Care Quality Commission

Good ●

Somerset 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)
RH572	Magnolia ward	Older people's mental health ward	BA20 2BN
RH576	Pyrland 1	Older people's mental health ward	TA2 7AU
RH576	Pyrland 2	Older people's mental health ward	TA2 7AU

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership NHS 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 Somerset Partnership NHS Trust and these are brought together to inform our overall judgement of Somerset Partnership NHS 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 wards for older people with mental health problems as **good** overall because:

- During this inspection, we found that the services had addressed the issues that had caused us to rate safe, effective and well led as requires improvement following the September 2015 inspection. The wards for older people with mental health problems were now meeting Regulations 12 and 11 of the Health and Social Care Act (regulated Activities) Regulations 2014.

- Staff assessed and addressed risks associated with the physical environment and implemented appropriate measures to mitigate the risks to people using the services. Staff received training and support to manage patients with challenging behaviours and the teams managed risk well. Staff completed thorough risk screens and communicated risk throughout different forums. Safeguarding was a high priority and staff completed mandatory training. The environments were very clean and hygienic and managers had closed some beds in order to support safety due to staffing shortages.

- Staff demonstrated they provided care and treatment with the consent of each patient, demonstrated good understanding and application of the Mental Capacity Act (MCA), and associated Best Interest decisions. Staff acted in accordance with the MCA in instances where there was a formal instruction of do not attempt cardiopulmonary resuscitation in place.

- Patient care records were complete and up to date, and each patient had a care plan outlining risks and day to day needs. All care records contained complete information, including medication. All physical health monitoring was taking place. There was good multidisciplinary and multi-agency communication.

- There were good examples and evidence of learning from incidents and changes made following incidents. Staff felt supported around incidents.

- Staff treated patients with kindness and respect. We observed excellent examples of good quality care and positive and supportive staff attitudes. Without exception, the staff were professional, courteous and committed to providing the best level of care possible. The trust had nominated and given staff awards around dignity and care of patients.

- The wards had good local bed management systems and were creative in managing the pressures around demand and discharge problems out of their control.

- Local governance systems were good and managers ensured they supported staff. Staff had good morale and demonstrated openness and transparency. There was strong local leadership. The ward managers were visible and staff told us they were approachable and supportive.

However:

- The majority of care plans or records were person centred but did not always demonstrate patient involvement. We did not find clear evidence in the care records to show that staff had discussed or offered patients their care plan, even if they had refused it.

- Staff did not feel fully confident or skilled in managing specific mental health problems such as schizophrenia, particularly the nursing assistants on the wards. The trust did not provide specific training to develop these skills.

- Managers did not ensure staff received regular supervision as per their own trust supervision policy.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

- The service had addressed the issues that had caused us to rate safe as requires improvement following the September 2015 inspection. At that time, staff had not addressed or recognised risk around all ligatures on the wards, and the trust had not provided sufficient measures to ensure the environment was as safe as possible. When we visited in March 2017, we found that staff and managers had identified ligatures and monitored these on the local risk registers. Staff had removed ligature points with no potential impact on patients and staff carried out robust and ongoing individual risk assessments and observations in order to mitigate any potential ligature risk.

- We also identified a problem around the management of physically fit, aggressive older adults in our inspection in September 2015. Staff had told us they did not feel confident and did not receive appropriate training. The trust had taken action by reviewing the training provided through a local working party led by the mental health patient safety lead to explore other de-escalation tools.

- Staff managed risk on the ward well, and completed and reviewed risk screens and assessments. Staff carried out patient observations.

- Ward environments were clean and well maintained despite having some old and original fixtures and fittings.

- Managers had closed some beds on two wards to support safety where there were problems with recruiting an appropriate number of suitably qualified staff.

Good ●

Are services effective?

We rated effective as **good** because:

- The service had addressed the issues that had caused us to rate effective as requires improvement following the September 2015 inspection. At that time, we identified a number of instances where the trust had failed to meet its legal obligations under the Mental Capacity Act (MCA) 2005. We were also concerned that some 'do not attempt cardiopulmonary

Good ●

Summary of findings

resuscitation' decisions were being reached without due process or involvement with relatives or an advocate. In March 2017, the trust had addressed this. Staff acted in accordance with the MCA.

- Patient care records were completed and each patient had a care plan. All care records contained complete information including consent to treatment. Physical health monitoring was taking place.

- Staff reported incidents and described good evidence of learning from incidents, including changes in practice because of learning from incidents.

However:

- The trust did not provide training in managing specific mental health problems such as schizophrenia, to staff on the wards.

Are services caring?

We rated caring as **good** because:

- Staff treated patients with kindness and respect. There were excellent examples of warm, compassionate and respectful care.

- Patients said staff treated them very well. They said they felt respected and that staff were kind.

- Patients were supported to access independent advocacy services, including independent mental capacity advocates and independent mental health advocates as needed. The advocates visited the wards weekly to provide independent support and advice.

- Family members/carers were involved where appropriate in admission and provided information, and staff offered them a family liaison meeting following admission.

However:

- The majority of care plans or records were person centred but did not always demonstrate patient involvement.

Good ●

Are services responsive to people's needs?

We rated responsive as **good** because:

- The wards managed access and discharge well and were creative in managing the pressures of acute mental health need and discharge delays.

Good ●

Summary of findings

- There was good multidisciplinary and multi-agency communication.

- All the wards had a range of rooms and equipment to support treatment and care appropriately.

- Staff could access interpreters to support patient's communication needs. Leaflets were also available in different languages if needed.

However:

- There was a potential issue around dignity on one of the wards, where a patient room looked out over a lane. People passing the room could see into it and there was no privacy screening or window coverings in place. This was addressed immediately when raised with the trust.

Are services well-led?   **Good** ●

We re-rated well-led as good because:

- The service had addressed the issues that had caused us to rate well led as requires improvement following the September 2015 inspection.

- In September 2015, staff did not necessarily feel engaged or part of the wider trust and felt they were losing their identity as a provider of specialised mental health inpatient services. There was evidence that staff training did not have sufficient specialised focus and due to this, their model of care was becoming outdated and lacking in a rehabilitation and recovery focus. In March 2017 although the staff still informed us they did not feel particularly engaged and were anxious about potential further changes afoot, the trust were taking steps to address the improvements needed such as communication, identity of the wards for older people with mental health problems and engagement of staff in future developments.

- Local governance of the wards was effective and well managed and there were clear processes in place. Staff participated in clinical audits and there was a clear and robust system for reporting, reviewing and learning from incidents.

- Staff morale was high. Despite staffing pressures and routinely working with some challenging patients the staff were resilient, supportive of each other.

- Ward managers were visible on the ward and respected by the staff team.

However:

Summary of findings

- Managers did not ensure staff received regular supervision as per their own trust supervision policy.

Summary of findings

Information about the service

Wards for older people with mental health problems are part of Somerset Partnership NHS Foundation Trust's core services. They provide inpatient support to older people with mental health needs.

There are three wards specifically for older people, both male and female with mental health needs. These are Magnolia Ward, which has 14 beds, providing assessment and treatment for older people suffering from dementia and other confused states. Magnolia ward is at the Summerland's hospital site in Yeovil in the east of the county and Pyrland 1 and Pyrland 2 wards, which are situated at the Wellsprings unit in Taunton in the west of the county. Pyrland Ward 1 has 14 beds providing assessment and treatment for older people suffering

from acute mental problems such as depression; anxiety and bi-polar disorder. Pyrland 2 has 15 beds providing assessment and treatment for older people suffering from dementia and other confused states.

When the CQC inspected the trust in September 2015, we found that the trust had breached regulations. We issued the trust with three requirement notices for wards for older people with mental health problems. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 11 HSCA (RA) Regulations 2014 Need for consent.

Our inspection team

Our inspection team was led by:

Team Leader: Gary Risdale, inspection manager (mental health), Care Quality Commission.

The team that inspected this core service comprised two CQC inspectors and a specialist advisor who was a consultant psychiatrist with experience of working in older people's mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether Somerset Partnership NHS Foundation Trust had made improvements to their wards for older people with mental health problems since our last comprehensive inspection of the trust in September 2015.

When we last inspected the trust in September 2015, we rated wards for older people with mental health problems as **requires improvement** overall.

We rated the core service as requires improvement for safe, effective and well-led and good for caring and responsive.

Following the September 2015 inspection, we told the trust to make the following actions to improve wards for older people with mental health problems:

- The provider must assess and address in full the risks associated with the physical ward environments as safe as possible, appropriate measures must be implemented to mitigate effectively the risks to people using the service.

- The provider must ensure that the training staff receive is adequate to be able to safely manage aggressive, physically fit and strong older adults.

- The provider must take the appropriate steps to demonstrate that care and treatment are provided with the consent of each patient or other relevant person, and be able to demonstrate that they act in accordance with the Mental Capacity Act 2005 (MCA) in all instances where a patient lacks mental capacity to make specific decisions and to consent to their care

Summary of findings

and treatment. Specifically, the provider must ensure they act in accordance with the MCA in all instances where a formal instruction to not attempt cardiopulmonary resuscitation (DNA/CPR) is in place.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 12 Safe care and treatment

Regulation 11 Need for consent.

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 a range of information that we held about these services, and requested information about the trust.

During the inspection visit, the inspection team:

- visited all three of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 10 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 17 other staff members; including doctors, nurses and social workers
- spoke with the Independent Mental Capacity Advocate
- attended and observed three hand-over meetings and three multi-disciplinary meetings.

- collected feedback from 14 patients and four family carers.
- looked at 26 clinical records.
- 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 they felt safe, the staff treated them with respect, listened to them, and treated them fairly. They felt the environment was always clean and welcoming and the staff were very caring and friendly.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all care plans and records demonstrate involvement with the patient throughout treatment.

- The provider should ensure the staff on the wards have the necessary skills and confidence to effectively manage older people with mental health problems and receive appropriate training to do so within current best practice.

- The provider should ensure that all bedrooms and ward areas protect patient privacy and dignity.

- The provider should ensure managers provide regular supervision as per trust policy.

- The provider should ensure they engage and involve all staff in all potential changes in the wards and support staff to have a voice in these changes.

CareQuality Commission

Somerset 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
Magnolia ward	RH572
Pyrland 1	RH576
Pyrland 2	RH576

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.

Records demonstrated that all wards visited adhered to the Mental Health Act (MHA) and associated code of practice. Training figures demonstrated only 57% of staff on the wards had completed MHA training, however we were told these packages were being rolled out and figures were low as a result of this.

Patient records had evidence that rights under the MHA were explained on admission and then re-read where appropriate.

Patients had access to independent mental health advocacy (IMHA) and staff were clear on how to access support as required. All patients detained under the MHA had access to the advocacy service for support.

Mental Capacity Act and Deprivation of Liberty Safeguards

During the last inspection, care and treatment were not always provided with the consent of each patient or other relevant person. Staff were not always able to demonstrate that they acted in accordance with the Mental Capacity Act 2005 (MCA) where a patient lacked mental capacity to make

specific decisions and to consent to their care and treatment. This included specific concerns where there was a formal instruction of do not attempt cardiopulmonary resuscitation(DNA/CPR) in place.

Detailed findings

At the current inspection, across the wards 83.7% of staff had completed Mental Capacity Act (MCA) training. Staff were more confident in explaining the MCA and records demonstrated good application of the MCA and clear and appropriate use of the MCA, including consent to treatment which had been sought and documented, and a best interests process where there was a specific decision to be made and the person lacked mental capacity.

There was clear process and application of the MCA where there was a DNA/CPR in place. This included liaison with the independent mental capacity advocate where the patient lacked appropriate family members.

On Magnolia ward there had been nine applications for Deprivation of Liberty Safeguards (DoLS) in the previous six months. There had been six applications in the same period on Pyrland 1 and 2 wards.

Are services safe?

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

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

Our findings

Safe and clean environment

- The environment on all three wards was warm and welcoming. Staff had attempted to enhance the environment using artwork and homemade furnishings. On Pyrland 2 ward however, the environment would have benefitted from a refurbishment, as the fixtures and fittings in place were tired. The ward was clean and well maintained despite the tired furnishings. Managers ensured environmental risk assessments were undertaken regularly.

- There were cleaning records in place and staff adhered to infection control principles including handwashing.

- All staff carried personal alarms on the ward. These were tested regularly. Patients and staff could also summon help using a nurse call system and emergency buzzer.

- Staff carried out fire alarm tests weekly, with a yearly evacuation test.

- The ward layout did not allow staff to observe all parts of the ward. On Magnolia ward there was a blind spot at the end of a corridor but staff had mitigated this risk by fixing a convex mirror.

- On Pyrland 1 ward there was a blind spot at the end of a corridor, which could not be seen by the nurses' station, and there were no convex mirrors to mitigate this. However, staff could tell us where the blind spots were and that during their observation rounds checked these areas regularly.

- During our September 2015 inspection, we were concerned there was a whole section of the far end of Magnolia ward unused, not visible to staff but also not closed off to patients. In this area of the ward, there was also a de-escalation room, which was drab, bare and was open and accessible to patients. During this current inspection however, staff had locked off this end of the ward completely so patients had no access. This mitigated the risk identified.

- At the time of the last inspection, there were obvious ligature points. There were multiple ligature risks on all

three wards. This was mainly due to adaptations and fittings to support older adults who also may have physical health problems, such as specialised beds and handrails. A ligature point is an environmental feature or structure, which is, load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. As Magnolia ward was primarily for older adults with an organic mental health problem such as Alzheimer's disease or dementia, the risk was likely to be less about deliberate self-harm but potentially more about accidental injury such as falls. Pyrland 2 ward was also primarily for older adults with an organic mental health problem and as such had similar type of risks.

- Pyrland 1 ward was primarily for older adults whose primary needs related to functional mental health conditions, such as depression, schizophrenia, mood disorders or anxiety. Consequently, staff on Pyrland 1 ward supported more physically fit older adults at a higher risk of deliberate self-harm.

- We were concerned at the time of the September 2015 inspection that although the trust had identified many of the risks through risk assessments and regular checks, they had not taken steps to actively mitigate or address these risks. However, during the current inspection it was apparent the trust had acknowledged these risks and had taken action.

- Staff had identified ligatures and monitored them on the local risks registers. Staff had carried out a formal risk audit dated 23 February 2017. Minutes of a trust meeting dated June 2016 discussed in-depth how to balance the risks of ligatures and maintaining and supporting independence and rehabilitation by having the fixtures and fittings on the ward. Staff had removed ligature points where there was no potential impact on patients and staff carried out robust and ongoing individual risk assessments and observations in order to mitigate any potential ligature risk.

- The wards were mixed gender. The wards complied with relevant national guidance on same-sex accommodation and in line with the 2015 Mental Health Act Code of Practice on same-sex accommodation. Sleeping and bathroom areas were segregated. The

Are services safe?

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majority had ensuite bathroom facilities and patients did not have to walk through an area occupied by another sex to reach toilets or bathrooms. There were also separate women only day rooms.

- Pyrland 1 ward had all ensuite bathroom facilities. Pyrland 2 ward had eight out of nine ensuite bathroom facilities. Magnolia ward had all ensuite bathroom facilities in the female sleeping area and shared bathroom facilities in the male sleeping area at the time of our inspection. Staff on Magnolia ward ensured there was no impact on dignity by the males having to share bathroom facilities. On Pyrland 2, the one bedroom currently in use which was not ensuite was situated next to a bathroom. This meant that the service was currently in compliance with same sex guidance. However if the currently closed beds reopened the trust would have to reconsider their arrangements.

Safe staffing

- Managers did not previously use a specific tool to establish staffing levels. However, during the current inspection there was new electronic software system, which linked to a staffing roster to determine staffing levels based on the needs of the patients.

- During the previous inspection, we were concerned at the high levels of nursing staff vacancies. This continued to be a challenge; however, the trust demonstrated they were making every possible effort to recruit suitable staff. In order to manage the shortfall of registered nursing staff, managers had decided to close beds on Magnolia and Pyrland 2 wards temporarily. This was to staff the ward safely until they could recruit.

- The trust had closed seven beds on Magnolia ward leaving seven in use. Pyrland 1 ward had 14 beds and all were open at the time of our inspection. However, managers had taken to decision to close four beds temporarily on Pyrland 2 ward; leaving ten beds in use.

- On Magnolia ward there was 37 whole time equivalent (WTE) staff. This included a band 8a manager, 0.8 WTE band 7, a band 6 registered nurse, 7.7 WTE band 5 registered nurses, 17.7 WTE band 3 nurses, 7.08 WTE service assistants, 0.6 WTE Band 6 occupational therapist and 1 WTE administrator.

- There were vacancies on Magnolia ward for 0.6 WTE occupational therapist, 3.4 WTE band 5 nurses, 0.8 WTE

band 7 nurse and 0.9 WTE service assistants. The ward had supplied extra nursing assistants to accommodate the shortfall of registered nurses, as the trust was struggling to recruit registered nurses.

- On Pyrland 1 and 2 wards, there were 65 WTE posts funded across both wards. Managers covered both wards using combined staffing figures. There was one band 8a manager, a band 7 nursing post that was currently on hold, 2.2 WTE band 6 nurses, 15.6 WTE band 5 nurses, 31.2 WTE band 3 nurses, one WTE occupational therapist, 2 WTE trainee assistant practitioners, 8 WTE service assistants, 1.0 WTE activities organiser and 1.8 WTE administrator.

- There were vacancies on Pyrland 1 and 2 wards for one WTE band 6 nurses and 0.4 WTE service assistant.

- Activities were taking place throughout our inspection and staff told us they never cancelled them due to staff shortages.

- There was adequate medical cover provided by consultant psychiatrists and junior doctors for the wards. The trust had an out of hours medical rota that meant doctors could attend in an emergency.

- There was a range of mandatory training across the core service. Managers had ensured staff attended and compliance figures were high at 96% overall. For example safeguarding children was 96%, safeguarding adults level one 96%, prevention and management of violence and aggression was 100% completed, consent training was 100%, safeguarding adults level two was 91% completed and fire training 96%.

- Staff received training on management of a deteriorating patient. The protocol was to call for emergency assistance in the event a patient became physically injured.

Assessing and managing risk to patients and staff

- We looked at 26 patient care records across the three wards. There were good clear risk assessments were present and reviewed regularly. Staff highlighted and transferred risk to management plans. Risk assessments included mental health and social care risks, physical health risks, and used specific risk screening tools such as waterlow assessment tool, falls assessment tool and the malnutrition universal screening tool (MUST).

Are services safe?

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

- As well as individual risk assessments, staff carried out risk assessments of the wider ward areas, including limited bed occupancy on Magnolia ward, lone working, medication errors, safer staffing, slips trips and falls, risk of ligatures.

- Staff demonstrated good examples of how they managed patient risk. This included good discussion in ward handovers and multidisciplinary meetings. We were shown examples of where staff shared risk amongst relevant agencies including safeguarding.

- The trust reported wards for older people with mental health problems had 64 incidents of restraint between 1 January 2016 and 31 December 2016. There was one incident of prone restraint (face down) and no incidents of rapid tranquilisation. There were no incidents reported of seclusion during the same period. We reviewed the reason for the prone restraint and saw this was managed appropriately.

- During the September 2015 inspection, some staff felt they did not have the skills or extra training to manage aggressive, physically fit older adults safely. At the current inspection, the trust had taken action by reviewing the training provided through a local working party led by the mental health patient safety lead to explore other de-escalation tools. Managers had worked alongside the training provider to develop a course focussing on the prevention alongside physical techniques. Staff informed us they felt more confident than before.

- During the last inspection, we raised concerns that there may have been episodes of seclusion not recognised or reported by staff. Staff during the current inspection were clear on the use of seclusion and policy. We were previously concerned about the use of the de-escalation room on Pyrland 1 ward, that this was also potentially being used as a form of seclusion.

- However, staff explained how they documented its use, and the trust provided us with the proactive care policy including de-escalation and seclusion. Staff would document the event on the incident reporting system, a physical restrictive intervention form and on the risk assessment in the electronic care records. When we asked when staff last used it, they confirmed there were no recorded incidents within the previous 12 months.

- Both wards were in the process of developing sensory areas on the wards to provide an alternative way of de-escalation.

Track record on safety

- The trust had a serious incident policy dated 2017. There were no serious incidents reported by the trust in the previous 12 months on Magnolia ward and three serious incidents on Pyrland 1 and 2 wards. The records demonstrated that staff responded appropriately and identified actions and learning.

- On Magnolia ward there were 320 incidents reported between February 2016 and February 2017. On Pyrland 1 and 2 wards there were 220 incidents recorded in total. These included physical aggression, medication errors and slip trip and falls.

- The ward manager, the risk team and the head of division reviewed incidents. They returned them to the teams to discuss in team meetings to identify learning.

Reporting incidents and learning from when things go wrong

- Staff discussed incidents in meetings and we looked at some minutes dated 15 November 2016 where there was an example a patient who fell resulting in fractures. There was a 72-hour report completed, staff discussed learning from this and implemented use of hip protectors as a learning outcome.

- Staff gave us other examples of learning from incidents. We observed there was a positive culture around learning from incidents on all three wards.

- Staff felt supported around incidents and received appropriate support, including a debrief process. Some staff described this as sometimes informal, but all felt supported by managers and peers.

- Staff reported and managed incidents well overall, with evidence that change took place through learning from incidents. For example, minutes from a staff meeting dated 9 February 2017 highlighted improvements made in the clinical practice of observations following an incident.

- Ward managers held weekly meetings to review and discuss themes or incidents. This provided improvements in risk management but also provided reflective discussion time to support the staff teams.

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

- All patient care records we looked at contained clear, complete, up to date comprehensive assessments and care plans. During the previous inspection we noted that although the care plans were effective in supporting patient need, they had insufficient focus on recovery and rehabilitation.

- During the current inspection, there was an improvement in this, and staff made efforts to identify clearer rehabilitation needs.

- Staff and managers did recognise the importance of individual personalised care. Staff used tools such as 'this is me' and life stories which identified patient history, preferences and likes and dislikes.

- All correct information was contained in the care records, including medication, physical assessments including malnutrition assessment to monitor tissue viability. All physical health monitoring was taking place.

- Staff stored care plans and patient records securely on an electronic system.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidelines in prescribing medication. Medicines management was good on all three wards, monitored by the trust pharmacist. Staff used an electronic prescribing system which staff assured us reduced risks around dispensing. Staff could get advice and support from the trust pharmacist when needed.

- When staff dispensed 'as required' medication we could not see clearly how this was monitored. However when we raised this the trust advised us the system could identify when the maximum dose had been administered and when no further doses were available. We observed that staff on all wards documented this medication and communicated this in handovers.

- Staff documented consent to treatment on the electronic system under the Mental Health section. All records we looked at demonstrated that staff sought consent. There were examples of patients who received medication covertly. This was clearly documented using

the Mental Capacity Act and Best Interest procedures. Medicines were stored securely and staff regularly monitored and audited stock and prescribed medication.

- Occupational therapists for the wards assessed the functional level of patients and provided activities suitable for the individual. This was contained within the care plans and monitored ability to carry out day-to-day activities. This would support decision making about whether the patient was able to return home.

- Although the wards for older people with mental health problems did not have their own psychologist attached to the service, they did have access. Staff completed a referral and provision varied across the three wards. Cover was limited due to the psychology staff covering both inpatient and community services. Staff felt the patients would benefit from more access to psychology.

- Staff confirmed the limited support they received from psychology was good and they provided advice when requested. The psychologists carried out initial functional assessments on admission and because the wards were not long stay, they would refer onwards to try to support patients to access psychological input on discharge. An enthusiastic psychologist who supported Pyrland 1 and 2 wards explained their plans to present a case to the clinical commissioning group (CCG) to request further psychology resources.

- Staff raised to us that they would like to receive specialist training in order to be able to offer more psychological interventions, for example cognitive therapy (CBT). This would support patients further within NICE guidelines.

- Ward staff took part in clinical audits. These included length of stay, delays to discharge, medicines management, clinical records, falls and infection control and care plans.

- There was good evidence in the clinical records that patients had their physical healthcare, nutrition and hydration needs met and had access to physical healthcare support throughout their stay. Access to dietitians and speech and language therapists was effective. Staff documented needs in care plans.

Skilled staff to deliver care

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.

- The wards had a range of disciplines including occupational therapists, healthcare workers, nurses, service assistants who supported with tasks such as cleaning and cooking, experienced managers, activities co-ordinators and supportive administration staff. The wards could also access community district nurses and speech and language therapists.

- The service previously had social workers integrated as part of the teams but this was no longer the case due to the separation of local authority from the trust. However, the teams could access support from social workers from the local authority.

- All the wards had registered mental health nurses (RMN) to ensure mental health needs were met. They also had access to psychiatrists and on Pyrland 1 and 2 wards and an occupational therapist who had previously worked in the community crisis and home treatment team. However, some nursing assistants told us that they felt they did not have all the skills or knowledge around specific mental health problems to be fully confident in all situations. This included anxiety, depression, and suicide risk and management.

- An on-site local induction covered a general introduction to the ward, including alarm systems, security, timesheets, travel claims, shift rotas, team meetings, reporting of sickness, appraisal management, staff supervision policy, line managers , mandatory training, confidentiality, patient related policies. Managers completed this with new members of staff within four weeks of appointment.

- All staff on the wards received yearly appraisals. We looked at ten staff records and saw they were all completed and up to date. Medical staff received supervision and appraisals and said they were happy with the support they received.

- Staff on the wards received clinical supervision and peer clinical supervision. Pyrland 1 ward had a supervision file, which included group clinical supervision but staff were not receiving regular managerial supervision. On Magnolia ward, the average supervision rate was 58% and Pyrland 1 and 2 wards 37% over 12 months.

- One staff member highlighted they last had supervision six months ago and records corroborated this. We raised it with the manager who agreed and confirmed this was a challenge on the ward currently. Staff told us despite these low numbers they felt supported and provided with clinical guidance.

- Managers considered additional specialist training on an individual basis. A senior nurse on Magnolia ward for example was supported to do the Mary Seacole leadership course and a ward manager was funded to do national vocational qualification (NVQ) level 4 in leadership and management.

Multi-disciplinary and inter-agency team work

- We observed three handovers, one on each ward visited. They were well attended and thorough, particularly on Magnolia ward where the senior nurse discussed all risks, observation levels, Mental Health Act status, daily activities and discharge plans.

- Although the handovers on Pyrland 1 and 2 wards were acceptable and risks, observation levels and MHA status were identified, they seemed to lack more pertinent detail and focussed more on the physical and daily activities than mental health presentation or active discharge plans. However, they were sufficient in meeting the day-to-day needs of the patients.

- We attended and observed three multidisciplinary (MDT) meetings on the wards. One was a regular conference call with service leads from other inpatient and community services. This was an effective bed management and communication tool to ensure as seamless as possible access and discharge to and from the ward. Communication was respectful and supportive.

- On Magnolia ward and Pyrland 1 and 2 wards, there were good relationships between team members, occupational therapy, psychology and psychiatry. Medication, in particular use of antipsychotics, was discussed in meetings to ensure prescribers adhered to NICE guidelines as well as application of the Mental Capacity Act. We also saw good planning under the Care Programme Approach (CPA) and discussions around Section 117 aftercare funding.

Adherence to the MHA and the MHA Code of Practice

- Records we looked at demonstrated that the wards adhered to the Mental Health Act (MHA) and associated

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.

code of practice. Training figures demonstrated only 57% of staff on the wards had completed MHA training, however we were told these packages were being rolled out and figures were low as a result of this.

- Patients had access to independent mental health advocacy (IMHA). Staff knew how to access support as required. All patients detained under the MHA had access to the advocacy service for support.

- Rights under the MHA were explained on admission and then re-read where appropriate.

Good practice in applying the MCA

- During the September 2015 inspection staff did not always provide care and treatment with the consent of each patient or other relevant person. Staff did not always demonstrate they acted in accordance with the Mental Capacity Act 2005 (MCA). This was where a patient lacked mental capacity to make specific decisions and to consent to their care and treatment, and included specific concerns where there was a formal instruction of do not attempt cardiopulmonary resuscitation (DNA/CPR) in place.

- MCA training had been introduced on electronic learning in the previous few weeks. The local MCA/DoLS (Deprivation of Liberty Safeguards) lead had developed a training package and was in the process of providing it for the team.

- At the time of this inspection across the wards 83.7% of staff had completed Mental Capacity Act (MCA) training. Staff spoke with more confidence when explaining the MCA. Records we looked at demonstrated good application of the MCA and clear and appropriate use, including consent to treatment that staff had sought and documented, with best interests processes evident where there were specific decisions and where the person lacked mental capacity to make the decision.

- There was clear process and application of the MCA where there was a DNA/CPR in place. This included liaison with the independent mental capacity advocate where the patient lacked appropriate family members.

- Magnolia ward had made nine formal applications for Deprivation of Liberty Safeguards (DoLS) in the previous six months. There had been six applications in the same period on Pyrland 1 and 2 wards.

Are services caring?

Good ●

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

Our findings

Kindness, dignity, respect and support

- Patients informed us staff treated them very well. They said they felt respected and that staff were kind. We received some carer feedback which said staff often went above and beyond to make their relative comfortable and supported.

- We observed that staff respected privacy and ensured that dignity was maintained. Staff were approachable, willing to help, polite and caring. One patient said staff helped them every day with their hair and were so kind and it made them feel very happy.

- We observed warm and supportive interactions on all the wards we visited. The activities co-ordinators provided cheerful and pleasant daytime activities, which the staff became a part of, including artwork, singing and dancing. We observed that patients enjoyed these activities.

- Without exception, the staff we met were courteous, conscientious and engaged in ensuring the patients received the best care possible. Staff discussed patients in a caring and respectful manner during the meetings we attended, and the discussions were always around the best interests and comfort of the patient.

The involvement of people in the care they receive

- The wards had a lead in family liaison as part of the 'triangle of care'. This meant they ensured liaison with carers or family members throughout the patient stay. Family members/carers were involved where appropriate in admission and provided information, and were offered a family liaison meeting following admission. This provided the opportunity to discuss any issues or concerns about their family member.

- Staff supported patients to access independent advocacy services (Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Act (IMHA) as needed. The advocates visited the wards weekly to provide independent support and advice.

- Staff and managers were able to tell us what advocacy and support services were available, and the environments provided information leaflets and contact details.

- However, we did not always see clear involvement with the patient in care plans. On Magnolia ward, Care plans were available to the patient in envelopes in their wardrobes, which also provided good information for non-regular care staff or family members visiting; but they lacked clear involvement. We raised this at the time of inspection. Despite this, the tone of the care plans was warm and respectful.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- The average bed occupancy between 1 January 2016 and 31 December 2016 (including leave days) was 85% on Pyrland 1 and 2. This fluctuated between 101% at the highest and 82% at the lowest. Magnolia ward was between 91% and 61%. Average length of stay ranged from 31 days to 118 across all three wards.

- In the same period, there was 612 delayed discharge days across all the wards. This was where the patient was ready for discharge from the ward but there were specific barriers to leaving. Magnolia ward had 189 delayed discharge days and Pyrland 1 and 2 had 423 days.

- Some staff raised that sometimes patients who were ready to leave unfortunately deteriorated again as they waited for their placements or care packages. However, this was largely out of their control and there was good proactive work with community teams and social services to reduce this as much as possible. Since the September 2015, inspection there had been a significant change in access to social workers, who were no longer part of the integrated into the local older peoples community mental health teams (CMHT's). This had led to increased barriers to accessing services provided by the local authority.

- There was also an increased pressure due to the reduction of beds necessary to address safe staffing issues. Magnolia ward introduced a new discharge pathway from May 2016 to address this and the issues around access to social workers. This led to a reduction in length of stay, supported by an agreed weekly attendance of a dedicated social worker and care co-ordinators.

- We observed a twice-weekly discharge teleconference call. The ward manager discussed all patients and looked at timescales and barriers or plans for discharge. Problems staff identified were waiting for funding panels to approve placements elsewhere, for example nursing or residential homes, or for packages of care.

- Managers told us there were no formal waiting lists, and the trust did not monitor overall activity elsewhere. For example, there could be a patient admitted to a general

hospital who required a specialist mental health bed. During conference calls managers discussed alternative options to admission such as the re-enablement team, community hospital, crisis team and integrated community team support.

- Managers kept the names of patients pending admission on a white board for when a bed became available, however this was not considered locally as a waiting list. Consultant psychiatrists were proactive in monitoring their patients in the community who may require a hospital bed in the future and informed the wards.

- There were no patients placed in beds out of the catchment area at the time of our inspection.

- All patients were subject under the Care Programme Approach (CPA) and had identified section 117 aftercare services for those who had been detained under section 3 Mental Health Act.

The facilities promote recovery, comfort, dignity and confidentiality

- All the wards had a range of rooms and equipment to support treatment and care. There were activity rooms, clinic rooms and quiet rooms. Pyrland 1 ward had a kitchen for activities of daily living, which supported recovery and rehabilitation. This was very useful for promoting independent living skills such as cooking.

- Pyrland 2 ward had bright and cheerful areas, which staff had decorated with pictures and reminiscence aids, and a hairdressing salon. All wards had access to outdoor space for fresh air. However, the environment was tired and still had the original fixtures and fittings.

- Staff had started to create a sensory room on Magnolia ward, which had relaxing chairs and bubble tubes and fibre optic lights. This was a work in progress but the staff felt positive about its use when fully functioning.

- We discovered a privacy issue on Pyrland 2 ward. Along one corridor of the ward, the majority of bedrooms were out of use, and staff were using them as storage space or meeting rooms. However, one patient's bedroom window looked out onto the path nearby where people walking by could see in and there was no privacy film. This was the same for the activities room. We raised this with the ward manager. Although this patient did not spend time in their bedroom during the day and the

Are services responsive to people's needs?

Good 🟢

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

curtains were drawn in the evening, there was potential for other patients in the future to have their dignity compromised as they could access their rooms any time of the day. The trust addressed this immediately when we raised it.

- On Magnolia ward there was a visitor's room, which family members used when visiting with children. This had toys and a chalkboard available. The reception area was welcoming with plenty of information available.

- Pyrland 1 and 2 wards were on one floor, there was not a dedicated visitor's room to see family members, and the ward staff used bookable rooms if available. The trust had a visitor's policy dated May 2016 and review date April 2019.

Meeting the needs of all people who use the service

- Patients had access to a wide range of information on all the wards we visited. This included information on advocacy services, different conditions, and patient rights including what to do if they wanted to complain.

- Staff could access interpreters to support patient's communication needs. Leaflets were also available in different languages if needed and some staff themselves spoke different languages.

- Each ward environment was adapted to ensure good access for disabled people and the specific needs of the patient group. This included toilets and ramps, bathrooms had a variety of hoisting equipment and adapted baths. Outdoor space provided good access for wheelchair users.

- We saw a choice of food was available in order to meet dietary requirements of different religious and ethnic groups. Patients confirmed the quality of food was good.

- Patients had access to spiritual support as required. A representative from the Christian church visited weekly, and we were told those of different faiths could access support as required.

- Patients had access to a project who attended on a Friday to offer alternative therapies such as hand massage, and a volunteer attended the ward to offer patients seated gentle breathing and movement exercises.

Listening to and learning from concerns and complaints

- The trust patient advice liaison service (PALS) visited the wards regularly to meet with patients or relatives to provide the opportunity to discuss any issues or concerns.

- According to trust figures, wards for older people with mental health problems received four formal complaints in the previous 12 months. The trust partially upheld all four. None were referred to the parliamentary health service ombudsman (PHSO).

- In the same period, the wards received 86 compliments. Magnolia ward received 67 and Pyrland 1 and 2 wards received 19. When we visited the wards, a large number of thank you cards from patients and relatives/carers were displayed.

- We reviewed the complaints report for the clinical governance board. This included a specific complaint dated Oct 2016. Managers had investigated this and had identified that staff had not routinely asked families on admission if they were happy if they contacted them during the night if an incident occurred. Staff subsequently put this in place and recorded it on the electronic patient record.

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 were largely aware of the organisation's values, but did not necessarily feel engaged by the wider trust, particularly around potential changes and developments. The older people's mental health wards had previously been part of the Somerset Partnership NHS Foundation trust mental health umbrella, the service had transferred to the community health umbrella. Some staff said they felt 'out of the loop' with developments or worried about plans pertaining to their core service. Others that they felt the trust senior management team did not consider them a mental health inpatient service. This was an issue raised in the previous September 2015 inspection.

- However, since the September 2015 inspection the trust had appointed five new clinical directors to work with the heads of service. This was to provide necessary additional leadership within the clinical governance framework and drive improvements of services. The aim was to support the improvements needed such as communication, identity of the wards for older people with mental health problems and engagement of staff in future developments.

Good governance

- Local governance of the wards was effective and well managed. There were clear processes in place. The wards had all relevant policies and procedures in place, which the trust reviewed regularly.

- Staff were up to date with their mandatory training, had received appraisals but did not receive regular supervision, which was not in accordance with their supervision policy.

- Sufficient staff managed the wards safely, despite overall staff shortages. Staff felt more able to provide 'one to one' care with patients because the trust had been proactive in managing staffing issues this by reducing the number of open beds. This had also led to an improvement in positive discharges.

- Staff participated in clinical audits and there was a clear and robust system for reporting, reviewing and learning from incidents and complaints.

- Staff raised during the previous inspection that they did not have access to specialist training relevant to a specialist psychiatric ward, and the focus was all on physical care. This was still apparent during the current inspection.

- During the current inspection, staff demonstrated an improvement in emphasis on recovery and rehabilitation. However, this appeared to be driven on the main by the medical staff and specialist staff such as occupational therapists. Managers had not ensured the nursing assistants had the opportunity to develop the skills required to provide care based on current best practice that specialist mental health training would provide.

Leadership, morale and staff engagement

- The wards had strong local leadership. The ward managers were visible and approachable and the senior nurses on the wards knowledgeable and supportive.

- All the wards had received recognition for their work at the staff recognition awards. The activities co-ordinator on Pyrland 1 and 2 wards had won the 'compassion in care' award for the commitment to delivering person centred care.

- The nursing team on Pyrland wards were also nominated for the 'dignity in care' award and were runners up in the category, a nursing assistant on Magnolia ward taking this accolade, for their work around dignity and end of life care. Understandably, staff were very proud of this achievement and the managers were proud of their staff teams.

- Staff morale was high. Despite staffing pressures and routinely working with some challenging patients the staff were resilient, supportive of each other and willing to help in any way possible to ensure the safe and effective running of the ward. Staff felt very supported by their ward managers and able to raise any issues or problems.

- However, the trust was in the process of reviewing inpatient mental health wards, and identified possible implications for wards for older people with mental health problems across the whole county. Staff

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Good 🟢

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explained they felt anxious and concerned about some proposed changes, some staff quite passionately. Staff also said they did not feel particularly involved or engaged in the process, which raised anxieties further.

• Staff were open and transparent. Staff could explain the principles of 'duty of candour' and gave examples of where they had explained to a patient when something had gone wrong.

Commitment to quality improvement and innovation

• Magnolia ward had implemented a 'twitter' account, which had over 1500 followers. This was innovative practice and a way of sharing good practice, networking and raising the profile of the trust. The nurse who implemented this was also nominated for a staff award.