Kent and Medway NHS and Social Care Partnership Trust

Wards for older people with mental health problems

Quality Report

Jasmine Unit
Darenth Wood Road
Dartford
Kent
DA2 8DA
Tel: 01322 421275
Website: www.kmpt.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)
RXYJ1		Jasmine ward	DA2 8DA

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership 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 Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust.

Summary of findings

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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Overall summary

We carried out a focused inspection of Jasmine ward on 17 April 2018, following concerns we had received through intelligence monitoring, a Mental Health Act review visit and from carers and relatives of patients. Concerns included poor monitoring of the physical health of patients and of their state of nutrition and hydration and staff's response to patients whose physical health was deterioration of, poor risk management, the safety of the ward environment and lack of family and carer involvement. The ward was last inspected in January 2017 as part of a comprehensive inspection. At the comprehensive inspection, we rated the wards for older people with mental health problems as 'good' in all key lines of enquiry of safe, effective, caring, responsive and well led.

During this inspection, we found the following areas of good practice:

- The ward had implemented a safe transfer to A&E protocol which was a collaboratively designed by both staff on Jasmine ward and the general hospital. This meant patients were not left waiting in unfamiliar surroundings which could add to their distress. Staff on Jasmine ward had developed strong links with specialist services.
- For patients with functional mental illness, staff were in the process of developing a tool and pilot to the use of 'one-page profile' was due to commence. The trust had a drive for a person-centred culture and to help reduce stigma, staff were also completing their own 'one-page profile'.
- Risk assessments and risk management plans were fully completed and detailed. Staff carried out risk assessments with patients, who had mental capacity to engage with this, within 72 hours of admission to the ward and regularly throughout their care and treatment.
- The trust had undertaken work to the ward environment to enable patients living with dementia. Toilets had red seats to contrast with the wall and floor. The use of clear colour contrasts on the ward helped define important aspects of the environment.
- Staff were aware of safeguarding procedures and protecting patients from abuse. Improvements to safety, mitigation of future risk and learning from incidents was evident. We saw evidence of changes made because of incidents.
- Staff carried out a range of assessments with patients on admission to the ward and throughout their care and treatment. Patients were involved in their care and had individualised care plans to support all areas of their recovery. All patients had a comprehensive physical health assessment. Physical healthcare needs were incorporated into care plans and were comprehensive and detailed.
- The multidisciplinary team had regular handovers and clinical meetings to ensure they were providing consistent evidence based care to patients. They delivered patient-centred care that was open, transparent, and inclusive of the individual.
- Staff were supportive and respectful towards patients and displayed a genuine interest in their recovery.
- Compliments and complaints were uploaded to datix and analysed by the trust complaints team.

However, we also found the following areas for improvement:

- The door to main entrance of the ward was a known concern to staff and the trust. The door did not close securely and staff had to ensure they checked when entering or exiting the ward that it was secured. However, proposed building works were in the planning stages.
- There was no de-escalation room on the ward. This meant that when patients were displaying signs of distress, agitation or unsettled behaviour, there was no designated space available to offer a calming, safe and low stimulus environment.
- The ward had some ligature risks present in the communal areas and patients' bedrooms. Although these were identified on the ligature audit, they were

assessed as no risk present and because of this no action was taken or considered to mitigate risk. We brought this to the attention of the ward manager and immediate action was taken by the trust.

- There was no direct provision of physiotherapy for patients on the ward, unlike some of the trusts other older persons inpatient wards. However, patients could be referred to physiotherapy at the local hospital.

Summary of findings

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

Are services safe?

We found the following areas the trust needs to improve:

- The door to main entrance of the ward was a known concern to staff and the trust. The door did not close securely and staff had to ensure they checked when entering or exiting the ward that it was secured. However, proposed building works were in the planning stages.
- The ward had some ligature risks present in the communal areas and patients' bedrooms. During the inspection, there were metal grills throughout the ward which had been installed to cover wall-mounted thermostats. Although these were identified on the ligature audit, they were assessed as no risk present and because of this no action was taken or considered to mitigate risk through removal, restriction or control by other means. We brought this to the attention of the ward manager and immediate action was taken by the trust to remove the metal grills.
- There was no de-escalation room on the ward. This meant that when patients were displaying signs of distress, agitation or unsettled behaviour, there was no designated space available to offer a calming, safe and low stimulus environment.

However, we found the following areas of good practice:

- Risk assessments and risk management plans were fully completed and detailed. Staff carried out risk assessments with patients, who had mental capacity to engage with this, within 72 hours of admission to the ward and regularly throughout their care and treatment. The multidisciplinary team reviewed risks and discussed changes to as part of the patient's multidisciplinary ward round review.
- Staff were aware of safeguarding procedures and protecting patients from abuse. The trust had a safeguarding lead and the ward manager had good links with external safeguarding services.
- The trust had undertaken work to the ward environment to enable patients living with dementia. Toilets had red seats to contrast with the wall and floor. The use of clear colour contrasts on the ward helped define important aspects of the environment.
- Staff shift-to-shift handover meeting were detailed and comprehensive with discussion of individual risks and management plans for each patient

Summary of findings

- Improvements to safety, mitigation of future risk and learning from incidents was evident. We saw evidence of changes made because of incidents.
- All staff except occupational therapists wore uniforms. Staff told us they would prefer to wear a uniform and felt this would better support the patients and visitors to the ward in identifying them as a member of their therapeutic staffing team.

Are services effective?

We found the following areas of good practice:

- Staff carried out a range of assessments with patients on admission to the ward and throughout their care and treatment.
- Patients, where possible, were involved in their care and had individualised care plans to support all areas of their recovery. These plans were reviewed regularly by the multidisciplinary team with patients' and families.
- The ward had appropriate systems in place to assess, monitor and review the physical healthcare needs of patients. All patients had a comprehensive physical health assessment. Physical healthcare needs were incorporated into care plans and were comprehensive and detailed.
- The multidisciplinary team had regular handovers and clinical meetings to ensure they were providing consistent evidence based care to patients. They delivered patient-centred care that was open, transparent, and inclusive of the individual.
- We saw evidence of effective working relationships with the local authority safeguarding team and general hospital. Staff on Jasmine ward had developed strong links with specialist services.

However, we found the following areas the trust needs to improve:

- There was no direct provision of physiotherapy for patients on Jasmine ward, unlike some of the trusts other older persons inpatient wards. However, patients could be referred to physiotherapy at the local hospital.

Are services caring?

We found the following areas of good practice:

Summary of findings

- Staff were supportive and respectful towards patients and displayed a genuine interest in their recovery. Staff demonstrated an excellent understanding of patients' individual needs and were committed and enthusiastic to improve patients' physical and mental health.
- Staff orientated patients to the ward and gave patients and carers an information pack.
- The feedback from patients, families and carers was positive. Families and carers were invited to ward round meetings and were kept up to date with information relating to their relatives care or treatment including physical health and any incidents. They felt their relative's health had improved since they had been receiving care on the ward.
- Staff enabled patients to be remain independent and be key partners in decision making about their care and treatment.

Are services responsive to people's needs?

We found the following areas of good practice:

- Details of how to make a complaint were included in the patient and carer welcome packs. The patients and carers we spoke with all knew how to make a complaint.
- The ward had a "you said we did" board. The board detailed the actions taken in response to suggestions, comments and complaints from patients and carers.
- Compliments and complaints were uploaded to datix and analysed by the trust complaints team.

Summary of findings

Information about the service

Kent and Medway NHS and Social Care Partnership Trust wards for older people with mental health problems provide care for people with organic mental disorders and for those with functional mental illness. An organic mental disorder is a form of decreased mental function due to a medical or physical disease, for example Alzheimer's disease and amnesia. Functional mental illness has a psychological cause and includes depression, schizophrenia and mood disorders.

Jasmine ward is a 16-bed mixed gender ward for older people with organic mental disorders and functional mental illness. There were 14 patients on the ward at the time of our inspection, five patients' living with dementia and nine patients with a functional mental illness.

We inspected nine wards for older people with mental health problems during a comprehensive inspection of the trust in January 2017. We rated the wards for older people with mental health problems as 'good' in all key questions (safe, effective, caring, responsive and well led).

Our inspection team

The team was comprised: three CQC inspectors, a nurse specialist advisor with expertise in older persons' mental health and an expert by experience.

Why we carried out this inspection

We undertook an unannounced, focused inspection of Jasmine ward following concerns we had received through intelligence monitoring, a Mental Health Act review visit and from carers and relatives of patients. Concerns included poor monitoring of the physical health of patients and of their state of nutrition and hydration and staff's response to patients whose physical health was deterioration of, poor risk management, the safety of the ward environment and lack of family and carer involvement.

As this was not a comprehensive inspection, we did not pursue all key lines of enquiry. As we only focused on concerns raised with us, we have not reconsidered the rating of this service.

How we carried out this inspection

During this inspection we considered aspects of the following key questions:

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

Before the inspection visit, we reviewed information that we held about this service.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with three relatives and carers
- spoke with the ward manager
- spoke with four other staff members; including occupational therapists, nurses and healthcare assistants

Summary of findings

- attended and observed a shift-to-shift hand-over meeting
- looked at 11 care records of patients
- 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

During the inspection, we spoke with four patients and three relatives and carers. Patients, carers and relatives were positive about their care or treatment and experience of the service.

Patients told us staff were supportive and caring. They felt involved in the planning of their care or treatment and staff were quick to respond to their needs whilst enabling them to be as independent as possible.

Relatives and carers told us they were confident in the care provided by staff to their relatives. They were invited to attend bi-weekly ward round meetings and were kept up to date with information relating to their relatives care or treatment including physical health and any incidents such as falls. They felt their relative's health had improved since they had been receiving care on the ward.

Good practice

The ward had implemented a safe transfer to A&E protocol which was a collaboratively designed by both staff on Jasmine ward and the general hospital. Patients who required assessment or treatment at A&E were transferred using a treatment room trolley specifically by staff who worked on the ward. Prior to taking a patient to A&E, staff on Jasmine ward would call the nurse in charge at A&E and seek advice when best to transfer the patient. This meant patients were not left waiting in unfamiliar surroundings which could add to their distress. Medics could liaise with the general hospital if a patient needed to be seen sooner and this was facilitated.

For patients with functional mental illness, staff were in the process of developing a tool and pilot to the use of 'one-page profile' was due to commence. Staff were keen this was a collaborative approach between staff, patients and families. The 'one-page profile' is more strengths based and so staff felt this was better suited to the patients' needs. The trust had a drive for a person-centred culture and to help reduce stigma, staff were also completing their own 'one-page profile'.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should review the fitting of an alarm on the main ward door to alert staff if not secured properly.
- The trust should ensure there is a suitable, safe and calming room available on the ward to de-escalate patients when needed.
- The trust should support occupational therapists who wish to wear a work uniform.
- The trust should review the provision of physiotherapy for Jasmine ward.

Kent and Medway NHS and Social Care Partnership Trust

Wards for older people with mental health problems

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Jasmine ward	Jasmine Unit

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 on Jasmine ward enabled staff to observe most parts of the ward. There were some restricted lines of sight but these were adequately mitigated through staff walking around the environment. We observed staff regularly monitoring patients' whereabouts whilst on the ward.
- The door to main entrance of the ward was a known concern to staff and the trust. The door did not close securely and staff had to ensure they checked when entering or exiting the ward that it was secured. There were plans to re-design the layout of the entrance to the ward with the addition of an air lock. At the time of the inspection, plans for the proposed building works had gone out for quotes but no start date had been confirmed. In the interim, notices were displayed on the main door advising of the need for staff to ensure the door is secured. However, as with fire doors, it was not clear why the trust had not considered putting a temporary alarm on the door to alert staff which would have helped minimise the risk of a patient exiting the ward unknown to staff. At the time of the inspection, there had been no incidents with entering or exiting via this door.
- The ward had some ligature risks present in the communal areas and patients' bedrooms. A ligature risk is an anchor point which patients can tie things from to assist self-harm. Staff were aware of most of these risks and most were clearly identified in the ligature audit that was carried out annually. The audit tool rated risks as part of the trusts ongoing ligature reduction programme. However, there were metal grills throughout the ward which had been installed to cover wall-mounted thermostats. Although these were identified on the ligature audit, they were assessed as no risk present and because of this no action was taken or considered to mitigate risk through removal, restriction or control by other means. We brought this to the attention of the ward manager who agreed with and acknowledged the concerns raised. Immediate action was taken by the trust and we were informed all metal grills were removed from the ward environment the day after the inspection.
- The service complied with the Department of Health guidance on same-sex accommodation. The ward admitted both males and females. Patient's bedrooms had en-suite toilet and shower facilities and there were designated zones to ensure that males and females had separate bedroom corridors which were locked.
- Assisted bathrooms were available in both male and female areas of the ward. There were shared toilet facilities on each corridor. All bedrooms and bathrooms contained call button alarms.
- The trust had undertaken work to the ward environment to enable patients living with dementia. Toilets had red seats to contrast with the wall and floor. This enabled patients with dementia to be as independent as possible and to distinguish from their surroundings and avoid potential falls and spills. The use of clear colour contrasts on the ward helped define important aspects of the environment. Bedroom doors were decorated in colour, and flooring and walls were subtle in colour and contrast.
- Bedroom doors had been designed to look like a 'front door' to help patients feel at home and create a familiar, welcoming environment, in keeping with everyday home life. Bedrooms were kept locked unless patients wanted to leave them open. There was a laminated photograph of each patient on their bedroom door and their named nurse was identified.
- There was no de-escalation room on the ward. This meant that when patients were displaying signs of distress, agitation or unsettled behaviour, there was no designated space available to offer a calming, safe and low stimulus environment. At the time of the inspection, staff we spoke with told us they were supporting patient's in their bedrooms or one of the meeting rooms located on the ward.
- During our tour of the ward, we observed symbols above each of the patients' bedroom doors. Staff we

spoke with told us they indicated patient needs and identified risk. For example, a falling star denoted that the patient was at risk of falls and a forget me not represented a diagnosis of dementia.

- Housekeeping staff kept the ward environment cleaned to a good standard.The ward was well maintained, as was the wall décor, furniture, fixtures and fittings. The corridors were clear and clutter free. During our tour of the ward, we spoke with staff about the lack of signage in the dining room. There were clear laminated signs encouraging patients to independently access drinks. However, there was no signage on the kitchen cupboards to support patients to know where items to make drinks were located. Staff took immediate action and placed both word and pictorial signs on the cupboards.
- The service had a safety alarm system. All staff carried a personal alarm which when activated alerted other staff that assistance was needed and in what location. This was an area for improvement identified at the comprehensive inspection in January 2017 which the trust had now taken appropriate action to address.

Safe staffing

- The ward had a minimum number of qualified and unqualified staff working on each shift. Staffing levels were regularly reviewed by the ward manager and were determined by the number of patients on the ward and their individual needs. Staffing consisted of two qualified nurses and four health care assistants during the day and two qualified nurses and three health care assistants at night. On the day of the inspection, the ward was fully staffed with the addition of a student nurse and two occupational therapists. Occupational therapists were supernumary so they could dedicate their time to providing activities with patients.
- Two consultant psychiatrists, a speciality doctor and a trainee doctor provided medical input to the ward. A duty doctor based at another site was available between 5pm and 9am weekdays and all-day on weekends. Staff we spoke with told us there have been occasions in the past when there had been a delay in the duty doctor attending the ward when required. However, staff were aware to contact an ambulance in an emergency and had forged good links with staff at the local general hospital.
- All staff except occupational therapists wore uniforms. Uniforms were different colours to differentiate staff roles and responsibilities. Information about different staff uniforms was displayed on notice boards for patients and carers. We spoke with staff from the occupational therapy team to ask why they did not wear a uniform. Staff told us they would prefer to wear a uniform and felt this would better support the patients and visitors to the ward in identifying them as a member of their therapeutic staffing team.

Assessing and managing risk to patients and staff

- We reviewed 11 patients' care records and found risk assessments and risk management plans were fully completed and detailed. Staff carried out risk assessments with patients', where they had capacity, within 72 hours of admission to the ward and regularly throughout their care and treatment. The multidisciplinary team reviewed risks and discussed changes to as part of the patient's multidisciplinary ward round review. We found that risk management plans summarised all risks identified, situations in which identified risks might occur and action to be taken in response to any crisis. Staff told us that, where risks were identified, measures were put in place to ensure the risk was managed. For example, observation levels of a patient might increase or decrease. Individual risk assessments considered the patient's previous history as well as their current mental state.
- Staff assessed patients' risk of developing pressure sores. They used the Waterlow score, which is a tool to give an estimated risk for the development of a pressure-related injuries. We saw many examples where patients' Waterlow score had decreased whilst receiving care or treatment on the ward. All patients' who were assessed at risk of developing pressure sores were provided with a pressure relieving mattress and barrier creams were used as a preventative measure.
- Staff assessed patients' risk of falls. A falling star was placed above the patient's bedroom to door to indicate if they were at risk from falls and pressure mats were available and in use on the ward. Incidents relating to falls were regularly reviewed and discussed by the multidisciplinary team.
- The trust had an observation policy in place. Staff we spoke with were aware of the procedures for the use of

observation. The multidisciplinary team determined the level of observation for each patient based on individual and clinical need. Nursing staff could increase the level of observation if required.

- We observed a staff shift-to-shift handover meeting which included a detailed discussion of individual risks and management plans for each patient
- Staff were aware of an increased risk on the ward due to the mix of people with organic mental disorders and for those with functional mental illness. Staff told us this could at times lead to an increase in physical assault and invading of patient's personal space. The concerns were on the risk register and staff continued to support and manage patients and risk through individual care plans.

Track record on safety

- We looked at the hospitals recording of serious incidents requiring investigation. Prior to the inspection, there had been two serious incidents raised in respect of Jasmine ward. In January 2018, a serious incident was reported regarding patient transportation to the emergency department at the general hospital. Improvements to safety, mitigation of future risk and learning from incidents was evident. A protocol was put in place which gave clear guidelines to enable staff to safely transfer patients to A&E. Staff from A&E supported the protocol and due to good working relationships between staff at the two hospitals, it was agreed that prior to transferring a patient to A&E, staff from Jasmine ward would call and speak with the nurse in charge at A&E and get advice on when best to transfer the patient. If a patient needed to be sooner there was a further agreement that the medics from both hospitals would communicate this and the patient would be seen. This meant patients were not waiting long periods of time in A&E in an environment that could be unsettling for them.
- In February 2018, a serious incident was reported regarding a patient managing to exit Jasmine ward, unknown to the staff. The patient was taken to A&E by police following a report from the public for the patient's welfare. Improvements to safety and learning took place. Changes to the ward environment and access to the ward via a fire door were immediately implemented. The observation policy was re-read by all staff to ensure they understood their responsibilities.
- The ward had adhered to duty of candour responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify clients (or other relevant persons) of 'certain notifiable safety incidents'. We saw evidence of this during the inspection in respect of both serious incidents reported. A letter was sent to the relative or carer explaining the nature of the incident, immediate action taken by the ward and details of further proposed actions. Relatives were invited to speak with the ward manager in person or via telephone call. The outcome of investigations was also communicated and any learning that had come because of the incident.

Reporting incidents and learning from when things go wrong

- There were appropriate systems embedded about safeguarding adults at risk. Staff regularly reviewed all safeguarding concerns and these were discussed during shift-to-shift handovers, as part of the wider multidisciplinary ward reviews, at team meetings and during staff individual supervision. Staff had received training in safeguarding adults at risk. At the time of the inspection, 26 staff had completed level one training, five staff had not. The ward manager was aware of this and regularly monitored training compliance.
- Staff we spoke with had a good understanding of safeguarding issues and their responsibilities in relation to identifying and reporting allegations of abuse. They were aware of the trusts safeguarding policy. They told us of the steps they would take in reporting allegations within the trust and felt confident in contacting the safeguarding lead if needed.
- The ward manager maintained oversight of all the safeguarding concerns raised by staff on the ward, the current stage of investigation and any received feedback from the local authority safeguarding team as to the outcome of investigations. This was then feedback to all staff involved in the incident or who raised the alert and the patient. The recording of incidents in the log was detailed and factual. However, the outcome of

investigations from the local authority safeguarding team was not always received from the local authority safeguarding team. We spoke with the ward manager about this and was told this continued to be an issue but weekly phone calls with the safeguarding team were now in place to monitor and chase outcomes and feedback from safeguarding referrals.

- We saw evidence of changes made because of incidents. For example, contraband items on the ward were reviewed and information communicated to all families and visitors. The arrangements for visitors accessing patients' bedrooms on the ward was also reviewed and communicated. This was to ensure when visitors were on the ward, all patients were safe and protected from harm.
- Staff told us that shared learning across the older person's service line and trust wide took place. Serious incidents were communicated to staff via newsletters, bulletins, during team meetings, and discussed as part of team away days. Staff were encouraged to participate in learning to improve safety as much as possible.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- We reviewed 11 patients' care records. All contained fully completed and comprehensive assessments of their individual and clinical needs and preferences.
- Staff carried out a range of assessments with patients on admission to the ward and throughout their care and treatment. These included a physical health, falls and Waterlow assessment as well as charts for sleep, food and fluids, bowel movement, behaviour, weight, moving and handling and pain.
- Care plans were comprehensive, personalised, and holistic and recovery oriented with to support patients through their care and treatment pathway. A care pathway is a structured approach to care delivery that clearly describes the journey a person is likely to take when moving through the care system. This ensures that individuals receive the most appropriate care and treatment, with clearly agreed timescales and in the least restrictive environment.
- Patients that had physical health conditions, such as diabetes and tachycardia, had corresponding care plans to support staff to manage these conditions. Care plans were clear and detailed and contained patient's views and areas where they could maintain independence or support was needed.
- Patients were referred to specialist services if a need was identified. For example, the diabetic nurse and speech and language therapist. Jasmine ward did not have an allocated physiotherapist, unlike some of the trusts other older persons inpatient wards. However, patients could be referred to physiotherapy at the local general hospital if needed.
- On admission to the ward, all patients had a food and fluid intake chart in place. This remained in place until the multidisciplinary team were confident and assured there were no concerns presenting with nutrition or hydration. Where a need for continued monitoring was identified, this was well care planned and patients received the right level of support for their individual needs. For example, some patients required assistance and encouragement from staff to eat their meals. The ward had implemented a finger food menu. Patients living with dementia can find cutlery difficult to manage as well as eating a full meal. Staff felt the introduction of finger foods had encouraged patients to enjoy food and drink again and an important factor in maintaining good physical health.
- During the inspection, we found there were no patients with a urinary tract infection (UTI). UTIs are common among older people. If a person has a memory impairment or dementia and has a UTI this can cause sudden and severe confusion. We spoke with staff who told us they were aware of the importance of encouraging patients to drink fluids, ensuring they were readily available and visible at all times and ensuring fluid intake was monitored. Given there were not cases of UTIs on the ward, this meant patients were supported to maintain good hydration.
- The ward had access to pressure mats for patients at risk of falls and pressure relieving mattresses for patients at risk of pressure-related injuries. A nurse completed an immediate and weekly review of falls.
- The ward manager had created an admission checklist for staff. The checklist identified actions for staff to complete immediately and within 24 and 72 hours of admission.

Best practice in treatment and care

- Risks to physical health were identified and managed effectively by trained staff. The service used a standardised system called Modified Early Warning System (MEWS) to monitor and record the physical health of patients. This system worked by staff allocating a score to a series of physical health measures such as blood pressure and oxygen saturation levels. When a patients' score reached a given level this triggered what action was required from staff. Staff were trained to use the MEWS tool to observe changes in patient's presentation. Qualified staff and doctors were easily available in the event a patient's physical health deteriorated. All patients had their physical health observations checked daily or more regularly if needed.
- Staff on the ward had previously used the dementia toolkit. However, it was identified through the trust 'Patient Steering Group' the quality varied across the wards greatly and different versions of the toolkit were being used by staff. In December 2017, at least three staff from each of the older persons inpatient wards

attended a training day. The psychology team redeveloped the tool to make it more user friendly and evidence based and renamed it 'person-centred support plan'. The tool is based on the Newcastle Model and Kitwood. The Newcastle Model provides a framework and process for staff to understand behaviour that challenges in terms of unmet patient needs, and suggests a structure to develop effective interventions that keep people with dementia central to their care. Staff worked together looking at areas of improvement, concentrating on areas such as "this is me" care plans. However, for patients with functional mental illness, the tool does not meet the needs of these patients. Staff were in the process of developing a tool and pilot to the use of 'one-page profile' was due to commence. Staff were keen this was a collaborative approach between staff, patients and families. The 'one-page profile' is more strengths based and so staff felt this was better suited to the patients. The trust had a drive for a person-centred culture and to help reduce stigma, staff were also completing their own 'one-page profile'.

- Staff completed antecedent, behaviour and consequence (ABC) charts. They also completed 'successful interventions' forms. This meant they could share good practice as to what worked well with patients. However, at the time of the inspection there was no psychologist in post on the ward. Therefore, the ABC charts were not analysed by a psychologist and the understanding of what the patient's behaviour was communicating was lost. The trust were aware of this and as an interim measure a clinical psychologist from another older person's ward was providing weekly support to staff to look at formulations and ensure care being delivered best met the needs of the patients.
- Staff from Jasmine ward and other wards carried out role modelling to ensure staff competence and good practice.

Multi-disciplinary and inter-agency team work

- The ward had a full multidisciplinary team meeting (MDT). A MDT is composed of members of health and social care professionals. The MDT collaborates to make treatment recommendations that facilitate quality patient care. Patients we spoke with confirmed many different professions supported them.
- Staff had handovers between each shift which were also attended by the junior doctors. We observed a handover, which was well structured, and all patients were discussed in detail, including risk, incidents and any physical health concerns. Staff clearly demonstrated in-depth knowledge about the patients they were caring for. Following handover, allocated roles for the shift were assigned to staff by the nurse in charge.
- A full range of care disciplines attended the weekly ward rounds. Staff we spoke with told us discussions were effective, and focused on sharing information, details about the patients' care and treatment and reviewing their progress and risk management.
- We saw evidence of effective working relationships with the local authority safeguarding team and general hospital. Staff on Jasmine ward had developed strong links with specialist services including the diabetic and tissue viability nurse, urology and the emergency department.
- The manager attended monthly leadership and inpatient forum meetings. Topics discussed during the meetings included safeguarding, shared learning and finance. Meetings had been arranged so that information could be shared with staff during the team meeting.

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 good interactions between staff and patients. Staff continuously interacted with patients in a positive, caring and compassionate way and they responded promptly to requests for assistance whilst enabling independence. For example, staff ensured all patients were offered and supported to access drinks hourly throughout the day to ensure they remained hydrated. We saw patients requesting drinks more frequently and they were encouraged and supported by staff to access these independently. Staff appeared interested and engaged in providing a high level of care to patients on the ward.
- We spoke with four patients' who all told us staff were supportive and caring. They felt involved in the planning of their care or treatment and staff were quick to respond to their needs whilst enabling them to be as independent as possible.
- When staff spoke with us about patients, they discussed them in a respectful manner and demonstrated a high level of understanding of their individual needs, including risk behaviours and physical health.

The involvement of people in the care that they receive

- Patients told us they were involved in decisions about their care and treatment. Where possible, staff involved patients in their care planning and risk management. Care plans showed active involvement and collaborative working between patients and staff. Input from carers and family members, where appropriate, was evident in care plans. We found care plans to be person-centred and recovery orientated with patients' strengths clearly identified. Patients emotional and social needs were a fundamental part of their care and treatment and embedded into care plans. Staff supported patients to maintain and develop their relationships and social networks with those close to them.
- Patients were orientated to the ward environment and received a welcome pack. Patients we spoke with all confirmed they received the welcome pack and felt that it was useful and informative.
- There were weekly community meetings where patients could provide feedback about the ward.
- There were monthly carers meetings and alternate carers events which took place on a weekend. We spoke with the ward manager about the uptake of the meetings and was told this could vary but was often low. We spoke with three relatives and carers. Relatives and carers told us they had been informed of the carers meetings and were confident in the care provided by staff to their relatives. They were invited to attend bi-weekly ward round meetings and were kept up to date with information relating to their relatives care or treatment including physical health and any incidents such as falls. They felt their relative's health had improved since they had been receiving care on the ward. The ward had staff take on the role of carers champion.
- We observed staff involving patients in making decisions about their care. Staff sought the patient's agreement throughout.

Are services responsive to people's needs?

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

Our findings

Listening to and learning from concerns and complaints

- There had been two formal complaints since January 2018. At the time of the inspection both were being investigated. The ward manager maintained a complaints log that contained details of the issues raised, current stage of investigation and who the investigator was.
- Staff tried to resolve complaints at a local level in the first instance. If this was not possible, complaints were escalated to the ward manager. Feedback and lessons learnt concerning complaints was communicated to staff during handovers, supervision and team meetings.
- Details of how to make a complaint were included in the patient and carer welcome packs. The patients and carers we spoke with all knew how to make a complaint and told us they would feel confident in doing so if needed.
- The ward had a "you said we did" board. The board detailed the actions taken in response to suggestions, comments and complaints from patients and carers. This was displayed in communal areas on the ward accessible to both patients and visitors.
- Compliments and complaints were uploaded to the electronic incident reporting system and analysed by the trust complaints team.