Good

Birmingham and Solihull Mental Health NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

50 Summer Hill Rd,
Birmingham, B1 3RB
Tel:0121 301 2000
Website: www.bsmhft.nhs.uk

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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)
RXTD5	Juniper	Bergamot ward	B13 8AQ
RXTD5	Juniper	Sage ward	B13 8AQ
RXTD5	Juniper	Rosemary ward	B13 8AQ
RXT06	Ashcroft	Complex care unit	B18 5SD

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Requires improvement
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:

- Staff took time to explain, orientate and re-assure patients as appropriate, supporting them to be safe but also to be as independent as possible. Ward managers were able to adjust staffing levels to take account of the fluctuating needs of patients, so that patients had additional support when they needed it. The service had a low rate of serious incidents. Staff used de-escalation techniques wherever possible as an alternative to restraint or seclusion. Positive comments by patients and visiting relatives reflected the good work by staff.
- The teams worked together effectively to resolve care and treatment issues. Wards had access to support from a variety of clinicians and other professionals. Psychology support was available to help support staff in understanding and resolving patient behaviours. Medical support was available promptly. Occupational therapists provided activities and assessments to help patients gain or regain skills and enhance their well-being.
- Care records were up to date, needs assessments and physical health care checks took place promptly after assessment. Monitoring systems were in place to ensure patient well-being.
- Wards were clean and there was a range of rooms and equipment to support treatment and care.
- Food was good and highly rated by patients. Patients were able to get snacks and drinks at any time of day or night.
- Staff morale was good; staff expressed confidence in being able to report anything of concern. Staff were very positive about their teams and the support from immediate managers and sickness and absence rates were below the national average. Effective systems ensured staff received training, supervision and appraisals.

However:

- The service was administering medication for physical health conditions covertly without appropriate safeguards in place for detained patients. There appeared to be no distinction between the procedure for administering medicines covertly for mental health needs and those for physical health needs.
- Some mental capacity assessments were only partially completed on Rosemary and Bergamot wards.
- Cleaning checklists were not always completed on Rosemary ward, indicating that equipment may not have been checked and cleaned as often as it should be.
- There was a lack of suitable short-term rooms for patients when they presented a risk to themselves or other patients. Many staff felt patients might benefit from having a purpose-made de-escalation room available.
- Lounge areas on the three Juniper wards were relatively small and were frequently crowded.

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.
- There were areas where patients could tie something to form a ligature and harm themselves but staff had risk assessments and observation procedures in place to reduce these risks.
- Not all ward areas had good lines of sight but staff reduced these risks by using observation procedures and individual patient risk assessments.
- Patients were safely separated by gender.
- Clinic rooms were clean and emergency equipment was well-maintained.
- Staff had personal alarms, so they could summon help quickly if required.
- There were sufficient staff to keep patients on wards safe, including carrying out physical interventions and personal care. Ward managers were able to adjust staffing levels to take account of the fluctuating needs of patients. Staff, including bank staff, were familiar with wards and the needs of the patients.
- Where staff used physical restraint, they did so to support personal care, the giving of emergency medication, or to guide a patient aware from challenging situations.

However:

- Staff did not always complete cleaning checklists for equipment on Rosemary ward, indicating that equipment may not have been checked or cleaned as often as it should be.
- There was no de-escalation room or safe and quiet space for patients to use when they presented a risk to themselves or others. Staff had used an empty patient bedroom because they recognised that a seclusion room was unsuitable for this patient group. Many staff felt that patients might benefit from having a purpose-made de-escalation room to use when they were particularly unsettled.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- We found evidence that staff had sometimes administered medication covertly. This means that some patients were given medication secretly, without having given their consent. For patients to be given medication without their consent we would expect to see staff following the trust covert medication

policy. We would also expect to see evidence that staff had carried out a mental capacity assessment and a best interest decision for patients. In the cases where we found that staff had covertly administered medication to patients, we found no evidence that staff had carried out mental capacity assessments or best interest decisions for these patients. There appeared to be no distinction between the procedure for administering medicines for mental health needs and those for physical health needs.

- We found evidence that in some cases, even though staff had started to carry out a mental capacity assessment, the paperwork was left unfinished.

However:

- Care records were up to date, and showed that needs assessments and physical health care checks took place promptly after assessment. Care plans included patients' views and were holistic and recovery orientated.
- Wards had access to support from a variety of clinicians and other professionals. The teams worked together effectively.
- Monitoring systems were in place to ensure patient well-being, with staff monitoring hydration, nutrition and pressure areas effectively.
- Wards benefitted from having a pool of experienced staff, many of whom had worked within the service for many years.

Are services caring?

Good

We rated caring as good because:

- Staff showed a good awareness and knowledge of the needs of individual patients.
- Staff on all wards took time to orientate, explain to and re-assure patients as appropriate, supporting them to be safe but also to be as independent as possible.
- Positive comments by patients and visiting relatives reflected the good work done by staff.
- Relatives and carers told us the service kept them informed and asked their views on treatments.
- We saw good examples of advance decisions and of recorded information used to inform quality care for patients who were no longer able to communicate such details easily.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- There was a range of rooms and equipment to support treatment and care.
- Structured activities took place, either on wards or off them. Occupational therapists supported activities, and could tailor them to individual needs and to enhance skills and well-being.
- There was good access to spiritual needs with all wards having faith rooms catering for all faiths and beliefs.
- Food was good and highly rated by patients. Patients were able to get snacks and drinks at any time of day or night. This was particularly important for those patients where dementia had disrupted their usual sleep and waking patterns.
- Although the service was receptive of complaints, there were very few complaints about it. We saw numerous compliments by patients, relatives and carers.

However:

- Lounge areas on the three Juniper wards were relatively small and were frequently crowded.

Are services well-led?

Good

We rated well-led as good because:

- Effective systems ensured staff received training, supervision and appraisals.
- Sickness and absence rates were below the national average.
- Staff morale was good; there were no reports of bullying or harassment and staff expressed confidence in being able to report anything of concern.
- Staff were very positive about their teams and the support from immediate managers.
- The wards all had Accreditation for Inpatient Mental Health Services.

However:

- There were no governance processes in place to identify that staff were not completing mental capacity assessments or best interests decisions before covertly administering patient medication.

Summary of findings

Information about the service

Patients and carers we spoke with were very positive about the service. Patients on Bergamot were able to comment on the ward and the staff and told us the ward was very clean and homely and that the food was good. Visitors to other wards were equally positive. The overwhelming view from patients and visiting relatives was that the staff were very good, that they listened to patients and attended to them, understood them and were calm and patient. One person noted that while the environment may have its minor shortcomings, that was of little importance compared to the warm homely atmosphere brought about by the staff.

Our inspection team

Chairperson: Michael Tutt, Non-executive Director, Solent NHS Trust.

Head of Inspection: James Mullins, Care Quality Commission

Team Leader: Kenrick Jackson, inspection manager, Care Quality Commission

The team that inspected this core service comprised: two CQC inspectors, one expert by experience, five specialist professional advisors and one observer. Experts by experience have experience of using services or caring for someone who uses services.

Why we carried out this inspection

When we last inspected the trust in September 2014, we rated wards for older people with mental health problems as requires improvement overall.

We rated the core service as requires improvement for Safe and Effective and good for Caring, responsive and Well Led.

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

• The trust must take proper steps to ensure that each person on the Hollyhill unit is protected against the risks of receiving care or treatment that is inappropriate or unsafe.

• The trust must make suitable arrangements to protect people on the Hollyhill unit who may be at risk from the use of unsafe equipment by ensuring that the equipment provided is properly maintained and suitable for its purpose.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited four wards
- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service

Summary of findings

- spoke with four carers visiting the service
- spoke with the managers or acting managers for each of the wards
- spoke with 34 other staff members; including doctors, nurses and social workers
- attended and observed four hand-over meetings and two multi-disciplinary meetings
- collected feedback from 13 patients or their carers using comment cards
- looked at 38 treatment records of patients
- carried out checks on the medication management on the four 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 carers we spoke with were very positive about the service. Patients on Bergamot were able to comment on the ward and the staff and told us the ward was very clean and homely and that the food was good. Visitors to other wards were equally positive. The overwhelming view from patients and visiting relatives was that the staff were very good, that they listened to patients and attended to them, understood them and were calm and patient. One person noted that while the environment may have its minor shortcomings, that was of little importance compared to the warm homely atmosphere brought about by the staff.

Good practice

All wards had 'All about Me' documents which gave a summary of patient's likes, dislikes, preferences, and life history and was used when a patient was discharged and may not be able to tell carers about themselves. It gave any new care setting a good personalised view of the patient to help ensure quality, person-centred care.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The service must ensure appropriate mental capacity assessments and best interests decisions are in place when administering medicines covertly for physical health conditions.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- Cleaning records were not always completed on Rosemary ward. Checks by the manager of the ward did not note this. Systems should be in place and used to ensure cleaning records are completed.
- The service should consider options for having a safe, therapeutic room for short periods for any patient who might be at risk to themselves or others.
- The service should ensure mental capacity assessments are always clearly completed. On Rosemary and Bergamot wards there were incomplete capacity assessments.
- The service should look further at ways to reduce the number of falls.

Birmingham and Solihull Mental Health NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

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.

- The service had a high compliance level in training staff in the Mental Health Act. The Trust target for Mental Health Act training was 90%. The wards for older people with mental health problems achieved 93.3% compliance.
- Staff knew where to access the trust's policies and procedures advice and support from the trust.
- Copies of Consent to Treatment forms were attached to medication charts where applicable.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely afterwards.
- There was a MHA administration team that staff could contact to get advice and support if required.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- There were quarterly and half yearly audits to ensure that the MHA was being applied correctly. The staff completed a weekly checklist and sent information to the Mental Health Act lead. They would then forward information to the MHA team who would monitor these to check compliance with the Mental Health Act.
- Patients could access the Independent Mental Health Advocacy services.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff training in the Mental Capacity Act (MCA) wasabove the trust target of 90%, standing at 91% across the service.
- Wards made DoLS applications appropriately. There was a policy on MCA including DoLS that staff were aware of and could refer to on the trust intranet.
- There was evidence of informed consent and capacity assessments on all the care records we looked at on Sage and Ashcroft wards. On Bergamot and Rosemary wards, some assessments were unclear or incomplete.
- Staff on the wards supported patients to make decisions where appropriate. Where they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff showed a good awareness of the capacity of patients with dementia to make specific decisions.
- Staff understood and where appropriate worked within the MCA definition of restraint. Staff understood that when providing personal care this may involve an element of restraint.
- However, some patients detained under the Mental Health Act were given medication for physical health reasons covertly without a mental capacity assessment or best interest decision.

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 layout of the wards allowed staff to observe most parts of the ward. There were concave mirrors in strategic points to assist in viewing otherwise less visible areas.
- Anti-ligature fixtures were in place and regular risk assessments highlighted any issues of concern. These were mitigated by observations. Observations were in place for patients assessed as at risk. Where people had dementia, some fixtures such as anti-ligature taps did not support the environment being dementia-friendly, as taps were not of a type patients were familiar with. Staff supported patients in using these.
- The service complied with guidance on same-sex accommodation. Rosemary ward was a service for female patients while Sage ward was for male patients. Ashcroft and Bergamot were mixed gender wards but both had rigid separation. There were bath and shower facilities on each corridor where facilities were not en-suite. On Ashcroft, the wards were separated by locked doors. Specific activities on all wards were mixed gender.
- Clinic rooms were clean, well-maintained and contained accessible resus equipment and emergency drugs that were checked regularly.
- There was no seclusion room in the service.
- All wards were clean, well maintained and with good furnishings.
- PLACE assessments showed high scores in areas of cleanliness (PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public - known as 'patient assessors'. They focus on different aspects of the environment in which care is provided). In respect of cleanliness, Ashcroft scored 100% and Juniper 99.6%. This high level of cleanliness reflected our observations during our visit. In respect of condition, appearance and maintenance, all four sites within this core service scored above the national average for this trust type. Three out of four sites scored 100%.
- Infection control was a high priority, as reflected by the environment and staff reminders to cleanse hands. There were constant reminders, both verbal and by posters and notices, to practice good hygiene.
- Equipment was well maintained and tested where appropriate. Items such as hoists and special baths were all regularly checked, with visible stickers to show when the next checks were due.
- Cleaning records were up to date and demonstrated that the environment was regularly cleaned. The only exception to this was on Rosemary ward. Here there were frequent gaps in equipment cleaning records. It was not clear if this represented a failure to clean regularly, or a failure to regularly record cleaning was taking place. All equipment and areas we observed were clean, leading to the probability that records were not accurately reflecting the work that had been done.
- All nurses had personal alarms so they could summon help quickly if required. There were call alarms in bathrooms on Ashcroft. If a patient needed an alarm, or considered they would benefit from one, they would be given one to use, subject to a risk assessment. Where the ward assessed a patient as being a high level of risk, corresponding levels of observations were in place.

Safe staffing

- Wards were staffed at levels of five nursing staff in the morning, five in the afternoon/evening, and four at night. Of these, at least two were qualified nurses with support from at least three health care assistants. These were numbers agreed by the service in order to meet the needs of patients. Additional staff were rostered where additional support was required to meet observation requirements for patients.
- Establishment levels for the service were 53.5 qualified nurses, and 53 healthcare assistants.
- Figures from the trust for 2016 showed no vacancies for nursing assistants. The service had 8.5 vacancies for registered nurses in December 2016.
- Twenty per cent (587 out of 2,922) of all qualified nurse shifts and 31% (1923 out of 6,163) of all nursing assistant shifts were filled by bank or agency staff. Much of this was to cover for additional observations. All of the bank

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staff that we spoke with during our inspection were experienced and knew the patient group well with either being ex-staff or existing staff who were doing an additional shift.

- From December 2015 to December 2016, staff sickness averaged 8.6%. On individual wards, there were a small number of staff on long-term sickness which accounted for much of the overall sickness.
- From December 2015 to December 2016, staff turnover averaged 10%. Many of the staff we spoke with had worked for the service for many years. The closing of Hollyhill unit in June 2016 and the subsequent movement of staff following that closure had an adverse effect on turnover figures.
- Ward managers were able to adjust staffing levels daily to take account of patient need. This was principally when additional staff were required for observations.
- There were sufficient staff so that patients could have regular 1:1 time with their named nurse or healthcare assistant. Staff told us healthcare assistants were usually more able to spend individual time with patients.
- Escorted leave or ward activities were rarely cancelled because there were too few staff.
- There were enough staff to safely carry out physical interventions. Discussions with staff and observations on the ward showed that a large proportion of physical interventions were planned in advance, as they were part of providing necessary personal care that the patient may not at times be agreeable to, such as toileting or bathing. Sufficient staff were made available to carry these out.
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. Staff and ward managers consistently informed us that they could summon assistance from a doctor promptly.
- Staff received and were up to date with appropriate mandatory training. The average mandatory training rate for staff was 96%, which was above the trust target of 85%.

Assessing and managing risk to patients and staff

- Patients were risk assessed on admission and risks were updated and amended regularly and after any incident.
- There were no unjustified blanket restrictions **other than the trust wide policy of searching patients on admission and on return from leave.**
- . Patients' rooms were locked only at their request. Patients could access snacks and drinks at any time upon request. Access to the garden area was restricted, because of the risks of falls. Patients wishing to use the garden area would be accompanied or observed by staff.
- There were very few informal patients. Most patients were detained under the Mental Health Act or under Deprivation of Liberty Safeguards (DoLS). We saw notices informing informal patients they could leave the ward if they wished. Extra staff were deployed when required for additional observations.
- We saw good practice in observations, with staff interacting positively with patients as part of the observation, and ensuring that patients requiring observation were in receipt of it.
- Between December 2015 and December 2016, there were 197 episodes of restraint on the four wards. There were 18 on Ashcroft involving 6 patients, 45 on Bergamot involving 16 patients, 76 on Rosemary involving 12 patients and 58 on Sage involving 16 patients. There were no incidents of mechanical restraints being used. One patient told us they had never been restrained, but had 'seen patients gently restrained or escorted to their room to calm down.' We saw several incidents of challenging behaviours dealt with calmly and effectively, using distraction, re-direction and re-assurance. Other restraints occurred when patients were given personal care that they were resistant to. This was the case when some patients required showering or assisting with hygiene. We overheard such a situation taking place in a private area and staff were managing the situation in a calming and sensitive manner. Of the restraints on the four wards between December 2015 and December 2016, 46 were prone restraints. There were none on Ashcroft; 11 on Bergamot; 8 on Rosemary and 27 on Sage. Ward managers and staff that we discussed these with all explained how prone restraints were in accord with policy on giving intramuscular rapid tranquilisation safely. Patients receiving this were in a prone position for the minimum time, (generally less than a minute), required to give the injection and were then supported to move to a more comfortable position, usually sitting on a chair.
- The overall number of incidents of rapid tranquilisation was 94. Rapid tranquilisation was in accord with trust

Good

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policy, which followed NICE guidelines. Staff involved followed pharmacy training and monitored in accord with guidelines relating to the use of rapid tranquilisation with older people.

- Trust figures showed that between December 2015 and December 2016, there were four episodes of seclusion. Three of these were on Sage ward, and one on Rosemary ward. Staff consistently told us that patients' rooms or quiet rooms were used when seclusions had taken place. These were in fact more akin to short-term segregations, with patients being kept away from other patients when they might be a risk to them, either physically or by upsetting them with particular behaviours. By referring these incidents as seclusions, the service was ensuring safeguards were in place for the patients in terms of monitoring their well-being and the duration of their segregation. Any such segregation was recorded as a seclusion on the trust electronic recording system, and monitored and reviewed in accord with seclusion policy. Where the service had been concerned about secluding a patient on Sage ward they had had contacted the local authority safeguarding team who had been satisfied they were taking appropriate measures and monitoring to ensure the patient was safe, and did not consider it met the threshold as a safeguarding concern. Nevertheless, staff recognised that a purpose –designed de-escalation room would be preferable. The clinical nurse manager for the service told us that this issue was on the risk register, and there were plans to visit a service that had such a room to see what might be most suitable.
- There were no recordings of long-term segregation within the service.
- Between December 2015 and December 2016 there were five safeguarding referrals, three concerning Bergamot, and one each for Sage and Rosemary wards. Staff we spoke with were clear about making safeguarding referrals and were able to explain the process. One long-standing member of staff felt the safeguarding policy was very good, that alerts were raised promptly and "everything was in place within hours."
- There was good medicines management with medicines stored and dispensed appropriately. All stock we looked at was within expiry dates, fridges were maintained at suitable temperatures and controlled drugs were stored and dispensed appropriately.
- Staff we spoke with acknowledged that it was not always possible to prevent falls where patients wished to be mobile without fully appreciating their own vulnerabilities. Staff felt they worked hard and often successfully to limit the number of falls in a very vulnerable patient group, and the service had brought in strategies to help reduce incidents. As soon as possible after a fall was recorded, a falls 'huddle' took place, whereby relevant staff and clinicians met to discuss the cause of the fall, and whether medication, footwear or other reasons were factors. This helped the service actively pursue ways of minimising falls for that patient, and for patients generally. Examples were given how particular factors were isolated and strategies put in place to minimise further falls for patients.
- Waterlow scoring charts were used to indicate risk of skin pressure areas developing Pressure areas risks were monitored with daily skin inspections. Referrals were made to the tissue viability nurse who visited the wards regularly and when required.
- There were rooms set aside for visiting outside the patient area of the wards, allowing families with children to meet loved ones away from other patients.

Track record on safety

- The trust reported that there were no serious case reviews in the past 12 months that were relevant to this core service
- There were nine serious incidents related to this core service during the period 1 November 2015 to 31 October 2016. The highest number of serious incidents was in the category of 'slips/trips/falls meeting serious incident criteria' with seven (78%). Rosemary ward had the most serious incidents with five. After each falls incident, a falls 'huddle' took place, at which professionals shared their experience, ascertained the cause of the fall, and worked together to minimise the risk of it recurring.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew what to report and how to report it. We discussed examples of how an incident such as a fall was managed and how it was recorded and reported. We discussed examples of incidents that were reported with managers. It was evident that staff erred on the side of caution in reporting.

Good

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- We discussed examples that showed that staff were open and transparent and explained to patients if and when things went wrong. This was confirmed by comments from patients and carers who told us they were kept informed of any incidents and concerns regarding their families.
- Staff discussed examples of where they had received feedback on incidents from other parts of the service and the trust. Staff told us the nature of this feedback was dependent on the nature of the incident and the relevance of any lessons. Some issues were discussed at handovers, others in supervision. A consistent theme from discussion with staff was that ward managers were approachable if staff had any queries about incidents.
- We were given examples of how learning was shared, with the aim of improving practice following incidents. These could be either incidents on the ward or ones that had happened elsewhere but still had relevance to practice on the ward.
- Staff were offered debriefing and support after serious incidents. Staff said they discussed any incidents as part of reflective practice, and consistently told us ward managers were very approachable if they wished to discuss any incidents that had occurred.
- The service had recognised that some incidents, particularly falls, had taken place when staff were called away to assist other staff. This had led to the introduction of red cards, carried by staff who were to oversee particularly vulnerable patients. Having a red card meant they were to remain with the patient, or hand the red card to another staff member who would take over.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- We looked at a sample of 38 care records on all four wards. These showed that comprehensive assessments took place following admission and that physical health care checks took place promptly and there was ongoing monitoring of physical health problems.
- Care records were up to date, personalised and included patient's views where these were forthcoming. If a patient was unwilling to provide views, this was stated.
- Care plans were holistic and recovery-oriented. Patients were given copies of their care plans on wards. On dementia wards care plans were displayed next to the patient's bed and carers could have copies of them upon request.
- Care records were stored electronically and were available to all staff. The only exception to this were agency staff, who had to ask permanent staff to update any care records. One member of staff we spoke with mentioned this as a distraction form their work, and felt it would be more efficient if agency staff who were competent to do so had access to input daily notes on the electronic system.

Best practice in treatment and care

- Staff prescribing medication were aware of required practice in line with National Institute for Clinical Excellence (NICE) guidelines on the use of antipsychotics for people with dementia.
- The service had access to psychology support with a psychologist being on wards for specific days. We spoke with the psychologist and they gave examples of work they did with individual patients to improve their well-being and minimise unhelpful behaviours and also to help staff recognise and understand causes of particular behaviours. One example discussed showed how psychology input was helping a patient with anxiety management.
- Patients had access to physical healthcare, including specialists as required. Where patients found it difficult to continue using their own dentist, a community dentist was available. A trust podiatrist visited patients requiring specialist foot care. In addition, a number of staff were trained to provide nail care to patients. Patients maintained their own GPs. Where patients stayed for longer periods, as on Ashcroft, they could register with a local GP. When acute hospital care was needed, a doctor would refer them to the local acute hospital. Staff would support patients as required. Trust physiotherapists were available as required and would assist in supporting safe mobility for patients.
- Patients' hydration and nutrition was monitored. We saw monitoring charts in regular use and food and drink was regularly available and offered to patients.
- Wards used recognised rating scales such Waterlow and HONOS to assess and record severity of need and outcomes of treatment. Staff were familiar with and used these and they helped inform care reviews and discharge plans.
- Clinical staff participated in clinical audits, particularly of care recording, ensuring these were completed fully. These had helped identify any shortfalls and help staff ensure they were completed fully. The service was also involved in clinical audits undertaken by the trust.

Skilled staff to deliver care

- There was a full range of mental health disciplines and workers to provide input to the services such as pharmacy technicians, a social worker and occupational therapists.
- Many staff were very experienced, having worked on wards within the service for many years. Health care assistants told us of the training they could access and how those who wished to were working towards further qualifications.
- Staff received appropriate induction. We spoke with two recently recruited staff who were able to tell us how induction processes had equipped them for their roles.
- We saw records of supervision and appraisals on each ward. These showed that both were taking place regularly. All staff we spoke with told us they had regular supervision, and in addition, they could see the manager or any senior member of the team regarding any issue for which they needed advice or support.
- Figures provided by the trust showed that non-medical staff were regularly receiving appraisals, with monthly figures for all wards showing over 90% of staff requiring appraisals receiving them that month.
- Staff training between December 2015 and December 2016 was above trust targets in almost every instance, with rates of 90% and above in most cases. Where there were minor shortfalls we found these had been

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.

addressed by the time of our visit. Staff received dementia care training. Staff also received specialist training such as dementia care, peg feeds, sepsis and nail care.
- We discussed with ward managers how they dealt with poor performance. Examples discussed showed that these were dealt with promptly and effectively and in ways that allowed the member of staff to improve to an accepted level.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary meetings on each ward. We observed one which involved a good mix of professionals.
- We observed effective handovers within each team. Essential information was conveyed efficiently and effectively, verbally with the assistance of printed out summaries.
- There were effective working relationships with other teams in the organisation with good lines of communication and contact with community teams. One ward manager told us of their regular meetings with the manager of the community mental health team. On Ashcroft, we saw good brief information sheets on each patient used for when patients were discharged to a care home or community setting, highlighting their needs, preferences and interests.
- A Community Enablement and Recovery Team provided intensive support for people at home. This was tailored to individual need and was aimed at facilitating discharge from wards and helping prevent admissions to either acute or mental health wards.
- The ward manager gave an example of positive working with the local safeguarding team, after the ward had raised a safeguarding alert. The team came out to assess and were happy with the actions taken by the ward.
- Wards would support patients who required support if they had to go to a general hospital, and the community mental health team liaised with the service to help ensure moves to care homes were successful and to provide additional support where necessary.

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

- The Trust target for Mental Health Act training was 90%. The wards for older people with mental health problems achieved 93.3% compliance. All wards within the service achieved the trust target other than Rosemary Suite, which reported a compliance rate of 83.3%. Training was undertaken on a three yearly basis. Nurses we spoke with showed a good awareness of the Mental Health Act.
- Copies of consent to treatment forms were attached to medication charts where applicable.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely afterwards. We saw this recorded in care records.
- There was a Mental Health Act administration team which staff could contact to get advice and support if required.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- There were quarterly audits to ensure that the Mental Health Act was being applied correctly. The staff completed a weekly checklist and sent information to the Mental Health Act lead. They would then forward information to the Mental Health Act team who would check it. We saw copies of the most recent monthly monitoring of these (February 2017) that showed full compliance where applicable. These included the examination of Mental health Act papers on admission. These also showed section 17 leave records were completed.
- People had access to the Independent Mental Health Act Advocacy (IMHA) services and staff knew how to access and support engagement with the IMHA to capture the wider issues of referrals, capacity issues, access to wards/records, re-referral if necessary.

Good practice in applying the Mental Capacity Act

- As at 17 January 2017, the overall compliance rate for Mental Capacity Act (MCA) training course across the core service was 91%; this was above the trust target of 90%. All wards within this service achieved the trust target of 90% compliance, other than Rosemary Suite, which reported a compliance of 77%. The frequency for this training course was three years.
- Trust figures showed there were 76 Deprivation of Liberty Safeguards applications made in 12 months from December 2015 to December 2016. These were highest in Rosemary ward (29) and Sage ward (31).
- There was a policy on Mental Capacity Act, including DoLS, which staff were aware of and could refer to on the trust intranet.

Are services effective?

Requires improvement

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

- We saw evidence of informed consent and capacity assessments on all twelve care records we looked at on Sage and Ashcroft wards. On Bergamot ward, we sampled six records in respect of capacity and assessment. All contained some incomplete information relating to consent and capacity assessments. For example, one patient's assessment form stated the patient 'does not engage' without clarifying how this meant that they lacked capacity. On Rosemary ward, we sampled five records in respect of capacity and assessment and found two of these had incomplete capacity assessments. There were also examples of assessments where no clear reasons were given as to why the decision was made.
- On all wards, patients were supported to make decisions where appropriate. Where they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff showed a good awareness of the capacity of patients with dementia to make decisions. For example, at mealtimes they would offer them direct choices, and used their knowledge of patients' preferences to be aware of what they were likely to opt for.
- Some patients had been correctly prescribed medication given covertly for their mental health as detained patients under the Mental Health Act. However, they had also been prescribed medicines for their physical health which was also given covertly. This can only be done after an assessment has found them to be lacking capacity and a best interest decision has been made. Prescribers in this service appeared unaware of this need.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff understood that when providing personal care, this may involve an element of restraint, as dementia patients at times did not understand or appreciate the need for personal care, or their need to be assisted in this.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed extremely positive interactions between staff and patients throughout the inspection. Staff showed a good knowledge and understanding of individual needs of patients. When patients showed signs of distress, staff were able to support them. Similarly, when patients started to become agitated, staff were able to divert them and de-escalate potential aggression.
- One patient told us staff were polite and kind and respected patient privacy. One carer commented that while the environment at Ashcroft could be improved, they felt strongly that the important thing was the approach of the staff and felt this could hardly be bettered, with staff doing all they could to make things homely. This was echoed by comments from two patients on Bergamot, who said they really appreciated the fact that the ward was more like a home than a hospital.
- Under the PLACE assessment scores for dignity and privacy, Juniper scored 96.6% and Ashcroft scored 94.4%. These high scores reflected our observations and by feedback from patients and carers we spoke with.
- We saw examples of the service caring for patients around the clock, allowing for their differing sleep patterns. One patient was in darkened room at 10am, to allow for natural waking. This was in accord with individual preferences. Staff showed a good awareness of which patients did not want waking or disturbing at particular times.

The involvement of people in the care they receive

- Staff welcomed patients and explained to them why they were on the ward. Information leaflets were available to welcome and explain services and facilities. For dementia patients, orientating, explaining and re-assuring was an ongoing process. We saw staff taking time to reassure and provide explanations to patients throughout our visit.
- Patients on functional wards were involved in risk assessment and planning. On dementia wards, relatives told us they were involved and consulted on care and treatment. We saw patients encouraged to maintain independence. At mealtimes for example, patients were given choices and supported, with appropriate utensils, in order to be as independent as possible.
- There were information leaflets advising patients of the available advocacy services.
- Carers we spoke with told us they were kept informed and asked their views on treatments and were also a valuable source of information regarding a patient's life history, their preferences and dislikes.
- We did not see evidence of recent surveys for the service. There were however, patient and carer meetings. Ashcroft ward had weekly patient meetings, these had been extended to include carers. These were recorded in minutes of the meetings. Many of the issues raised included individual food preferences, which the service then amended menus to comply with these. One issue concerned a patient saying they were cold at times. The service responded by ensuring the patient was helped to sit in a warmer spot, near a radiator. For those less able or willing to participate in meetings, a staff member would spend one to one time with them, using pictures if needed to gauge their preferences. Dementia wards had weekly visits from Admiral nurses, who would talk with carers and patients, give support and identify areas where further support or action was needed, and feed these back to the ward. Issues such as lost items or menu changes would be actioned by the ward.
- We saw a very good example of advance decisions made by a patient in anticipation of them not having capacity at some point in the future. Ashcroft had an 'All about me' document which gave a summary of patients, their likes, dislikes needs and life history, designed for when they moved to another setting, so that setting would have relevant information to inform good quality care.

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

- The trust provided details of bed occupancy rates for the wards between 01 December 2015 and 30 November 2016. The service had an average bed occupancy of 98%. The individual percentages were Ashcroft 97%, Bergamot 102%, Sage 97% and Rosemary 97%
- There were no out of area placements relating to this core service between 01 December 2015 and 30 November 2016.
- From December 2015 to December 2016, the average lengths of stay were as follows; Ashcroft: 854 days; Bergamot 87 days; Rosemary 127 days and Sage 72 days. Hollyhill had an average stay of 1214 days until its closure. The high level of average stays on Ashcroft was due to patients having moved from Hollyhill who had been on the ward for several years. There were patients on Ashcroft for whom it was very difficult to find suitable alternative placements. This was an issue discussed with staff and carers. Carers, particularly on Ashcroft, were concerned that no other local setting would be able to meet the patient's needs as effectively as their current placement.
- There was access to a bed on return from leave. One patient had been on extended leave to another care setting. As a result of concerns that the placement might break down, the bed had been left open for them. This bed was now considered ready for use, as the patient was assessed as having settled in their new home.
- 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. The only examples we saw where patients had been moved was where it had become clear their needs were of a dementia rather than functional nature, or vice versa and that their needs were best met on a different ward. When patients were moved or discharged, this happened at an appropriate time of day.
- In the 12 months from December 2015 to December 2016, there had been no delayed discharges from Ashcroft unit; 13 delayed discharges from Bergamont ward; 28 delayed discharges on rosemary ward and 28 delayed discharges on sage ward. Delayed discharges were caused by the lack of suitable nursing or care beds being available in care homes to meet the particular needs of patients being treated by the service.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms and equipment to support treatment and care. The three wards on Juniper unit shared therapy rooms that were outside the wards, but within the main unit. This allowed patients from the three wards to mingle whilst undertaking positive activities. We saw evidence of positive activities benefiting patients, such as a walking group, where staff escorted a small number of patients on a walk through the pleasant grounds around Juniper unit. All the patients returned in a positive frame of mind, having enjoyed the walk. Wards had a good range of rooms for patient activities. However, unless directed to different areas for various activities, patients tended to congregate in the lounge areas. The lounge areas on Juniper unit were rather cramped, with a large number of patients gathered in there with staff. At various times when we looked in there were few or no empty chairs.
- Occupational therapists and occupational therapy assistants were responsible for the majority of activities and they worked independently of staff pressures in wards. On Juniper we saw off-ward activities taking place.
- There were designated quiet areas on the wards and a designated room where patients could meet visitors, including children.
- Patients had access to pleasant garden areas. However, as most patients were assessed as unable to be safely outside unless escorted, access to the outdoor area only took place if staff were able to accompany patients.
- We sampled food on two wards, at the ward's invitation, and found the food to be freshly prepared, tasty and nutritious. Comments from patients and carers we spoke with were positive about the food. Each ward had a dining area for patients. Patients could also eat in their own rooms at their request. Some patients took this option, and were supported by staff to eat as required. On the most recent PLACE survey for food, the service scored better (98.5%) than both the national average (91%) and the trust overall score (98%).
- People were able to request, or have staff help them to make, snacks and drinks at any time of day or night.

Are services responsive to people's needs?

Good

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

- Patients were able to personalise bedrooms. This was more evident, not surprisingly, in rooms where patients were staying longer. One patient had their room adorned with paraphernalia of their favourite football team.
- Wards offered lockable facilities where patients could store items of value.
- We saw activities taking place, particularly on Juniper unit, where activities took place both on and off wards, with wards participating jointly in activities in a separate activity area. There were schedules of activities on wards. Activities were tailored to the interests of patients. Occupational therapists led activities which were able to help rekindle interests and skills. There was a gardening group using an outdoor area on Rosemary ward.

Meeting the needs of all people who use the service

- Wards were accessible to people with disabilities. Many patients had age-related impairments. There were wheelchair users on wards; there were two on Sage ward at the time of our visit. There were hoists and other specialised equipment available and maintained, ready for use when required. There were assisted bathrooms, showers and suitable grab rails and handrails. Special utensils and cups were available for assistance as required. Suitable beds, mattresses and crash mats were widely in use to assist mobility and comfort and reduce risks from falls and pressure sores. In respect of disability and dementia, both Ashcroft and Juniper scored above the national average for this trust type in the most recent PLACE survey. Ashcroft scored 96.3% for dementia and 98.1% for disability, and Juniper scored 88.4% for dementia and 96.1 for disability. These compared with trust figures of 84,8% and 89% and national averages of 82.9% and 84.5%.
- Each ward had leaflets and information on display regarding local services, patients' rights, and how to complain. In dementia wards, these were mainly available outside the patient area, being intended primarily for relatives and carers. Posters and information intended directly for patients were available inside the wards. Ward managers told us all trust information leaflets could be printed on demand in different languages using the trust's IT system.
- Staff told us that they could access translators and interpreters if needed.
- All wards had choices to meet dietary and other specific needs. Kitchen staff had lists of all such requirements, and these guided the preparation of individual meals. Thickened fluids and special diets were in place for patients with swallowing difficulties. The Speech and Language Team (SALT) provided assessments and supported treatment for those with swallowing difficulties.
- There was good access to spiritual support. Each ward had a spiritual room. A visiting chaplain explained how all denominations were supported by regular visits by a variety of representatives.

Listening to and learning from concerns and complaints

- Trust figures showed that no formal complaints were received by this service between December 2015 and December 2016. We looked at complaints and compliments books on wards. These showed very few complaints and these were all dealt with informally on the ward.
- Patients and carers we spoke with told us they were able to raise concerns or complaints. Staff on one ward told us of their regular patients' meeting, where patients could raise issues. A patient and a carer told us they knew how to complain, but could find very little to complain about. Admiral nurses visited the dementia wards regularly and passed on to the ward for action any concerns raised by patients or carers.
- Staff told us carers would comment on missing items, which staff would attempt to locate. We discussed with ward managers whether they should record such comments as informal complaints. This would give managers a clearer picture of what issues were regularly occurring and might need addressing.

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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

- We saw posters detailing the trust values. Staff worked in accord with these. Staff knew and agreed with the organisation's values and felt positive about leadership for the older adults' wards. Staff demonstrated these values in the way they treated patients with dignity and respect throughout all aspects of the care they were giving.
- Staff were aware of senior managers and said that senior management visited wards. They were aware of the immediate service managers and no staff told us they felt isolated or ignored by the trust.

Good governance

- Systems within the wards were effective in ensuring that staff received mandatory training, were appraised and supervised.
- The service was involved in trust wide audits, and also conducted local audits. Band 6 nurses audited care plans to ensure they were holistic, person-centred and contained all necessary information. The care plans we sampled met these standards. Audits showed the number of falls occurring on wards, and prompted multi-disciplinary work to reduce these.
- Wards were covered by a sufficient number of staff of the right grades and experience. There were high numbers of bank and agency staff used. These were primarily to provide additional staff to cover when high levels of observation were required. The service used bank staff who were familiar with the wards.
- Incidents were reported and staff learnt from incidents and feedback. There was learning from incidents that were communicated across wards.
- Safeguarding procedures were followed.
- As there were few recorded complaints, there was little evidence of learning from these.
- Our observations saw staff interacting with patients, as opposed to being busy on administrative tasks.
- Mental Health Act and Mental Capacity Act procedures were followed. However, there were no governance processes in place to identify that staff were not completing mental capacity assessments or best interests decisions before covertly administering patient medication.
- The service used Key Performance Indicators (KPIs) and other indicators to gauge the performance of the service in areas such as discharge planning, length of stay and care plan completions. The measures helped inform teams if there were areas to improve upon and were used by the staff team who develop active plans where there were issues.
- Ward managers consistently told us they had sufficient authority and administrative support.
- We were given examples of items that had been submitted to the risk register, such as the vacancies for four nurses. Managers told us this was now being resolved by successful recruitment.

Leadership, morale and staff engagement

- Sickness and absence rates were below the national average. When a small number of instances of long-term sickness were taken into account, general sickness levels were very low.
- There were no bullying and harassment cases reported.
- Staff were able to tell us how they would use the whistle-blowing process and told us they felt able to raise concerns without fear of victimisation.
- Good staff morale was indicated by positive comments we had from all staff we spoke with.
- Staff told us that there were opportunities for staff who wished to develop further. Health care assistants told us of the training they could access and how those who wished to were working towards further qualifications.
- Staff were very positive about the teams and the support they were able to get and give.
- Staff gave examples that showed they explained to patients when things were not going well. This tended to be about particular problems and lack of progress, rather than things actually going wrong. Carers and patients we spoke with told us staff were open and transparent about patients.
- Staff told us they could give feedback to service development but were unsure as to whether this had any effect.

Commitment to quality improvement and innovation

- The Wards all had Accreditation for Inpatient Mental Health Services (AIMS) at 'level 1 excellent'.
- The wards are part of the Dementia friendly hospitals network

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.

- The wards are taking part in the Prime Minister's National Dementia Challenge
- Dementia awareness training for paramedics was provided. Training for taxi contractors and carers support was delivered in places such as John Lewis in Birmingham
- Wards used the Royal College of Physicans National Falls Bundle to reduce falls.

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
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11HSCA (RA) Regulations 2014 Need for consent Patients were being given medication covertly for physical health reasons without a mental capacity or best interests meeting having been undertaken for that medication. This was a breach of regulation 11(1)