Good

Oxleas NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Date of inspection visit: 26 - 28 April 2016
Date of publication: 13/09/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RPGAR	Memorial Hospital	Oaktree Lodge	SE18 3RZ
RPGAE	Oxleas House	Shepherleas Ward	SE18 4QH
RPGAH	Woodlands Unit	Holbrook Ward	DA14 6LT
RPGAD	Green Parks House	Scadbury Ward	BR6 8ND

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	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

We rated Oxleas NHS Foundation Trust as good for older peoples' mental health wards because:

- All the wards were well resourced in terms of staff, environments, and activities. The staff teams were consultant psychiatrist led and came from a range of appropriate disciplines. Each environment had older people in mind and were suitably adapted with the right resources. The activities on offer were varied, age appropriate and were rehabilitative in approach.
- Holbrook ward had been purpose built as a dementia specific ward to meet the specific needs of the patient group. For example, there were bespoke rooms, furniture and even smells to provoke pleasant memories.
- Oaktree Lodge offered and provided comfort, spiritual and religious support and activities to people with long-term conditions and some who were at the end of life.
- Staff appraisal, mandatory training and supervision rates were high and there was a commitment from the trust in continuing professional development, career progression and specialist training for their staff.
- Staff used evidence-based tools to assess, monitor, and manage individual patient needs and risks. Assessment and planning was thorough and considered the patient's physical and mental health. Family, carers and other professionals were involved in the patients' treatment.
- Staff used outcome measures to assess treatment effectiveness.
- All patients and carers we spoke with were positive about the service's care and treatment, and patients said they felt well supported. The service had a carers' support group.
- Staff had a commitment to quality improvement and innovation. Clinicians took part in audits to improve the quality of care. We saw learning from complaints, concerns and incidents and there was a culture of making service improvements as a result of that learning.

However:

- None of the wards had clear lines of vision. The layout of the wards meant that there were blind spots.
- On Scadbury ward we saw that some fire extinguishers were kept in locked cupboards and all staff did not have keys. A more accessible one was kept in the nurses' station. The trust have provided us with subsequent evidence that this was approved by their fire safety officer and the London fire service.

Summary of findings

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

Are services safe?

Good

We rated safe as good for older people mental health inpatient wards because:

- The ward environments were clean and well maintained. There were good infection control procedures in place. Environmental risk assessments in place to ensure patients and staff were protected from harm
- Staff used appropriate screening assessment and monitoring tools to ensure patient well-being and safety. There were environmental risk assessments in place to ensure patients and staff were protected from harm.
- Senior management adjusted staffing levels to reflect and meet current patient assessed needs.
- Staff effectively monitored and protected against risks associated with older patients such as pressure sores and falls.
- Trust employed pharmacists supported staff to safely manage medicines
- Staff had a good understanding of safeguarding processes and knew their responsibilities to protect patients from harm and abuse. Staff reported incidents and management ensured that learning from incidents helped to improve patient safety.
- There was clear learning following serious incidents which was shared across the trust. Regular team meetings and other opportunities allowed staff to receive debriefings and share feedback and lessons learned.
- Wards complied with the Department of Health guidance on the elimination of mixed gender accommodation.
- On Scadbury ward we saw that some fire extinguishers were kept in locked cupboards and all staff did not have keys. A more accessible one was kept in the nurses' station. The trust have provided us with subsequent evidence that this was approved by their fire safety officer and the London fire service.

However:-

- None of the wards had clear lines of vision. The layout of the wards meant that there were blind spots. Staff reported they managed this by actively deploying staff in these areas and by carrying out observation of all patients. During inspection, we observed that staff were visible on ward communal areas.

Are services effective?

Good

We rated effective as good for older people mental health inpatient wards because:

Summary of findings

- Staff had demonstrated a good understanding of the Mental Capacity Act (MCA). Consent for treatment and capacity assessments were completed
- Each ward had a comprehensive and cohesive multi-disciplinary team. Patient assessments on admission included mental and physical healthcare needs as well as nutritional and hydration needs and these were monitored regularly.
- Patient care plans were person centred and included other people involved in the patients care, for example, carers and other professionals. Clinical staff regularly completed clinical audits and improved practice accordingly. Handovers and multidisciplinary team meetings concentrated on individual patient's needs.

Are services caring?

Good

We rated caring as good for older people mental health inpatient wards because:

- Staff were sincere and positive in the support and treatment they provided. They were compassionate and supportive with patients.
- Staff knew and understood the complexities of the patient group and displayed a good understanding of patients' individual needs. Patients and relatives gave positive feedback about staff. They told us that they felt welcomed and involved in the care provided.
- The trust offered support groups for carers and encouraged carer engagement.

Are services responsive to people's needs?

Good

We rated responsive as good for older people mental health inpatient wards because:

- Holbrook ward was a dementia-friendly adapted ward with a range of features that work well for the patient group. Activities were supported on and off site and there were dedicated rooms with adequate resources.
- Staff responded to complaints and general comments from patients and relatives and tried to resolve them with the patient's best interests in mind.
- The trust was open and transparent about incidents. They displayed their findings for the public to view and were open to learning lessons and making improvements
- Each ward had access to a good range of equipment to meet the needs of patients with physical disabilities, and in a timely manner.

Summary of findings

- The multi-disciplinary teams were cohesive and worked well together.

However;

- Scadbury ward and Shepherdleas ward were not always the appropriate environment for patients with a functional and dementia diagnosis. Patients and staff felt that the mixed functional and dementia wards did not work as well as if it were a separate service with specific resources to cater for those specific needs.

Are services well-led?

Good

We rated well-led as good for older people mental health inpatient wards because:

- Staff had a good understanding of the trust's values and vision.
- Robust clinical governance arrangements were in place and used to improve care and treatment outcomes for patients.
- Staff appraisal rates were high and mandatory training targets were met
- Senior management shared good practices among wards and implemented practice changes to improve patient care and experience
- Senior managers used up to date technology and communicated well and regularly with other wards to ensure good practice and skills were shared.

Summary of findings

Information about the service

Oxleas NHS Foundation Trust older people mental health inpatient wards provided inpatient services for people aged 55 and above with mental health conditions. The service included patients who were admitted informally as well as patients who were detained under the Mental Health Act 1983 (MHA). The trust had four wards for older people who were inpatients:

- Scadbury Ward (Green Parks House), a 22-bed mixed gender assessment ward and Shepherdleas Ward (Oxleas House), a 19-bed mixed gender assessment ward, provided services for Bexley, Bromley and Greenwich residents primarily functional mental health problems when inpatient assessment and/or treatment becomes necessary. These units offer a range of therapeutic programmes including occupational therapy and ward based activities. Both wards were for older people aged over 65 with functional mental health problems such as depression.
- Holbrook Ward (Woodlands Unit), a 22-bed mixed gender ward, was a dementia intensive care unit for people aged over 65, who had complex needs and behaviours related to their dementia.
- Oaktree Lodge (Memorial Hospital), a 17-bed mixed gender unit, was a continuing care unit providing care for people over the age of 55 years, with long-term mental health rehabilitation needs. Assessment, treatment, and active rehabilitation was provided.

The CQC had previously inspected these older people mental health inpatient wards.

Our inspection team

The comprehensive inspection was led by:

Chair: Joe Rafferty, Chief Executive, Mersey Care NHS Trust

Head of Inspection: Pauline Carpenter, Care Quality Commission

Inspection managers: Peter Johnson and Shaun Marten Care Quality Commission

The team that inspected Oxleas NHS Foundation Trust older peoples' mental health wards comprised of: one CQC inspector, two specialist professional advisors, both of whom were social workers experienced in working with older people's inpatient wards, and one expert by experience.

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 fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

Summary of findings

- visited each ward and looked at the quality of the ward environment and observed how staff were caring for patients
- met with seven carers of patients who were using the service
- spoke with 15 patients who were using the service
- interviewed the four managers for each of the wards and two modern matrons; one who covered Oaktree Lodge and the other covered the remaining three wards
- interviewed the service director with responsibility for these services
- spoke with 27 other staff members; including three consultant psychiatrists, three health care assistants and a ward secretary
- attended and observed two hand-over meetings
- reviewed in detail 12 care and treatment records of patients
- carried out a specific check of the medicines management on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients told us that they were well looked after and the staff were warm and kind. They told us that there was a good range of snacks and drinks available to them and they could access them when they wanted to. They were given choice at meal times and were involved in menu options.

Carers spoke positively on behalf of those patients who were unable to communicate. They told us that they were involved in the care and treatment of their relative. They confirmed that staff were kind and open towards them.

Areas for improvement

Action the provider SHOULD take to improve
Action the trust SHOULD take to improve

- The trust should ensure that steps are taken to mitigate the blind spots on each ward to ensure the safety and well being of patients.
- The trust should ensure that all staff are trained in the Mental Health Act and receive regular refresher training to promote their knowledge and understanding of the legislation.

Oxleas 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
Oaktree Lodge	Memorial Hospital
Shepherleas Ward	Oxleas House
Holbrook Ward	Woodlands Unit
Scadbury Ward	Green Parks House

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.

- Mental Health Act (MHA) training was not mandatory for clinical staff. The trust provided legislation updates through a range of media, for example, their intranet.
- Staff demonstrated their knowledge of the different MHA sections.
- Staff told us they explained to detained patients their rights under the Mental Health Act on a weekly basis. We could see in patient notes that this had been documented.
- Staff knew who to contact within the trust for further advice and support regarding the MHA and the code of practice.
- Staff we spoke to reported that they could access the advocacy service.
- Each ward had a checklist in place to review MHA documents on admission.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that they had received training and updates on Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS).
- Ward staff had an understanding of the Mental Capacity Act (MCA), in particular the five statutory principles. We listened to discussions between staff and saw recorded information that demonstrated their knowledge and understanding. For example, one consultant told us about one informal patient who had to be reassessed, have a best interests meeting and subsequently be assessed for DoLS.
- Ward staff demonstrated an understanding of the MCA in practice. For example, we that patients' capacity assessments covered general areas around admission and treatment plan. There were specific decision capacity assessments, such as a patient's capacity to consent to medication or delivery of personal care.
- Independent mental health advocates were available and staff knew how to make referrals.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Ward and office areas were clean and well maintained. The trust used a contracted cleaning service, cleaning staff had their own store cupboards and their supervisors checked the quality of the cleaning daily. At Holbrook unit, there was a cleaning supervisor who had a checking system in place, and this was signed off daily.
- Staff had an hourly checking system for bathroom cleanliness. We saw signed charts which were updated hourly.
- To prevent the likelihood of legionnaire's disease, there were up to date flushing of cold water systems in place.
- Current environmental risk assessments in place for all wards. These identified ligature risks and considered fixtures, fittings and ward layout. Risk management plans were in place to mitigate against these risks.
- Clinic rooms were clean, tidy, and well organised. Each clinic room had accessible resuscitation equipment and emergency medicines. At Holbrook ward there was no patient couch and patients were seen in their bedrooms. Staff told us that this did not present as a problem.
- We reviewed documents, which confirmed daily equipment checks were carried out and equipment was calibrated in line with best practice guidance.
- Temperature logs for fridges showed that minimum and maximum temperatures were recorded on a daily basis.
- We observed good hand hygiene and infection control practices across the wards.
- All staff wore mobile alarms and we saw timely responses to assistance calls.
- Nurse call buttons were in all patient bedrooms and bathrooms for patients to use when needed.
- Cleaning cupboards were secure and there was correct storage of cleaning products. Control ofsubstances hazardous to health (COSHH) standards were met, which meant potentially toxic cleaning products were kept in a locked cupboard away from patients.
- The wards did not have seclusion rooms.
- Patient led assessments of care environment scores (PLACE) for the wards were above the trust average for cleanliness, food, and dementia friendly environment.
- On Shepherdleas ward there was a male on the female corridor on the day of our visit. However it was acceptable for this patient because he had an ensuite bathroom in his room. There was double door between this bedroom and the rest of the corridor.
- Each ward had a designated female only lounge. However, at Scadbury ward the female lounge was isolated from the rest of the ward. One patient told us that it was too far away and that it was rarely used as a result.
- None of the wards had clear lines of vision. The layout of the wards meant that there were blind spots. Staff reported they managed this by actively deploying staff in these areas and by carrying out observation of all patients. During inspection, we observed that staff were visible on ward communal areas.
- On Scadbury ward we saw that some fire extinguishers were kept in locked cupboards and all staff did not have keys. A more accessible one was kept in the nurses' station. This was because a patient, who was no longer on the ward, used the fire extinguisher as a weapon. This could meant that in the event of a fire staff might not have immediate access to the fire extinguisher. The trust has provided us with subsequent evidence that this was approved by their fire safety officer and the London fire service.

Safe staffing

- The trust followed national guidance and displayed the number of actual staff on duty compared to the planned staffing level (day and night and registered and care staff) on each ward. They also told us what the gaps were and action taken to address them.
- We looked at staffing figures across all four wards for January 2016 and February 2016. The trust calculated their staffing needs based on 7.6 whole time equivalent (wte) qualified nurses per 10 older adult beds and 0.5 wte consultant psychiatrists per 10 older adult beds.
- Trust staffing data showed all of the wards were adequately staffed for January and February 2016, except Holbrook. Holbrook used additional staff to cover increased acuity on the ward. Holbrook ward were below establishment levels at 84.6% for registered

Good

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nurses in both January and February on day shifts. Staffing increased to 107% for qualified staff and 127% for support staff to cover the night shifts because of increased acuity.

- Holbrook ward had 33.5 wte substantive staff with 19% vacancies.
- Shepherdleas had 21.5 wte substantive staff with 9% vacancies.
- Oaktree Lodge had 24 wte substantive staff with 4% vacancies.
- Scadbury ward had 21 wte substantive staff with 15% vacancies.
- Records we looked at indicated that bank staff were used across fifty seven shifts and agency staff were used once over a four week period. Substantive staff who worked as bank staff on the ward were used regularly. The service manager had an approval system in place and a bank and agency monitoring system to ensure bank and agency staff were only used when necessary.
- We reviewed rotas across all wards. Each ward displayed the planned and actual staffing levels with other key information such as who is in charge.
- All staff we spoke with confirmed there was enough staff on shifts to carry out any physical interventions. However, staff also told us they sometimes struggled with the additional demands of those patients with dementia. Managers told us, if extra support was needed for the dementia patients, they were able to access support from the dementia ward.
- On call consultant psychiatrists provided psychiatric medical cover out of hours.
- The trust ran a mandatory training programme across each area. The average mandatory training uptake for the older adults inpatient staff as at 95% as of February 2016. During inspection, we reviewed documents, which confirmed that staff had been booked on for future mandatory training.
- The completion rate for prevention and management of violence and aggression training (PMVA) and manual handling training as of February 2016 was 80%. We looked at records of those staff that had not completed the training. Two staff were permanently exempted and two were temporarily exempted for physical health reasons. Three new starters had since completed the training. The ward safe staffing tool ensured that each shift had an appropriate number of PMVA trained staff. Those staff who were not trained in PMVA had received breakaway training.
- Two student nurses told us they had a thorough induction on to the wards and that they were encouraged to learn and develop through practical experience.

Assessing and managing risk to patients and staff

- There had been no incidents of seclusion in the last six months. Staff told us they did not use seclusion.
- During April to September 2016 there were twenty incidents of restraint on Holbrook ward used on fourteen patients. Six incidents of restraint on Shepherdleas ward used on six patients. Five on Scadbury ward used on four patients and two on Oaktree Lodge on two patients. Staff told us that restraints were used as a last resort and with minimum force. None of the wards used prone restraint, however they did use rapid tranquilisation but this was usually care planned in advance.
- Staff explained different types of de-escalation techniques they employed to reduce any need for restraint. These included distraction, engaging in activities, and identifying risks and triggers of individuals. During inspection, we observed staff sensitively using light restraint when a patient was physical aggressive. There were care plans in place, which showed how staff could manage them and avoid the need for rapid tranquilisation. We saw the patient back on the ward within the hour involved in activities.
- Staff carried out risk assessments of every patient on admission. Of the twelve care records we reviewed, all, except one, had an up to date risk assessment completed. The service manager looked at the care records where the risk assessment was missing and we saw that the risk assessment had been completed and stored in the progress notes. The consultant updated the patient's risk assessment immediately.
- Most patients' bedrooms were unlocked. Some patients' bedroom doors were kept locked to ensure patients' possessions were safe and reduced the risk of patients wandering into others bedrooms. Staff said they would always open patient bedroom doors on request.
- On each ward, there were both informal and detained patients. Inspectors observed the entrance door to be both locked and unlocked at different times throughout the visit. Staff said informal patients could leave at will and that they would open the door if it were found to be locked. There were also signs to remind informal patients of their right to leave.

Good

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- Observation policies were in place and staff understood them. We observed staff discussing observation levels of all patients in handovers. We saw observations taking place in line with assessed and recorded risks on all wards.
- Rapid tranquilisation was used across all four wards. The service did not collect the number of rapid tranquilisation and as such we did not have exact figures. Staff we spoke to confirmed that it was rarely used. They were able to explain the procedure and how it should be recorded and monitored, adhering to NICE guidelines and trust policies. While on Holbrook ward we witnessed a patient receive rapid tranquilisation which was care planned and used to de-escalate a challenging situation.
- The wards were proactive in their approach to reducing levels of violence and aggression. Each ward had a staff board, with staff photos and information about their personal interests. This prompted conversations between staff and patients and helped develop interpersonal relationships, which in turn helped to reduce the level of violence and aggression.
- All staff we spoke with could identify what would constitute a safeguarding concern and knew how to alert the local authority or trust safeguarding team.
- Prescription charts were clear and well documented. Pharmacists and technicians regularly visited the wards. A pharmacy inspector visited Holbrook ward and identified an error in relation to medicines that could not be crushed as per the covert medicines administration policy. This was immediately changed to a suitable medicine and an incident report completed.
- All staff we spoke to were clear about the covert medicines policy and what procedures they would have to go through in order to administer medicines covertly.
- Nursing staff and junior doctors ensured patients prescribed medicines were correct on admission.
- Patients who were vulnerable to falls had a falls assessment and management plan in place. We noted they were up to date and amended as necessary.
- Visitor rooms were available across the locations on or off the wards.

Track record on safety

- There were two serious incidents (SIRIs) reported in the last 12 months, one on Holbrook ward and one on Shepherdleas ward. These had been investigated appropriately.

Reporting incidents and learning from when things go wrong

- Staff reported incidents using the trust's incident reporting system. The data was accessible via the intranet to all staff. Incidents were analysed and reported to staff via the ward dashboards.
- We looked at each incident record with the service manager. As a result, there was a service redesign and other changes to, for example, use of the Modified Early Warning Score (MEWS), which is the assessment of physically unwell patients. This helped staff identify the severity of a physically deteriorating patient, and to take appropriate clinical action.
- Staff received a bi-monthly e-newsletter. We looked at the April 2016 newsletter, which identified trends in areas of concern and some of the recommendations for changes in practice. One of the items in the newsletter was 'what can we learn?'
- Staff shared examples of learning from when things go wrong. For example, within the past 12 months, following a serious incident, changes had been made to improve processes regarding falls risks. The falls policy had been reviewed. Assessments used to be completed over 72 hour period, and had been changed to within 24 hours and part of the admissions check lists.
- Staff received debriefs after incidents and were able to request this as and when needed.
- Staff we spoke to were aware of Duty of Candour and the need to be open and transparent.

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

- We reviewed 12 care records. They confirmed that patients had a comprehensive assessment on admission, which included mental and physical health, nutritional and hydration needs. On-going assessment was evident. All patients had food and fluid charts started on admission and malnutrition universal screening tools (MUST) were completed. 'MUST' was a five-step screening tool to identify adults, who were malnourished, at risk of malnutrition (undernourished), or obese. It also included management guidelines that could be used to develop a care plan.
- Care records were stored on an electronic care record system. They were accessible by all staff across the trust. This meant that staff from across directorates and services and could access patient records at any time. We were given examples of where this has worked to benefit patient care. For example, the dietician was involved at assessment and could access all patient records on the shared electronic record system.
- Care records showed that staff documented actions such as recording medical early warning scores and acting appropriately when the scores were rising, for example, monitoring observations, calling the doctor or ambulance as appropriate.
- Physical health checks took place within 24 hours of admission. There was evidence of on-going assessments of mental state, risks, physical health needs along with food, and hydration needs.
- Care plans were recovery focused where possible, holistic, and personalised and where views of the patient could not be determined, views of relatives or carers were sought. At Shepherdleas ward, a member of staff took the role of care plan champion. This meant they carried out local audits and commented where improvements were needed.
- Carers assessments were kept on the electronic record system. Patients and carers were involved in care and discharge planning.

Best practice in treatment and care

- Each ward was consultant led with junior and specialist doctors. Oaktree Lodge worked closely with general practitioners, who attended the ward four times a week to do physical health checks. They were also closely linked with end of life care, the local hospice and the consultant geriatrician based at the trust acute hospital. Trust pharmacy teams helped monitor stock levels of medicines on wards and attended ward reviews and multidisciplinary team reviews.
- We saw many examples in patients' notes of referrals to dieticians and physiotherapy. We observed thorough and detailed discussions of patients' physical health care needs taking place on ward rounds. Health care professionals shared information within the ongoing care records to ensure continuity and clear plans of care.
- Staff followed patients' nutrition and hydration charts. Areas of concern were monitored and actions taken for example encouraging fluid intake, taking blood sugars or making a referral to a dietician or member of the speech and language team if there were particular concerns. One patient had lost weight whilst on the ward so staff referred them to the dietician. The dietician prescribed supplement drinks and continued to monitor the patients' weight.
- Wards worked collaboratively with other professionals in the trust to ensure best outcomes for patients. For example, diabetic liaison nurses worked effectively with wards to reduce potential challenges associated with diabetics on the wards.
- We reviewed clinical audits that had been completed by clinical staff. Many had resulted in action plans of proposed or actual change.
- All wards followed NICE guidance. For example, falls in older people: assessing risk and prevention and in meeting the nutritional needs of people living with dementia. One consultant psychiatrist developed a guidance document sourced from evidence-based standards published by NICE (CG42). This was to help staff develop their skills using national and professional guidance in working with the small number of dementia patients on the wards.

Skilled staff to deliver care

- Scadbury and Shepherleas wards admitted a mix of functional patients and dementia patients. People with dementia could require higher levels of staffing and an understanding of the patient group. Staff knowledge and skills were limited on these two wards, however, support was provided by the dementia ward to staff to improve the skills where this was needed.

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.

- Staff on each of the wards were provided with specialist training. For example, malnutrition universal screening tool (MUST) training around nutrition monitoring and diabetes.
- Each ward had a 'champion' in specific areas, for example, safeguarding, to encourage improvement in practice.
- All wards had a psychologist who facilitated a reflective practice meeting.
- There was an electronic monitoring system to ensure all staff had appraisals and supervision, which were up to date and review dates highlighted.
- Staff had good career progression opportunities. Senior staff were supported in achieving leadership qualifications. There was succession planning for those staff who were close to retirement and the service encouraged recruitment of newer qualified staff. Healthcare assistants were supported to apply for nurse training.

Multi-disciplinary and inter-agency team work

- Each ward had access to a comprehensive multi-disciplinary team. Each multi-disciplinary team had clearly structured meetings. There were standard items for discussion at these meetings and families were involved where appropriate.
- The consultants facilitated handovers around three times a week. Each handover had a junior doctor in attendance.
- A pharmacist attended each ward weekly. They checked drug charts and identified any prescribing or administration errors. The pharmacist has a referral system in place for patients who wanted to speak with them. A pharmacist attended the carers group when requested.
- Relationships with local authority social services varied depending on the borough. It was acknowledged that some local authority services were stretched. Staff thought that those services that were integrated were thought to be the most effective.
- Each ward had access to a psychologist, a psychology assistant and a psychology trainee two days a week.
- Each ward had access to a physiotherapist. They worked with groups and carry out individual assessments and compile treatment plans.
- An occupational therapist was available on the wards and there was a rota in place for Saturday working.
- Staff told us that the multidisciplinary team worked well together.

Adherence to the MHA and the MHA Code of Practice

- Mental health act (MHA) training was not mandatory at the trust. However, for example at Shepherdleas ward, the consultant psychiatrist provided ongoing training and development for staff.
- One manager told us that the trust's MHA administrator did practical training for staff in November 2015.
- The MHA paperwork was comprehensive and the handover forms were comprehensive.
- Each ward had access to an independent mental health advocate IMHA service. An IMHAis an independent advocate who is specially trained to work within the framework of the MHA to support people to understand their rights under the Act and participate in decisions about their care and treatment. At inspection there was at least one patient seeing the IMHA. All patients could access the IMHA but we did not have information about the number of referrals made.
- Staff told us they explained to detained patients their rights under the MHA on a weekly basis. This was recorded in the care records.
- MHA administration systems were in place ensuring that required documents were received and scrutinised in accordance with the MHA and Code of Practice (CoP).
- All staff we spoke with knew who to contact within the trust for further advice and support regarding the MHA and MHA CoP.
- Each ward had a checklist in place to review MHA documents on admission. The trust sent reminders to staff to review MHA documentation. A consultant told us he had forgot to renew a patient's MHA paperwork. To avoid any future omissions, the consultant had a member of staff keep a reminder system for review on top of the reminders sent from the trust.

Good practice in applying the MCA

- Both modern matrons told us that staff were trained in the Mental Capacity Act (MCA). One consultant psychiatrist told us that they had developed guidance for staff in applying the principals of MCA and that the understanding of the MCA was growing. There were laminated prompts relating to MCA on the walls in nurses office.

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.

- There was consistent evidence of early consideration of patient capacity in patient care notes. Each patient's notes were specific, detailed, and patient centred.
- Staff consistently gave examples of issues relating to MCA based on patient assessed need. For example, they raised the issue of fluctuating capacity.
- At Oaktree Lodge, staff supported patients in planning for end of life care with the support of local end of life care services. They took steps to ensure that patient wishes were discussed and plans put in place if they lost capacity. These wishes were recorded, families and other professionals were involved if appropriate.
- Each ward had access to an independent mental capacity advocate (IMCA), who was used when someone did not have family or carers to support them during their stay on the wards.
- Case notes indicated MCA family inclusive care plans. We saw family input on electronic case notes, for example, a family invited to a best interest meeting.
- Staff discussed MCA during meetings, at ward rounds and handovers and we saw these discussions written up in electronic case notes.
- Oaktree Lodge challenged a best interest assessor decision about a patient who they still had concerns about.
- In the April 2016 newsletter, we saw reference to a Deprivation of Liberty Safeguards (DoLS) audit. They sampled random cases to look at adherence with the Mental Capacity Act (2005) and specifically the DoLS. This meant that the trust were identifying gaps and learning around MCA and DoLS.

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

- All patients and carers we spoke with told us that staff were caring, kind and compassionate.
- Relatives and carers were welcomed and supported in continuing with providing assistance with personal care and activities of daily living if appropriate.
- One carer told us that the hospital had respected their loved ones request for a liquid medicine rather than an injection.
- Staff we spoke with had a good knowledge of the patients' individual needs. Staff were able to relate behaviours, patient preferences and histories, where known.
- On Scadbury ward, a patient wanted to leave hospital because they were distressed. The manager spent time with the patient in a neutral place, offsite, to encourage them to stay until the morning to see the consultant. This meant that the patient felt less distressed and could be safely looked after on the ward until they could be reviewed by their consultant.
- At Oaktree Lodge, the manager and consultant told us that patients were permitted to stay on the ward if there were terminally ill. They supported those patients in planning ahead and ensuring their advanced wishes if known, were respected at every stage.
- Staff gained consent from patients to speak with CQC staff at the inspection about their care and treatment.
- Privacy and dignity was supported in many ways across the wards, for example, patients had choice different environments to eat their meals, and medicines were given in the patient's bedroom or clinic.
- On Scadbury and Shepherdleas, some patients told us that staff were often busy with dementia patients who required more intensive care and input which made them feel that staff didn't have enough time to spend with them.
- Most rooms on the ward had new name placards with patient names and 'knock before you enter' signs. However, we did see two staff enter patient bedrooms without knocking. This was bought to the attention of senior staff during the inspection.

The involvement of people in the care they receive

- Care and treatment records included quotes from some patients. There was good input from family and other carers.
- There were open surgeries and clinics for patients, carers, and families to attend.
- Patients could use an electronic feedback device to give comments about their stay on the wards on discharge.
- The admission process informed and orientated the patient to the ward. Information leaflets were available for patients and carers. However, there were no leaflets in any other languages. Staff told us they could access other language leaflets if needed.
- Staff we spoke with on the dementia care units said that involving some patients in their care could be challenging due to the patients cognitive levels. However, staff said they worked with relatives and carers where applicable to develop care plans and would attempt to care plan with the patients where appropriate. One carer told us that staff had hoped to involved them in care planning, however their loved one refused and this was respected.
- There were carers support groups. At Holbrook, a group of eight carers had put together their own support group. This was in addition to what was offered by the trust. Carers told us they were fully involved with patients care where appropriate.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The number of delayed discharges over the last six months for Shepherdleas was zero. Holbrook had the highest number of delayed discharges – four over the past six months. Delays were due to a lack of suitable nursing homes to meet the patients' needs. At the time of inspection there was one delayed discharge on Holbrook.
- There were four delayed discharges on Scadbury ward. All four delayed discharges were being managed and reviewed regularly. One patient had been delayed because commissioners could not find a suitable placement. One patient was awaiting a placement out of area to be cared for by a family member. One patient required supported living, however was assessed as unsuitable based on his ongoing mental health needs. This patient had also declined suitable offers, which has contributed to the delay.
- Average length of stay for patients at Oaktree Lodge was around 3 years. Oaktree was a long stay unit. Some patients might be near end of life and these patients can remain at Oaktree Lodge if this is what they request.
- There was a high bed occupancy. Average occupancy from the period 1 July 2105 to 31 December 2015 for Oaktree Lodge was 88.1%, Scadbury ward 97.6%, Shepherdleas 95.6% and Holbrook 94%. Wards for older people with mental health problems avoided sending patients out of area; however, some patients were transferred between the wards for older people with mental health problems whilst awaiting transfer or discharge**.**
- Patients were moved from wards to another when it was justified on clinical grounds or at the request of the patient. An example given was of a patient being transferred to a ward, which was geographically local to the patient's home.
- Wards for older people with mental health problems avoided sending patients out of area; however, some patients were transferred between the wards for older people with mental health problems whilst awaiting transfer or discharge**.**

The facilities promote recovery, comfort, dignity and confidentiality

- Each ward had a range of communal and gender specific rooms.This enabled patients to mix with each other, partake in different activities, or spend time in quiet areas.
- Holbrook ward was age and dementia friendly, decorated with pictures, photographs, doors were three-dimensional and there were a range of sensory items throughout. Rooms had bold clear signage with contrasting colours. All toilet/shower seats, flush handles, and rails contrasted to the sanitary ware, floor, and walls. Reminiscence props were placed around the wards such as a hat stand and hats, sensory boxes and books.
- The corridors enabled the patient to walk around without coming to a dead end, minimising any frustration they might feel at doing so.
- There was a 'shed', a 'formal' dining room and salon as separate spaces for patients, which were filled with memorabilia to promote independence and offer familiarity.
- Each ward had an activity room equipped with various activities such as crafts, games, jigsaws and activities of daily living kitchen.
- On Scadbury and Shepherdleas wards, patients could independently access snacks and drinks.
- There were facilities on all wards for patients to make a private telephone call if needed or they could use their own mobile phone.
- Patients had an accessible garden at each ward and we saw patients access the garden throughout the day.
- Patients had a private room that they could use to spend time with their relatives including children. Children were allowed on the wards when accessing the family designated areas following appropriate risk assessments carried out prior to their visit.
- Patients had their spiritual needs supported and spiritual leaders visited the wards and patients were supported in attending religious venues outside the hospital. A vicar attended an event while we were inspecting Holbrook ward. Staff and carers told us that the vicar attended regularly.
- A musician attended the wards. We saw the musician at two of the wards during inspection.
- Pet therapy was used across the wards and we saw a pet on Holbrook during the inspection.

Are services responsive to people's needs?

Good

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

- The physiotherapist supported patients to do group exercises and we saw at least fourteen patients doing chair based exercises. This was done every morning. Patients said they looked forward to it.

Meeting the needs of all people who use the service

- There were facilities for people requiring additional support, including hoists and wheelchair access. This meant the staff could effectively manage patients with physical needs well as mental health needs.
- There were information leaflets but limited in different languages at the main receptions. Staff told us they could print in specific languages if needed. There were numerous notice boards around wards sharing information to patients and carers. Examples of these were patient advice liaison services, independent mental health, advocacy, and other support groups, detained patients' rights and how to complain.
- Information about physical and mental health treatments, as well as detained patients' rights were on notice boards.
- All wards had access to variety of dietary requirements from finger food, soft, low potassium or culturally specific.
- Functional patients told us that it was not good to have dementia patients on the ward. They told us that it was not the right environment to support the needs of dementia patients. Staff told us that they were keen to have the tools to do a good job working with dementia patients.

Listening to and learning from concerns and complaints

- Incident notices were displayed on a board for all to see, which promoted a culture of transparency
- Patients had weekly community meetings. Minutes of the meetings were accessible to all. The action points were discussed at handovers. Staff told us that they dealt with issues on the day if they could and would discuss bigger issues as a team. Feedback was given to patients the following week to update on actions
- There had been a recent complaint, which was being investigated, the report was not finished at the time of inspection. Staff told us generally complaints were informal and dealt with immediately
- Managers and nurses met with families within the first two weeks and try to get to know relatives and catch issues before they ended up as 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

- Staff on wards were aware of the trust's values. It was evident that their approach to their work, and their responses to patients and relatives, demonstrated their agreement with these values. Staff spoke positively about their work, about their role within the trust and were proud of the job they did.

Good governance

- Managers monitored mandatory training and encouraged timely completion and that targets were met.
- All staff received mandatory management and clinical supervision. Staff appraisals were completed and reviewed annually.
- There were regular and recorded monthly staff meetings with action plans identified. These were accessible to all staff and stored on the shared drive.
- Staff reported incidents. Ward managers analysed these and shared themes with staff. It included an analysis of data, themes and variance, safety data, patient feedback, lessons learnt. Each report documented progress, risks, and action plans. Staff were manging their beds to try and avoid breaching the department of health guidance on eliminating mixed gender accommodation
- Junior doctors reported that they had supervision weekly.
- Consultants said they had regular supervision and time for teaching and study days.
- The wards used key performance indicators (KPI) to make sure they knew what their objectives were and what targets they had to meet. Ward managers felt they had sufficient authority and administrative support.

Leadership, morale and staff engagement

- Staff across all wards consistently told us that they felt able to raise concerns without fear of victimisation. They said they were clear regarding whistleblowing procedures and felt confident raising issues with managers. No individual concerns were raised regarding bullying or harassment.
- Staff we spoke with told us how the trust was supporting them with personal development. For example, one manager told us that he had been supporting in attaining a leadership qualification.
- One newly qualified nurse told us that they were encouraged in their development and given the time to consolidate their learning at a good pace.
- Staff spoke of job satisfaction and sense of empowerment. Staff consistently praised the local management of the wards.
- Managers ensured there were sufficient staffing which included the use of consistent bank staff.
- Sherpherdleas staff said they were tired; there had been an increased number of admissions. Managers acknowledged the staff tiredness and staff had an away day in January 2016 to look at how they could improve their work life balance.
- Staff told us that have respect for each other, that they work well together and had the support of their managers.
- One member of the multidisciplinary team told us they would give staff morale on the ward a 10 out of 10.

Commitment to quality improvement and innovation

- Wards had quality dashboards, which enabled staff to monitor bed status, incidents, and lessons learnt. Staff were aware of these and knew how to use them in order to improve the care and treatment provided for patients.