Good

Avon and Wiltshire Mental Health Partnership NHS Trust

Wards for older people with mental health problems

Quality Report

Avon and Wiltshire Mental Health Partnership NHS Trust,
Jenner House,
Langley Park,
Chippenham
SN15 1GG
Tel: 01249 468000
Website: www.awp.nhs.uk

Date of inspection visit: 20-29 June 2017
Date of publication: 03/10/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RVNEQ	Callington Road Hospital	Aspen ward	BS4 5BJ
RVN9A	Fountain Way	Amblescroft North and Amblescroft South Wards	SP2 7FD
RVN4B	Longfox Unit	Cove and Dune Wards	BS23 4TQ
RVN2B	St Martins Hospital	Ward 4	BA2 5RP
RVNCE	Victoria Centre	Hodson and Liddington Wards	SN3 6BW

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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 Avon and Wiltshire Mental Health Partnership NHS trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We re-rated wards for older people with mental health problems as **good** overall because:

- Following our inspection in May 2016, we rated the services as good for caring but requires improvement for safe, effective, responsive and well-led. During the most recent inspection, we found that the service had addressed the majority of the issues and had made sufficient improvements.
- The wards for older people with mental health problems were now meeting Regulations 10, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- In May 2016 the trust did not have effective alarm systems for the use of patients and staff in all wards. When we visited in June 2017, we found this had been addressed and a replacement system due to be installed on one site.
- In May 2016 the trust were not ensuring staff received the necessary training to respond to a physical emergency. When we visited in June 2017, the majority of staff had received this training and those who had not received it had a date booked within the next two weeks.
- In May 2016, the trust did not transfer patients to seclusion using safe or dignified methods. When we visited in June 2017, the trust had implemented a new seclusion policy to ensure the safe and dignified transfer of patients.
- During our May 2016 inspection, there was no psychology cover for Hodson and Liddington wards. When we visited in June 2017, the wards had recruited to this post.
- In May 2016, the trust did not ensure staff adhered to Mental Health Act (MHA) legislation and the standards described in the MHA code of practice. When we visited in June 2017, we found managers had made improvements so staff worked appropriately within the legislation.
- In May 2016, the trust was not ensuring privacy and dignity on all the wards. Windows that looked out onto public areas did not have privacy film. When we visited in June 2017, the trust had applied opaque style window film. Also in May 2016, most of the wards for patients with dementia were not dementia friendly (where the environment is changed to help patients with dementia cope with their surroundings). When we visited in June 2017, we saw the trust had made significant improvements to ward environments and this work was ongoing.
- During the 2016 inspection, the wards did not have good governance systems around the application and monitoring of the MHA. When we visited in June 2017, we saw improvements in this area with staff monitoring paperwork and storage and dedicated MHA administration staff.
- All wards had access to physical health equipment and staff assessed patients on admission. Staff completed initial risk assessments on admission and ensured emergency equipment was stored safely and checked regularly. Medicines management was good across all wards.
- Care records overall contained some detailed admission information although on some wards documentation was more thorough than on others. Staff demonstrated good examples of providing holistic ongoing care on most wards. Staff made efforts to involve patients in care planning where possible.
- Staff prescribed medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. They followed best practice to avoid using antipsychotic medicine where possible.
- All wards held multidisciplinary meetings to discuss complex patient needs, discharge planning, Care Programme Approach reviews and risk management. We observed some robust and good quality discussions between the wards and partner agencies.
- We observed kind, discreet and respectful interactions by staff towards patients. Feedback from patients and carers was highly positive across the wards.

Summary of findings

- The trust monitored admissions and readmissions carefully. Managers escalated delayed discharges to senior trust staff that monitored inpatient capacity through the corporate risk register.
- Ward managers were visible on the wards and had made improvements to their areas of responsibility since the 2016 inspection. Staff described them as approachable and hands-on and staff reported good morale on the majority of the wards.

However:

- Although they had partially addressed the risk issues identified in May 2016 around ligatures, The service still did not fully meet regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 in this and some other areas.
- Staff did not always clearly document how they were managing initial or ongoing risks. There was not always a clear path from the initial risk assessment to the planning of care. Documentation of risk was disjointed and not well communicated in places, such as handover or the daily records, which meant risks could be overlooked.
- Ward 4 in Bath had dormitory style shared accommodation. This increased risks to patients particularly at night. This was a dementia ward with some complex, confused and sometimes aggressive individuals and the staff could not guarantee optimum levels of safety as compared to individual bedrooms.
- Aspen ward had blind spots that staff could not mitigate well particularly at night and had no convex mirrors in place to aid this. This area of the corridor had handrails that the trust had not adapted or boxed in to reduce risk. Patients were in the garden area unsupervised during our inspection when we were told they should be monitored.
- The trust had addressed the issue of privacy and dignity on wards with bedroom windows looking out on public areas.
- There were too many generic care plans that lacked individualisation across all the wards. Occupational therapy (OT) and psychology cover was sparse on Cove and Dune wards. Staff did not consistently use health of the nation outcome scales in order to effectively measure outcomes.
- Dune ward was still awaiting improvements to the environment. The flooring was problematic for the patient group, as it was multi-tonal and shiny, potentially increasing visual perception problems and confusion in this client group. Ward clocks were too high for patients to see clearly.
- Not all managers had completed root cause analysis (RCA) training in order to investigate incidents.

Summary of findings

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

Are services safe?

Requires improvement 

We rated safe as **requires Improvement** because:

- Although the service had addressed most issues that had caused us to rate safe as requires improvement, there were still some areas of practice that still did not fully meet our requirements under the Health and Social Care Act (Regulated Activities) Regulations 2014.
- We did not see good robust risk management, monitoring and communication documented on some wards. Risk issues were not always clearly identified and did not consistently translate into care plans.
- Ward 4 in Bath had dormitory style shared accommodation that increased risks particularly during the night.
- Aspen ward had blind spots that staff had not clearly mitigated and had no convex mirrors in place to aid this.

However:

- In May 2016, we found the trust did not have effective alarm systems for the use of patients and staff in all wards. When we visited in June 2017, we found that the trust had addressed this issue.
- In May 2016 the trust were not ensuring staff received the necessary training to respond to a physical emergency. When we visited in June 2017, the trust had almost completed its training programme to do this.
- In May 2016, the trust did not transfer patients to seclusion using safe or dignified methods. When we visited in June 2017, the trust had implemented a new seclusion policy to ensure this was no longer the case.
- All wards had access to physical health equipment and staff assessed patients on admission.
- Staff received feedback following incidents and staff we spoke with told us they received debriefs and support following serious incidents.

Are services effective?

Good 

We rated effective as **good** because:

- The service had addressed the issues that had caused us to rate effective as requires improvement in the May 2016 inspection.

Summary of findings

- During the May 2016 inspection, we said the trust should ensure that staff involve patients in their care plans. When we visited in June 2017, we saw some improved documentation around involvement in care planning.
- During our May 2016 inspection, there was no psychologist cover for Hodson and Liddington wards in Swindon. When we visited in June 2017, the trust had recruited to this post.
- During our May 2016 inspection, staff were not completing health of the nation outcome scores (HoNOS) for over 65's (older adults) to measure treatment outcomes. When we visited in June 2017, we saw some improvement in this although it was not consistent across all wards.
- In May 2016, multidisciplinary meetings held in Weston-super-Mare (Cove and Dune wards) did not have a full range of professionals and used inappropriate rooms. When we visited in June 2017, we observed good attendance with improved use of venues.
- In May 2016, staff did not adhere fully to Mental Health Act (MHA) code of practice. When we visited in June 2017, we saw improved documentation around the MHA with relevant staff demonstrating a good understanding of the legislation.

However:

- Psychology and OT cover on Dune and Cove wards was very limited.
- There were too many generic care plans that lacked individualisation across all the wards. They were not always relevant or person centred.

Are services caring?

Good

We rated caring as **good** because:

- Staff were kind, compassionate and respectful towards patients.
- Feedback from patients and carers regarding the staff was positive. We saw good engagements with families.
- Wards provided an information pack for carers and patients at admission.
- All wards displayed posters for advocacy services to protect their patients' rights. Carer representatives visited the wards and provided quality feedback.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The service had addressed the issues that had caused us to rate responsive as requires improvement in the May 2016 inspection.
- In May 2016, the trust did not ensure privacy and dignity on all the wards. Bedroom windows looked out onto public areas without privacy film. When we visited in June 2017, we saw the trust had put up opaque style window film.
- In May 2016, the majority of wards nursing patients with dementia were not considered dementia friendly. When we visited in June 2017, we saw significant improvements with further plans for positive changes to the environment.

However:

- Dune ward was still awaiting improvements in the environment. The flooring was inappropriate, as it was multi-tonal and shiny potentially increasing visual perception problems and confusion in this client group. Ward clocks were too high for patients to see clearly.
- The bedroom window film did protect privacy. However, it restricted the view to the outside areas, which caused confusion, and distress to some patients.

Are services well-led?

Good

We rated well-led as **good** because:

- The service had addressed the issues that had caused us to rate well led as requires improvement in the May 2016 inspection.
- During the 2017 inspection, staff told us managers were visible on the wards and were approachable, hands-on and staff on the majority of the wards reported good morale.
- There were a number of new managers on the wards who had made good improvements to their areas since the 2016 inspection, particularly on the dementia wards.
- In May 2016, patients who were detained under the Mental Health Act (MHA) on Cove ward did not have their rights protected because there were no effective governance arrangements to monitor and review how the functions and powers of the Act were used. When we visited in June 2017, we saw this had improved sufficiently.

Summary of findings

- Ward managers were inspiring and supported staff to make improvements and take pride in their work.

However:

- Ward managers were not ensuring staff consistently completed mandatory training. Not all managers had completed root cause analysis training in order to investigate incidents.

Summary of findings

Information about the service

Avon and Wiltshire Mental Health Partnership NHS Trust provides wards for older people with mental health problems at five sites within the trust.

In Bath, there was Ward 4 at St Martin's Hospital. A 12 bedded mixed gender ward for people experiencing dementia.

In Bristol, there were two wards at Callington Road Hospital. Laurel ward is an 18-bedded mixed gender ward for people experiencing dementia. Aspen ward is a 24-bedded mixed gender ward for people with functional illnesses such as schizophrenia, bipolar disorder or depression. Laurel ward had temporarily closed at the time of our inspection so was not inspected at this time.

In Salisbury, there were two wards. Amblescroft South is a 20-bedded mixed gender ward for people experiencing dementia. Amblescroft North is a 20-bedded mixed gender ward for people with functional illnesses such as schizophrenia or depression.

In Swindon there were two wards. Liddington Ward is a 12-bedded mixed gender ward for people experiencing dementia. Hodson Ward is a 14-bedded mixed gender ward for people with functional illnesses

In Weston-super-Mare, there were two wards. Dune Ward is a 10-bedded mixed gender ward for people experiencing dementia. Cove Ward is a 15-bedded mixed gender ward for people with functional illnesses.

We carried out a comprehensive inspection of the trust in June 2014. We issued compliance actions about records, the assessing and monitoring of the service, safeguarding arrangements, medicines management, safety and suitability of premises, safety, availability and suitability of equipment, respecting and involving service users, staffing and supporting workers. The requirements made in 2014 were not just for the inpatient wards listed above, they also included the community teams across the area like the Bath and North East Somerset complex intervention team (CIT) for old people with mental health problems (OPMH), Swindon CIT (OPMH) and Bristol CIT (OPMH).

We inspected the core service again in May 2016 and found that the service had met or partially met the requirements from the 2014 inspection which had directly related to this core service. Three requirements were partially met because further improvements were still required to the ward environments, potential ligature risks and training in emergency response and physical interventions.

Our inspection team

Our inspection team was led by:

Team leader: Karen Bennett-Wilson, Head of Hospitals inspection.

The team in week one of the inspection comprised two CQC inspectors and a specialist advisor with clinical experience of working with older adults.

The team in week two comprised two CQC inspectors, three specialist advisors with clinical experience of working with older adults and one expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example, as a carer).of findings

Summary of findings

Why we carried out this inspection

We undertook this announced inspection to find out whether Avon and Wiltshire Mental Health Partnership NHS Trust had made improvements to their wards for older people with mental health problems since our last comprehensive inspection of the trust in May 2016.

When we last inspected the trust in May 2016, 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, responsive, well led and good for caring.

Following the May 2016 inspection, we told the trust to make the following actions to improve wards for older people with mental health problems:

- The trust must ensure it takes all actions required to protect patients from the risk of ligatures in a timely fashion.
- The trust must ensure that appropriate and effective alarm systems are in place for the use of patients and staff in all wards.
- The trust must ensure that ward environments are dementia friendly and fit for the purpose of managing patients with these conditions.
- The trust must ensure that changes are made to ward environments to protect patients' dignity and privacy.
- The trust must ensure that all staff members complete the physical emergency response training or practical patient handling training. Managers must receive training in root cause analysis to ensure that they can complete their role effectively when investigating incidents.
- The trust must ensure that there is psychologist cover for Hodson and Liddington Wards in Swindon.
- The trust must ensure that staff follow risk assessment and care plans completed to ensure their own and patient's safety.
- The trust must identify a safe and dignified method of transferring patients in need of seclusion between wards.

These related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 10 Dignity and Respect

Regulation 12 Safe care and treatment Regulation 17 Good governance

Regulation 18 Staffing

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 and staff at a number of focus groups.

During the inspection visit, the inspection team:

- visited all eight of the wards at the five hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 19 patients who were using the service and collected feedback from 6 patients using comment cards
- spoke with 14 carers of patients using the service
- spoke with the managers or acting managers for each of the wards and a selection of senior managers including modern matrons

Summary of findings

- spoke with 45 other staff members including doctors, nurses, occupational therapists, psychologists, physiotherapists, support workers and activity coordinators
- attended and observed seven meetings including handovers and multidisciplinary meetings
- looked at 59 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 and their carers were extremely positive about the care provided. They described staff as dedicated, professional, kind, caring and respectful. Families told us they felt involved in the care of their relative and that they felt staff did their best to support them.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure clear risk management and staff must ensure they clearly document and review risk management. Staff must ensure they transfer patients' risks clearly to care plans.
- The trust must ensure blind spots on Aspen ward including the garden are observed safely and mitigated.
- The trust must ensure they prioritise removal of dormitory accommodation on ward 4 in order to ensure optimum safety of patients particularly at increased risk times such as at night.

Action the provider SHOULD take to improve

- The trust should ensure they continue attempts to recruit staff to fill the registered nursing shortfalls and OT and psychology staff to support patients to carry out activities.
- The trust should ensure care plans are relevant, person centred and individualised, avoiding use of generalisation.
- The trust should ensure managers who have not yet received root cause analysis training do so.
- The trust should ensure all staff complete mandatory training in order to achieve trust targets.
- The trust should ensure consistency in the use of HoNOS 65+ (older adults) to effectively measure treatment outcomes.
- The trust should ensure the timely completion of the work to make environments dementia friendly.
- The trust should review the bedroom window coverings in order for patients to not have such restricted view to the outside areas.

Avon and Wiltshire Mental Health Partnership NHS 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
Aspen ward	Callington Road Hospital, Bristol
Amblescroft North and Amblescroft South Wards	Fountain Way, Salisbury
Cove and Dune Wards	Longfox Unit, Weston-super-Mare
Cove and Dune Wards	St Martin's Hospital, Bath
Hodson and Liddington Wards	Victoria Centre, Swindon

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.

In May 2016, we told the trust they must ensure that staff adhere to Mental Health Act (MHA) legislation and standards described in the Mental Health Act (1983) code of practice. When we visited in June 2017, we found good documentation of the MHA where relevant and clear improvements around its application.

The trust provided staff with training in the MHA (1983) and staff demonstrated an understanding of the legislation throughout of visit. We saw evidence of reading of patients' rights under section 132 and entries in the clinical records if unable to do so.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust provided staff with training in the Mental Capacity Act (MCA). Staff we spoke with were confident in its use and we saw some excellent examples of mental capacity assessments and best interest decisions in the clinical records.

There was evidence of informed consent and records demonstrated involvement in discussions around medication where possible.

Staff supported patients to make decisions where appropriate and when a decision was made in their best interests, staff considered the patient's wishes, feelings and personal history.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Some wards had blind spots where staff could not observe patients, but staff managed this through regular observation and monitoring throughout the day. However, on Aspen ward there was poor observation of some corridor areas.
- Since our last inspection, the trust had moved the staff office on Amblescroft North ward to an alternative area of the ward to allow safer and improved observation of blind spots.
- During our inspection in 2016, we identified that not all wards were managing and monitoring ligature risks safely. When we visited in June 2017, the wards had several potential ligature points (a ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) but staff used the 'Manchester tool' to identify and monitor these through an annual ligature risk audit. Staff updated this audit whenever they identified a new risk as well as the yearly reviews.
- Due to the nature of some physical conditions associated with older adults on the wards, managers deemed it impossible to remove all potential ligature points. These were present in fixtures such as grab rails, some types of beds and mobility equipment. The trust had reduced ligatures where they felt appropriate and mitigated most risks through individual risk assessments and observations. Some wards also provided 'low ligature' rooms for patients deemed a higher risk.
- However, on Aspen ward there were ligature risks not fully mitigated particularly at night. The staffing numbers meant two staff were occupied for long periods with the medication round and the remaining two staff were then responsible for ensuring safety on the ward. There were four corridors with handrails all around area that were not boxed in and no convex mirrors to mitigate or aid observation. Therefore, despite some improvement the trust had not fully met this requirement.
- The trust had a policy to allow wards to admit patients to beds allocated to the opposite gender in an emergency. The protocol specified what actions managers had to take to ensure that the trust had not breached single sex accommodation guidelines. The trust reported breaches appropriately.
- All wards had specified female lounges to provide them with a safe space and the majority of wards had single rooms with ensuite bathroom facilities.
- We found on Aspen ward in Bristol there was a male patient asleep in the female designated lounge and staff were not observed to ask him to move. There was also a female assisted bathroom in the male sleeping area though staff informed us that as it was assisted the patient was never alone in it.
- Over the 12 months from 1 April 2016 to 31 March 2017 there were nine mixed sex accommodation breaches within older people wards, four of which occurred on Aspen ward, two in Swindon and one on Dune ward. The remaining two were on Laurel ward, which was closed temporarily. The trust reported breaches appropriately.
- Ward 4 in Bath had dormitory (shared) accommodation. Staff ensured males and females did not sleep in the same dormitory. Ward 4 staff assured us they were doing what they could to ensure privacy and dignity, and the dormitories were large and provided good space and privacy, but we were concerned because the ward sometimes had to manage some complex, unpredictable and occasionally aggressive individuals who could be confused and may wander. The ward could not guarantee safety particularly at night due to this type of accommodation.
- The wards all had emergency equipment including automated external defibrillators (AED) and oxygen. Staff checked these regularly to ensure they worked. Staff also checked the physical emergency bag was complete and contained the required equipment. Managers ensured staff maintained cleaning records. Clinic rooms were clean and well maintained.
- PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care

Requires improvement

Are services safe?

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

providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which staff provide care, as well as supporting non-clinical services. For the 'cleanliness' score, four of the five sites in this core service scored higher than the England average (97.8%). Only Ward 4 in Bath scored lower, with 93.7%. All five sites scored higher than the England average (94.5%) for 'condition, appearance and maintenance.

- During our visit, all the wards were clean and welcoming. Dining areas were light and airy and we could see in all wards that staff made the effort to provide a positive environment whilst maintaining safety where possible.
- During our inspection in May 2016, we told the trust they must ensure that effective and appropriate alarm systems were in place for the use of patients and staff. Inspectors had found the alarms were of variable quality and some were louder than others were. Some did not work at all. When we visited in June 2017, we found this was improved. Alarms worked in all wards. The alarm system at the Salisbury hospital site (Amblescroft north and south) was an old system, which staff tested daily when they arrived for work. Staff had additional support with screech alarms. The trust was due to provide the site a new alarm system by end October 2017.
- Patients had access to a nurse call system in bedrooms and communal areas to summon help if needed.

Safe staffing

- Figures quoted by the trust from April 2017 until May 2017 confirmed that all wards had vacancies for qualified nurses. However, there was a recruitment plan in place to address these concerns. The trust had calculated the number of staff required on each shift using the safer staffing tool and process.
- In Salisbury (Amblescroft North), there were 15.6 whole time equivalent (WTE) nurses and 14.6 WTE nursing assistants. This left 6.4 nursing vacancies and 2.4 nursing assistant vacancies. That meant a 41% nursing and 16% nursing assistant vacancy rate. In Amblescroft South, there were 15.3 WTE nurses and 26 WTE nursing assistants. This left 4.9 nursing and 7.6 nursing assistant vacancies. This meant there was a 32% nursing and 29% nursing assistant vacancy rate.
- In Swindon (Liddington ward), there were 15.6 WTE nurses and 14.6 WTE nursing assistants. This left 5.8 nursing and a surplus of 1.6 nursing assistant vacancies. This meant there was a 37% nursing and a surplus of 11% nursing assistant vacancy rate. Hodson ward had 10.4 WTE nurses and 10.8 WTE nursing assistants leaving 1.2 nursing and 0.4 nursing assistant vacancies which meant 12% nursing and 3% nursing assistant vacancy rate.
- Callington road in Bristol (Aspen ward) had 16.2 WTE nurses and 17.3 WTE nursing assistants. This left one nurse and 2.5 nursing assistant vacancies meaning the ward had a 6% nursing and 15% nursing assistant deficit.
- Ward 4 in Bath had 16 WTE nurses and 16.4 WTE nursing assistants with 4.6 nursing and 5.1 nursing assistant vacancies. This meant a 29% nursing and 31% nursing assistant deficit on the ward.
- In Weston-super-Mare Dune ward had 10.4 WTE nurses and 10.8 nursing assistants leaving 1.4 nursing and 2.4 nursing assistant vacancies. This meant there were 14% nursing and 23% nursing assistant vacancies. Cove ward similarly had 10.4 WTE nurses and 10.8 WTE nursing assistants leaving 1.2 nursing and 2.2 nursing assistant vacancies. This meant a 12% nursing and 20% nursing assistant vacancy rate.
- Staff filled deficits by use of trust bank staff and agency workers, many of whom they used regularly and were familiar with the wards. However, some were not. We saw managers tried to ensure where possible they booked familiar staff to cover shifts.
- Ward managers told us that they increased staffing numbers if staff placed patients on 1-1 observations. The first member of staff required to manage this came out of the ward numbers. If they required more than one member of staff to manage 1-1 observations, staff were able to book additional workers. Staff on Dune and Cove wards told us they enjoyed working on the wards and often travelled some distance to work there on bank.
- Staff on Cove and Dune wards told us they struggled to ensure activities took place due to a reduction in occupational therapy and psychology staff. The trust

Requires improvement

Are services safe?

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

told us they were struggling to recruit an occupational therapist. We spoke with a psychology lead who confirmed there was pressure on the service and they could not provide enough support to the wards.

- All wards had access to medical staff during office hours. During evenings and weekends, staff contacted an on call duty doctor for support.
- The trust supplied training compliance data for 22 mandatory courses for this core service.
- During our May 2016 inspection, we found the trust were not ensuring all staff members completed the physical emergency response training (PERT) and served a requirement notice. We also told the trust they must ensure managers receive training in root cause analysis (RCA) to ensure they can complete the role effectively when investigating incidents. When we visited in June 2017, we found that compliance rate for PERT training was at 77%. We raised this and found that although not all staff had completed PERT training, those outstanding were booked to attend a course in the next few weeks. Managers told us previous planned sessions had been cancelled hence why there were still some outstanding. However, not all managers had attended RCA training. We raised this at the time of our inspection and managers assured us they would access the training following our inspection.
- At as March 2017, training compliance for older people wards was 89% average overall against the trust target of 85%.
- As at March 2017, six of the 22 training courses had compliance rates below the trust target. These were safeguarding children level 3 (50%), practical patient handling (58%), physical emergency response training (PERT) (77%), basic resuscitation (80%), managing conflict (82%) and food safety awareness (83%).

Assessing and managing risk to patients and staff

- There were 271 incidents of restraint on 159 different patients for this core service across the 12 months. This included 21 prone restraints and 73 incidents of rapid tranquilisation. Ward 4 had the highest number of uses of restraint with 63. Cove ward was second with 44 and accounted for the most restraints resulting in rapid tranquilisation (20).
- During our inspection in May 2016, we found there were 23 incidents of prone restraint (face down) reported in a six-month period. When we visited in June 2017, this had reduced slightly to 21 over a 12 month period. Staff we spoke with demonstrated an understanding of risks associated with this practice.
- There were 19 incidents of seclusion but no instances of long-term segregation or mechanical restraint for this core service. Following our May 2016 inspection, we told the trust they must identify safe and dignified methods of transferring patients in need of seclusion between wards. When we visited in June 2017, the trust had created new seclusion procedures for transferring patients to ensure safety and dignity.
- Cove unit had the highest number of seclusions with eight, half of which occurred in the final month of the reporting period. During our May 2016 inspection, we told the trust they should ensure patient records always give clear information as to when seclusion commenced, who authorised it and who had made the decision to end the seclusion. We looked at some seclusion records and found good, clear documentation.
- Staff on all wards undertook a risk assessment and physical health assessment on admission. However, evidence of ongoing monitoring of risk was variable on the wards. In Amblescroft north and south clinical records, we saw some excellent examples of risk management clearly documented, however risk was not always transferred to the care plans. On ward 4 in Bath, we again saw high quality examples of documentation but did not see consistent evidence of waterlow (an estimated risk for the development of a pressure sore) or malnutrition universal screening tool (MUST) screening in the records. There were no individual plans for managing the risks of the dormitory accommodation in records.
- Cove and Dune ward had good organisation of risk assessment and management. Risk summaries were in place and up to date. Few of the assessments or care plans however demonstrated an understanding of the nature of the risk. For example, on Dune we saw aggressive behaviour identified but no explanation of triggers or identified interventions to address the risks safely. All physical health risks were present in the care plans.

Requires improvement

Are services safe?

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

- On Hodson and Liddington wards in Swindon, there was clear progression of risks highlighted in the risk summary through to care planning. Although there was no 'risk' heading in the progress notes. Progress notes were structured and they included mental health, physical wellbeing, medication and nutrition plus falls and sleep. Risks of aggression or self-harm were documented generally under a 'mental health' heading.
- On Aspen ward at Callington road there was no clear path from assessment to planning care. Records were disjointed which meant staff could overlook risks or they could be lost in the assessment process. Staff did not clearly discuss risk in the handover despite there being unfamiliar agency staff present. We saw patients in the garden area for lengthy periods of time which we were told should have been supervised or monitored.
- All wards had implemented the "safe wards" initiative to reduce the level of risk and produce a calm ward environment. They used different tools and methods of engagement to reduce the amount of conflict on the wards. For example, positive words, where staff gave positive feedback on each patient during handover; discharge messages, where patients and their carers leave messages of hope for others to read when they were discharged.
- The service had made two adult safeguarding referrals to the local authority between 1 April 2016 and 31 March 2017. Staff we spoke with on all wards were clear and confident around safeguarding and the referral process. Wards clearly displayed safeguarding information and a flowchart for staff to follow.
- Staff followed policies and procedures around searching of property on admission. Staff searched patients' property based on individual risk profile and suspicion of concealing inappropriate items such as knives. Following an incident on Liddington ward, the trust reviewed their search procedures and will be implementing use of an admission checklist to safeguard staff and patients around potential weapons.
- Managers of each ward ensured that good medicine management practices were in place. Pharmacists and medicine management technicians visited the wards. They monitored stock levels and completed reconciliation of medicine for new admissions. Pharmacists checked that Mental Health Act consent paperwork covered medicine doctors had prescribed if applicable. They also checked if doctors had prescribed medicine within National Institute for Health and Clinical Excellence (NICE) guidelines. Staff completed weekly audits of medication administration records.

Track record on safety

- CQC received three direct notifications from Avon and Wiltshire Mental Health Partnership NHS Trust relating to the core service between 1 April 2016 and 31 March 2017. All were deaths in detention at three separate wards.
- In the last 12 months, there has been a prevention of future death report in relation to older adult mental health wards. We did not investigate specific issues around this as separate processes were being carried out at the time of our inspection.
- At the time of our inspection, the trust was also being investigated due to patients being inappropriately secluded on a ward.
- The core service reported eight serious incidents. There were no reports of never events (errors that should never happen and are preventable) related to older people's wards. Slips, trips or falls accounted for half of the eight incidents reported over the 12-month period from 1 April 2016 to 31 March 2017.

Reporting incidents and learning from when things go wrong

- All staff we spoke with understood the process of reporting incidents and demonstrated awareness of what incidents to report. We saw evidence of learning from incidents that staff discussed in supervision and team meetings, as well as displayed on notice boards. For example, Hodson and Liddington wards had reviewed falls and demonstrated how they would improve practice from the outcomes.
- Staff demonstrated knowledge of the principles of the duty of candour. They recognised the need to be open and honest with people who used the service and their carers (where appropriate) when things went wrong.
- Staff received feedback following incidents and staff we spoke with told us they received debriefs and support following serious incidents. Psychologists offered support to staff where possible after these events.

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 59 clinical records for patients receiving care and treatment on the wards for older people. Staff had assessed patients' needs promptly after admission and most had completed physical health assessments and care plans. However, quality of the records was inconsistent. Some records were disjointed with entries missing and some contained good clear documentation.
- For example, on Aspen ward we found staff had used a screening tool but the majority of it was incomplete with the medical history, medication and allergies blank. Staff had only completed fully two out of seven physical examination sections. We found reference to nicotine replacement therapy but no care plan evident. Staff created detailed care plans which focussed on physical wellbeing and lifestyle (for example smoking and pain relief, poor mobility, and healthy diet). However, no evidence of these needs was in the physical health assessment. Staff made largely descriptive entries in the clinical records focusing on mood, diet and sleep. We could not find evidence of psychological input documented. We saw high quality care documentation around pressure ulcers and some well-documented evidence of successful treatment outcomes.
- Staff on both Cove and Dune wards recorded comprehensive physical health and mental state examination assessments on admission and the majority of needs had care plans related to them. However, they did not clearly refer to specific mental health needs or nursing/risk interventions in care plans except for the use of observations. Clinical records demonstrated some excellent care support staff provided to some highly complex patients.
- On Amblescroft North and South and Ward 4 there was documented evidence of comprehensive assessment on admission and ongoing management of care. Staff assessed physical needs and met these with person centred interventions. We saw evidence of some excellent management of complex needs on all three wards.
- On Hodson and Liddington wards, records demonstrated good examples of staff meeting mental health needs using planned nursing interventions. We saw some personalised care plans and entries in the progress notes referred clearly to the care plans.
- Staff created care plans for all the patients on all the wards but the majority of care plans were generic and task orientated rather than individualised. Patients had a high number (in one case 19) of care plans some of which were standard across all wards and identified tasks or rules as opposed to being person centred. For example, during our May 2016 inspection, we had identified that staff were not liaising with families or carers before locking private property in cabinets. Although this practice had ceased, all patients now had a care plan around this. Similarly, under 'spirituality' all had standard care plans stating there was use of the faith room if required as opposed to identifying individual faith or spiritual needs. The care plans were generated through the electronic system and it was difficult to see overarching needs. We raised this at the time of inspection. We did observe that most staff had attempted to personalise these generic care plans as much as possible. However, staff told us they the trust had directed them to complete these.
- During the May 2016 inspection, we said the trust should ensure that staff involve patients in their care plans. When we visited in June 2017, although care plans were generally generic, we did see improvements in this and staff documented discussion where appropriate.
- Staff used the trust's computerised system for storing patients' records. They scanned in any paperwork completed in the course of a patients' care, for example section papers issued under the Mental Health Act (MHA) 1983. Staff confirmed that records were stored securely and that they were available when required.

Best practice in treatment and care

- We spoke to consultants and doctors within the wards we inspected. They were aware of the National Institute of Health and Care Excellence (NICE) guidance regarding the prescribing of medication. They stated that they tried to use non- pharmacological interventions for behavioural problems in dementia. They tried to avoid antipsychotic medication where possible and tried to reduce medication as soon as possible.

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.

- In May 2016, we said the trust should ensure that staff completes health of the nation outcome scales (HONOS) for over 65s, which would enable staff to measure patient improvement or decline in mental health. When we visited in June 2017, we did see some improvement however there were still some wards not completing this.
- Staff used recognised screening tools such as the waterlow score (gives an estimated risk for the development of pressure sores), MUST (malnutrition universal screening tool) and NEWS (national early warning score) which determines the degree of illness of a patient and prompts critical care intervention, although we did find some gaps in records.

Skilled staff to deliver care

- There was limited cover for occupational therapist (OT)across wards. Cove and Dune wards were lacking in OT cover which meant activities and groups were very limited. There was also no activities coordinator. Liddington and Hodson wards shared therapists and held OT and physiotherapy groups and had two activity coordinators. Amblescroft North and South wards and Ward 4 in Bath had good OT cover.
- During our May 2016 inspection, there was no psychologist cover for Hodson and Liddington wards. When we visited in June 2017, the wards had recruited a new psychologist due to start August 2017.
- All other wards could access psychology. However, Cove and Dune ward struggled to provide psychology cover and the lead psychologist for the community service provided support where possible. Staff told us this was because the trust had withdrawn funding for a psychologist on the ward when the national commissioning for quality and innovation for older people and dementia ended.
- Pharmacists visited the wards approximately three times per week to provide support with medication issues. Swindon wards had access to art therapists. Staff accessed speech and language therapy services when required by referral. A dietician was also available wards to help monitor dietary intake.
- The trust provided details of clinical supervision rates for non-medical staff over the 12 months between 1 April 2016 and 31 March 2017 relating to the core service. As at March 2017, the overall service achieved this with 85% compliance. They also achieved this target in every month of the year at a core service level.
- However, as of March 2017 three of the wards did not meet the internal target of 85% compliance. These were Aspen ward (81%); Hodson ward (60%) and Liddington ward (55%). Staff we spoke with told us they felt supported and received informal supervision often. At the time of our inspection staff assured us they had supervision booked in and were happy to access it when needed.
- The appraisal rate for non-medical and medical staff combined was 97% as of March 2017, which is above the trust compliance target of 95%. The core service failed to achieve the compliance rate only on Liddington ward which achieved 89% in March.

Multi-disciplinary and inter-agency team work

- We attended seven multidisciplinary meetings including handovers throughout our inspection. All wards held regular and effective meetings discussing complex patient needs, discharge planning, risk management and medication. We did not consider the handover on Aspen ward however to be effective or holistic, focussing mainly on daily tasks, medication compliance, behaviour and leave.
- In May 2016, we said the trust should ensure that multidisciplinary meetings in Weston-super-Mare (Cove and Dune wards) had a full range of professionals and were held in appropriate rooms. The meetings we attended where in a room near the main entrance and on a hot day the windows would be open. However, on our visit staff ensured windows were closed where appropriate or speech kept to a low volume. The trust had just installed a Wi-Fi hotspot so staff could use alternative rooms for meetings if necessary.
- We observed a discharge planning meeting on Cove and Dune between the ward staff and the community complex intervention team (CIT). There was excellent communication around patient access and discharge plans. The ward managers ensured the patient's voice was heard.

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.

Adherence to the MHA and the MHA Code of Practice

- The service received seven Mental Health Act (MHA) review visits between January and November 2016 and all were unannounced. Mental Health Act reviewers identified 55 issues. The highest category for issues was 'protecting patients' rights and autonomy' with 27 issues. Care, support and treatment in hospital followed with 20 issues. Managers told us they had focussed on these issues and taken action.
- Staff received training in the MHA and had achieved 92% compliance for Mental Health Act as at March 2017, against a target of 85%. Laurel ward and Hodson were the only two wards to score slightly under the trust target with 82%.
- In May 2016, we told the trust they must ensure that staff adhere to Mental Health Act legislation and standards described in the Mental Health Act (1983) code of practice. When we visited in June 2017, we found good documentation of the MHA where relevant and staff we spoke with had an understanding of the MHA relevant to their role.
- Dedicated staff managed and stored the relevant legal paperwork and ensured staff were prompted when section 132 rights were due or a patient had a MHA tribunal due.
- We saw documented evidence across most wards that staff had read detained patients their rights. Where they had not re-read them, we raised this with the wards. On all wards, staff documented that where patients lacked the capacity to understand them. In this situation, the staff had contacted an independent mental health advocate (IMHA) to act on behalf of the patient.
- Mental health administration staff we spoke with told us they could get advice from a central team within the trust. Staff we spoke with told us that the mental health act administrator was available to help them and was easily contactable by phone. We spoke with a mental health act administrator who was confident in their role and knowledge about the MHA.
- We saw posters and leaflets on all wards advertising the advocacy services. Staff told us that patients and their carers can refer to the service or that staff can refer on behalf of the patients. Staff we spoke with were clear about how to access advocacy services.

Good practice in applying the MCA

- The trust provided staff with training in the Mental Capacity Act (MCA). Staff we spoke with were confident in its use and we saw some excellent examples of mental capacity assessments and best interest decisions in the clinical records. There was evidence of informed consent and records demonstrated involvement in discussions around medication where possible.
- The core service as a whole met the trust's internal compliance target rate of 85% for Mental Capacity Act training as at March 2017, achieving 94% overall. The only ward that did not achieve this was Dune ward with 78% compliance.
- There were 92 Deprivation of Liberty Safeguard applications made by older people wards of which seven (8%) were approved. CQC received notice of 13 applications across the 12 months for this service, 11 of which were from Amblescroft South. The remaining two were from Hodson and Liddington wards in Swindon.

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

- During the inspection, we observed staff interactions with patients that were kind, discreet, compassionate and respectful. Staff spoke to patients with respect and encouraged interaction throughout activities. We observed particularly warm and kind interactions on Amblescroft South ward between support workers and patients.
- Feedback from patients and families or carers was generally positive. They reported that the care provided by staff was good. Feedback was overwhelmingly positive on Liddington and Hodson wards. Staff were praised about the level of respect shown and how they ensured privacy and dignity. Staff on all wards discussed ways of improving the patient experience during our inspection.
- Staff demonstrated a high level of knowledge about the needs of their individual patients. We saw evidence in care plans that staff engaged with patients to establish their likes and dislikes to help plan the care they provided.

The involvement of people in the care they receive

- On all wards, we saw posters for advocacy services. These also provided independent mental health advocate (IMHA) and independent mental capacity advocate (IMCA) services. This helped protect the rights of the patients admitted to the wards. Patients confirmed they had access to advocacy if needed and advocates visited the wards regularly.
- Patients and families were able to give feedback on the service. Carer representatives visited the wards and provided quality feedback. We looked at a letter to a carer that had welcome information and requesting 'this is me' information about their relative.
- We saw evidence of family involvement in best interest meetings, care planning and risk assessments where appropriate. The wards working with patients experiencing dementia produced "this is me" documents. These were documents which contained person centred information in order to support the patient individually. Relatives contributed information to the documents.
- However, active involvement and participation in care planning and risk assessments was not evident in all records. Staff told us they found it difficult to involve some patients with this process.

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

- Bed occupancy for older people wards ranged from an average of 87% to 97% over the previous 12 months.
- The average length of stay for older people's wards between January and June 2017 ranged from 41 to 106 days. Some patients required longer stays than others dependent upon the acuity or complexity of their illness.
- There were 43 out of area placements between 1 April 2016 and 31 March 2017 for older people wards. The duration of placements ranged from two days to 21 months in one case.
- For the majority of wards within the service, there were no readmissions over the previous year. Where there were emergency readmissions these occurred within three wards. These were Aspen ward with 11% readmissions in May 2016, Dune ward had 33% readmissions in January 2017 and Cove ward had two occasions of 14% within July 2016 and 50% within February 2017.
- In total, the core service accounted for 8196 delayed discharge days with an average of each discharged patient delayed for 15 days. Amblescroft North has the highest number of delayed days per discharge with an average of 27 days closely followed by ward 4 at 26 days.
- Managers told us the main reasons for delayed discharges were difficulty in securing timely packages of care or suitable placements such as nursing or residential homes. We attended a 'board round' meeting between the ward and community mental health teams on Dune and Cove wards. Staff questioned the estimated date of discharge and reasons for delay. Cove and Dune wards had a daily bed management call with a modern matron and access service manager to discuss bed management.
- All wards had processes in place for communicating with relevant agencies such as social services or the community mental health teams.
- The trust monitored inpatient capacity locally and through the corporate risk register. It identified that service users may not receive the most appropriate care and treatment if the trust did not manage inpatient capacity. This could lead to further pressure on existing resources and a requirement to use out of area beds for adult, PICU and older adults, creating significant pressure on the trust. Actions were in place to mitigate this risk, such as bed management meetings, a 'bed management escalation protocol' and bed availability information on the trust intranet for prompt access. The trust made block purchases of beds from the private sector if necessary.
- Managers confirmed that patients rarely moved between wards during admission unless there was a clinical need for a move to an acute ward.

The facilities promote recovery, comfort, dignity and confidentiality

- During our May 2016 inspection, we noted that windows in the bedrooms at Liddington and Hodson wards did not have film to maintain patients' privacy. This was also the case on Amblescroft north and south. This compromised patient dignity and privacy as the bedrooms looked out onto gardens that other patients used to exercise and a public car park. When we visited in June 2017, we saw the trust had placed opaque type window coverings in all bedrooms in Hodson and Liddington wards in response, as opposed to one-way mirror type. This obscured the view outside, made the rooms appear darker, and more closed in. We did not feel this promoted recovery and several patients and families expressed concern this was causing some distress.
- Staff informed us they had tried but been unable to influence the decision to use this type of film. Staff we spoke with told us the film caused distress to some patients who were confused because they could not see outside. Staff were trying to grow the hedge outside high enough to remove the opaque film from the windows.
- All wards had ensuite bedrooms except Ward 4 in Bath. There were two single rooms without ensuite and dormitories sleeping either two or three patients. Curtains divided the bed spaces in these dormitories. Staff gave us assurances that although less than ideal,

Are services responsive to people's needs?

Good

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

staff did what they could to ensure privacy and dignity. We had concerns over potential risk issues around these dormitories however, discussed in the safe section of the report.

- All wards had clean and organised clinic rooms that varied in size. The wards also had quiet areas where patients could meet visitors and have time to read or relax. There were rooms for therapies and activities to take place that were warm and welcoming on all the wards. During our inspection in May 2016, we noted patients could not always access a telephone for private calls if they wished. When we visited in June 2017, staff informed us there was the use of the office and mobile phones for this purpose.
- Patients had access to outside space on all the wards. We saw some beautifully tended garden areas particularly at Amblescroft north and south and Ward 4 in Bath. Patients were enjoying the gardens at the time of our visit and the atmosphere was relaxed and tranquil. Some patients told us they enjoyed the garden areas and staff supported them to tend them.
- During our May 2016 inspection, we said the trust must ensure that ward environments were dementia friendly and fit for the purpose of managing patients with these conditions. When we visited in June 2017, we saw significant and ongoing improvements. This related particularly to Amblescroft South and Dune wards. Amblescroft South ward had been bleak and sparse with little in the way of decoration and no dementia friendly signage.
- When we visited in June 2017, we saw bright furniture and clear signs, clocks, comfortable furnishings and managers showed us orders they had placed for chairs, lockers and miscellaneous items to improve the environment. There were several initiatives locally on the wards. For example, Ward 4 was looking at creating patients individual music playlists with the help of families that they could access as and when they wished. On Amblescroft South, the manager had set up teams using 'inspiring dementia care in hospitals', which set a challenge to a small group of staff to implement dementia friendly improvements over a three-month period. When their period was over a different team took over. Staff told us this inspired improvements as well as providing competition and fun between the staff.
- Ward 4 in Bath had a number of features to make the ward more comfortable for people experiencing dementia. They had orientation boards for patients, themed picture displays and dolls for attachment theory work. They also had artwork completed by patients, dementia appropriate signage and red toilet seats that assisted in allowing patients to self-care.
- Liddington, Dune and Ward 4 had tactile fiddle boards with taps, locks, switches and a 'Think and grow' dementia board. On Liddington ward there was a memory corner with wall coverings with old time film and music stars. Hodson and Liddington wards had a computer that patients could access with software called RITA (reminiscence interactive therapeutic activity). This was mobile and could be used on the ward to work with patients with either organic or functional illnesses. There were plans in place to get Wi-Fi installed in order for patients to be able to Skype friends and family.
- However, on Dune ward, the flooring was shiny and multi-tonal which was not conducive to recovery in a dementia environment, potentially increasing visual perception problems and confusion in this client group. The lighting on both wards was too dim and reflected shapes and new clocks were too high for patients to see comfortably.
- Aspen ward had a wellbeing day every Wednesday and a therapeutic gardening group weekly. There was also an activity community engagement group (ACE).
- There were activities taking place on Cove and Dune ward at the time of our inspection. However, numerous staff members informed us that ensuring therapeutic activities on these wards was a problem and sometimes sparse. The wards had one occupational therapist (OT) and they were struggling to recruit another. Nurses and nursing assistants did their best to provide activities but often had to prioritise personal care and support over activities.
- Wards had different methods of accommodating visitors to the ward. Some allowed patients to have visitors in their rooms. This was risk assessed first. Some used quiet lounges on the wards for visitors to use. Others had access to rooms off the ward to use. This was particularly relevant when young children visited the wards.

Are services responsive to people's needs?

Good

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

- On the functional illness wards, patients had access to hot and cold drinks at all times. Staff obtained them snacks on request. On the organic illness wards, staff obtained patients hot drinks when they requested them. Snacks were available on request. There were also regular drinks rounds.

Meeting the needs of all people who use the service

- All wards were on ground floors and accessible to patients with limited mobility or in a wheelchair. In Amblescroft North and South, the OT completed a mobility assessment on admission. Other wards had access to physiotherapists or OTs to assess mobility needs. There was flat paving around buildings, grab rails, walk in showers and adjustable beds. All wards had assisted baths for patients' use. A range of hoists and moving aids were available on each ward. Maintenance staff had checked these in the previous six months.
- Care plans we looked at being generic did not consistently reflectcultural, language and religious needs in all wards other than Hodson and Liddington in Swindon. However, we found patients could request a visitfrom representativesfrom different faiths. A chaplain visited wards weekly or fortnightly and assisted patient's access information about other faiths. In Swindon, the chaplain was active in contributing to care plans where appropriate.
- All managers could access interpreters tohelp assesspatient'sneeds and explain their rights, as well as their care and treatment. Leaflets explaining patients' rightsunder the Mental Health Act (MHA) 1983 were available in all wards. Staff obtained these in alternative languages if needed. All wards had information boards that included information about local groups and how to make a complaint.
- A choice of meals was available if patients did not want the meal provided. Patients were involved in some decisions about the food and there were discussions at patient meetings.Patients we spoke with told us they enjoyed the food.

Listening to and learning from concerns and complaints

- Wards for older people with mental health problems received 11 complaints with two fully and seven partially upheld (82%) during the previous 12 months. No complaints were referred to the Ombudsman during the 12-month period.
- Four of the 11 complaints received for this core service related to 'Admissions discharge and transfer arrangements' which was the most common complaint reason.
- Aspen ward received the highest number of complaints across the 12 months with three.
- Wards for older people with mental health problems received 219 compliments during the previous 12 months. Ward 4 received the highest number of compliments with 41.
- Patients could make complaints via patientfeedback forms and communitymeetings and managers monitored these. Relatives and others involved in supporting patients were made aware of how to make a complaint on admission and at reviews. All wards displayed information on how to make a complaint on notice boards. Information was included in the welcome packs for patients and their representatives.Ward managers ensured staff discussed learning from complaints at team meetings.

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

- Most staff we spoke with knew and agreed with the organisation's values. Each ward had a vision for their ward and staff were proud of the work they had done over the previous 12 months.
- Staff were aware of the senior managers in the trust and told us they had visited the ward prior to the inspection.

Good governance

- Staff reported incidents using the trust's incident reporting system. Records indicated that managers reviewed incident forms and provided feedback to staff. A dedicated team in the Bristol area provided root cause analysis (RCA). In the Wiltshire area managers across all services on a rota basis provided this. During our 2016 inspection, managers who investigated incidents were concerned that there was no specific training for the investigations. When we visited in June 2017, only two managers only had completed the training.
- During the 2016 inspection, ward managers across the locality did not have a consistent approach to safeguarding or incidents. Whilst there was clear evidence that all managers reported and acted upon safeguarding incident there was some level of inconsistency about criteria if the issue was a safeguarding issue or an incident. When we visited in June 2017, all managers and staff we spoke with were clear and confident about safeguarding procedures.
- During the May 2016 inspection, governance around the application of the Mental Health Act (1983) was not effective, as managers in Cove and Dune wards had not ensured the protection of patient's rights under the Mental Health Act. When we visited in June 2017, we saw good procedures and governance in this area.
- Ward managers told us they had sufficient authority to enable them to complete their tasks and manage their wards.

Leadership, morale and staff engagement

- Staff we spoke with told us that the ward managers were approachable and supportive. They described them as having a visible presence on the wards. Morale was good on most wards despite some staffing and acuity pressures. We observed ward managers being 'hands on' on the wards and supporting staff. However, on Aspen ward the atmosphere was tense during our inspection and staff on all wards told us they felt uncomfortable talking to us 'in case they said the wrong thing' and were nervous about our visit.
- All teams described themselves as hardworking and mutually supportive of each other. All staff we spoke with told us they felt comfortable raising concerns with their immediate leader.
- Ward managers on the dementia wards had ensured good positive changes following our 2016 visit. They told us they felt some satisfaction with the changes but were inspired to improve further.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff were not doing all that is reasonably practicable to mitigate risks to both themselves and patients. Staff did not ensure clear risk management or clearly document, review and monitor risks on all wards. Risks did not always translate to careplans. Staff did not ensure they safely observed or mitigated blind spots on Aspen ward. The trust provided shared dormitory accommodation on ward 4. This was not appropriate or acceptable for safe management of this client group particularly at increased risk times such as at night. This is a breach of regulation 12 (1) (2) (a) (b) (d)