Good

Tees,Esk & Wear Valleys NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Roseberry Park	RX33A	Westerdale North Westerdale South	TS4 3AF
Cross Lane Hospital	RX3LK	Rowan Lea	YO12 6DN
Springwood	RX3KW	Springwood	YO17 7NG
Sandwell Park	RX3NH	Wingfield	TS24 8LL
Auckland Park Hospital	RX3AT	Hamsterley Ceddesfeld	DL14 6AE
Friarage Hospital Mental Health Unit	RX3XX	Ward 14	DL6 1JG
Lanchester Road Hospital	RX3CL	Roseberry Picktree	DH1 5RD

Summary of findings

Alexander House	RX3XL	Rowan	HG5 0UB
West Park Hospital	RX3MM	Oak Ward (East)	DL2 2TS

This report describes our judgement of the quality of care provided within this core service by Tees, Esk and Wear Valleys 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 Tees, Esk and Wear Valleys NHS Foundation Trust and these are brought together to inform our overall judgement of Tees, Esk & Wear Valleys 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 Wards for Older People with Mental Health Problems	Good
Are wards for older people with mental health problems safe?	Requires Improvement
Are wards for older people with mental health problems effective?	Good
Are wards for older people with mental health problems caring?	Good
Are wards for older people with mental health problems responsive?	Good
Are wards for older people with mental health problems 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 older people's inpatient services good because:

- Safeguarding vulnerable adults, was a priority. Incident recording and reporting was effective and there was a culture of openness, transparency and learning.
- Patients' care was delivered following a full assessment of their needs. Information was gathered from other health and social care professionals and family members. Patients were involved in the planning of their care. Consent was obtained or assessed for all treatments. Patients could access psychology support, occupational therapy, dietary and medical assistance when necessary.
- Staff were qualified and had the necessary skills to carry out their roles effectively. Staff told us they were well supported and supervised. Staff were able to identify and access training to ensure their skills remained current. Staff were able to support patients from a diverse community. This support included the use of pictorial information, the use of interpreters and the provision of multi faith rooms, and special diets.
- Patients who used the service and their relatives told us that staff provided them with information and support about their treatment. Patients told us that as they got better staff enabled them to manage their own health and wellbeing needs.
- Most North Yorkshire staff told us the move to Tees Esk and Wear Valleys Foundation Trust in 2011 had been beneficial to patients and staff. We were told training had improved and they were well supported to manage the services effectively were better.
- Staff were supported by the management of the trust. They were aware of the vision and values on the trust and patient care was their primary concern.
- All the wards for older people with mental health problems had been purpose built or adapted to incorporate NICE guidance and Sterling Design. The advice related to the use of different colours, stimuli and layout of accommodation to provide a more relaxing environment for people with mental health problems.

However we also found the following areas for improvement:

- Medicines were administered by one nurse to all patients on Hamsterley Ward before any records were signed.
- Medicines were covertly administered to patients on both Ceddesfeld and Hamsterley without reference to a best interests meeting or advice from the pharmacist.

Summary of findings

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

Are services safe?

Requires Improvement

- We rated older people's inpatient services as requires improvement .
- Medicines were administered to all patients on Hamsterley Ward before any records were signed.
- Staff on both Ceddesfeld and Hamsterley Wards administered medication to patients covertly. They did so without reference to a best interests meeting, or seeking advice from a pharmacist.

However there were areas of good practice.

Patients' needs were assessed on admission and updated where there had been a change in needs. Staffing levels on the wards were set at a minimum level. However the managers were able to adjust staffing levels to reflect the acuity of the ward.

Safeguarding vulnerable adults, was a priority, appropriate systems were embedded across the wards. Incident recording and reporting were effective and embedded across all services. Where possible all of the wards used de-escalation techniques and were looking to eliminate the need to use physical restraint.

All the wards for older people with mental health problems had been purpose built or adapted to incorporate NICE guidance and Sterling Design. The guidance related to the use of different colours, stimuli and the layout of accommodation to provide a more relaxing environment for people with mental health problems.

Are services effective?

Good

We rated older people's inpatient services as Good

Patients care was delivered following a full assessment of needs, over a 72 hour period. Information was gathered from other health and social care professional and family members.

Staff received support and training to ensure they had the skills necessary to provide the care needed. However staff were unsure of where the Mental Capacity Act could complement their practice.

Are services caring?

Good

We rated older people's inpatient services as Good

Patients were treated with dignity and respect in all interactions observed. Feedback from patients and their relatives confirmed that

Summary of findings

staff provided support with empathy and consideration. We saw positive examples of where staff had ensured that patients whose first language was not English could be involved in care planning meetings.

The use of advocates was promoted for patients who required support in understanding their rights whilst in hospital. Patients who used the service and their relatives told us that all staff provided them with information and support about their treatment. They said that as they got better staff enabled them to manage their own health and wellbeing needs.

Are services responsive to people's needs?

Good

We rated older people's inpatient services as Good because:

Patients were involved in planning of their care and consent was obtained or assessed for all treatments.

Services took in to account the needs of different people; we saw multi faith rooms, menus appropriate for people of different faiths, the use of interpreters. Patients were able to access care and treatment in a timely way.

Patients and their families told us that they did not have any complaints but felt confident to raise any concerns with any of the staff. Staff said they would help patients to contact patient advice and liaison services (PALs), advocates or complete a written complaint. We saw evidence that where concerns had been raised in a patient focus group they had been addressed by the ward manager

Are services well-led?

Good

We rated older people's inpatient services as Good because:

Staff had a clear understanding of the vision and values of the trust. They told us they were well supported by the management of the organisation, and received supervision at least 8 times a year but also told us they could request supervision at any time.

Quality assurance systems were in place to ensure the service looked to improve. Discharge feedback was obtained on a monthly basis and the information was used to improve services.

Summary of findings

Background to the service

Tees Esk and Wear Valleys NHS Foundation Trust have a total of seven registered locations in which 12 inpatient units for older people with complex mental health needs are based.

Rowan Lea is based on the Cross Lane Hospital site. This ward is a mixed sex ward for up to 20 older people with complex organic illnesses with associated frailty.

Springwood is a ward for up to 14 older people who have organic or functional mental health needs. It is based in Malton

Ward 14 bed is a ward for up to 9 older people who have organic or functional mental health needs. It is based in The Friarage Hospital in Northallerton.

Alexander House is a mixed sex ward for up to 16 people who have organic or functional mental health needs. At the time of our inspection this location was being used to care for patients normally accommodated on Rowan Ward.

Westerdale North is a mixed sex ward for 16 older people who have functional mental health needs. It is based at Roseberry Park Hospital.

Westerdale South is a mixed sex ward for up to 16 people who have organic mental health needs. It is based at Roseberry Park Hospital.

Roseberry ward is mixed sex ward for up to 15 people who have a wide range of mental health problems. It is based at Lanchester Road Hospital.

Picktree ward is mixed sex ward for up to 10 people who have dementia. It is based at Lanchester Road Hospital.

Wingfield Ward is a mixed sex ward for up to 9 older people who have organic or functional mental health needs. It is based in the Sandwell Park Hospital in Hartlepool.

Oak Ward is a ward for up to 12 older people who have predominantly organic or functional mental health needs. It is based at the West Park Hospital in Darlington.

Ceddesfeld Ward is a ward for up to 10 older men who have predominantly organic mental health needs. It is based at Auckland Park Hospital in Bishop Auckland.

Hamsterley Ward is a ward for up to 10 older women who have predominantly organic mental health needs. It is based at Auckland Park Hospital in Bishop Auckland.

Ceddesfeld and Hamsterley Wards have previously been inspected by the Care Quality Commission (CQC). There were no issues raised. None of the other wards have previously been inspected by the CQC. However, all wards have received a Mental Health Act monitoring visit from CQC Mental Health Act reviewers since their registration by the Care Quality Commission. There are no current enforcement or compliance actions being taken by the CQC in relation to any of the older persons inpatient wards at the time of this inspection.

Our inspection team

Our inspection team was led by:

Chair: David Bradley, Chief Executive South West London and St Georges.

Team Leader: Patti Boden, Care Quality Commission

Head of Inspection: Jenny Wilkes, Care Quality Commission

The team that inspected the older persons wards comprised of a CQC inspector, a Mental Health Act reviewer, a trainee nurse; two experienced nurses, a consultant psychologist, an expert by experience and a pharmacist.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Prior to the inspection we reviewed a range of information we held about wards for older people with mental health problems and asked other organisations to share what they knew.

We carried out an announced visit on 21 and 22 January 2015 to the following wards:

- Rowan Lea
- Springwood
- Ward 14
- Rowan Ward –This service was located at Alexander House whilst Rowan Ward is updated.

We carried out a further announced visit on 27, 28 and 29 January 2015 to the following wards

- Hamsterley
- Ceddesfeld
- Westerdale North
- Westerdale South
- Oak Ward (East)
- Roseberry
- Picktree
- Wingfield
- During the inspection visit, the inspection team
- spoke with 25 patients and 10 relatives.
- spoke with the managers for each of the wards visited,
- spoke with 58 other staff members including consultant psychiatrists, psychologists, modern matrons, qualified nurses, health care assistants, speech and language specialists occupational therapists, pharmacists and ancillary staff
- attended and observed multi-disciplinary, and daily report out meetings on five wards.
  - We also:
  - Looked at 36 treatment records of people.
  - carried out a specific check of the medication management.
  - looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 25 patients and ten relatives. They all were very positive about the service they had received whilst in hospital. We were told "in the four weeks that I have been here the staff have stopped my downward trend and I am now looking forward to my first home leave" and "it's like the staff care about me and that is very re-assuring". Other comments include "they have helped me keep in touch with my family and I have been able to visit my home" and "they are good here".

Relatives told us "I would give the care 11/10 I can't fault them" and "I visit every day and I am happy with the support offered to X, the care is consistently excellent". Other comments included "it's a wonderful facility I can't speak highly enough of the staff" and "there is always someone to speak to and we always get asked if we want to speak to the doctor".

Summary of findings

Good practice

Each ward had a daily report out meeting. We observed five of these meetings. Each patient was discussed in detail, with information from health care professionals including but not exclusive to consultants, nurses, a pharmacist, and a psychologist. This enabled staff to plan treatment and a patients discharge in a timely manner.

Springwood and Rowan Lea were using specialist computer programme to enable them to interact with people wth memory problems in a positive way.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that administration records for medication for patients on Hamsterley Ward were signed as the medication was administered.
- The trust must ensure that medication is not administered to patients on both Ceddesfeld and Hamsterley Wards covertly, without reference to a best interests meeting, or seeking advice from a pharmacist.

Tees,Esk & Wear Valleys NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Westerdale North Westerdale South	Roseberry Park
Rowan Lea	Cross Lane Hospital
Springwood	Springwood
Wingfield	Sandwell Park
Hamsterley Ceddesfeld	Auckland Park Hospital
Ward 14	Friarage Hospital Mental Health Unit
Roseberry Picktree	Lanchester Road Hospital
Rowan Ward	Alexander House
Oak Ward (East)	West Park Hospital

Mental Health Act responsibilities

A Mental Health Act reviewer visited Wingfield ward as part of this inspection. They reviewed the detention documentation for the detained patients and a separate report will be issued.

Overall, we saw most of the documents were in order and patients were lawfully detained and all the patients' nearest relatives had been consulted during the assessment procedure. However the AMHP report for one patient could not be located and so it could not be

determined they were detained lawfully. Patients had been made aware of their rights under the MHA 1983 and in most cases section 17 leave forms had been completed. However one patient had taken section 17 leave but there was no paper work to support this.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff told us they were not aware of how the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) could apply to their work. A member of ward staff was designated a specialist worker for MCA and DOLS. They received some training in both the MCA and DOLS but staff told us they would contact the trust's safeguarding team for advice. MCA and DOLS training for all staff did not form part of the mandatory training received by staff on a regular basis.

Staff said they did not routinely consider the Mental Capacity Act 2005 and worked primarily with the Mental Health Act 1983. We found on one occasion at Springwood they had used a DOLS for a patient transferring to residential care. The modern matron told us this was not a common occurrence but in this instance it had enabled staff to use the least restrictive option for a patient who was ready for discharge.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated older people's inpatient services as requires improvement because:

- Medicines were administered to all patients on Hamsterley Ward before any records were signed.
- Staff on both Ceddesfeld and Hamsterley Wards administered medication to patients covertly. They did so without reference to a best interests meeting, or seeking advice from a pharmacist.

However there were areas of good practice.

Patients' needs were assessed on admission and updated where there had been a change in needs. Staffing levels on the wards were set at a minimum level. However the managers were able to adjust staffing levels to reflect the acuity of the ward.

Safeguarding vulnerable adults, was a priority, appropriate systems were embedded across the wards. Incident recording and reporting were effective and embedded across all services. Where possible all of the wards used de-escalation techniques and were looking to eliminate the need to use physical restraint. However on Rowan Lea there were 59 instances of restraint used and on Ceddesfeld there were 50 instances of restraint used in the three month period from 1 April 2014 to 31 September 2014. On examination of the records we saw that patients had been assessed regularly to limit the use of restraint and none of the episodes of restraint used resulted in patients being put in the prone position.

All the wards for older people with mental health problems had been purpose built or adapted to incorporate NICE guidance and Sterling Design. The guidance related to the use of different colours, stimuli and the layout of accommodation to provide a more relaxing environment for people with mental health problems.

Our findings

Safe and clean ward environment

Staff described working to the least restrictive practice with patients and told us they rarely used restraint. Information received from the trust indicated the use of physical restraint should be only used when someone's life is at serious risk of harm. The wards visited confirmed they did not use physical restraint but used de-escalation techniques. 79% of staff had completed their management of violence and aggression training (MOVA). None of the wards had a seclusion room. When patients became distressed, staff supported them in the quiet or low stimulus rooms.

Each ward had their main door locked but there was information for patients who were admitted on an informal basis on how to leave the ward. Staff confirmed that they would let people go out as long as they had been risk assessed as to their safety. Patients had risk assessments for dietary needs, mobility and challenging behaviour. We saw evidence on all the wards visited that these assessments were reviewed regularly. Each ward had a 'daily report' out where each patient was discussed and if people were restricted in any way then these restrictions were looked at and if possible they were reduced.

Case files contained risk management plans and these plans were reviewed on a regular basis.

The trust provided us with information before the inspection that demonstrated the service had commenced a ligature and risk project group. On Wingfield ward there was a bathroom out of commission because the ceiling track hoist, which the ward manager told us they did not need to use, presented a serious ligature risk. They had determined it was not safe to use it until the equipment has been removed. The ward manager told us that if a patient needed to use a hoist then they had an occupational therapy assessment a and suitable hoist was hired for their admission.

We found the ward was clean and well maintained. Information provided by the trust showed 89% of staff from Teesside mental health services for older people (MHSOP)

Requires improvement

Are services safe?

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

and 81% staff from North Yorkshire MHSOP had completed their infection control training. The wards visited with the exception of Alexander House had dedicated housekeeping time. This ensured the wards remained clean.

The wards visited provided separate sleeping and social accommodation for male and female patients. However, on Oak ward we found that, following an emergency admission, a male patient had been admitted to a room meant for females only. We raised this as a concern with the trust and they immediately took action to remedy this by ensuring the male patient was moved to a male bedroom immediately. On a review of the evidence gathered during the inspection we identified that on Picktree ward the accommodation was situated on one corridor with zoned male and female areas. The bedrooms were all single rooms. The bathroom facilities were designated for female or male use. However, both male and female patients had access to the corridor at all times and bedrooms were generally unlocked.

Clinical rooms were checked regularly. They were clean, tidy and equipped with appropriate resuscitation equipment and emergency drugs.

Safe staffing

We visited 12 wards and found the staffing complement was two qualified nurses and at least two health care assistants during the day and one qualified nurse and two health care assistants at night. Staff told us the number of staff increased if the acuity of patients increased and needed enhanced observations. Rotas we reviewed demonstrated where this had happened. The trust supplied information prior to the inspection that indicated that there were vacancies on several wards. The ward managers and clinical leads for each ward were not counted in the staffing numbers and were available to assist Monday to Friday 9-5.The services in North Yorkshire struggled to recruit and retain qualified staff. A modern matron told us they were looking at different methods of recruitment to try and fill the vacancies. This included having a recruitment event in a local town and looking at how staff could be incentivised to work in the North Yorkshire area.

Staff on the wards were supported by a minimum of one consultant, a general registrar, a junior doctor or trainee doctor, a psychologist, occupational therapist, physiotherapist, a pharmacist and a physical care nurse. If patients required treatment for a physical health need this this was provided by the junior doctor during working hours. Out of hours care was provided by the out of hour's doctor or for something more serious staff had to dial 999. We found that on Westerdale South the occupational therapist was unavailable and no cover had been provided for this service

Assessing and managing risk to patients and staff

The design of the wards meant that patients could be out of sight for long periods of time. Staff told us that each person had been risk assessed to determine the observations needed. Records seen confirmed that risk assessments had been done and appropriate support had been identified in the care plan. Staff told us if someone was not assessed as needing 1:1 support then frequent checks were carried out as to their welfare. We observed staff checking patients who could not be seen in the main areas. Patients told us "I feel safe here" and "the staff are very good and I can tell them if I am unhappy". Another patient said "I have an advocate who comes to see me when I need them". All of the patients we spoke with said there was someone they would tell if they felt unsafe.

Staff told us they would report any incidents of alleged abuse, they were able to explain what they meant by the word 'abuse'. We saw evidence that incidents were reported to the trust safeguarding team and investigations carried out. There was information in the ward office about which agencies to contact and when in relation to safeguarding adults. There was information on the notice boards informing patients who they could contact if they, their relative or carer needed extra support.

Patient records contained appropriate risk assessments and risk management plans were in place to help staff to manage those risks. These plans were formulated within the first 72 hours of admission and re-assessed on a regular basis. We saw evidence that patients were being regularly assessed and re-assessed in relation to their risk management plan.

Information pertinent to each patient was communicated to staff each day at handover and at regular multi-disciplinary meetings (MDT). A staff member told us "people's behaviour can change several times a day so someone's observation may change during the shift. It is about knowing your patients and recognising the signs to changes in behaviour and interactions between patients".

Requires improvement

Are services safe?

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

Restraint was only ever used as a 'last resort' and staff were usually able to use de-escalation techniques to defuse challenging behaviours. Seclusion was not used, and when rapid tranquilisation was used it was done so in line with the person's risk assessment and care plan and in line with trust policy. We saw evidence in care plans of reviews where the patient's behaviour had been challenging and staff told us the reviews helped them to develop the way they dealt with patients.

Several staff on Ceddesfeld ward told us that before Christmas they had administered medication covertly to a patient who was refusing medication. They did this by crushing tablets in to a spoon of jam. They told us they had not had a best interests meeting or consulted with pharmacy. Different staff told different inspectors the same information at different times during the visit. On Hamsterley ward staff told us that medication was being administered covertly and whilst the pharmacist had been consulted, there was no paperwork to support this. During our visit the medications were administered but the records were not signed. This was brought to the attention of the trust immediately and they took action to ensure this did not happen again.

The medicines management team reconciled all patients' medicines on admission and assessed the suitability of patients' own medicines for use where necessary. Pharmacy staff carried out a full clinical check of all prescription and administration records daily, Monday to Friday, and alerted clinical staff if patient safety monitoring checks were due or had been overlooked, or if a person's medication required review.

Medicines were stored safely and pharmacy staff audited medicines security and the management of controlled drugs. We observed in a clinic room with permission from the patient, staff taking bloods. They wore appropriate personal protective equipment and disposed of the used equipment appropriately.

Track Record on Safety

Information about adverse events was cascaded to staff within the trust. This was done via a weekly e-bulletin to all staff and through team briefings. The managers were able to demonstrate where lessons had been learnt and practices had been changed. A recent example of this was following an unexpected death involving a call bell in a patient's bedroom. Environmental risk assessments now included the call bell system.

Health and safety checks were carried out in accordance with guidance from the manufacturers

Reporting incidents and learning from when things go wrong

There were systems in place to capture and review individual incidents and accidents that enabled staff to identify potential risks. We reviewed a sample of incident report forms completed by staff on the computer (DATIX) system. The ward manager reviewed the forms assessing the severity of the incidents and then sent the forms to the modern matron and risk manager. The ward manager on Hamsterley Ward explained that following an audit of incidents on the ward they had requested the occupational therapist carry out a falls risk analysis. This was to see what actions the staff might take to reduce the number of falls. The ward manager on Rowan Ward showed us how they had used the information from the incidents to help in the care planning for one patient whose behaviour was unpredictable. A pattern in the incidents allowed them to develop a management plan that caused the patient less distress. Staff told us that there was a de-briefing process following incidents. Such incidents were discussed at the daily report out meetings and in clinical supervision.

When things went wrong management were open and transparent. Incidents were investigated, learning was communicated and action was taken to improve care. This was demonstrated by the manager of Oak ward in response to medication errors on the unit. Staff were involved in the learning process.

Are services effective?

Good

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

Summary of findings

We rated older people's inpatient services as Good

Patients care was delivered following a full assessment of needs, over a 72 hour period. Information was gathered from other health and social care professional and family members. Patients were involved in planning of their care and consent was obtained or assessed for all treatments.

Staff received support and training to ensure they had the skills necessary to provide the care needed. However staff were unsure of where the Mental Capacity Act could compliment their practice.

Our findings

Assessment of needs and planning of care

Staff completed a full assessment within 72 hours of a patients admission. This assessment was reviewed at regular intervals, sometimes daily, dependent on their acuity.

In each of the patient files we viewed we saw that they all contained an assessment of their mental capacity. This assessment was solely for their inpatient stay. This 'blanket' assessment of all patients goes against the principles of the Mental Capacity Act 2005. Staff should presume patients have capacity to make decisions. We saw evidence in case files where staff had tried to explain the patients' rights under the Mental Health Act 1983 even when someone was very confused and could not understand simple instructions. These were revisited at regular intervals.

Health care staff carried out baseline health assessments on a daily basis recording at blood pressure, pulse and temperature. These assessments allowed them to recognise changes in the patients general health and treat accordingly. During the daytime patients had access to a junior doctor and/or an advanced nurse practitioner, to ensure their physical health needs were met. If patients required the attention of a doctor during the night then the emergency out of hours services were called.

Best practice in treatment and care

The trust services for older patients with a mental health problem have incorporated the excellence in practice accreditation mentored by Teesside University in to their practice. This scheme allowed the service to bench mark itself against best practice and improve practice. They have also appointed a member of the executive board to monitor guidance provided by the National Institute for Health and Care Excellence (NICE) to ensure their policies, and procedures reflect good practice.

Skilled staff to deliver care

Patients had access to occupational therapy, psychotherapy services consultant, speech and language therapy and the dietician. Staff mandatory training records indicated that by November 2014 over 88% of staff had completed safeguarding level 1 and 2, health and safety, manual handling objects, care coordination, care programme approach and clinical supervision. Only 79% of staff had completed their management of violence and aggression training. The Mental Health Act 1893 and the Mental Capacity Act 2005 were not part of the mandatory training. Most staff told us if a patient who was in hospital on an informal basis wanted to leave the ward they would use their powers under the MHA if they needed to prevent them leaving the ward. They could not identify any of the principles of the Mental Capacity Act 2005. This meant that staff could not be sure they were using the 'least restrictive' method of support with patients.

Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role. In addition to the statutory and mandatory training staff had also completed training in; diabetes care, dementia pathways, epilepsy and challenging behaviour.

New staff had a period of induction before being included in the staff numbers. Ward managers had access to the electronic staff records for their team. This allowed them to oversee their progress in completing their training. The training helped to ensure staff were able to deliver care to patients safely and to an appropriate standard.

Staff were supported by the trust or their line manager to access other training courses. A health care assistant on Roseberry ward told us they had identified a course at the acute hospital about the 'six C's in nursing' as they felt their practice would benefit from this course. A more senior

Are services effective?

Good

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

nurse told us they had just got funding for them to undertake a degree level course. All of the staff told us that training was an important part of their role and they felt supported by their managers.

Staff told us they received regular clinical and managerial supervision every month, where they were able to reflect on their practice and incidents that had occurred on the ward. There were regular team meetings and staff felt well supported by their manager and colleagues on the ward.

Multi-disciplinary and inter-agency team work

Ward round/multi disciplinary team meetings (MDT) occurred once a week for two to three hours where the team reviewed six or seven patients' care and treatment. Patients did not always take part through choice or illness, so the consultant psychiatrist would make contact with the patients following the ward round. The staff who attended these meetings included the consultant psychiatrist, nursing staff, the physiotherapist, a health care assistant and pharmacist. Information was provided by the nursing staff via a summary sheet that was used by the consultant psychiatrist to make decisions about patients' on-going treatment.

There were daily' report out meetings where each patient was discussed to monitor their progress. We attended several meetings and reviewed the records. These meetings discussed a patient's behaviour and general wellbeing as well as external influences on their ability to get well such as their support network. From these meetings staff discussed with families and carers what help they could access. This help included day services, social services, voluntary groups and help with benefits. A visitor told us staff had helped them organise extra help for when a relative goes home. They said "I didn't realise you could get any help the nurses have been marvellous not only with X because they had been violent at times. They have made sure I am alright and we are now getting extra support so I have some support when they come home. They have been fantastic".

We were told that every three months patients who were detained under the Mental Health Act 1983 would have a care programme approach meeting (CPA). The CPA meeting assessed patient needs and planning it included staff from both health and social care services.

Adherence to the MHA and the MHA Code of Practice

Staff told us they had not received training in the Mental Health Act 1983 or the MHA Code of Practice. They told us it was not trust practice to include this in the required training by staff. Whilst the trust does not provide MHA training as part of their mandatory training programme we found that staff were complying with the Act. However, this also meant they could not be sure they were using the least restrictive course of action when providing support for patients.

A Mental Health Act reviewer visited Wingfield ward as part of this inspection they reviewed the detention documentation for the detained patients. Overall, we saw most of the documents were in order and patients were lawfully detained and all the patients' nearest relatives had been consulted during the assessment procedure. However the AMHP report for one patient could not be located and so it could not be determined they were detained lawfully. Patients had been made aware of their rights under the MHA 1983 and in most cases section 17 leave forms had been completed. However one patient had taken section 17 leave but there was no paper work to support this.

Information on the rights of patients who were detained was displayed in wards and independent advocacy services were readily available to support patients.

Staff were aware of the need to explain patients' rights to them. Staff knew how to contact the MHA office for advice when needed and regular audits were carried out to check the MHA was being applied correctly.

Good practice in applying the MCA

Staff told us they were not aware of how the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) could apply to their work. We were told they did not routinely consider the Mental Capacity Act 2005 and worked primarily with the Mental Health Act 1983. A member of ward staff was designated a specialist worker for MCA and DOLS. They received some training in both the MCA and DOLS but staff told us they would contact the trust's safeguarding team for advice. MCA and DOLS training for all staff did not form part of the mandatory training received by staff on a regular basis.

Are services effective?

Good

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

We found on one occasion at Springwood they had used a DOLS for a patient transferring to residential care. The modern matron told us this was not a common occurrence but in this instance it had enabled staff to use the least restrictive option for a patient who was ready for discharge.

Good

Are services caring?

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

Summary of findings

We rated older people's inpatient services as Good

Patients were treated with dignity and respect in all interactions observed. Feedback from patients and their relatives confirmed that staff provided support with empathy and consideration. We saw positive examples of where staff had ensured that patients whose first language was not English could be involved in care planning meetings.

The use of advocates was promoted for patients who required support in understanding their rights whilst in hospital. Patients who used the service and their relatives told us that all staff provided them with information and support about their treatment. They said that as they got better staff enabled them to manage their own health and wellbeing needs.

Our findings

Kindness, dignity, respect and support

Prior to and during the inspection we held listening events and focus groups. Feedback from these events indicated that relatives thought the support provided was 'excellent' and 'the staff seem to really care'. Staff told us "The trust is very patient focused" and when asked what was the most important issue for the trust all staff told us "patient care, the patients are the most important thing for the trust".

Staff treated patients with respect, spent time with them and dealt with everyone in a relaxed and calm manner. We saw evidence that patients with different needs were supported. In one case an interpreter had been used to ensure the patient understood what was going on. The interpreter had visited the ward at least twice a week as well as attending the multi disciplinary meetings and care programme approach meetings. This meant the patient was treated with respect and supported at all times. Some patients had used the telephone interpreter's services. Another patient told us they were able to practice their religion whilst on the ward.

Patients also told us:

•"It's okay here, I am treated well" (Roseberry)

•"Staff treat me with respect and observe my dignity" (Wingfield)

•"Staff are very aware on my privacy" (Picktree)

Relatives told us:

•"We are happy with the care and support offered to X, we attend every day and the care is consistently excellent" (Springwood Ward

•"The care is great I would give it 11/10 I can't fault them" (Westerdale North).

We observed compassionate, knowledgeable and attentive interactions between staff and patients on all the wards. In one instance we observed staff transferring a patient from their chair to a wheel chair. Staff explained what they were doing at all times and the patient was constantly given re-assurance about what was happening. In another instance we observed a doctor spend time with a patient who was not very well and once the doctor had left the patient was joined by a nurse. The patient received reassurance and support when they were not well.

The involvement of people in the care they receive

Patients told us they were involved in their care and that the nurse and/or the doctor explained what was happening. One patient told us "I didn't know what was happening when I first came in but now I am better I understand what is going on and I am looking forward to my first home leave".

We attended multidisciplinary team meetings (MDT) on most of the wards.. Patients were either invited in to the meetings or after the meeting staff explained what had been said and planned in the meeting. On one ward (Roseberry) the named nurse contacted the family once a week to discuss what progress had taken place, this was done with the patient's consent. One relative said "they keep me fully informed and X is going home tomorrow and they have helped us both enormously"

We observed staff answering questions from patients about their care and explaining what was going to happening to them. Patients told us they had used independent mental health advocates to ensure they had been involved in their care even when they were ill. Information was available on the notice boards in the wards about advocacy and how to contact these services.

Good

Are services caring?

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

Staff told us they always talked with the patients after an MDT meeting to ensure they understood what the plan was for their continued recovery and ultimate discharge. Patients had signed their care plans and where that was not possible then their carer had signed it.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated older people's inpatient services as Good because:

Services took in to account the needs of different people; we saw multi faith rooms, menus appropriate for people of different faiths, the use of interpreters. Patients were able to access care and treatment in a timely way.

Patients and their families told us that they did not have any complaints but felt confident to raise any concerns with any of the staff. Staff said they would help patients to contact PALs, advocates or complete a written complaint. We saw evidence that where concerns had been raised in a patient focus group they had been addressed by the ward manager

Our findings

Access, discharge and bed management

The wards provided care to both men and women over the age of 65 and their diagnosis was either organic or functional mental health problem. Staff on all wards liaised with the community services to provide access at the most appropriate time for the patients and families. Staff operated a risk based bed management system and worked flexibly to enable this to happen. Patients were admitted outside of their home area and staff reviewed the admissions in order to assess whether or not the service was the most appropriate.

Discharge was planned for from admission to the wards, and reviewed as part of the CPA or MDT meetings. On discharge patients could be offered both increased support from community mental health teams (CMHT) and help to return to their home environment. Discharge plans were shared with the patients, their GP, their families or carers and other professionals involved in their care.

The environment optimises recovery, comfort and dignity

We visited 12 wards during our inspection. Five of these wards had been purpose built and the remaining seven had been adapted for use with older patients with complex mental health needs. The trust had taken in to account NICE guidelines and Sterling Design standards for people with dementia. An example of what this means is that purpose built properties had a walkway with no end so that when looking for the door or a way out people keep walking rather than banging at a door and becoming distressed. Doors not to be used by patients were painted the same or very similar colour to the corridor whilst doors they were encouraged to use were very different and stood out. Staff told us this enabled patients to maintain their own independence regardless of their mental health problem.

The environments were light, airy, with space for patients to walk, with pictorial prompts to orientate them as to where they were in the building. Patients accessed a safe outdoor space during day light hours.

There was private space available for meetings with relatives in all wards. In recently built units, there was an entrance area separate from the ward for visitors with children to use and for visitors to use following a visit. The majority of the wards had a separate activities room where staff could spend 1:1 time with patients. We also saw evidence that activities took place on each ward.

Patients could access a telephone for private calls on each ward and snacks were available 24 hours a day.

Policies and procedures minimise restrictions

All of the wards were kept locked and informal patients were informed of their rights and how to access and leave the ward. The doors to the internal garden were not always locked and patients could use the garden even if they needed an escort.

Patients were assessed as to their suitability to hold a key for their bedroom. All patients were able to lock their rooms from the inside when they went into them. When we visited, we observed the bedroom doors unlocked and there were no restrictions on use.

Meeting the needs of all people who use the service

All patients who accessed the service had a full assessment of needs including their life history as well as their current illness. This meant that staff had an understanding of patients' cultural religious or medical beliefs. Staff assessed how patients communicated and how they liked to be addressed.

Are services responsive to people's needs?

Good

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

We visited several multi faith rooms, across the trust. Interpreters had been used when necessary.

Where a patient did not have capacity to consent to treatment or access any other support network, staff automatically referred them to an advocacy service to ensure their needs were considered in the care planning process.

We also saw information about how people who could not verbally express themselves communicated and how their behaviours changed when they were unhappy, or wanted something. Staff told us they worked with the carers so they could understand how someone expressed themselves.

On Rowan Lea and Springwood patients accessed a computer system designed to assist them with memory problems and actively take part in reminiscence. A health care assistant showed how it was easy to use. Patients could just slide the pictures on the screen and it brought up a different topic. An example of this was music and in one instance a patient with severe memory problems had been able to identify their own wedding music. Staff noted how the music had a calming effect on the patient so it was saved to the memory of the computer and when the patient became unsettled staff could access the right music to help settle the patient. Another patient had been looking at old pictures of Bradford and they had been able to tell staff what year the photos had been taken based on the uniforms worn by the shop staff. Staff on both wards told us they had found this piece of equipment an easy and very useful way of involving patients in developing their own life histories, interests or just what music patients liked.

Other wards had pieces of art work created by patients displayed around the building. Where patients did not want to take part in art work or creative tasks then staff played games with them. These games included scrabble, bingo, crosswords, and bowls.

Listening to and learning from concerns and complaints

Information on how to make a complaint was displayed in the wards, as well as information on the patient advice and liaison service (PALS) and independent advocacy services. Patients and/or their families knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise a concern should they have one and believed staff would listen to them.

Patients on the wards told us:

"I can talk to with nurses if I am unhappy and they help"

"I would speak to my advocate if I was really unhappy but the staff are always asking how everything is I think they care"

"I don't know how to complain but my relative does and they would if necessary"

Each of the wards had regular community meetings where any issues were discussed. We saw minutes of these meeting and they showed that where patients had complained about something on the ward the ward manager had responded in writing as to what was going to happen. One of these issues was about having fish and chips for tea from a local café and this was organised.

Staff told us that because they talked to their patients every day they quickly became aware if something was wrong and many issues were sorted at ward level. Wards also held a relative's afternoon once a month to encourage relatives to come for afternoon tea and contribute their experiences to staff so that practice could continue to improve.

Are services well-led?

Good

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

Summary of findings

We rated older people's inpatient services as Good because:

Staff had a clear understanding of the vision and values of the trust. They told us they were well supported by the management of the organisation, and received supervision at least 8 times a year but also told us they could request supervision at any time.

Quality assurance systems were in place to ensure the service looked to improve. Discharge feedback was obtained on a monthly basis and the information was used to improve services.

Our findings

Vision and values

Staff understood the visions and values of the organisation. Staff at different levels on every ward we visited could tell us who members of the board were. Several people said they had contacted the chief executive with suggestions or concerns. Several staff told us they had received a response to their concerns.

Good governance

Staff had received regular supervision. We saw evidence on the wards of contracts for individual supervision stipulating that staff would have a minimum of eight hours per year. Staff said they usually had supervision once a month either in a group or as an individual.

Information about 'lessons learned' was circulated throughout the trust in an e-bulletin sent to all staff. These incidents were discussed in team meetings and at handovers as well to ensure all member of the team were involved.

The trust had undertaken a series of audits to check the quality of the services provided. The inpatient wards for older patients with a complex mental health problem were overseen by a modern matron. They carried out regular sample checks of work done on the ward. This included checking case files and auditing training figures for staff and generally talking to patients and their relatives about the service they had received.

Ward managers told us they had enough time and autonomy to manage the wards. They also said that, where they had concerns they could raise them. Where appropriate the concerns could be placed on the trusts risk register.

The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust. One example of this was the electronic staff record that monitored the training that staff had received and informed staff and managers when training needed to take place.

Leadership, morale and staff engagement

Staff had a monthly meeting to discuss any issues on the wards and to look at ways of improving practice. Staff told us that they didn't have to wait for this monthly meetings as they could discuss any issues earlier than required with their manager. Staff felt supported by the management arrangements on the wards and felt that they worked together as a team. On Wingfield Ward staff told us that two staff teams had been incorporated in to one and they felt they worked well together. A member of staff told us that they had recently moved into an established team and been made to feel welcome and well supported by everyone. On Roseberry ward the ward manager told us that they had an additional informal weekly meeting to ensure that staff could access support when needed.

All staff spoken with told us they could also seek extra support if they felt they needed it. They told us that senior staff were always available and if not present they could be contacted by telephone.

Commitment to quality improvement and innovation

The trust had a comprehensive quality assurance system in place to ensure continuous improvement of care. We saw evidence that the meetings produced improvement plans and these were reviewed and updated regularly. An example of this was the trusts' response to the Francis report. The report identified that patient and relative views had not been considered at Winterbourne. As a result of this report the trust had implemented a questionnaire for patients and their relatives when they were discharged from the service. This meant staff were able to continually improve their practice and the patient experience. One

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.

patient said the purpose of their medication had not been explained and a direct result was the instruction 'medical staff to inform patients of changes to their medication as they occur'.

Where medication errors occurred the patient, and their family were informed and an apology was offered. Staff were made aware of the responsibility of the duty of candour in an information bulletin sent to all wards.

A member of the executive board was responsible for monitoring all the National Institute for Health and Care Excellence (NICE) guidance bulletins and ensuring these were incorporated in the trusts own policies and procedures.

Staff were encouraged to put ideas on how to improve services forward to the trust. The trust also had an awards night for staff. The older patient's inpatient team had been nominated for team of the year award and a ward manager from an older patient's inpatient team has been put forward for the leadership award. Staff told us these awards did matter and helped to make them feel valued by the trust and contribute their experiences to staff so that practice could continue to improve.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of having their medication administered as prescribed. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: At Ceddesfeld and Hamsterley medication was covertly administered without reference to the pharmacist or through a best interest meeting. On Hamsterley Ward we found that medication records were not been signed when the medication was given Regulation 12(f)(g)