledge and skills to achieve optimum outcomes for patients' physical and mental wellbeing. Health care support workers worked alongside nurses on all wards. The balance of qualified and unqualified staff was approximately 50/50 on all wards. Support workers in many cases had received additional training and support to enable them to take on additional responsibilities. One support worker, for example, had taken on the role of discharge co-ordinator, a role they were undertaking confidently and ably.
- Staff received and were up to date with appropriate mandatory training. Records of mandatory training for the whole service showed an average rate between 85% and 90%. Training records on wards showed less than 10% of permanent staff overdue on mandatory training and, except in the case of prolonged absence such as maternity leave, the training had been scheduled to take place.
- The trust induction policy was in place and all new staff received appropriate induction. Agency staff were able to describe the induction they undertook and staff were clear on what tasks they were trained and confident to undertake, such as, in the case of some support workers, taking and recording blood pressure.
- There were regular, monthly staff meetings. We saw minutes of these. Supervisions were offered when needed, but there were no formal arrangements for these. Staff told us they did not receive notes of any supervision; they went straight to files. The manager on ward 4 acknowledged that supervisions needed to be recorded more effectively. Five supervisions were recorded as taking place in August, two in July, and none in June. There was a variety of informal supervision taking place, as part of feedback, learning, group supervisions. All staff we spoke with told us they felt well supported by their manager.
- All staff had regular appraisals. We saw records of these and all staff we spoke with told us they had appraisals at least annually.
- All staff within the trust had basic dementia awareness training. This consisted of a one hour session. There was no required dementia training other than that, although registered mental health nurses had accessed dementia training as part of their initial and refresher regular training. Staff told us of individual dementia training they had accessed. Staff learned from each other. However, we spoke to one trust support worker who did not appear to be aware of how a patient's life experience could influence presentations in their behaviours. Other staff we spoke with showed this awareness. This indicated that while most staff had benefitted from dementia training and learning, not all had.
- There was a trust performance management policy, but managers on all the wards told us there were no issues at present with permanent staff. This reflected our observations and discussions, which indicated there was positive effective team work on all wards. If there were issues with agency staff these were raised with the agency and requests could be made for particular staff not be used again.

Multi-disciplinary and inter-agency team work

Are services effective?

Good

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.

- Regular and effective multi-disciplinary meetings took place weekly. These involved a range of clinicians and staff. General and mental health nurses, support workers, occupational therapists, physiotherapists, discharge co-ordinators, activity co-ordinators, geriatricians, psychiatrists, dieticians, podiatrists, pharmacists and social workers were all involved as required.
- Effective handovers took place with staff sharing relevant and up to date information on patients. The handovers were patient focussed, with information on personal histories and plans for discharge discussed.
- Ward rounds were patient focussed with the emphasis on treatment, recovery and discharge. Social aspects as well as medical and health issues were discussed. For example, a patient's relationships and financial concerns were noted as issues that could impact on a successful discharge, and plans formulated for relevant support. Where a patient had swallowing difficulties, arrangements were made for SALT to visit, assess and advise the next day. This showed the service was effectively liaising with and utilising the expertise of other professionals.
- There were effective working relationships, with other teams in the organisation. Knowledge and information was shared effectively. We saw that safeguarding alerts made to the local authority were responded to promptly**.** The discharge co-ordinator worked with social services to ensure discharges happened as effectively and smoothly as possible. Staff and managers spoke favourably of social worker input to assist the finding and funding of suitable places for people ready to move on.

Adherence to the MHA and the MHA Code of Practice

- On ward 4, all of the registered mental health nurses employed by the trust had training in the Mental Health Act, but registered general nurses employed by the acute trust did not. There was one detained patient on ward 4. They were supported by a general nurse with additional support by a mental health nurse. On wards 6 and 7 nurse all nurses had training in the Mental Health Act. There were seven detained patients on ward 7 and five detained patients on ward 6. Figures confirmed by the modern matron showed that all staff employed directly by the trust had training in the Mental Health Act and the Mental Capacity Act.
- There was evidence of assessments of mental capacity on all but 2 of the 31 care records looked at. There was evidence of informed consent being obtained on all records on wards 6 and 7. On ward 4 it had been recorded on 9 of the 13 looked at.
- 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.
- Staff consistently praised the support of the trust's mental health act team. One ward manager described their support on issues relating to deprivation of liberty safeguards as "brilliant".
- Each ward had a mental health checklist to ensure all the documentation was recorded. This was checked by the manager, the deputy or a designated link person. Wards did peer reviews of each other's documentation. The manager on ward 7 advised that these peer audits identified minor issues to address, such as ensuring relevant documentation was filed with medication records.
- Independent mental health advocates were available. However, they did not come on the ward to raise awareness of the service. We were not made aware of patients wishing to raise advocacy issues whilst on the wards. Patients were generally on the wards for little more than a month.

Good practice in applying the MCA

- The service applied for Deprivation of Liberty Safeguards as appropriate. There had been 32 applications in the past six months; 17 from ward 4, 14 from ward 6 and one from ward 7. This showed staff were alert to the need for ensuring patients were not being deprived of liberty for unlawful or unjustified reasons.
- Capacity to consent was assessed and recorded appropriately. This was done on an individualised basis with regards to significant decisions. Patients were given help to make specific decisions for themselves before

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they were assumed to lack the mental capacity to make it. We consistently saw patients being offered choices, whether this concerned, food, activities or where they wanted to sit or move to.

- When patients lacked capacity to make decisions, best interests assessments were undertaken and recognising the importance of the person's wishes, feelings, culture and history. Best interest decisions were made with the recorded involvement of appropriate people. A covert medication agreement for one patient was signed by doctor family member and pharmacist.
- Staff said they were well supported by the trust mental health act team in the event of any queries or uncertainties. One ward manager described their support on Deprivation of Liberty Safeguards as "brilliant".

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

- Staff treated and supported patients in warm, positive and understanding ways. Privacy and dignity were supported, for example, in eating and drinking. Where necessary, anti-slip mats and plate-guards encouraged patients' independence in eating. Continence assessments and management helped support patients in maintaining or regaining continence.
- We did three recorded observations of patient engagements and interactions with staff. These showed positive engagements by staff with patients taking place.
- We received twelve comment cards for wards 6 and 7. All five for ward 7 were positive. Of the eight received for ward 6, three were positive, two were mixed and one was negative. Two were unclear in their comments. Patients we spoke with were overwhelmingly positive about staff politeness, warmth and friendliness. Patients told us staff always knocked on bedrooms doors before entering. One patient told us "they don't come barging into my room or anything like that." We saw screens being used to ensure privacy and dignity when physical examinations were needed, when, for example, one patient had problems with breathing. Staff were skilled at putting patients at ease and giving additional support when needed.
- Staff showed a good understanding of the individual needs of patients. Staff were generally able to relate behaviours, patient preferences and past histories, where known.

The involvement of people in the care they receive

- The admission process informs and orients the patient to the ward and the service. There were information leaflets explaining all aspects of treatment care and further support. Ward 6 was particularly good in this respect.
- We saw patient and carer involvement in reviews. They were able to discuss matters of concern and obtain information. Patients and relatives we spoke with were very positive about this. "We are always kept informed" was a typical comment from a relative. Patients or relatives did not get copies of the care plan. Patients were on wards for a relatively short period. Patients or relatives had copies of after care plans where they were the prime carers following discharge.
- Advocacy leaflets were available and notices displayed on the wards. There was an advocacy service, Assist, based at the trust and referrals were made to this service if required.
- We were present at reviews where issues such as covert medication were explained to and discussed with family members. This showed the service involved and explained care and treatment to interested parties. They also discussed funding, placement options, techniques of caring to minimise distress and future care arrangements.
- Patient forums took place on ward 6. The results of these were minuted and the highlights recorded on 'you said, we did' boards in communal areas. The patient forums also included relatives. One issue that had arisen recently was the access to and provision of hot drinks for visitors. The manager informed us this was in the process of being actioned in response to it being raised. On wards 4 and 7, patient forums had just been initiated, and responses were similarly displayed on 'you said, we did' boards in communal areas. One response to feedback from relatives had been the introduction of laundry baskets to reduce the amount of laundry items lost.

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

- Trust figures showed average bed occupancy at January 2015 was below 80%. Wards 6 and 7 had bed occupancies of 79% and 80% while ward 4 had an occupancy rate of 66%. This reflected what we saw during our visit. This showed that the wards were managing beds without patients having to wait for beds to be available in order to be admitted. The waiting list for the service was rarely more than a day. People from within the trust's catchment area were able to be provided with beds. We were not made aware of any out of area placements.
- Records and discussion with staff showed that beds remained available for patients on leave. There was one patient on ward 4 on leave. The period of leave was proving to be successful, but their bed was held open in the event of them returning, until discharge was confirmed.
- Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and was in the interests of the patient. People were discharged at times agreed with all concerned with the discharge. The discharge co-ordinator undertook this as part of their role. We saw patient and carer involvement in discussions about discharge.
- Trust data showed there had been a total of 40 delayed discharges in the six months from October 2014 – March 2015 in the three wards; 21 on ward 6, 16 on ward 7 and 3 on ward 4. The modern matron explained the process for dealing with delayed discharges caused by funding delays. A weekly revalidation meeting was held with the city and county social care funding authorities to highlight and resolve any funding issues. The targets for length of stay on the wards were 68 days on each ward. The modern matron informed us these targets were currently being reviewed. Staff on ward 7 told us the new target was 40 days for their ward. The actual lengths of stays were well below current targets: 34 on ward 7, 40 days on ward 4 and 48 days on ward 6. This showed that patients were being assessed, treated and discharged well within agreed time limits. It also indicated that where discharges were delayed, the delays were relatively short.

The facilities promote recovery, comfort and dignity and confidentiality

- There was a good range of communal rooms on each ward, enabling patients to mix with others, do a variety of activities, or spend time in quiet areas. Corridors and rooms were light, airy and spacious. The one exception was the dining room on ward 4, which would have been very crowded if all patients wished to use it at the same time. Staff assured us this was not an issue, as many patients here opted to eat in their rooms, elsewhere, or at different times. This was borne out by our observations during our visit. The dining areas on the other two wards were spacious.
- There was no psychiatric intensive care unit for older patients, so challenging behaviours were managed on the wards. We saw one person with very challenging behaviour being supported on ward 6 with additional staffing and a 'breakout' area. Here, the patient had privacy with staff but could also interact with other patients whenever the patient's behaviour was not distressing to others. During our visit, we saw this patient use the breakout area as well as their own room and communal areas. They had one to one support at all times. This person was supported to keep their clothes on. When they undressed and became engrossed in behaviours related to their past history, such as closely examining/cleaning the floor, they were supported to maintain privacy and dignity by staff ensuring others did not enter the breakout area. We did not consider this seclusion, but a way of maintaining this person's dignity and privacy and avoiding distress to other patients during these periods of behaviour. Records and discussions with staff showed this patient's behaviour becoming less extreme. They now needed less staff directly supporting them.
- There were a variety of rooms for visitors and patients to use. Visitors met with patients either in communal areas, quiet rooms or in the garden. We saw a number of visitors meeting with patients in the wards during our visit. They mostly sat with patients in lounge areas, in the garden, or in one of the smaller, quieter rooms, according to patient preference.
- People were able to use a phone from the office if required, or use a 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.

- Each ward had a garden area which could be used by patients. Ward 4 had an attractive garden where patients were encouraged and supported to tend and enjoy the plants in pots and raised beds.
- Wards were age and dementia friendly with lots of nostalgic posters and photographs. There was a large calendar on the wall of ward 4, showing the date, weather and season. This helped orientate patients suffering from memory loss or who were uncertain of their environment.
- Patient-led **assessment of the care environment (PLACE)** showed high (99%) satisfaction with food on the wards at Harplands hospital. All patients we spoke with were complimentary about the food, and especially the choice. Patients were given a choice of breakfast and main meals. They could choose where to sit and who with. One patient told us: "the food is very good. I have porridge. They put salt in it for me". This was an example of individual patient choice was being catered for.
- Water and soft drinks were available for patients at all times. Hot drinks, fruit and snacks were available at all times from staff. Staff were pro-active in offering drinks, and food, particularly with patients who they knew would particularly benefit from additional food and drink.
- There was limited personalisation of bedrooms. Patients were on the wards in most cases for only a few weeks. Nevertheless it was surprising to see many rooms without cards or photographs. Staff told us there was no problem with patients bringing in personal items. On ward 4, there were relevant pictures on individual doors to help patients identify their rooms. This was in response to a Healthwatch visit to this ward earlier in the year, which had suggested this.
- There were lockable drawers in patients' bedrooms where any valuables could be stored if this was required.
- There was a good range of activities, both in individual wards and with wards attending joint activities. Ward 4 had a daily breakfast club for patients going home. This helped patients regain and improve skills as well as being a social event, and helped occupational therapists assess individual needs. We saw a hymn session that patients from all three wards enjoyed. Activities such as dominoes and, quizzes took place on wards. We saw activities timetables showing activities taking place throughout the week, including weekends. Activities organiser worked 4 days a week, but we saw staff using their initiative to lead activities. Staff told us they had to change timetabled activities to suit patient needs and wishes. Patients and relatives consistently told us activities took place and that they joined in or not, depending on preferences. There was a sensory room on ward 6 available for patients to use at any time.

Meeting the needs of all people who use the service

- There were facilities for people requiring additional support, with good disabled facilities on each ward, including hoists and good wheelchair access. This meant the wards could effectively manage patients with physical needs well as mental health needs.
- There were carers' information boards and feedback boards on the wards. One patient told us that they found the information booklet they were given was easy to read. Interpreters and signers could be made available as needed. We were given several examples of how patients and families whose first language was not English had been supported.
- There was accessible information on treatments, local services, patients' rights, and how to complain on the wards. This was limited at the time of our visit on ward 7, as they were routinely collected by one current patient. It was anticipated these would be freely available once this patient had been discharged. Strategies put in place to prevent this patient collecting and retaining these leaflets had so far been unsuccessful. Ward 6 had a reception area, prior to the main ward area. This enabled leaflets and other information to be available for visitors. These included information about other organisations who could be help as well as help offered by the trust, information and guidance about mental health issues, and what to do in respect of complaints and advocacy. Ward 4 had an information board and leaflets and information available.
- There was a choice of food to meet dietary requirements of religious and ethnic groups. Staff we spoke with were clear on patients' dietary needs.

Are services responsive to people's needs?

Good

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

Agency staff who were unfamiliar with patients asked patients or other staff about particular wishes or needs, such as preferred names, whether they had special diets or needed help.

- In the past 12 months there had one formal complaint on ward 6, one on ward 4, and four on ward 7. None had been upheld, and none had been referred to the health services ombudsman. The formal complaint on ward 4 had regarded a discharge decision. This had been responded to by the modern matron. Carers we spoke with were confident about complaining if they felt they had reason. Two said they wouldn't know how to complain, but none of those we spoke with said they had any complaints. The manager on ward 4 described the majority of complaints as 'low level' ones that were resolved locally. This tallied with issues raised by relatives who spoke with us. A number said they had no complaints, but had raised with staff when clothes had gone missing. This had led to laundry baskets being introduced and had led to a reduction in missing clothes. This showed the service was responding to concerns.

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.

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 were positive about their work, about their role within the trust and were proud of the job they did.
- The modern matron was a visible presence on wards. The clinical director and service manager were known to staff.

Good governance

- Staff training was effectively monitored so that managers could see mandatory training was taking place and were alerted to any gaps so they could take prompt action to remedy these.
- There were regular, minuted monthly staff meetings. Supervisions were offered when needed, but there were no formal arrangements for these. Staff told us they did not receive notes of any supervision; they went straight to files. The manager on ward 4 had begun introducing regular, recorded supervisions. Staff consistently told us they felt well supported and supervised by ward managers.
- Staff received regular appraisals, which were given, signed, and returned.
- Shifts were covered by a sufficient number of staff of the right grades and experience. There was a mix of registered nurses and support staff.
- Staff were consistently on the wards, responding to the needs of patients. The one exception was where a ward manager complained of having to be off their ward on a rota basis to fulfil the role of senior nurse for the hospital.
- Incidents were reported. The modern matron was aware of when there were clusters of particular types of incidents, such as falls, and could therefore investigate to see what action, if any, was required. Safeguarding procedures were followed. Staff learned from incidents, complaints and service user feedback
- Wards had 'dashboards' which enabled the managers and the modern matron to monitor areas such as admissions, length of stay, discharges waiting lists. These were referred to the executive team as required. These showed the wards were working within agreed target levels.
- Ward managers had sufficient authority and administrative support. The only concern raised by a ward manager was the arrangement by which each manager in turn had to act as senior duty nurse for the site, dealing with all issues that arose, serious and trivial. For an example of the latter, when we arrived, rather than the manager of the ward being summoned to greet us and show us to the ward, this became the task of the senior nurse on duty, who was invariably the manager of a different ward. The manager felt that this, and other more serious issues, could be dealt with by managers on each ward, and followed up, if necessary, with the service manager at a suitable time. The trust had responded in part by introducing someone to take on this role in office hours, but at least one manager still felt it was problematic outside these hours, as it took them away from giving full and proper attention to their own ward when they were assigned to this role.
- Wards were able to submit items to the trust risk register. The one item we were advised had been submitted concerned the high use of agency staff and the associated problem of difficulties caused by bank and agency staff cancelling shifts at short notice

Leadership, morale and staff engagement

- Sickness and absence rates varied between 3% and 6% over the previous 12 months. Managers did not raise any concerns about sickness, other than the issues of agency or bank staff ringing in sick or unavailable for shifts at short notice.
- Staff consistently told us they felt able to raise concerns without fear of victimisation. They were clear and confident in discussing whistle-blowing. Equally, they felt confident in being able to raise any issues with ward managers. No concerns were raised regarding bullying and harassment.
- Staff showed high morale, job satisfaction and sense of empowerment. Staff consistently praised the

Are services well-led?

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management of the wards they were on, felt they were part of a good team and worked well together. This positive ethos extended form mangers and nurse to support workers and domestic staff.

- We saw excellent examples of staff being supported in personal development. One support worker had taken on the role of discharge co-ordinator and was being supported by the trust to do a relevant degree. The majority of staff we spoke with about training were positive about the support offered by the trust. The consistent response from staff was that the trust were very good at supporting individual staff who wished to develop their career. We saw one example of a staff member who had started as a cleaner and had been supported by the trust to progress and was now a nurse. We spoke with support workers who had been supported to develop their roles and skills.
- We saw teams working together effectively to ensure good outcomes for patients, from sharing knowledge and information at handovers and reviews, to good team working on shifts. We saw staff helping each other effectively and discreetly during minor incidents, such as incontinence occurring in a communal area.
- We were made aware of an issue, referred to under the 'safe' section, which demonstrated how the service made users aware and explained to them when things went wrong.There had been a misunderstanding following a death, where the partner trusts had two different protocols. The trust had been open with the family about the problems and had subsequently amended procedures.
- We were consistently told by staff that ward managers listened to and respected staff views and opinions. Staff meetings, debriefings and feedback sessions gave staff forums to express their views on service development. Managers had monthly 'innovation' days as well as regular meetings to look at meeting the standards required for accreditation for inpatient mental health services.

Commitment to quality improvement and innovation

- Ward 4 had been re-opened as a shared care ward and was showing how acute and mental health services could work together effectively to best meet patient need in this area.
- An integrated care pathway had been introduced to bring all admission, assessment and monitoring tools checklists and procedures together in a consistent document for all wards.
- The service had reviewed the environment with patient and carer input to make it more patient and dementia-friendly.