Kent and Medway NHS and Social Care Partnership 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)
RXYP8	Priority House	Orchard Ward	ME16 9PH
RXYF6	Frank Lloyd Unit	Hearts Delight Ward Woodstock Ward	ME10 4DT
RXYJ1	Jasmine Centre	Jasmine Ward	DA2 8DA
RXY03	St Martins Hospital	Cranmer Ward	CT1 1TD
RXYAK	Littlestone Lodge	Littlestone Ward	DA2 6PQ
RXYM1	Medway Maritime Hospital	Ruby Ward	ME7 5NY
RXYT1	Thanet Mental Health Unit	Woodchurch Ward Sevenscore Ward	CT9 4BF

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership 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 Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated older persons inpatient service at Kent and Medway NHS and Social Care Partnership Trust (KMPT) as requires improvement because:

We found that there were extreme variations in the quality of care provided by the older peoples' inpatient service. The quality of care provided was not consistent across the whole service, with some wards providing good care while others provided poor and inadequate care.

We had serious concerns about the quality of care at Littlestone Lodge. We identified poor practice including, staff not meeting the needs of patients and observed unsafe care. For example, we found patient's pain was not being managed; all patients were wearing incontinence pads without their needs being assessed and medicines being administered covertly without rationale. There was also a lack of senior clinical staff presence on this ward.

KMPT had failed to respond appropriately to the risks it identified on Littlestone Lodge. In December 2014 an acting ward manager was appointed to help improve the quality of care. However, the trust's senior managers had visited the ward in February 2015 and although has addressed some issues had failed to identify and rectify all the key risks, including the need to provide additional experienced nurses to support the day to day delivery of care. This left an inexperienced band six nurse, on temporary promotion to address a large range of serious issues with limited support. However, the acting ward manager had been provided with advice from specialist nurses, for example, the physical health nurse and had provided opportunities to discuss the actions and improvements required with senior managers. We were also concerned about the culture on Littlestone Lodge, lack of care by some staff, lack of recording and lack of responsiveness by staff to the acting manager's attempts to improve the service and the lack of detailed and appropriate recording in patient notes, care plans and prescription charts.

We asked the provider to take immediate action to address concerns and also took enforcement action, serving two warning notices. The two warning notices served notified the trust that CQC had judged the quality of care being provided as requiring significant improvement. The first warning notice was to ensure the safety, care and welfare of the patients. The second notice highlighted the trust's failure to monitor the service it provided adequately. The warning notices expiry dates were 15 May 2015 (for further information see below).

Serious concerns regarding the care and welfare of patients were identified in other wards across the older persons' inpatient service. In particular, we were concerned with a large number of issues related to poor care deliver and lack of care planning for patients' needs on Cranmer ward.

Some wards had better access to in-house allied health professionals, such as dieticians and physiotherapists. Whereas some wards had none, and access was gained through primary medical services, causing delays in treatment being received.

We found evidence that some patients were admitted to the inpatient services without comprehensive assessments, including identifying pressure area risks and safe manual handling procedures. This meant that there was a risk that patients would not have all their needs met and potential related health complications would not be identified in a timely manner.

We found poor compliance and practice in relation to the application of the Mental Health Act 1983 (MHA 1983).

Staff across the older people's services told us that they felt supported by the leadership locally. However, some staff in inpatient services told us that they felt there was a disconnect with higher level leadership across the trust. The majority of staff in the older people's services delivered services in a thoughtful and compassionate manner and people who used the service were positive about the service they received from staff, with the exception of Littlestone Lodge.

We received much positive feedback from patients and families of people who used the service. We observed positive interactions and skilled dementia care being delivered in many inpatient settings. We also saw that staff who worked across the services showed commitment to people who used the service.

Summary of findings

Staff from the community teams and inpatient services worked well together.

Additional information relating to Littlestone Lodge

In March 2015 we inspected Littestone Lodge as part of a comprehensive inspection of Kent and Medway NHS and Social Care Partnership Trust. During our inspection we found that the trust was not meeting the standards expected in meeting the care and welfare needs of patients, and how it assessed and monitored the quality of the service at Littlestone Lodge.

We found the trust to be in breach of regulations 9(1) (2) and 10(1) ((2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued two warning notices under each of these regulations on 30 March 2015. We told the trust that it must comply with the requirements of the regulations by 15 May 2015. The trust sent us an action plan, and later confirmed that it believed it was compliant with the requirements (as of 15 May 2015).

We carried out an unannounced, focussed inspection on 21 May 2015 to assess if the trust had addressed the concerns identified at our inspection in March 2015, and to determine if it was now compliant with the requirements of the regulations. We found that the trust had taken action, that improvements had been made to the services delivered at Littlestone Lodge since our visit in March, and that staff were positive about the changes to the unit. A number of new or revised processes had been implemented for ensuring that patient care and welfare needs were met. However, we found that these were not always carried out or recorded consistently.

Our inspection in March 2015 assessed compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations were replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) on the 1 April 2015. As such, the inspection carried out on 21 May 2015 looked at the trust's compliance with the 2014 regulations (namely the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Due to the improvements made we were able to withdraw the warning notices. However, we found that the trust had not met all the requirements of the regulations and as such we have issued a requirement notice in respect of Regulation 17(1)(2)(b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance.

A separate report of the unannounced, focussed inspection of 21 May 2015 has been produced that details our specific findings at Littlestone Lodge (March 2015) and the related finding from our focussed inspection (May 2015). This report also provides details of the requirement notice that the trust must take action to address.

This can be found on our website.

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:

- The care and welfare of patients on Littlestone Lodge was inadequate at the time of the inspection. We served two warning notices which required the trust to make improvements by 15 May 2015. Following an unannounced focused inspection on 21 May 2015 we found the trust had taken action and improvements had been made but care and treatment was not carried out or recorded consistently. We have lifted the warning notices but the trust must make further improvements to ensure safe care for patients.
- We found that most wards were not managing their medicines safely. We found missed signatures on prescription cards and issues with the storage and disposal of medicines and regular covert use of medication without appropriate assessment and rationales.
- Some wards did not always meet the Department of Health guidance on gender separation.
- Staff were aware of safeguarding and were able to verbalise what they would do in the event of a safeguarding incident. However, we noted that although safeguarding alerts and concerns were being raised, this was not consistent practice across the whole service.
- We found inadequate senior medical cover at Littlestone Lodge.
- Most of the wards were not entirely ligature free and although staff had an audit of ligature risks and plans to reduce harm to people, some of these assessments on two of the older adult wards, Littlestone Lodge and Woodchurch. Woodchurch had been due for completion in February 2015 but had not been completed by the time we undertook our inspection. All others were complete and in date.
- All of the wards had staff vacancies and relied on agency staff members to compliment staff numbers.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- On the majority of wards care plans were not personalised and did not meet the individual needs of patients.

Summary of findings

- There was no evidence, on Littlestone Lodge, of patients having been involved in the planning of their own care and treatment.
- On Cranmer Ward and Littlestone Lodge assessment tools available were not being used. For example, pressure ulcers tools, continence, moving and handling procedures and physical health assessment tools.
- We had serious concerns that patients' physical health needs were not assessed or managed safely and effectively on Cranmer and Littlestone Lodge.
- On Jasmine and Cranmer wards we found the MHA and DoLS were not being correctly implemented and on Littlestone Lodge the MCA was being used on a consistent basis and routinely when the MHA 1983 should have been considered and applied.

Are services caring?

Good

We rated caring as good because:

- Most of the patients spoke highly of the care and attention provided by staff and this was supported by patient's family and friends.
- We saw examples on most wards of staff supporting patients if they became distressed. Staff on most wards were respectful and caring towards patients.
- Through the use of the short observational framework for inspection (SOFI) we saw that staff were genuine, empathetic, patient and compassionate towards patients.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- On some wards we were concerned that care was not responsive to patient's needs, for example, we asked that pain management was addressed immediately for two patients.
- Not all wards had the same level of access and input from staff of different disciplines, causing delays in assessment and treatment, for example, dietetics and physiotherapy.
- On some wards patients did not know how to raise complaints.
- Some patients were not informed of their right to advocacy representation. There was no evidence that staff had informed patients of the advocacy services available to them.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

Summary of findings

- Most staff across older people's services were positive about their teams and wards. Most staff felt supported by their immediate team manager. However, most staff told us that there was a disconnect between the wards and higher level leadership.
- The governance processes were not working as well as they should have been and we saw that there was a wide variation in the quality of care delivered across the services for older people.
- The leadership and governance infrastructure across the services was variable

Summary of findings

Background to the service

The trust's inpatient wards for older people provides care to patients who require both organic and functional services.

Jasmine ward at the Jasmine Centre provides care for 15 men and women with both organic and functional mental health problems.

Cranmer ward based at St Martins Hospital provides care to 15 women and men with both organic and functional mental health problems. At the time of our inspection, four men had been moved to Orchard ward whilst refurbishment at Cranmer ward was undertaken. The refurbishment project aimed to address mixed gender issues and provide better facilities for both men and women.

The Orchards is a sixteen bedded mixed gender ward for older people and is based at Priority House. This ward cared for patients with both organic and functional mental health problems. It specifically designed for organically unwell patients who are over the age of 65, but was also providing services to working age adults or patients that live out of the area . At the time of the inspection the ward was divided into two areas: Lambourne and Worcester. Worcester was a female only area and Lambourne was a male only area.

The Frank Lloyd Unit is a 40 bedded, continuing care ward for people with a diagnosis of dementia and associated needs. The unit consists of two twenty-bed wards; Woodstock ward is for men and Hearts Delight ward is for both men and women. Both had a range of dementia-friendly therapeutic facilities.

Littlestone Lodge is a 16 bedded continuing care unit for people with a diagnosis of dementia.

Both Sevenscore and Woodchurch ward based at the Thanet Centre. Sevenscore is a 15 bedded inpatient unit for male and female patients with complex needs which includes a diagnosis of dementia. Woodchurch ward is a mixed functional 15 bedded unit for males and females is a 15 bedded acute and assessment unit for both men and women with an organic dementia illness.

Ruby ward based at the Medway Maritime Hospital is a fourteen bedded facility for both men and women, providing admissions for those with functional and organic illness.

Our inspection team

The team included CQC inspectors, Mental Health Act reviewers and a variety of specialists, including a consultant psychiatrist and a junior doctor, specialist nurses, an occupational therapist, a hospital manager and a social worker who were experienced in older peoples and neuro -rehabilitation care.

We were also accompanied by an expert by experience that had experience of caring for a relative.

We were, on occasions, also accompanied by a pharmacist where we found areas of concern with the management of medicines.

Why we carried out this inspection

We inspected this trust as part of our on going comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information.

During the inspection visit, the inspection team:

• Visited nine wards across seven locations and looked at the quality of the ward environments and observed how staff were caring for patients;

• Used a short observational framework inspection tool (SOFI) to observe the interaction between staff and patients;

• Spoke with 32 patients who were using the service and their family members;

• Spoke with the managers or acting managers for each of the wards;

• Spoke with 48 other staff members; including nurses, doctors, nurses, occupational therapists, psychologists and social workers;

• Attended and observed two hand-over meetings;

• Looked at 41 treatment records of patients;

• Carried out a specific check of the medication management on all wards

- Examined in detail the legal records in relation to people's detention under the Mental Health Act 1983;
- Looked at a range of policies, procedures and other documents relating to the running of the service;
- Held a focus group for staff from Hearts Delight and Woodstock Wards;
- Facilitated a focus group of a range of disciplines that supported the care pathway associated with Jasmine Ward.

What people who use the provider's services say

We saw that the wards in the old people's services at Kent and Medway NHS and Social Care Partnership Trust completed regular surveys which allowed people to feedback to the service about their experiences of the care which they had received. We saw that most of the feedback from these surveys was positive.

We spoke with people who used the service and also received mostly positive feedback.

We left comments cards in the locations and saw that most of the feedback from these comment cards was generally positive.

Good practice

- We found that the environment on Woodstock ward was age and gender appropriate, with a virtual bar (no alcohol) and a barber on site.
- Orchard ward provided a member of staff who undertook a family liaison role, spending time with families of patients in their homes or on the ward, creating a formulation tool that provided life details of patients.
- We found evidence on Sevenscore ward of good use of interpreting services and as a result the ward were able to repatriate a patient to their country of origin. Staff had gone over and above expectations to ensure this happened appropriately and in a timely manner.
- Sevenscore ward ensured all staff, including agency, were aware of those patients who might be at risk of

falls. Patients identified at risk of falls had a falling star above their bedroom door. The unit also had nonslip socks available and cushioned flooring to reduce the risk of patients having falls .

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider must take to improve:

- The governance arrangements in place at Littlestone Lodge failed to identify that the level of care provided was inadequate. Other procedures such as medicine and care plan audits had failed to identify poor practice. The trust must ensure that it has systems in place to effectively monitor practice and procedures on all wards and that key risks are escalated appropriately and timely action taken as a result of monitoring.
- The trust must ensure Hearts Delight ward complies with the Department of Health gender separation requirements.
- The trust must take action to ensure all safeguarding incidents on Woodstock, Cranmer and Littlestone Lodge are referred to safeguarding teams in a timely manner.
- The trust must take action to ensure the administration and storage of medications on all wards, with the exception of Orchard Ward, are in line with national and local guidelines; this also includes ensuing policies and procedures, such as the medicines management procedures are in line with national guidelines and recognised good practice.
- The trust must ensure that all staff are competent in applying apply the MHA, MCA and DoLS at Jasmine and Cranmer wards.
- The trust must ensure and monitor that all wards complete ligature assessments on a routine basis, taking into account each individuals risk to ensure that all risks of harm are identified and that appropriate action is taken.
- The trust must ensure that that patient's pain management and physical health needs are responded to on all wards and that it addresses and monitors issues relating to the delivery of safe and effective care to all patients.

Action the provider SHOULD take to improve

- The Frank Lloyd Unit should review the arrangements for patients to use the shared garden between the two wards. Currently male patients have to walk through the mostly female ward to gain access.
- All wards should ensure that they are working, where possible, in collaboration with patients and relative to formulate individualised and personalised plans of care.
- The trust should ensure that it continues to actively recruit to vacant posts.
- All wards should ensure that patients are provided with information around access to advocacy services.
- The trust should work with its local commissioning organisations to address variations in how services are commissioned, giving particular attention to Cranmer ward and its lack of access to services such as dieticians and physiotherapy.
- During our inspection a large number of patients expressed concern about the quality of food. The trust should seek to provide better quality food that is nutritious and that patients can enjoy.

Kent and Medway NHS and Social Care Partnership 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
Orchard Ward	Priority House
Hearts Delight Ward Woodstock Ward	Frank Lloyd Unit
Jasmine Ward	Jasmine Centre
Cranmer Ward	St Martins Hospital
Littlestone Ward	Littlestone Lodge
Ruby Ward	Medway Maritime Hospital
Woodchurch Ward Sevenscore Ward	Thanet Mental Health Unity

Mental Health Act responsibilities

- We found that Section 62 (emergency treatment) of the Mental Health Act 1983 (MHA) had been used on Jasmine ward when routine application of the MHA should have been applied.
- People on Cranmer ward were informed of their rights under the MHA on admission, but not routinely thereafter. Some patients on Cranmer and Jasmine wards were not informed of their right to advocacy representation. There was no evidence that staff had informed patients of the advocacy services available to them.
- Staff training records indicated that staff are trained in the MHA , the Code of Practice (COP) and the guiding principles.

Detailed findings

- Staff we spoke with on all wards were able to verbalise their understanding of the application of the MHA the CoP and guiding principles.
- Copies of Consent to Treatment forms were present and attached to treatment cards where applicable on all wards.
- Staff were aware, on all wards, that they could access administrative support and legal advice on the implementation of the MHA. Detention paperwork on all wards was completed correctly, up to date and stored appropriately.
- We saw evidence, on all wards, that there are regular audits to ensure that the MHA is being applied correctly and there was evidence of learning from these audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence on most wards that Deprivation of Liberty Safeguards (DOLS) applications were not consistently being made when required, and that staff did not always understand when to make a DoLs application and to whom.
- Staff had received trained in the Mental Capacity Act (MCA). Staff we spoke with generally had a good understanding of the MCA.
- There was a policy on the MCA including DoLS which staff were aware of and able to refer to. Staff told us where they were able to get advice regarding the MCA and DOLS within the Trust.
- There was evidence that capacity assessments were undertaken appropriately and documented effectively. There was evidence on Hearts Delight and Woodstock wards that best interest meetings with patients were being held. However, we noted that this was not consistent practice across the rest of the older people`s service. We found at Littlestone Lodge the MCA was being used routinely when the MHA should have been considered and applied. The medical staff across the services held a general consensus that the MCA was the least restrictive option.

Requires improvement

Are services safe?

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

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

Summary of findings

- We found that the care and welfare of patients on Littlestone Lodge was inadequate at the time of the inspection. We served two warning notices which required the trust to make improvements by 15 May 2015. Following an unannounced, focused inspection on 21 May 2015 we found the trust had taken action and improvements had been made but that care and treatment was not carried out or recorded consistently. The trust had made enough improvement to allow us to lift the warning notices but the trust must make further improvements to ensure safe care for patients.
- We found that most wards were not managing medicines safely. We found missed signatures on prescription cards and issues with the storage and disposal of medicines and regular covert use of medication without appropriate assessment and rationales.
- Some wards did not always comply with the Department of Health gender separation requirements.
- Staff were aware of safeguarding and were able to verbalise what they would do in the event of a safeguarding incident. However, we noted that although safeguarding alerts and concerns were being raised, this was not consistent practice across the whole service.
- We found inadequate senior medical cover at Littlestone Lodge.
- Most of the wards were not entirely ligature free and although staff had an audit of ligature risks and plans to reduce harm to people, some of these assessments were out of date. This was the case on two of the older adult wards, Littlestone Lodge and Woodchurch. Woodchurch had been due for completion in February 2015 but had not been completed by the time we undertook our inspection. All others were complete and in date. All wards have ligature champions who meet on a Trust wide basis at the Ligature Standards Steering Group.
- All of the wards had staff vacancies and relied on agency staff members to compliment staff numbers.

Our findings

Safe and clean ward environment

- The layout and design of Cranmer ward did not allow for good observation at all times. However, we observed that staff were visible on the ward and engaged with and observed patients.
- Wards were not entirely ligature free and although staff had undertaken audits of ligature risks and had some plans to reduce the risk of harm to patients, some of these assessments were out of date. For example, on Littlestone Lodge the most up to date ligature audit had been completed in 2010 and Woodchurch had been due to complete its ligature assessment in February 2015 but had not done so by the time we undertook our inspection. Managers on all of the wards were able to explain how they managed the ligature risks, through observation and increased staffing.
- We saw a completed ligature risk assessment for both Hearts Delight and Woodstock ward, including the use of the shared garden. Toilet areas where alarm cords were positioned for patients to call staff for assistance were assessed as being a ligature risk and cords were cut short as a risk management measure to comply with trust health and safety requirements. This meant they were difficult for patients to reach in an emergency. However, we were told that patients were always escorted to the toilet (as they were unable to go alone) and staff would call for assistance if needed.
- Wards did not always comply with the Department of Health gender separation requirements, although wards were taking measures to address this. For example, Hearts Delight ward was in the process of moving towards an all-female ward. As male patients were discharged from Hearts Delight only female patients

were admitted. One male patient's bedroom was directly opposite the female lounge/dining room. This could impact on the privacy of patients. However, the trust acknowledged this did not meet guidance but felt there was a clear clinical and safety rationale for this.

- Most wards had quiet areas and visitors rooms. Most mixed sex gender wards had a separate lounge that was gender specific, for example, for women only. Hearts Delight ward did not have separate gender specific rooms.
- The room temperature in the treatment room on Woodstock ward was extremely high. This could affect the effectiveness of medication were this was linked to specific storage temperatures.
- We observed that the wards were clean. However, some wards required refurbishment due to old decor and layout. We were shown plans to address the appearance and location of Cranmer ward.
- Hearts Delight and Woodstock ward were GP led services, with patients registered with a local onsite practice. The GP services could be contacted out of hours. There was also a minor injuries unit a short walk away from the unit, where patients had access to and some had previously attended. In the event of a medical emergency, staff called the emergency services rather than using the trusts emergency cover.
- Woodstock, Hearts Delight, Jasmine and Orchard ward environments promoted good observation. We observed that Jasmine and Orchard wards also promoted easy orientation for patients with dementia.
- On all wards there were treatment rooms with accessible resuscitation equipment and emergency drugs. We saw evidence that these were checked regularly by the staff team.
- The decor on Jasmine, Woodstock, Ruby and Hearts Delight ward was of a high standard and adapted to meet the needs of the patients. For example, on Woodstock ward, the staff team had converted a room into a virtual pub (no alcohol) with authentic pictures and artefacts. Downstairs there was a hairdressing room with 1950s pictures, music and artefacts. Hearts Delight and Woodstock ward had won awards from the trust for their innovative environments.
- Environmental risk assessments were completed and up to date and entered onto the trust risk register as standard practice on all wards visited except Littlestone Lodge; the environmental risk assessment had not been completed since 2010.
- Ward alarm systems varied in type. For example, Jasmine ward had wall mounted alarm systems. On some wards staff carried personal alarms, for example, Orchards ward. All wards had appropriately placed staff assistance alarms in addition to those described above placed in bathrooms/toilets and bedrooms.

Assessing and managing risk to patients and staff

- Risk assessment information was not routinely updated after an incident, or consistently completed on admission for every patient across the wards, with the exception of Ruby ward.
- We were concerned that on Cranmer ward and Littlestone Lodge, assessment tools available to prevent pressure ulcers were not being used. Therefore, pressure area care was not being given consistently to all those that needed it, placing patients at risk of developing pressure sores.
- We were concerned that on Cranmer ward there were three patients who required manual handling to ensure safe movement from either one area to another or during palliative and/or personal care. In each instance assessment tools for the reduction of risk of injury during moving and handling procedures were not being used.
- We were concerned that on Littlestone Lodge, assessment tools for the use of bed rails (cot sides) were not being used to determine risk to patients.
- Risk assessments, in particular for the risk of falls, were not being completed or updated on Littlestone Lodge.
- We saw that patients on Jasmine and Cranmer wards did not have unlimited access to drink making facilities. Both wards did not allow patients to make their own drinks or snacks. Both kitchens were staff access only. Jasmine ward told us that patients could be supported and supervised to make their own drinks, otherwise drinks and snacks outside of a schedule on both wards was subject to request.
- There was a lack of assessment of patients' ability to swallow prescribed medication. At Littlestone Lodge we found a general approach of crushing medication and administering of medication covertly.
- Staff were aware of their responsibilities in relation to safeguarding. Staff could explain the process for raising a safeguarding concern. We saw examples of safeguarding alerts and concerns which had been raised. We were concerned that there was variation in practice between the wards. For example, on

Woodstock ward there was an incident where a patient significantly physically hurt another patient. It was investigated by the manager as an incident but not referred to the local safeguarding team. We saw other examples detailed on incident records that should have been escalated to local authority safeguarding team. There was a general practice in place, on most wards, that only qualified staff were able to report safeguarding incidents.

- Giving medication covertly, without rationale or appropriate approval, was normal practice on Littlestone Lodge. This was not in line with recognised good practice and national guidelines which advocates that each medication should be individually considered if appropriate for covert administration.
- The pharmacist on our team raised concerns that the crushing of some of the medication would reduce the clinical effectiveness of medication. Medication designed for modified release was being crushed against manufacturer's recommendations not to crush it.
- Sevenscore ward ensured all staff, including agency, were aware of those patients who might be at risk of falls. Patients identified at risk of falls had a falling star above their bedroom door. The unit also had nonslip socks available and cushioned flooring to reduce the risk of patients having falls.
- On Orchard, Hearts Delight and Woodstock ward, patients had free access to drink and snack making facilities throughout the day and night.
- We reviewed records and found that staff followed the trust observational policy.
- We found no records to show that rapid tranquillisation practices had been used. Ruby ward did have rapid tranquillisation NICE guidelines in place and accessible to staff.

Pain Management

- We observed, found evidence in care notes and were told by staff that there was a lack of responsiveness and appropriate plans in place for managing some patients' pain. We had to ask the service to respond to two patient's pain needs immediately. We had to repeat this request the next day as one patient's pain needs hadn't been dealt with immediately although staff on Littlestone Lodge had agreed to do so.
- Routine pain assessments that would be expected, in line with national guidelines and recognised good practice for this patient group, were not found in any of the patients care notes we reviewed. In addtion, when analgesia was given we were concerned about the lack of monitoring and recording of patients response to analgesia.

Equipment

- The beds at Littlestone Lodge were old and inappropriate, but new beds had been ordered.
- The fire extinguishers on Littlestone Lodge were all in locked boxes and no member of staff on the unit, during our first visit to the ward could identify where the keys to those boxes were kept, despite searching and trying a different number of keys.
- Nursing staff on Woodstock and Hearts Delight wards did not know how to reset the fridges. They could not be assured that medicines like antibiotics and flu vaccines were stored at the correct temperature. This meant that staff could not be assured that these medicines were still effective.

Safe staffing

- There had been a serious lack of senior clinical staff presence on Littlestone Lodge. A locum doctor, who had little experience of working with the type of conditions and needs of the patients on this ward provided medical cover to the ward. The doctor had made efforts to identify and implement improvements needed to patient care but staff, other than the acting ward manager and a small number of other staff had ignored what had been raised. The consultant psychiatrist with overall responsibility had not attended the ward, although we were told they could be contacted by telephone if needed. The staff on the ward had told us that they had belived the locum speciality doctor was the consultant psychiatrist until our inspection.
- The ward managers for Jasmine, Cranmer and Orchard ward stated that they were able to adapt staffing levels in response to changing patient need and clinical demand.
- We saw evidence to show that patients were receiving regular one to one nursing care, where required.
- All of the wards had staff vacancies and relied on agency staff members to compliment staff numbers. We saw through records that the wards did try to use the same

Requires improvement

Are services safe?

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

agency staff to create a consistent and familiar approach to care and treatment, but this was not always possible. We saw evidence to show that staff who were new to the wards received a trust and ward induction.

- There was adequate medical cover day and night for Jasmine, Cranmer and Orchard ward. We were advised that a doctor was able to attend the ward quickly in an emergency.
- A GP visited Hearts Delight and Woodstock wards twice a week. A consultant psychiatrist visited the unit once a week.
- We reviewed training records for all the wards which showed that staff had completed the required mandatory training. The trust compliance target for completing mandatory training was 85% and all wards were on target to meet this. Orchard ward had exceeded this expectation with an average percentage of staff having completed mandatory training 97% of the time.

Track record on safety

- We found that there were extreme variations in the quality of care provided by the older persons' inpatient service.
- The trust had identified serious concerns at Littelstone Lodge in December 2014 including a grade four and two grade two pressures ulcers, poor care planning, poor assessment of risks, poor medicines practice. An acting ward manager had been brought in to make improvements. An action plan to address concerns had been developed at ward level. Progress had been made against the action plan but the trust had failed to support day to day care delivery and had not placed additional, experienced staff on the ward to support the acting ward manager to make improvements. Some additional support, through advice from specialist nurses and discussions with senior managers, had been provided but the acting ward manager had to deal with several staff who were resistant to the changes required to bring about improvement; a number of these staff were subject to having their performance managed. During our inspection we found that a number of issues had not been addressed and care was still inadequate, despite the best efforts of the acting ward manager.
- Where environmental issues had been identified we found some plans in place to address the issues, such as plans for Orchard ward, building work was underway on Cranmer ward to improve the overall environment and we saw plans for Cranmer ward to be relocated to a new and purpose built facility.
- The trust had reduced the volume of physical restraints used with older patients from 704 incidents in 2013 to 197 in 2014 in line with Department of Health guidance: Positive and Proactive Care.

Reporting incidents and learning from when things go wrong

- There were systems in place to report and record incidents. Staff were able to explain how they reported incidents. All wards were operating a paper based incident reporting system. However, incident records were not always fully completed on Cranmer, Hearts Delight, Woodstock and Littlestone Lodge.
- Staff informed us that they received feedback from investigation of incidents. We saw evidence in staff meeting minutes on Orchard and Cranmer wards that supported this.
- We saw evidence on Orchard ward that new systems being implemented as a result of lessons learnt. These included records with identifying information, descriptions of patients and contact details of patients who were taking leave, so that staff where aware of where patients had taken leave to and with whom they had taken leave with and that patients could be contacted if need be. In addition, following a serious incident on Hearts Delight ward, we saw evidence of learning across both Hearts Delight and Woodstock ward in relation to the use of hoists.
- We saw evidence, on most wards, that staff had access to debrief sessions after serious incidents had occurred. Staff told us that they felt supported following incidents.
- Woodstock ward had identified areas where patients frequently slipped or had fallen and altered the surrounding space to minimise risks. Sevenscore and Woodchurch wards used an initiative called 'productive ward' effectively to monitor incidents and concerns. There was evidence of learning and feedback being given to patients and relatives. These included improving ward signage on Sevenscore ward and the lighting in the lounge area within the past 12 months.

Are services effective?

Requires improvement

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

Summary of findings

- On the majority of wards care plans were not personalised and did not meet the individual needs of patients.
- There was no evidence on Littlestone Lodge of patients having been involved in the planning of their own care and treatment.
- On Cranmer Ward and Littlestone Lodge assessment tools available were not being used, for example, pressure ulcers tools, continence, moving and handling procedures and physical health assessment tools.
- We had serious concerns that patients' physical health needs were not assessed or managed safely and effectively on Cranmer and Littlestone Lodge.
- On Jasmine and Cranmer wards we found the MHA and DoLS were not being correctly implemented and on Littlestone Ward the MCA was being used on a consistent basis and routinely when the MHA 1983 should have been considered and applied.

Our findings

Assessment of needs and planning of care

- We had serious concerns that patients' physical health needs were not assessed or managed safely and effectively on Cranmer and Littlestone Lodge. We requested that immediate action was taken to address the physical health needs of two patients on both wards.
- We were concerned that on Littlestone Lodge, patients' continence needs were not being met. We looked at patients continence assessments; we reviewed six in detail and spot checked a number of other patient's records. Continence assessments were not always being carried out and we found that there were no continence aids other than pads available in the unit. Incontinence pads were being used routinely and a patient told us that she found the unessecary use of pads upsetting.
- We were concerned that on Littlestone Lodge the monitoring of weight and nutrition was not being carried out and changes to care implemented as a result. This meant that risks were not assessed and managed, which put patients were put at risk of harm. During our inspection of Littlstone Lodge we examined completed nutrition and fluid intake monitoring charts. The forms that the staff were using on the first day of our inspection were not completed fully and not all patients who needed them had a form. We asked to see the previous day's charts. The ward operated a system where the ward clerk would scan the previous day's charts onto the electronic records system. Despite both the ward clerk and ward manager looking for the previous days charts, only a few could be found; these were also incomplete. Given the type of patient (older people with dementia) cared for at Littlestone Lodge the monitoring of nutrition, dietary and fluid intake would be expected to ensure patients welfare.
- On Cranmer ward and Littlestone Lodge we saw that care plans were not personalised and did not meet the individual needs of patients. For example, in Littlestone Lodge, generic statements were being made around patients care which was not individualised and applied to all patients regardless of their need.
- A combination of paper and electronic systems were used on all wards. Paper records were not always stored securely and available to staff when they needed them.
- On Hearts Delight and Woodstock ward the paper records were found to be in a disorganised and patient files were not clearly separated. Agency staff did not routinely have access to electronic files, so used paper files; this information was then updated on the electronic system by substantive staff. When the electronic system was not working staff used paper files. During the inspection the electronic system was frequently inaccessible to staff as the system had crashed and was not working for periods of time. Not all staff members knew how to access information, on the RIO system.
- We reviewed care records on Woodchurch, Woodstock, Hearts Delight, Jasmine and Orchard wards, and saw that care plans were personalised. For example, patients' individual needs were clearly identified and included information about patients' routines and preferences.
- We saw evidence in care records on Woodchurch, Orchard, Cranmer, Hearts Delight, Woodstock and Jasmine ward that a physical examination of patients was undertaken on admission and annually.

Are services effective?

Requires improvement

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.

Best practice in treatment and care

- We found evidence on Littlestone Lodge to show that the covert administration of medicine was being practiced as a matter of routine. A pestle and mortar was used to crush the medication which was then mixed with jam or jelly. The pestle and mortar was not cleaned between each patient. This meant that there was a risk of receiving traces of other patient's medicine. All the covert medication charts were out of date. There was no evidence of the covert medication charts being regularly reviewed and there were no clinical reasons given for the use of covert medication. This was not in line with trust policy.
- On Littlestone Lodge nine of the 15 patients had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR forms completed. We were concerned that six of these had not been countersigned by a consultant, as required. Whilst four had been completed fully with clear rationale and families' views had been included, the other five had little detail included. Four had been completed in 2013 with exactly the same wording of "Dementia; Will not improve Quality of Life", without any further rationale. Three of these had been written on the same day in August 2013 and none of the four that had this wording had been countersigned by a consultant. Families' views on these four patients only had a single line of, "discussed with…" We were concerned that contrary to best practice guidance none of the DNACPR forms had been reviewed to see if the decision still stood or that the provider had followed its own guidance in ensuring forms were countersigned to protect the welfare of the patients.
- Not all wards had the same level of access and input from staff of different disciplines. For example, Cranmer ward had to make referrals for physiotherapy and dietetics to primary medical services, causing delays in treatment.
- Hearts Delight and Woodstock wards had good access to primary medical services. The service was GP led, and a consultant psychiatrist visited people at the unit weekly.
- Orchard ward referred all patients to physiotherapy services within the trust as standard procedure for initial mobility assessment upon admission to the ward.
- We found evidence to show that Hearts Delight, Woodstock and Orchard ward followed NICE guidance in relation to the prescribing and administration of medicines.
- We found evidence to show that a range of psychological therapies were being used across all wards visited.

Skilled staff to deliver care

- We saw evidence on Littlestone Lodge and Jasmine wards that staff performance issues were being addressed. However, this was not a consistent practice across the older people's service. For example, where errors had occurred around the administration of medicines on Cranmer ward, this had not been addressed through staff performance policies and procedures.
- All wards, with the exception of Cranmer and Littlestone Lodge, had a full range of health disciplines available to provide input to the ward. Cranmer ward had to refer to primary medical services in order to access dieticians and physiotherapy etc.
- There was minimal evidence of medical leadership or input on Littlestone Lodge. Arrangements for senior medical cover for the ward was not clear. Medical cover was provided by a locum doctor who had been working in the unit since October 2014 and who had limited previous experience of caring for patients with dementia. The staff on the ward we spoke with during our inspection believed the doctor was a consultant, but the person was an associate specialist. The locum doctor received supervision from a consultant psychiatrist specialising in older people's care but the consultant did not visit the ward, so patients and their families did not have direct access to a consultant psychiatrist.
- Staff had access to managerial supervision on a regular basis and we saw records that reflected this. There was limited evidence of clinical supervision being adopted on most wards. We saw minutes of team meetings that were being held regularly on all wards.

Multi-disciplinary and inter-agency team work

- We attended a handover meeting on Jasmine ward. We observed effective communication and information sharing. For example, a range of structured tools were being used to ensure good information sharing during handover times.

Are services effective?

Requires improvement

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.

- All wards held multi-disciplinary ward rounds on a regular basis and we saw evidence of this through observation and records.
- With the exception of Crannmer ward and Littlestone Lodge we found effective working with other teams involved with patient care. For example, community mental health team care coordinators and local authority social services.

Adherence to the MHA and the MHA Code of Practice

- On Jasmine ward, we found that Section 62 (emergency treatment) of the MHA had been used when routine application of the MHA should have been applied.
- Cranmer ward did display signage for patients who may want to leave the ward voluntarily. However, this sign was being displayed on exit of the ward, which could only be seen by patients once they had entered into an air lock area. There was no sign indicating patients' rights to leave at the first air lock door within the ward area.
- Patients on Cranmer ward had had their rights under the MHA explained to them on admission, but not routinely thereafter. Some patients on Cranmer and Jasmine ward were not informed of their right to advocacy representation. There was no evidence that staff had informed patients of the advocacy services available to them. Staff records indicated that staff were trained in the MHA, COP and the guiding principles.
- Staff we spoke to on all wards were able to verbalise their understanding of the application of the MHA, the COP and guiding principles.
- Copies of consent to treatment forms were present and attached to treatment cards where applicable on all wards.
- Staff were aware, on all wards, that they could access administrative support and legal advice on implementation of the MHA.
- Detention paperwork on all wards was completed correctly, up to date and stored appropriately.
- We saw evidence, on all wards, that there are regular audits to ensure that the MHA was being applied correctly and there was evidence of learning from these audits
- Information about advocacy services was not clearly displayed or consistently given to patients. On Littlestone Lodge there was no access for the patients to an IMCA (Independent Mental Capacity Advocate).

Good practice in applying the MCA E6

- Staff had received training in the Mental Capacity Act (MCA). Staff we spoke with generally had knowledge of the MCA and we saw training records to show that staff had attended MCA training. However, we saw evidence on most wards that DoLS applications were not consistently being made when required. Staff did not always understand when to make a DoLs application and to whom.
- There was a policy on the MCA including DoLS which staff are aware of and able to refer to. Staff told us where they were able to get advice regarding the MCA, including DoLS, within the trust
- There was evidence that capacity assessments were undertaken appropriately and documented effectively on most wards. Care records reflected that Hearts Delight and Woodstock wards held best interest meetings with patients. However, from reviewing care records, best interest meetings were not consistent practice across the service.
- We found that on Littlestone Lodge the MCA was being used when the MHA should have been considered and applied. .
- There was no system for ensuring patients' subject to DoLS were provided with information about their rights. Fourteen of the patients on Littlestone Lodge ward were subject to DoLS . There was no evidence of rights being explained as required in six records looked at by our Mental Health Act reviewer. The acting ward manager confirmed there was no framework in place for the regularly advising patients of their rights. Patients did not have routine access to an IMCA (a requirement under the MCA). At the time of our inspection none of the patients on the ward had seen an advocate and there was no information available on how to see one. The system to regularly assess and monitor the quality of the service had not identified that it was not making suitable arrangements to ensure that service users are enabled to make, or participate in making, decisions relating to their care or treatment by providing appropriate information in relation to their care.

Good

Are services caring?

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

Summary of findings

- Most of the patients spoke highly of the care and attention provided by staff and this was supported by patient's family and friends.
- We saw examples on most wards of staff supporting patients if they became distressed. Staff on most wards were respectful and caring towards patients.
- Through the use of the short observational framework for inspection (SOFI) we saw that staff were genuine, empathetic, patient and compassionate towards patients.

Our findings

Kindness, dignity, respect and support

- Most of the patients spoke highly of the care and attention provided by staff. This was also supported by patient's family and friends.
- We saw examples, on most wards, of staff supporting patients if they became distressed. We observed that staff on most wards were respectful and caring towards patients. Staff demonstrated a good understanding of individual`s needs.
- Through the use of the short observational framework for inspection (SOFI) we saw that staff were genuine, empathetic, patient and compassionate towards patients. Staff managed patient distress by speaking softly and implementing distraction techniques, for example, talking about something that was meaningful to the patient.
- Orchard ward had established a family and carers link worker, who supported the needs of the family and carers of the patients. As a result, a patient formulation tool had been devised which contained specific details of the patient's life.

The involvement of people in the care they receive

- The admission process on all the wards informed and orientated patients to the ward and the service.
- We saw little evidence, in the care records we reviewed, of active involvement and participation of patients in care planning and risk assessment. If patients were unable to be involved in this process due to the nature of their illness, we did not find any evidence on care records to show that this had been considered.
- We saw evidence on wards of community meetings and patient satisfaction surveys being used to inform practice and service development. We saw evidence on most wards of actions taken as a result of community meetings. For example, a change in ward based therapeutic activities and menu planning.
- Patients had advanced decisions documented within their electronic care records. There was evidence this was discussed with patients. Staff informed us that in a medical emergency they would attempt to resuscitate all people using the service, unless there was an active do not attempt cardio pulmonary resuscitation (DNACPR) form in place. Four of five files viewed on Hearts Delight and Woodstock ward had a DNACPR form in line with trust policy.
- We saw evidence on Woodchurch ward to show that DNACPR decisions for each patient was routinely reviewed.
- We saw evidence of interpreting services being used on Sevenscore ward to help and with communication and repatriation of a patient to their native country Staff went above and beyond that which would be expected to ensure this happened appropriately and in a timely manner.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

- On some wards we were concerned that care was not responsive to patient needs, for example, we had to ask that pain management was addressed immediately for two patients.
- Not all wards had the same level of access and input from staff of different disciplines, causing delays in assessment and treatment, for example, dietetic and physiotherapy.
- On some wards patients did not know how to raise complaints.
- Some patients were not informed of their right to advocacy representation. There was no evidence that staff had informed patients of the advocacy services available to them.

Our findings

Access, discharge and bed management

- Access to Hearts Delight and Woodstock ward was via continuing care nurses who referred patients. Access to Jasmine ward was through the community nurses. The staff in these community teams mostly completed the initial assessments.
- Both Hearts Delight and Woodstock ward admitted people of working ages with early onset dementia.
- Patients were not moved between wards during an admission episode. When patients were on leave, they were able to return to their allocated bed.
- Discharge plans were agreed with patients and relatives, where appropriate. Hearts Delight and Woodstock ward were usually long term placements for people. Ward managers informed us that delayed discharges were rare but where this did occur, the reasons were due to finding suitable accommodation.

The ward optimises recovery, comfort and dignity

- All wards had access to outside space. However, on Woodstock ward male patients had to walk through the female area of the ward to use the shared garden.
- Currently there was no direct garden access on Woodchurch ward. Staff escorted patients into a secure garden area outside the ward meaning that patients were dependent on staff being available to access fresh air. We saw evidence to show that leave and activities were happening as planned. Activities took place on all the wards. For example, breakfast clubs, music workshops and pet stroking took place regularly.
- We observed menus that met the dietary requirements of religious and ethnic groups, but on all ward, most patients we spoke with were unhappy with the choice and quality of the food provided. Hearts Delight and Woodstock wards were reliant on food that was provided by the adjoining hospital kitchen. Staff members in Hearts Delight ward had worked closely with the hospital kitchen staff to develop a menu based on the preferences of the patients on their ward.
- We were concerned at the quality of the food we observed on Woodchurch and Sevenscore wards. The trust had recognised that there were problems with the quality of meals due to the supplier and the amount of time it had to travel across the county. The trust was currently in negotiations with the local acute hospital trust to source all meals from it in order to improve the quality of the meals.
- Most wards did not use clinic rooms to undertake physical examinations of patients. These usually took place in patient bedrooms.
- Jasmine ward had a dedicated area for alternative therapies which was used regularly throughout the week.
- All wards offered facilities so that patients can make a telephone call in private.
- There were facilities on Cranmer wards to store patients' belongings.
- We observed and saw documented evidence that patients had access to a wide range of activities, including at weekends. Some activities were tailored to their individual needs. For example, activities on Hearts Delight and Woodstock ward were run by occupational therapists or designated care staff. The activities provided included art therapy, gardening, crafts, a weekly breakfast club, and a wellbeing and independence group. There was a 'gardening room' where the occupational therapist worked with people. Patients planted bulbs and pot plants to give to relatives as Christmas gifts. There were also volunteers who provided a 'petting' dog. There was a singing group. The occupational therapist also provided one-to-one sessions for people.

Are services responsive to people's needs?

Requires improvement

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

Meeting the needs of all people who use the service

- There were examples of adjustments being made to bedrooms, other rooms, entrances and exits for people and patients requiring disabled access and ramps were being installed We saw that larger rooms had been equipped with additional facilities to help support patients who required assistance. Examples included, on Sevenscoreward the flooring had been replaced throughout the unit to introduce cushioned flooring to reduce the risk of injury to falls. Staff had used their incident data intelligently, mapping out the incidents and making physical adjustments to the physical environment where there had been a concentration of incidents.
- We saw information leaflets available in different languages. We observed evidence on Sevenscore ward of the effective use of interpreters.
- A chaplain visited most wards on a regular basis. Patients could leave the wards supported by staff, if needed, to ensure their religious and spiritual needs could be met.

Listening to and learning from concerns and complaints

- Most patients we spoke to on Cranmer and Jasmine wards did not know how to raise a complaint. Some patients we spoke to said that they had not been given information around raising complaints and some patients were less able to make complaints due to the nature of their illness. Hearts Delight and Woodstock wards were aware of how to complain. Relatives we spoke with also knew the process.
- Staff explained how to manage and respond to complaints appropriately. They identified how to escalate that information. Formal complaints were investigated by the manager and shared with the trusts complaints department.
- We saw evidence on community meeting on all wards and staff meeting minutes on Orchard ward that staff received feedback on the outcome of investigations of complaints and actions taken. We found that staff had learned from incidents and investigations and had taken action to ensure similar problems did not occur again.
- Woodchurch and Sevenscore wards used iPads to capture feedback from patients and their families.

Are services well-led?

Requires improvement

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

Summary of findings

- Most staff across older peoples' services were positive about their teams and wards. Most staff felt supported by their immediate team manager. However, most staff told us that there was a disconnect between the wards and higher level leadership.
- The governance processes were not working as well as they should have been and we saw that there was a wide variation in the quality of care delivered across the services for older people.
- The leadership and governance infrastructure across the services was variable

Our findings

Vision and values

- Staff we spoke with knew the trust visions and values. We saw the organisation's visions and values displayed on notice boards.
- Most staff were aware of their service line manager. The service managers were present on the wards on a regular basis. Staff were not always aware of who the executive team members were.
- Although senior managers had identified issues on Littlestone Lodge, had brought in an acting ward manager to help improve care and had provided some advice and support from specialist nurses. They had failed to identify and rectify, in a timely manner, all the key risks, including the need to provide additional experienced nurses to support the day to day delivery of care. The acting ward manager for Littlestone Lodge had raised a number of systemic concerns regarding Littlestone Lodge in her short time there and developed and submitted an action plan to address them. The scale of concerns had not been understood by senior managers within the organisation. For example, the concerns were not identified on either the divisional or corporate risk register and only placed on the local risk register following the CQC inspection.
- We had serious concerns about the culture on Littlestone Lodge. Some examples of this included a lack of care, where staff failed to respond to a patient's physical injury, lack of recording and lack of responsiveness by some staff to the acting ward manager's attempts to improve the service. We were told the attempts by the locum clinician to address some of the care planning were not listened to. We identified serious concerns relating to the management of patients pain. Despite CQC inspectors requesting that this was addressed immediately staff on duty failed to do this and CQC inspectors had to insist this was addressed the next day on discovery that it had not be actioned.

Good governance

- One of the warning notices issued was in relation to Regulation 10 (1) (2) of the Regulated Activities Regulations 2010, assessing and monitoring the quality of service provision
- In December 2014, a new acting ward manager was appointed at Littlestone Lodge to bring about improvements that the trust identified were required. An action plan was developed at ward level to address concerns. The version of the action plan updated in February 2015 showed that progress had been made, but that there were a number of issues that had still not been addressed. This included falls and risk assessments not being completed or updated, monitoring of weight and nutrition not being carried out and changes to care implemented as a result, and gaps in incident reporting and analysis. This meant that risks were not assessed and managed, which put patients at risk of harm. However, none of these concerns were entered onto the local or corporate risk register. The local risk register had not had any risks added since 2012 and no risks had been escalated via the service risk register or the trust risk register so the trust were not fully aware of the risks. The system to identify, assess and manage risks was not operating effectively to identify assess and manage the risks that existed within Littlestone Lodge. The governance process had not ensured that the service provided was being monitored. With the exception of Orchard ward, audits used to monitor management of medicines were not effective.
- There was some evidence of incident monitoring and lessons learnt. However, this was not a consistent practice across all of the service. There was little evidence of learning from incidents at Littlestone Lodge. We were told that ward managers could use the trust

Are services well-led?

Requires improvement

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.

risk register as a way of informing the executive team of risks identified, for example environmental risks. We found that key risks were not routinely escalated to the trust wide risk register.

- All the wards were participating in the 'safer staffing' initiative and had staffing information, including staffing levels on a shift on a day to day basis displayed for patient and public viewing.
- Staff on all wards were receiving mandatory training and on Orchard ward were exceeding trust requirements for adherence and compliance with the trusts targets for staff completing training.
- Staff received regular managerial supervision and an annual appraisal. However, at Littlestone Lodge we saw that although the qualified nurses had been receiving regular supervision since the arrival of the acting ward manager, it was less consistent for support workers. The acting ward manager had addressed this by introducing group supervision for the support workers whilst she worked with the qualified staff to take on that role.
- In some areas we identified audits and reviews where actions were not being completed. For example, medicines and care plan audits showed that this was the case and on both Hearts Delight and Woodstock Ward, in all the records we reviewed there were errors in the recording of the medicines given to patients. Both staff teams were not following the trusts medicine policy in relation to the monitoring and auditing of these documents. The nurses in both teams did not know how to accurately reset the fridges to ensure accurate recoding of the temperature. They could not be assured the medicines, like antibiotics and flu vaccines, were stored correctly and therefore effective. It was evident by the concerns we found regarding this example that the audit process may be capturing concerns but the service was not responding to these concerns in a robust manor.

Leadership, morale and staff engagement

- All staff we spoke with on all wards, with the exception of Littlestone Lodge, said that they were supported by their managers and peers. There were no reports of bullying and harassment. Staff described morale as good.
- Staff on most wards were aware of the whistleblowing process. Staff felt able to raise concerns and that they would be listened to.
- Most staff, on most wards, told us that they are able to access training outside of the statutory and mandatory agenda, including leadership courses. Staff informed us that training was effective.
- Cranmer ward manager told us that they had been involved contributing to the new hospital development at St Martins Hospital.

Commitment to quality improvement and innovation

- Orchard ward had developed a family link worker within their staff team this had enabled them to produce a holistic patient formulation document, which held specific details of the patients life.
- Woodstock ward had designed their ward environment to meet the recreational and personal needs of the patients by having a barber shop and a bar installed.
- We saw evidence on wards of involvement with national projects. For example, accreditation for inpatient mental health services by the Royal College of Psychiatrists, an initiative that seeks to improve standards on inpatient wards for people with mental health problems and local initiatives such as the 'most improved ward environment' on Cranmer ward.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not have procedures and processes in place to respond appropriately to any allegation of abuse. We found evidence on Woodstock Ward, Littlestone and Cranmer wards, where concerns had not been recorded and reported to the safeguarding team. This was in breach of regulation 11(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not take measures to ensure that patients were protected against the risks associated with the unsafe use and management of medicines. We found unsafe, covert administration of medicine of Littlestone Lodge ward. We found missed signatures on prescription cards and issues with the storage and disposal of medicines on Jasmine, Cranmer, Woodstock, Hearts Delight, Sevenscore and Littlestone Lodge.

This section is primarily information for the provider

Compliance actions

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not always provide care and treatment in a way that ensured people's dignity. This includes making sure that people have privacy.

Male patients' bedrooms, on Hearts Delight ward, were in view of female patients.

This was in breach of regulation 17(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not have effective operations which enabled the trust board to regularly assess and monitor quality of the services and identify, assess and manage risks.

This section is primarily information for the provider

Compliance actions

The current governance processes are not effectively identifying risks and monitoring quality of services for older people wards which are not performing well, so that improvements can take place and be closely monitored.

This was in breach of regulation 10(1)(a)(b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not ensure the trust board acted in accordance with the Mental Capacity Act 2005 or if Part 4 or 4A of the Mental Health Act 1983 applies to a service user, where the person was unable to give such consent because they lack capacity to do so. We found that Deprivation of Liberty Safeguards (DoLs) applications had been made but this was not a consistent practice across the whole older people's inpatient service. We found poor compliance and practice in relation to the application of the Mental Health Act 1983 (MHA 1983). This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11(3)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe.

Patients were not receiving effective assessment and care for physical health and mobility needs, and pain management on Littlestone Lodge and Cranmer ward.

This was in breach of regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(a)(b)(c)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 (1a)(1b) and (2a)(2b)(2c)(2d)** **The Trust did not take measures against inappropriate or unsafe care and treatment by failing to identify, assess and manage risks relating to the health and welfare and safety of patients by failing to undertake falls and risk assessments, monitor the weight and nutritional needs and changes of patients and failing to report on incidents and review analysis of incidents.** Relates to Littlestone Lodge.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1a)(1b) and (2)** **The Trust did not take measures against inappropriate or unsafe care and treatment by failing to assess and meet the individual needs of patients in their care by not undertaking an appropriate assessment of individual needs, and responding to patients' pain management and other personal needs.** Relates to Littlestone Lodge.