

Coventry and Warwickshire Partnership NHS Trust

Woodloes Avenue

Quality Report

Woodloes Avenue

Warwick

Warwickshire

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This report describes our judgement of the quality of care at this location. It 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.

Summary of findings

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Summary of findings

Overall summary

Woodloes Avenue provides acute assessment and treatment to people over 65 years of age with organic mental disorders. The service is registered with CQC to have up to 25 beds and has not previously been inspected.

We found Woodloes Avenue had systems in place to ensure people were kept safe. The service had good procedures for reporting incidents and learning from them. Staff had a good understanding about safeguarding and how to report any concerns.

Staff were caring and compassionate and had a good understanding of peoples' needs.

We had concerns that the location did not adhere to the codes of practice set out by the Mental Health Act 1983. For example, there was limited flexibility to accommodate single sex corridors or bathrooms.

There were inconsistencies in how people were involved with their treatment and the recording of information on peoples' care plan records.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Systems were in place to ensure people were kept safe. The service had good procedures for reporting incidents and learning from them. Information leaflets on how to report safeguarding and make a complaint were available.

Incidents were well documented with a robust quality reporting system in place. This meant that incidents could be analysed and lessons learned and shared.

Staff demonstrated a good awareness of what should be reported and their responsibilities if they suspected abuse was happening. Staff told us that they knew where to find the safeguarding policy and they understood it.

Staff had a good understanding of each person's care needs and potential risks to their health and safety.

Assessments had been completed to see if people had the capacity to make decisions about their own care and treatment. Some records had not been fully completed, so we could not confirm everyone had been assessed.

Staff told us they shared learning from incidents to avoid the same thing happening again.

People told us they felt safe in the hospital and they could talk with members of staff if they had any concerns about their safety or any issues on the ward. However, people's privacy was not always maintained. There appeared to be enough staff to deal with the needs of people on the day of our visit.

Are services effective?

There were good examples of collaborative working across different services.

People we spoke with had mixed experiences with some receiving good outcomes and others poor ones.

We saw staff knew people well, including their needs and preferences.

The information given to people about advocacy services was inconsistent.

There was a good mix of staffing levels, with additional staff available should anyone need to be observed. Staff were qualified to provide treatment to people using services and they told us they had completed their mandatory training and understood the deprivation of liberty safeguards.

Forum meetings were held weekly to discuss the service.

Records of Section 17 leave demonstrated that a second opinion had been sought and the reasons were clear on the decision for the leave of absence. It was not clear whether people or family members had been involved with the planning of leave.

A range of professionals were involved in ward rounds, which included people using the service and family members whose involvement had been recorded.

During our visit to the units we found there was no information available on the independent mental health advocacy (IMHA) service. No-one had seen a representative from IMHA and the service was not proactive in making referrals to the service.

We saw that people were provided with information on their rights and how to appeal against their detention if they wished.

Summary of findings

Are services caring?

Staff were caring and compassionate with people and knew about their likes and dislikes.

There were inconsistencies on how people were involved with their treatment and the recording of information on peoples' care plan records. However, we noted that there was good physical health monitoring and response in peoples' files.

We saw there were positive comments from people at the forum meetings such as one person stated that they felt more positive about their treatment and a person on the ward felt they had improved in their mental state.

72-hour assessment forms were comprehensive and observed a range of people's' needs being met.

People ate meals together and meal times were protected from visitors and interruptions. They had a choice of meals and there was a rotating menu every four weeks which offered variety. We noted there were drinks and fresh fruit available for people in the lounge areas.

Are services responsive to people's needs?

On Loxley Unit people have individual bedrooms but we saw there were male and female bedrooms next door to each other. There were no ensuite bathrooms but bathrooms are identified for single sex use.

There was a 'You said' feedback from visitors and people using services poster displayed with a 'We did' poster to demonstrate what action the service had taken in response to comments made.

There was limited space for staff to de-escalate someone who was presenting challenging behaviour.

Staff told us that there had been a lot more engagement about redesigning the unit and that the Trust acted on any information received from the service.

Staff were anxious that some services were closing in the future and this had not been communicated well.

Are services well-led?

Staff told us how they had been involved with some of the redesigning of the service and had a good understanding of the Trust's structure. They were able to tell us about the Trust's values and beliefs, and these were presented on ward information.

The Trust had a programme of mandatory training and staff confirmed that they had completed it.

There were regular staff on the units who knew people's treatment needs and preferences.

Incidents were well documented and the manager demonstrated they had a robust quality reporting system in place. This meant that incidents could be analysed and lessons learned and shared.

As well as group supervision sessions, staff supervision sessions were held, but the manager identified they were not held as often as they would like them to be.

Summary of findings

What we found about each of the main services at this location

Services for older people

There were inconsistencies in how people were involved with their treatment and the recording of information on peoples' care plan records. Staff were caring and compassionate and had a good understanding of peoples' needs.

Summary of findings

What people who use the location say

During our inspection we did not review any surveys relating to the services for older people. We found there were no comment cards returned locally from visitors to the service to review.

Areas for improvement

Action the provider **MUST** take to improve

- We found inconsistent record keeping and details of people's involvement within their care plan records.
- Make suitable arrangements to ensure that people's privacy and dignity is respected.

Good practice

- We found good practice in peoples' involvement through ward rounds and forum meetings.
- We noted that the manager had responded to this feedback.
- We saw some good examples of multi-disciplinary working with other services within the Trust.

Woodloes Avenue

Detailed findings

Services we looked at:

Services for older people

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included CQC inspectors, a Mental Health Act Commissioner and a number of specialists including a doctor and a nurse.

Background to Woodloes Avenue

The Trust has a total of 21 active locations serving mental health and learning disability needs, including three hospital sites: Brooklands, St Michael's Hospital and Caludon Centre.

The Trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Coventry.

Coventry and Warwickshire Partnership NHS Trust has been inspected 21 times since registration. Out of these, there have been 12 inspections covering five locations which are registered for mental health conditions. Woodloes Avenue is a location which has not previously been inspected.

Woodloes Avenue provides acute assessment and treatment to people over 65 years of age with organic mental disorders. The service is registered with CQC to have up to 25 beds.

Why we carried out this inspection

We inspected Coventry and Warwickshire Partnership NHS Trust during our wave 1 pilot inspection. The Trust was selected as one of a range of Trusts to be inspected under CQC's revised inspection approach to mental health and community services.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

The inspection team inspected the following core services at this inspection:

- Mental Health Act responsibilities
- Services for older people

Detailed findings

Before visiting, we reviewed a range of information we hold about the location and asked other organisations to share what they knew about the location. We carried out an announced visit on 22 and 23 January 2014. During the visit we held focus groups with a range of staff who worked in the Trust. These included nurses, doctors (consultants, registrars and junior doctors) and therapists. We also held drop in clinics for staff and carers. We talked with people

who use services and staff from all areas of the location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

We met with people who use services and carers, who shared their views and experiences of the location. We carried out an announced inspection at this location.

Services for older people

Information about the service

Woodloes Avenue provides acute assessment and treatment to people over 65 years of age with organic mental disorders. The service is registered with CQC to have up to 25 beds and has not previously been inspected.

Summary of findings

There were inconsistencies on how people were involved with their treatment and the recording of information on care plan records. Staff were caring and compassionate and had a good understanding of peoples' needs.

Services for older people

Are services for older people safe?

We found Woodloes Avenue had systems in place to ensure people were safe when using the service. We saw there was evidence of learning from incidents and robust reporting procedures. We found that incidents were well documented and the manager demonstrated they had a robust quality reporting system in place. This meant that analysis of incidents could be obtained and reports for lessons learnt from any incidents could be shared.

We found there were information leaflets on how to report safeguarding and make a complaint available in the reception area. There was a 'You said' feedback from visitors and people using services poster displayed with a 'We did' poster next to it to demonstrate what action the service had taken in response to comments made.

We spoke with two staff members about what they thought abuse was. They demonstrated a good awareness of what should be reported. They understood their responsibilities for reporting any concerns regarding abuse. The staff members told us that they knew where to find the safeguarding policy and they understood the policy. We also saw that staff had undertaken safeguarding training and members of staff were confident in reporting any signs of abuse.

We spoke with the manager about when they would make a referral to the local safeguarding team regarding any person being at risk of harm. They told us about their process for reporting any concerns and how they would involve the local safeguarding team.

They told us that 15 minute observations were undertaken for each person throughout the night to ensure their safety. We found the manager had responded to peoples' feedback on how the observations were carried out. People using the service had raised concerns over the night lights shining in their eyes whilst being observed during the night and were not happy with being woken up. The manager had acted accordingly and people were happy with how night time observations were conducted.

We found that staff had a good understanding of the potential risk associated with individuals and their care needs. This meant that staff were able to protect people as they knew about the risks or triggers.

People's care plan records showed that capacity assessments had been completed on some of the records. This is where a person's capacity to make decisions is measured by the service. We found other records where the capacity assessments had not been fully completed. This meant we could not confirm that people's capacity had been assessed to ensure they could make decisions about their care and treatment on their own.

We saw good examples in the care records for staff to follow if people asked to return home due to the person experiencing dementia. This meant staff had the necessary guidance to enable them to manage and explain to people about their wish to return home.

One record showed that a safeguarding referral had been made as a result of an incident on the ward between two people using services. We found that a safeguarding alert had been made with the supporting incident form attached.

Staff told us they shared learning from incidents that had occurred at the regular team meetings to try and avoid the same thing happening again.

People using the service we spoke with, told us they felt safe in the hospital and felt they could talk with members of staff if they had any concerns about their safety or any issues on the ward.

We saw the environment was safe, however people's privacy was not always maintained. Staffing levels on

the day of our visit appeared adequate to deal with the needs of people at Woodloes Avenue.

Are services for older people effective? (for example, treatment is effective)

We saw there were inconsistencies with information that was provided to people and access to advocacy services.

We found Woodloes Avenue provided care for people which was effective; however, the environment in which people were treated did not meet the requirements of the Mental Health Act. It was not always clear whether bathrooms available were for use by men or women as signs had been removed. We were told staff were managing the access to bathrooms.

Services for older people

We saw good examples of collaborative multi-disciplinary working across different services. For example, in one care plan record we found a referral had been sent to the Caludon Centre which had a female only ward. The care plan detailed how the person responded better to female staff and other people using services.

People told us about mixed experiences in how they had received good and poor care outcomes. People told us that they had to go out into the garden with a member of staff, although had to get permission to use the garden. They told us the care was generally good but there was not always enough staff to facilitate the use of the garden. One person told us that being at Woodloes House had made them feel very good.

We saw staff knew people well, including their needs and preferences. For example staff knew what they would like to be called, what music people liked to listen to and what their interests were. This meant staff were effective when they delivered care and support to people as they understood people's needs

We noted that there was a good mix of staffing levels and additional staff were available should anyone require close observation.

We saw from training records and speaking with staff that they were suitably qualified to provide treatment to people using the service. Staff told us they had completed their mandatory training and understood the deprivation of liberty safeguards.

We found there were forum meetings held which were weekly meetings with people about the service. We saw they had provided feedback on menu choices, activities and night staff. We noted that the manager had responded to feedback and implemented changes to the service which had improved the experience for people using the service.

On another care plan we saw that a section 17 leave of absence form had been counter signed by another consultant. This demonstrated that a second opinion had been sought and the reasons were clear on the decision for the leave of absence.

On some care plan records we saw there was no copies of section 17 leave forms given to people or family members. We found copies of the section 17 leave forms had been

completed by health professionals but were not signed by people or relatives. This meant it was not clear on whether people using the service or their family members had been involved with the planning of leave.

We found there was a range of professionals involved with ward rounds. We saw this included people using the service and family members whose involvement had been recorded.

During our visit to the units we found there was no information available on the independent mental health advocacy (IMHA) service. We found that no-one had seen an IMHA and the service was not proactive with making referrals to the service.

We saw that people were provided with information on their rights and how to appeal their detention if they wanted to.

Are services for older people caring?

We found staff were caring and compassionate to people using the service. However, we saw there were inconsistencies in how people were involved with their treatment and how information was recorded on people's care plan records.

Staff got down to people's level and let the person take their time and did not rush them when they assisted them. Care staff we spoke with knew about people's preferences, likes and dislikes.

When we visited Woodloes Avenue on 22 and 23 January 2014, we found people were enjoying reading newspapers and listening to music. We found the location to be clean and tidy. We found that staff tried to ensure that meal times were protected from visitors and interruptions. People ate their meals together and people had a choice of meals. There was a rotating menu every four weeks which offered variety. We noted there were drinks and fresh fruit available for people within the lounge areas.

We saw there were positive comments from the forum meetings such as one person said that they felt more positive about their treatment and another felt they had improved in their mental state.

We saw some good examples of care plan records where there was full admission documentation for each person and these were accompanied with good risk assessments.

Services for older people

We noted there was good physical health monitoring and response to deterioration of physical health in care files. We saw that where fluid intake was identified as a risk, that peoples' fluid intake was recorded and they were prompted for drinks if this was required. However, we saw other care plan records where some sections had not been completed and peoples' capacity assessments had not been recorded.

When a person was brought to the unit, the policy was that the person must be assessed within 72 hours and a decision will be made about the person's detention. The decision would be either that the person must be admitted (detained) or should be admitted (informal status). We found 72 hour assessment forms to be comprehensive and observed a range of peoples' needs being met.

We spoke with one person who had recently been admitted to the service and was unsure why they had been admitted. Within the care plan records we looked at, there was inconsistency on how people were involved with their treatment. We saw examples of records where people had signed to confirm they had been involved with their treatment. We also found other records which were not signed without any explanation of why the person was not able to sign their care plan records. People we spoke with were not always sure whether they had seen their care plan. However, we saw involvement of people within the ward rounds. One person told us that they might have had a care plan, probably had got one but whatever they were happy with the care.

One person told us that staff had been really good to them and were aware of their named nurse who they described as lovely. Others told us that they were totally bored out of their skulls at weekends; the staff are caring and responsive and there were not always enough staff for them to go on leave. Another person told us that they thought their care and treatment was fine.

Are services for older people responsive to people's needs?
(for example, to feedback?)

We saw peoples' bedrooms were not en suite and on Loxley Unit there were male and female bedrooms next

door to each other. On the day of the visit a shower room did not have a sign to indicate if it was to be used by men or women. We were told that this was because it had been removed by a person using the service.

We found one room was opposite and in view of a communal seating area. The location had clear glass panels so people could see through the courtyard and other corridors. This meant that their privacy and dignity needs were not being met.

We found that for Loxley Unit there was a corridor used by men and women as due to the layout of the unit there was no flexibility in accommodating single sex corridors. The Code of Practice states that mixed sex accommodation refers not only to sleeping arrangements, but also to bathrooms or toilets and the need for people to pass through areas for the opposite sex to reach their own facilities. As long as men and women are cared for in separate bays or rooms and have their own toilet facilities, then it may be appropriate for them to be on the same ward being cared for by the same team of doctors and nurses. We were told that the ward always tried to offer separate accommodation and identify bathrooms for single sex use.

This also meant that there was limited space for when staff needed to de-escalate a person who was presenting challenging behaviour. We noted other and were no ensuites. This meant that peoples' privacy and dignity needs were not being met.

One person told us that they were afraid of men, and one who did not dress appropriately.

We noted that there was a designated women's only lounge area. One person told us that the lounge was not always available but was generally made available upon request.

Staff told us there had been a lot more consultation with them regarding the service redesign as the unit was changing its base. They said that the Trust acted on any information received from the service. However they told us that some services were closing in the future and this had not been communicated as well.

Services for older people

Are services for older people well-led?

We found the service was not meeting the governance framework for their Mental Health Act duties through not having sleeping areas segregated for men and women.

We spoke with the manager and the staff about the structure of the Trust. The manager told us how they had been involved with some of the redesigning of the service and had a good understanding of the structure.

Staff were able to tell us about the Trust's values and beliefs which demonstrated they understood the Trust's vision. We saw information on the ward about the values the Trust had implemented.

The Trust had a programme of mandatory training for staff to complete which we found staff had completed. Staff told us there was now a more robust link with the executive team than there had been previously.

Staff felt there was more interaction between the 'board' level and the 'floor' level. This was demonstrated when a non-executive board member went 'back to the floor' to complete a shift on the units.

On the days we inspected we saw there was regular staffing on the units and staff knew people's treatment needs and preferences. We noted there were two staff vacancies and there had been recent approval to recruit from the bank or agency staff that had been working at the service.

We found that incidents were well documented and the manager demonstrated they had a robust quality reporting system in place. This meant that analysis of incidents could be obtained and reports for lessons learnt from any incidents could be shared.

We noted there were staff meeting notes available for a meeting held during January 2014 and this included a 'core brief'. A member of staff explained that a core brief included a recap of the chief executive's blog and information on the service.

We noted that supervision sessions were being undertaken and the manager had identified they were not held as often as they would like them to be. We noted that group supervision sessions were held.

We noted that the ward was at 100% capacity with no-one currently on leave. The manager told us that if someone was to go on leave then their bed remained open for when they were due to return and would not be reallocated. This meant that people received their care consistently as staff had an increased understanding of people's needs.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HCSA 2008 (Regulated Activities) The manager had not as reasonably practicable made suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17(1) (a)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HCSA 2008 (Regulated Activities) People who use services were at risk of unsafe or inappropriate care and treatment from a lack of proper information about them and the safe keeping of their information. How the regulation was not being met: We found inconsistent record keeping and details of people's involvement within their care plan records. Regulation 20(1)(a)(b)(i)(2)(a).