Good

5 Boroughs Partnership NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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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)
RTV06	Hollins Park	Kingsley Ward	WA2 8WA
RTV04	Leigh Infirmary	Sephton Ward	WN7 1SD
RTV03	Brooker Centre	Grange Ward	WA7 2DA
RTV51	Knowsley Resource and Recovery Centre	Rydal Ward	L35 5DR

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership 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 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

Overall, we rated the wards for older people with mental health problems as good. This was because:

- There were good multidisciplinary teams in place on each ward, which included nurses, doctors, physiotherapists, occupational therapists and other skilled staff.
- The teams worked well together and had good links with community services.
- The inpatient services focused on helping people with their physical health, nutrition and maintaining mobility, as well as their mental health needs.
- The staff we saw were kind and courteous in all their dealings with patients and carers.
- Patients and their family members told us that they were happy with the care they received and were involved in assessing and planning care. They also told us that staff would let them know if things were not right as soon as possible and always kept them informed.
- The wards complied with same sex guidance for accommodation by providing en suite bathrooms. On Sephton ward, where same sex dormitories were provided, there were designated male and female bathrooms and toilets.
- There was a good range of activities and things to do on the wards.
- Staff understood and demonstrated the visions and values of the trust.

However,

- Women-only lounge areas were not available on Grange or Kingsley. The clinic room on Grange ward was warm and staff told us it can vary between 25 – 30 degrees. This could affect the quality of the medications stored there.

Summary of findings

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

Are services safe?

Requires improvement

We rated the wards for older people with mental health problems as requires improvement for safe because:

• Women-only lounge areas were not available on Grange or Kingsley wards.

• The clinic room on Grange ward was warm and staff told us it can vary between 25 – 30 degrees. This could affect the quality of the medications stored there.

However

• when admitted on to the wards all patients had comprehensive assessments of their needs and there were good systems in place to provide on-going monitoring of physical health.

• Everyone had an up-to-date risk assessment and there was evidence that these were being regularly reviewed.

Are services effective?

Good

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

- there were good multidisciplinary teams in place on each ward
- the teams worked well together and had good links with community services
- physical health, nutrition and maintaining mobility were seen as priority areas of patients' needs
- there were flexible visiting arrangements so families and carers could visit and work alongside the ward staff providing practical help and support to the patients
- there was a good range of individual and group activities taking place on each of the wards
- speech and language, physiotherapy and tissue viability staff regularly attended the wards and worked alongside the mental health team
- senior clinical staff provided leadership for the rest of the team around key areas such as safeguarding, infection control and mentorship for junior staff.

Are services caring?

Good

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

- the staff we saw were kind and courteous in all their dealings with patients and carers

Summary of findings

- patients and their family members told us they were happy with the care they received and felt involved in the assessing and planning of care decisions
- family members told us that staff would let them know if things were not right as soon as possible and always kept them informed.

Are services responsive to people's needs?

Good

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

- there was a good range of activities and things to do on the wards
- the service responded well to complaints and worked to improve things based on feedback
- there were no delayed discharges and bed occupancy was well managed
- there was information for carers to ensure they got the information, help and support that they needed
- pharmacists were able to meet with patients and their carers to provide information about medicine and discuss any concerns that they may have.

Are services well-led?

Good

We rated the wards for older people with mental health problems as good for well-led because:

- the trust had worked to reduce vacancies and the impact of sickness levels on the wards
- staff knew who their senior managers were and what the visions and values of the trust were
- the majority of staff were receiving regular line management and clinical supervision
- there were monthly meetings where performance was monitored and action plans agreed to address any problems
- there were systems in place for learning from incidents to be shared across the wards

Summary of findings

Information about the service

The wards for older people with mental health problems were located at four bases across 5 Boroughs Partnership NHS Foundation Trust. Each of the wards was located within a specialist mental health unit based within the grounds of an acute general hospital. There were corresponding community mental health teams at the same locations, which were combined with the wards as part of the later life and memory services.

Kingsley ward had 18 mixed sex bedrooms. Seventeen were single rooms with en suite shower rooms, and one was a double room able to accommodate couples. The majority of patients admitted had organic illness, most usually dementia were from residential and nursing care homes who had been unable to offer the level of support and specialised interventions required. Grange ward was an eight bedroom mixed sex unit that admitted patients with an organic illness, most usually dementia. Rydal ward also provided mixed sex accommodation in 12 bedrooms. The majority of patients were admitted from care homes when there had been problems meeting their needs. The focus of the admission was to reduce the crisis and to have a period of reassessment to determine where the patient's needs could best be met when the crisis had finished.

Sephton ward was a 23 bed dormitory type mixed sex ward, for people with an organic illness. There were an additional eight beds for individuals with functional mental health problems and associated age-related physical health problems. The majority of admissions were through accident and emergency presentation, people assessed as requiring admission by the mental health Rapid, Assessment, Interface and Discharge Team at Leigh infirmary, or people admitted from residential care homes. The trust was moving toward the final stages of commissioning a new mental health inpatient facility to replace this, which would provide more bespoke accommodation and be more in line with the other inpatient wards. The trust aimed to have this completed by December 2016.

This was the first comprehensive inspection of these services undertaken by the CQC. Each of the wards had been visited as part of the work the Mental Health Act reviews, which CQC undertook throughout 2014, and each ward was provided with a detailed report of the findings from those reviews.

Our inspection team

Our inspection team was led by:

Chair: Kevin Cleary, Medical Director, East London NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Patti Boden, Inspection Manager, Care Quality Commission,

Sarah Dunnett, Inspection Manager, Care Quality Commission

The team that carried out the inspection of this core service comprised two CQC inspectors, two qualified nurses, an occupational therapist, an expert by experience and a pharmacist.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew.

To fully understand the experience of people who use these 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?

During the inspection visit, the inspection team:

- visited the four wards for older people with mental health problems across the trust
- spoke to four ward managers
- spoke with 25 other staff members, including doctors, nurses, trainees, housekeepers, pharmacists and occupational therapists
- observed three medication rounds
- reviewed 37 medication charts and associated T2 and T3 documents
- attended and observed two handover meetings and three multidisciplinary meetings and a care programme approach meeting
- attended five groups provided by the activity co-ordinator and attended by a number of patients and nursing staff
- spoke to nine carers and received a comment card completed by another
- spoke with nine patients who were using the service
- reviewed the welcome packs available for each of the wards
- spoke to an independent mental health advocate
- observed staff undertaking their work
- looked at 16 treatment records, which included care plans and risk assessments
- reviewed medication management and a range of other policies and procedures on the wards.

What people who use the provider's services say

Patients told us they were happy with how clean and well-kept the wards were, in particular the bathrooms. Patients told us staff were kind, courteous and always patient. When they were asked, they said they thought there were enough staff on duty on the wards. Patients also told us they liked the food. Patients told us they were able to continue to shower and dress themselves and to choose their own clothes, but staff were available if they required assistance.

Family members and carers told us they were satisfied with the care that their relative received. They told us that the ward areas and individual bedrooms and bathrooms were clean and well kept. Carers and family members told us that, in general, there seemed to be adequate numbers of staff and they were familiar faces. Family members told us that staff always treated them with kindness and patience and that they had confidence in them. Carers and family told us their positive comments were for the whole team from the manager to the housekeepers and cleaners. Family members were told they could visit anytime, except during meal times, unless they were doing so to assist their family member to have their meal. They said when they have had worries or concerns they felt listened to by the staff, who always tried to address them.

When we asked patients and their relatives if they had been involved in drawing up care plans and risk assessments not all of them knew what we meant. They were able to explain that they were asked lots of questions about how things had been and what they would like to be different, and their preferences and wishes about discharge planning. It was clear that they were involved in assessments and care plans, but were not always clear how staff used the information to inform care plans.

Summary of findings

Good practice

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

The trust must ensure that female only lounge areas are available and clearly identified for patients on all of the wards.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should review the practice of leaving open door observation windows into patients' bedrooms.
- The trust should continue the work addressing the temperature of the clinic room on Grange ward.
- The trust should ensure the use of the Careflex Smart seat is recognised as a potential mechanical restraint and is included in an associated policy.
- The trust should ensure that it maintains the recent improvement in staff receiving line management supervision.

5 Boroughs Partnership 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
Kingsley Ward	Hollins Park
Sephton Ward	Leigh Infirmary
Grange Ward	Brooker Centre
Rydal Ward	Knowsley Resource and Recovery Centre

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act (1983). We use our findings as a determiner in reaching an overall judgement about the Provider.

- Patients that were detained under the Mental Health Act (1983) had the required paperwork in place.
- There was access to an independent advocate for all detained patients and these workers maintained regular contact with the wards.
- Patients were being informed of their rights and we saw that written information was also being provided for patients and relatives.

Mental Capacity Act and Deprivation of Liberty Safeguards

The majority of patients on the wards for older adults were detained under the Mental Health Act 1983 (MHA). There was evidence that the trust was making applications under the Deprivation of Liberty Safeguards (DoLS) where appropriate. Staff demonstrated a good understanding about the Mental Capacity Act and there was evidence that patients were supported to make their own decisions wherever possible.

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

Our findings

Safe and clean environment

All the wards appeared clean and there were detailed cleaning schedules completed each day. Nursing staff locked the doors leading to the bedroom corridors during the day. This was because the en suite bathrooms had a number of aids such as hand rails and these were potentially ligature points. Staff said there was also an increased risk of falls if patients were not supervised. Staff stated that any patients who wished to have an afternoon nap would be able to do so in one of the quieter ward areas. The exception to this would be if someone were physically unwell; in those circumstances, they would be able to spend time in their rooms. All bedrooms had nurse call systems, but not all the bathrooms.

The wards were well-decorated with block colours and different coloured bathroom and toilet doors. Using colour and contrast can help patients remain more independent by helping them to find their way around the ward if they have failing eyesight. There were uncluttered corridors and patients were able to walk around if this was their preference. There were handrails to assist with mobility. The furniture was in generally good condition. There were bright pictures and enclosed notice boards.

All the wards were mixed-sex. On Sephton ward bedrooms were same sex small dormitories. The other three wards provided single room accommodation, with access to en suite shower and toilet with bedrooms for males and females located on the same corridors. Women-only lounge areas were not available on Grange or Kingsley wards. Staff stated that at night there were nurses stationed on each of the bedroom corridors, which improved the safety of patients, especially in light of non-separate male and female bedroom areas. Some of the bedroom doors had window viewing-panes that could be fully opened to enable staff to have an unobtrusive view into each bedroom. These could not be closed from within the room.

None of the wards had seclusion rooms, but each ward could access a seclusion room on a neighbouring ward if this was required.

There were specialist baths with hoists on each of ward and hospital standard profiling beds were available. There was evidence that these were checked regularly. Managers confirmed they were able to rapidly access additional equipment, such as pressure cushions.

Each of the wards had well-equipped clinic and treatment rooms and facilities for undertaking a range of physical interventions. Nursing staff regularly checked the emergency equipment, medication cupboards and fridge temperatures on a regular basis.

The heat in the clinic room on Grange ward was noted to be excessive and staff stated that at times the temperature was between 25 and 30 degrees. While some medicines will be unaffected at temperatures consistently above 25 degrees, this is not the case for all. Staff told us they had reported this issue on a number of occasions to senior managers. The trust provided assurances that they were working to ensure the safe storage of medication in all its clinical areas. This issue had been placed on the risk register.There were on going actions in place for addressing this.

There were clear protocols in place for infection prevention and these were well-communicated across the staff teams. The housekeeping staff on the wards were informed of the clinical indications of bacterial infections, such as MRSA, and were able to undertake appropriate cleaning and safe disposal. The housekeeping staff had effective systems in place for communicating and maintaining a safe environment within the wards.

Safe staffing

Staffing posters were displayed on each ward. These detailed the planned and actual number of nursing and care staff for the day and night shifts that week. The ward administrators were responsible for updating the posters each day. These enabled patients, visitors and staff to see how the ward had been staffed over the week. Staff told us it was unusual to be left short-staffed and they were supported by senior managers to replace staff that were off sick or to get more staff if required due to clinical need. There were usually two qualified nursing staff on each shift

Requires improvement

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and a number of health care assistants. At night, there was usually one qualified staff nurse on each ward. The staff that comprised the multidisciplinary team were in addition to these figures.

The trust provided the following information about staffing:

Staffing establishment (WTE):

Kingsley ward - qualified nurses 13.1 nursing assistants 15.8

Sephton ward - qualified nurses 13 nursing assistants 20.6

Grange ward - qualified nurses 8.8 nursing assistants 13.4

Rydal ward - qualified nurses 13 nursing assistants 12

Staffing vacancies (WTE):

Kingsley ward - qualified nurses +0.1 nursing assistants 1.4

Sephton ward - qualified nurses 0.7 nursing assistants 2.2

Grange ward - qualified nurses 1 nursing assistants 0

Rydal ward - qualified nurses 5 nursing assistants 1

Staff sickness:

Kingsley ward - 3%

Sephton ward - 8.8%

Grange ward - 3%

Rydal ward - 14.5%

There was significant sickness levels on Rydal ward. The ward manager was managing this sickness in line with the trust policy and was working toward staff members successfully returning to work.

The wards mostly used bank staff to ensure that they were familiar with the wards, but on occasion agency staff were also used. In some instances, agency staff were block booked for a set period of time to ensure continuity and consistency across the team. Managers told us that when bed occupancy was at the preferred 85% rate, the staffing levels were adequate. A key pressure for staffing was if patients needed to be escorted to general physical health appointments or urgent investigations, which was more likely with this patient group and it was often at short notice. This could require staff to be off the ward for an extended period of time.

The majority of mandatory training was accessed through the trust's Oracle Learner Management (OLM) system. Training courses were accessible via the OLM system. Across the four wards, the majority of staff had completed the mandatory training, in compliance for trust target of 85% of staff having completed the following training.

Fire safety	78%
Infection control	100%
Moving and handling	89%
Basic life support	86%
Immediate life support	89%
Information Governance	89%
Equality, diversity and human rights	93%
Conflict resolution	85%
Health and safety	99%
Risk management	97%
Safeguarding children	85%
Safeguarding adults	93%
Clinical risk and risk management	22%
Medicines management	25%
Mental Capacity Act	89%
Mental Health Act	87%
Dual diagnosis	2%
Care programme approach	24%
Restrictive physical interventions	94%
Rapid tranquilisation	14%

An action plan had been implemented in order improve access to these mandatory training, which the trust shared with us during the inspection. We were informed the trust were in the final stages of completing a review, which would be followed by an update of the training packages

Requires improvement

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relating to the below five mandatory training courses. Staff from the older adult inpatient wards would have access to eLearning packages for the training courses by September 2015 via the OLM system:

- clinical risk assessment
- dual diagnosis
- care programme approach (effective CPA)
- clinical supervision
- rapid tranquilisation

The action plan identified that training for medicines management and moving and handling (patient) would be provided locally and would be reliant on local arrangements for these to be completed:

All newly qualified nursing staff undertook a period of preceptorship where they were offered a period to guide and support their on-going development to make the transition from student to a competent qualified staff member. There were induction plans on each of the wards for new starters, including bank and agency staff. All qualified nursing staff had a medication competency assessment when commencing work on the ward and the pharmacy staff regularly audited medication management issues including signing of prescribed medications. Ward managers were informed if there were problems with how medicines were managed.

Assessing and managing risk to patients and staff

Staff on the wards were aware of the trust's observation policy and any patient observations undertaken were and records of patient observations were thorough and precise. A staff member was allocated to undertake set observations for each shift. Staff were able to explain actions that would be taken if a patient were to go missing from the ward. Staff had a good understanding about safeguarding and what types of situations would generate a need for a safeguarding referral.

The trust used an electronic risk reporting system and staff knew what types of actual incidents and near-miss incidents should be recorded with it. The trust provided the following details of incidents of restraint, seclusion and the use of rapid tranquilisation. The following data was from October 2014 to April 2015:

Incidents of seclusion:

Kingsley ward 4

Sephton ward 1

Grange ward 0

Rydal ward 3

During the same period of time there were no incidents of long term segregation.

Incidents of restraint:

Kingsley ward 393 (1 prone restraint) 24 rapid tranquilisation

Sephton ward 137 (2 prone restraint) 54 rapid tranquilisation

Grange ward 66 (1 prone restraint) 6 rapid tranquilisation

Rydal ward 102 (1 prone restraint) 11 rapid tranquilisation

Based on the data provided by the trust, the highest number of restraints occurred on Kingsley ward. This was one of the larger inpatient wards and the majority of patients admitted required care and support that could not be provided by the staff form the residential and nursing homes they had been admitted from.

All of the staff spoken to could describe the various techniques that they employed to help patients who are becoming distressed or agitated. The trust directs that restraint should only be used as a last resort and all the staff we spoke to supported this. Each of the wards had pleasant garden areas, quiet rooms and areas where patients could go if they wished to remove themselves if the ward area was becoming too busy or they needed some space. Staff said it was rare to place a patient into a face down or prone position during an episode of restraint and in the event that this happened they would clearly record it as such on the electronic risk reporting system.

On Rydal ward, a specialised posture support chair, which included a lap belt, was occasionally used with patients. Posture support chairs are used to provide comfortable pressure relief whilst sitting and are specifically for patients with poor mobility who present as a high risk of falls. However, the care plans and risk assessments that were reviewed did not clearly detail when the chair should be used as a clinical intervention. This was highlighted to the trust at the time of inspection, which took immediate

Requires improvement

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action. When we returned to the ward a few days later there was a clear protocol in place detailing specifically when the chair could be used, with care plans and risk assessments being updated to reflect the new protocol.

Each ward had access to a number of chair and bed sensors. Sensors are particularly useful when patients are frail and at additional risk of falling. These had been used successfully and the four older adult wards were in the process of purchasing more. These sensors were part of the trust's falls management strategy. A lead nurse on each ward acted as the falls champion. They provided an additional resource to the team around best practice. They were also the wards' link to the trust-wide falls group. All falls were recorded on the electronic risk recording system. Data provided by the trust showed that there was a 21% reduction in falls across all wards during 2012/13 after implementation of the falls strategy actions.

Each ward had a tissue viability champion who worked closely with specialist tissue viability nurses in the acute hospitals to ensure access to best care and treatment for their inpatients.

Managers explained that risks that had been reported were reviewed in a monthly performance meeting attended by the modern matrons and the business managers. Staff confirmed that when there had been untoward incidents, they were informed of them and in particular about lessons learned in order to ensure, where possible, that similar incidents could be avoided in the future.

Each of the wards had undertaken a local ligature risk audit. These were annual assessments undertaken on each inpatient ward to ensure staff were made aware of any facility from which ligatures could be created. This provided staff with a clear picture of the potential risks associated with patients who might self-harm to assist in managing and minimising those risks. However, on Kingsley ward, we found non-collapsible shower rails in some en suite bathrooms. The removal of non-collapsible shower rails was a requirement of the Department of Health in 2004. The trust took immediate action when informed of these. Within a week of the inspection, the trust confirmed the rails had been removed and replace with collapsible rails.

The majority of the ligature risk points across the wards were present due to the extra facilities in place for bedroom mobility and bathroom assistance. Staff stated they managed these by keeping bedroom doors locked during the day and locking the toilet and bathroom doors. During the time we spent on the wards, we saw that staff acted quickly if someone appeared to want to go into the toilet and would immediately unlock the door. The staff waited until the patient had exited the toilet before locking it again.

There was clinical pharmacy support provided to each of the wards. A pharmacist regularly visited to the wards to review medication charts, oversee the safe and secure storage of medicines and offer clinical input to staff, patients and carers. The pharmacist also ensured that there was liaison with GPs after an admission to ensure medications that someone had been on prior to admission to the hospital were continued if this was required.

Staff we spoke with had a good understanding of safeguarding vulnerable patients and what to look out for. They knew their roles and responsibilities in raising and reporting concerns. There were posters in the staff areas on all the wards detailing what to do if they were concerned about either child or adult abuse. The trust had a safeguarding lead that staff were able to contact for advice if required. A body map was completed on admission across all the wards as part of the inpatient additional safeguarding assessments.

During medication rounds, staff wore distinct tabards to indicate they were undertaking a medication round. This was to ensure they were disturbed as little as possible. They were observed undertaking the rounds effectively, checking the identification wristbands that each patient was wearing.

Track record on safety

Throughout each shift, staff were deployed to different areas of the ward to ensure that all areas were observed and to ensure all patients had access to staff. On Rydal ward, there was detailed information regarding falls that had occurred on the ward. This was displayed on the staff notice board as a large poster. This identified the time and the area of the ward where patients had previously had a fall. This information had been compiled following an audit of incidents on the ward. The information had then been used to assist in deployment of staff across areas to reduce the risk of further falls.

Serious and untoward incidents may 2014 - April 2015

Kingsley ward - 4 unexpected deaths 2 slips, trips and falls

Requires improvement

Are services safe?

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

Sephton ward - 1 unexpected death 1 grade 3 pressure ulcer

Grange ward - 0

Rydal ward - 2 unexpected deaths 1 medication incident

The wards had previously experienced a number of serious and untoward incidents and provided detailed reports from the electronic risk recording system about these. The staff were aware of what needed to be recorded and how to do so. There was evidence that the trust undertook comprehensive reviews following serious and untoward incidents, completed within three days of the incident occurring. In the event that more detailed investigations were required to provide better understanding of the events that occurred, the trust would ensure that this was completed by someone who did not work directly within the service where the incident occurred. The report would aim to review any lessons learned and to ensure that these were cascaded across services to ensure other clinical areas could take steps to avoid a similar incident occurring. Staff confirmed they were informed of this learning in individual supervision, in team meetings and by communications in the core brief. There was evidence that debrief meetings occurred in order to offer immediate support to staff. Staff we asked confirmed that the trust dealt with incidents in a positive manner without adding additional stress to staff involved.

Staff told us they aim to let patients and relatives know at the earliest opportunity if there had been problems and carers we spoke to confirmed that staff keep them informed at all stages. The trust sent a regular "core brief" with detailed information and updates from across the trust. There were systems in place on all wards for staff to confirm that they had read the core brief.

Reporting incidents and learning from when things go wrong

Staff we spoke with had a good understanding of incident reporting and were clear on their responsibilities. The staff understood about the Duty of Candour and said that ward staff contacted relatives as quickly as possible to inform them of any issues that had arisen. There was evidence of this in the clinical records.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Occupational therapy staff attended the MDT meetings and daily handovers. They provided individual or group work, to complete detailed and comprehensive assessments. Physiotherapy posts had been recently filled and this had improved access to specialist assessments and interventions.

The inpatient wards used a range of standardised assessment scales including for specific physical assessments such as pressure sore assessments, mobility and falls risk, to review and assess diet and fluid intakes and specific assessments to assess and monitor improvements to mental health. Comprehensive assessment meant care plans were individualised to meet very person specific patients' needs.

There was a lead on each ward for the advancing quality indicators who ensured that required assessments and specific interventions within clear care pathways were completed as required. The lead audited that they had been done and reminded staff about the range of assessments that required completion. The trust data was submitted as part of the national advancing quality (AQUA) submissions and can be compared across other similar organisations.

The trust used an electronic clinic record system called OTTER, which all inpatient nursing staff completed. However, this system was not accessed by all clinical staff in the trust. Risk assessments, care plans and contemporaneous notes were completed in OTTER by the nursing staff and then printed out and placed in a hand written medical records folder. These larger clinical records contained entries by anyone else involved in the clinical care and these were hand written in defined sections within the clinical records. The trust was moving toward a new electronic clinical record system that will be used by all disciplines of staff.

An interests' checklist had become part of the 'Welcome Pack' on the wards and all patients families were encouraged to complete a "this is me" booklet to enhance ward staff knowledge and understanding of the patient and their needs, preferences, likes and dislikes. There was evidence of these completed booklets in a number of the clinical records.

Sixteen care plans were reviewed during the inspection and these were generally of a good quality. The care plans were up to date and regularly reviewed, usually monthly but more often if required. They covered a broad range of needs including physical health needs and were recovery focused. All the notes reviewed had up to date risk assessments and risk management plans.

Best practice in treatment and care

The trust had a National Institute for Health and Care Excellence guidance group. This group reviewed best practice and communicated these across services. These included promotion of best practice in older adult mental health care and supported the design and implementation of care pathways that clinical staff were able to follow. The trust was required to submit information in relation to advancing quality indicators, and the national safety thermometer which specifically monitors how well a trust is managing four specific types of harm including pressure ulcers and falls. The trust continued to undertake patient-led assessments of the care environment and the actions identified in the most recent assessment in 2014 had all been completed.

Staff members were allocated to specific patients at meal times to support with feeding and drinking or to provide prompts. There was protected meal times on all the wards, with the exception of Kingsley. This was to ensure time and attention could be devoted to ensuring adequate nutrition and fluids. Family members were encouraged to come and assist with meals if they wished to support their relative. There were noticeboards with detailed information about the services available for carers and families, with leaflets explaining about carer assessments and how to access these.

Each ward had an activity coordinator who provided a range of individual and group sessions. Groups were provided by other MDT staff and included exercise groups and cognitive stimulation groups. The groups in progress during the inspection were well received by the patients and delivered by the nursing and occupational therapy staff. The activity coordinators demonstrated abilities to engage with all the patients despite differing needs and the patients attending the groups observed were well engaged and appeared to enjoy the activities.

Staff on Sephton ward described that due to the size of the ward it could take up to two hours to complete the larger

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.

medication rounds. The manager told us that there had been lots of work done to try to reduce the amounts of medications being dispensed at each round but with limited success.

A number of patients had a do not attempt resuscitation order in place. There were clear processes in place for ensuring this was discussed with the patient, where appropriate, and their families. These were well communicated and included agreements and communications between the inpatient wards, care homes, GPs and residential care services.

Skilled staff to deliver care

In addition to the nursing and health care assistants on the wards, physiotherapy vacancies had been filled and all wards had access to specialist assessments and interventions. Speech and language therapy staff regularly attended the ward following referrals and the ward staff were supported by the palliative care teams in the locality if this was required.

There was a full time occupational therapist at each unit where the older adults wards were. They provided two full clinical days per ward each week. . There was access to tissue viability specialists and they worked alongside the ward staff to ensure best practice. Staff told us this had improved their knowledge about wound care and access to specialist equipment. Rydal ward had regular access to four hour of psychological interventions but access for the other wards was by referral to the community services and unlikely to be in place prior to discharge. There was no representation by psychological therapy staff at the meetings that we attended.

Each of the wards had a dedicated consultant psychiatrist assigned to the inpatient ward. The exception to this was Rydal ward where each of the three community consultants continued to provide medical care within the hospital.

The senior nurses on each of the wards took lead responsibility for falls, mental capacity, deprivation of liberty knowledge, safeguarding adults, tissue viability, infection control and student link/sign-off mentorship.

The wards reviewed learning deficits within their own teams. In addition to ensuring attendance at mandatory training staff, individual wards utilised the knowledge within their own team to provide more informal training. For example, Kingsley ward had arranged additional training in relation to mental capacity/advance directives and lasting power of attorney.

Multi-disciplinary and inter-agency team work

There was evidence of good multidisciplinary team (MDT) working. MDT and review meetings with patients and family that we observed during the inspection were effective. They were structured to ensure attendance by other health professionals from outside of the ward teams including carers, family and staff from the community teams.

We observed effective handover meetings where information was passed between the nursing staff that had been on duty to the new shift taking over. There were well-managed multidisciplinary team meetings and care review meetings. Staff on the wards had a good knowledge of the patients' needs and progress and that they discussed issues such as capacity, preferences and wishes in those meetings. Families were involved in care, information was shared with them and explanations of care given. All multidisciplinary staff contributed to the medical records.

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

The wards confirmed that a high proportion of patients admitted were subject to detention under the MHA. The wards were well supported by the administration staff from the MHA office. There was information about the MHA in the welcome packs for the wards, which included a leaflet about an individual's rights and responsibilities as an informal patient. The patients that were detained had the correct legal paperwork in place in their files.

There were established procedures for managing covert medication administration. The covert medication plans were attached to the appropriate medication charts and clearly indicated which medications had been agreed for covert administration. A copy was also located within the clinical records. All of the wards had systems for administering covert medication, which meant disguising medication in order to persuade someone to take it. Staff confirmed medication is offered in the first instance and administered covertly only if the patient declined to accept it. The administration of covert medications was observed on two of the wards and these correctly followed the trust procedure.

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Patients had access to independent mental health advocacy services and the worker visited the wards regularly and always in response to referrals. Details explaining how to contact the advocacy workers was given in the information packs for the ward, displayed on posters in all the wards and their involvement checked in the multidisciplinary meetings. The advocate was able to meet with family members and undertook home visits to discuss with family members what help may be available if this was required. The advocate also attended the ward review and then provided feedback to family if they had been unable to attend.

Good practice in applying the Mental Capacity Act

Staff we spoke to had a good understanding of the Mental Capacity Act, in particular that capacity can fluctuate and capacity assessments should be undertaken specifically in relation to a specific decision. Mental capacity assessments were carried out at admission and specifically relating to medication. An allocated named nurse ensured that there had been a meeting with the patient, and their family, if appropriate, to discuss medication and to explore consent. This was followed up in the multidisciplinary meeting. We saw evidence of this in the clinic notes and at the meetings attended during the inspection. Best interest meetings were held to review administration of medication without the persons consent and to agree if this was to occur.

There was evidence that the trust were appropriately completing Deprivation of Liberty Safeguards (DoLS) and a total of 27 DoLS applications were made between 1 January 2014 and 13 May 2015.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Patients told us they were happy with how clean and well-kept the wards were in particular the bathrooms. Patients also told us the staff were kind and courteous and always patient. When asked, they said they thought there was enough staff on duty on the wards. Patients also told us they liked the food. Patients told us they were able to continue to shower and dress themselves and to choose their own clothes, but staff were available if they required assistance. The exception to this was one patient who described being shouted at for doing stupid things such as being late going for his meals. We observed staff behaving toward people with courtesy and respect, and saw them attend to individual needs, including personal care, in a manner that maintained their dignity and privacy.

Family members and carers told us they were very satisfied with the care that their relative was receiving. They stated they found the ward areas and individual bedrooms and bathrooms were clean and well kept. Carers and family told us that, in general, there seemed to be adequate numbers of staff and they were familiar faces. We were told staff always treated their family members with kindness and patience and they had confidence in them. Carers and family members told us their positive comments were for the whole team from the manager to the housekeepers and cleaners. Family members were told they could visit anytime, except during meal times, unless they were doing so to assist their relative with their meal. They said when they have had worries or concerns they felt listened to by the staff and they always try to address concerns raised.

When we asked patients and their relatives if they had been involved in drawing up care plans and risk assessments not all of them knew what we meant. However, they were able to explain that they were asked lots of questions about how things had been and were asked what they would like to be different, as well as their preferences and wishes about discharge planning. It was clear that they are involved in assessments and care plans but maybe it is not described to them in that way.

The involvement of people in the care that they receive

Staff on the wards showed us a comprehensive welcome pack they gave to all patients when they arrived on the ward. In addition to giving information and detail about the day to day routine of the ward, patients and carers were encouraged to complete the enclosed patient activity checklist and “this is me” booklet. This was to encourage patients and their families to share as much personal information, including likes and preferences as possible.

Ward reviews and meetings were planned to ensure families would be able to attend. The advocate representative also stated they often attended and met with family later to feed back. There was little evidence that patients had been given a copy of their care plan but there were notes in the clinical records detailing when staff had discussed the care plans and provided updates to carers and family members in the contemporaneous records. The relatives and carers that we spoke with told us they were kept informed of their relatives’ progress and notified about any problems or incidents. A patient told us he had not heard of a care plan but that he recalled being asked on a number of occasions about things he liked and disliked. He also said his family visit often and spent time with staff as well.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

NHS England collects data about the total number of beds occupied from all inpatient wards in the NHS. NHS England suggests that if bed occupancy rises significantly above the target of 85% it may begin to affect quality of care. The trust had set a target of bed occupancy of 85%.

The trust provided the following information about the bed occupancy in older people inpatient wards in the trust for the period October 2014-March 2015:

Kingsley Ward 85%

Siphon Ward 85%

Grange Ward 84%

Rydal Ward 91%

Overall the majority of the wards managed bed occupancy within the 85% trust target. There were no delayed discharges at the time of the inspection and those which had occurred tended to be a result of awaiting agreement for funding for a patient to be discharged to a specialist home. There were daily bed management meetings across the trust and the ward staff felt well supported in patient flow between admission and discharge processes.

The facilities promote recovery, comfort, dignity and confidentiality

Each ward had a dining room that could accommodate all the patients for meals. There were menus in the dining rooms so patients could see in advance what meal choices were available and dementia-friendly bright crockery. Adapted cutlery was available where required. The main kitchen was locked when the meals were completed, but patients had access to soft drinks 24 hours a day; hot drinks and snacks were also available on request.

There were lounges, activity rooms and access to pleasant enclosed gardens. The wards had televisions in the lounges areas, with the exception of Kingsley Ward. We were informed a patient had tried to pull it from the wall a few days earlier. There was a pay phone with a privacy hood available on each ward.

Each of the wards had quieter areas, a dining room and activity rooms, which could be used to meet with family or for private interviews. There was a dedicated area away from the ward for meeting children. These were in addition to patients having their own rooms and a bathroom. The exception to this was Sephton ward, which provided dormitory style accommodation. In addition, each ward had a pleasant garden area and was located within an inpatient facility with access to the dining and café facilities at the general hospital sites where the wards were located.

Each ward had adjustments for patients and visitors who required disabled access. There were private toilet and shower facilities and each ward had bathing facilities including hoists with adapted baths. Individual bedrooms could be personalised but we found few had done so and patients and carers informed us this was their choice as the admissions to the wards were seen as short term only. In contrast, the walls in the corridors and lounges were bright and colourful with lots of interesting information, details and pictures. There was variety of items on display including information about local support services, and posters and pictures detailing key historic events throughout the dorridors. There were large clocks in all communal rooms and in each bedroom.

Most of the individual bedrooms on the wards had little personalisation and we were told this varied between patients and depended on what family and friends brought in for them. Carers we spoke with confirmed they tended to bring few belongings into the ward as they viewed their relatives stay as short and time limited.

There was a choice at meal times and people could access hot and cold drinks as they wished. There were activities available on the wards as well as activities to attend off the ward on a one to one basis. At present, the activity coordinators are only available Monday to Friday but two of the wards were reviewing the possibility of extending activities over the weekend also.

Meeting the needs of all people who use the service

Activity coordinators provided group work on the wards but also undertook one to one work with patients such as going for walks or shopping. The wards had developed a room focusing on reminiscence. On Grange ward, this was called the tea room and small tea parties were held in this room or group reading sessions. There were plans to increase the work of the activity coordinator on Kingsley ward to cover seven days per week.

Staff understood, promoted and supported patients diversity and looked to meet individual cultural, language

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Good

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and religious needs. Each of the wards were regularly visited by a local chaplain and other faith leaders were contacted as required. Arrangements were in place to meet dietary needs. Information leaflets and access to interpreters for patients and carers whose first language was not English were available.

Families were encouraged to visit and there were no restricted visiting times except for from late evening and protected meal times. Carers were given information about contact details for support services and carer assessments. Rydal ward had successfully implemented a system by which patients and their family and carers could maintain closer contact by the use of an iPad and skype meetings. This had been effective locally but had also enabled a patient to maintain regular contact with their family in Australia. Pharmacists provided information for relatives in medication information groups.

Listening to and learning from concerns and complaints

Leaflets advising how to raise concerns and make complaints were available on the wards, in the welcome packs and detailed in posters on noticeboards**.** Staff told us they tried to resolve the concerns when patients or relatives raised complaints with them and if they were unable to resolve concerns at that point would ensure people knew how to raise their concerns formally. During the inspection, we spoke with carers who informed us that the ward staff maintain regular contact with them and let them know immediately if there had been any problems.

The trust provided us with the following information regarding complaints received over a 12 month period – although there was no specific date indicating what this time period referred to:

Kingsley Ward had received six complaints and two were upheld.

Sephton Ward had received six complaints and three were upheld.

Grange Ward had received no complaints.

Rydal Ward had received two complaints and two were upheld.

No complaints had been referred to the ombudsman.

The trust had investigated a number of complaints. The trust governance team stated they had made recommendations following the lessons learned in all of these complaints.

Are services well-led?

Good

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

Our findings

Vision and values

We saw evidence of the NHS England's endorsed 6 Cs care, compassion, commitment, competence, communication, and courage throughout the wards. There posters displayed within many of the staff areas. The trust's visions and values were displayed on the splash screen of all the trust computers.

The trust circulated a regular core brief and we saw that these were discussed in detail within team meetings. In addition, staff were required to sign to confirm that they had read the most recent edition. Staff we spoke to could describe the types of information and detail shared via the core briefs. These briefs included lessons learned.

Ward staff were aware of immediate senior managers responsible for their areas and described knowledge of very senior staff within the trust.

Good governance

Appraisal and associated personal development plans were in place for the majority of staff. The trust policy stated that line management supervision should be every six to eight weeks. There had been a recent significant improvement in the provision of supervision across all the teams with the majority of staff receiving line management supervision in June 2015. Across the wards, however, a number of staff had received no line management supervision for between eight and 12 months. This excluded staff who were absent from work long term through sickness or maternity leave.

Staff that were new in post confirmed that, prior to starting on the ward, they undertook a range of essential training as part of their induction and were given good quality preceptorship support. The majority of staff had not completed all mandatory training but this was in the process of being rectified and was going to be available for all staff from September 2015 via the eLearning system.

There were monthly meetings with ward managers and senior clinical leads, modern matrons and business managers. These meetings looked at all areas of governance and performance and monitored the directorate risk registers.

The trust had started briefing sessions with all staff called the future fit events. These were meetings for the trust to share information about the plans to return services back to individual boroughs and marked the commencement of the staff consultation process.

Staff undertook some clinical audits and were fully compliant with advancing quality indicators and safety thermometer audits. Pharmacy staff ensured regular audit of all medication management arrangements and notified ward managers and senior nursing staff if there were issues that required addressing with individual staff members.

Staff confirmed the rota staffing mix was appropriate and additional staff was sourced via the bank or through an agency when patients' clinical needs required extra resources to ensure the safety on the ward.

Leadership, morale and staff engagement

Staff described that morale was good generally. They described feeling supported to do their job and that they were encouraged to undertake a range of training over and above the mandatory requirements. This included encouraging staff to undertake maths and English GCSE qualifications and to access NVQ 3 training if they wished to.

The trust scored slightly lower than it had the previous year in the most recent friends and family test in the section asking how good was the trust to work for. It scored as well as other comparable trusts and better than some, in the section asking if staff would recommend the trust as a good place for their own family to receive care and treatment.

In the 12 months before the inspection Rydal ward had struggled with sickness levels of 16%. The high level was because of long-term sickness. The trust had appointed staff on a one year temporary basis to address the shortfall. In addition there had been 12% nursing vacancies over the same period and again the trust was in the final stages of recruiting staff. Similarly, although sickness levels on Sephton ward were lower over the same period, at 9%, there were also staff vacancies at 14% that had added to staffing pressures. Again, the trust had taken action and were in the process of appointing staff to vacancies.

Commitment to quality improvement and innovation

There was evidence in the team meeting minutes that the trust communicated with the services in relation to lessons

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learned and these lessons were cascaded to the rest of the team on the inpatient wards**.** We saw examples of these in every ward. Ward managers were able to detail specific lessons that were learned and practice changed in relation to incidents and learning with in their own wards.

The trust encouraged staff to undertake leadership training. In addition most of the wards were engaged with the accreditation for inpatient mental health services. This demonstrated the older peoples inpatient wards were involved in a process of reviewing good practice and the quality of care and were working toward addressing areas for improvement. The wards also had improved scores in the most recent patient-led assessments of the care environment. There were two issues of concern identified within the inspection and both of these were addressed swiftly and efficiently.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect In two wards there were no identified female only lounges which is not in line with best practice. This was a breach of regulation 10(2) (a)