Requires improvement

Mersey Care NHS 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)
RW438	Mossley Hill Hospital	Oak	L18 8BU
RW438	Mossley Hill Hospital	Acorn	L18 8BU
RW449	Southport General Infirmary	Boothroyd	PR8 6PH
RW435	Heys Court	Heys Court	L19 5NG
RW4X2	Clock View Hospital	Irwell ward	L9 1EP

This report describes our judgement of the quality of care provided within this core service by Mersey Care NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Mersey Care NHS Trust and these are brought together to inform our overall judgement of Mersey Care 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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Requires improvement** 
Are services responsive?	**Good** 
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

Contents

Summary of findings

Overall summary

We gave an overall rating for wards for older people with mental health problems of **requires improvement** because:

- We had serious concerns about the safety of patients on Irwell ward. It did not comply with the guidance on same sex accommodation. It did not have any action plans in place to mitigate against the risk of suicide that the environment may present. It was in breach of its own plan to help prevent the risk of suicide. The ward environment presented risks for older people with dementia. Staff did not have clear lines of vision to ensure good levels of observation of all areas.
- Boothroyd and Oak wards also presented challenges to good levels of observation of all areas.
- The alarm system for patients on Boothroyd was insufficient.
- On Irwell ward staff were not adequately skilled to safely meet the needs of patients.
- On Irwell ward identified risks were not appropriately addressed in care plans.
- On Irwell ward staff providing care and treatment were not adequately supervised or supported in their role.
- Across all wards there was poor understanding of the Mental Capacity Act 2005.
- Patients receiving care and treatment were not afforded privacy whilst accommodated on Irwell ward.
- On Irwell ward patients were not provided with food and drinks in a manner that promoted their independence and dignity.

This inspection highlighted a number of problems and issues on Irwell ward. This was a dementia assessment unit in Clock View hospital. The ward had only been open for four months. The issues identified on this ward, were at variance with the other older people's inpatient services we inspected at Mersey Care.

Patients and their relatives were mostly positive about the care and treatment provided on the wards. Staff were mostly caring and compassionate. We observed some very kind and responsive interactions between staff and their patients.

The trust had a robust falls management process that was well embedded on all the wards. During our inspection we saw outstanding falls management, on Acorn ward and Heys Court led by committed multidisciplinary teams.

There was a good understanding of staff responsibilities in adhering to the Mental Health Act and its Code of Practice. The trust had provided training for staff on the Mental Capacity Act 2005 (MCA) but we found that staff knowledge and application of the law was poor in most areas.

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:

- Irwell ward was not a safe environment for older patients with dementia. It did not comply with the guidance on same sex accommodation. There were no action plans in place to mitigate against the risk of suicide that the environment may present. It was in breach of its own plan to help prevent the risk of suicide.
- The environment on Irwell, Boothroyd and Oak wards presented some challenges to good levels of observation.
- The alarm system for patients on Boothroyd was insufficient.

However:

- Staff on all wards learned from serious untoward incidents.
- All wards were proactive in the prevention of falls.
- Staff were trained in safeguarding adults at risk and were able to describe how they would escalate a concern.
- Staff recognised and understood the principles of the trust "no force first" initative.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- On Irwell ward staff were not adequately skilled to safely meet the needs of patients with dementia.
- On Irwell ward identified risks to patients' health and wellbeing were not properly addressed in care plans.
- On Irwell ward staff providing care and treatment were not adequately supervised or supported in their role.
- Across all wards there was poor understanding of the Mental Capacity Act 2005.

However:

- Across all wards we saw robust falls management processes in place and this was closely monitored at a local and senior level.
- Patients were mostly provided with a wide range of activities.
- Acorn ward was trialling a person centred approach to assessment and care planning that was more appropriate and accessible for older people with dementia.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

Summary of findings

- Patients receiving care and treatment were not afforded privacy whilst accommodated on Irwell ward. Although the trust responded to our concerns regarding patients not having access to their locked bedrooms.
- On Irwell ward patients were not provided with food and drinks in a manner that promoted their independence and dignity.

However:

- We observed respectful and positive interactions on all wards. This demonstrated to us that staff were kind and mostly compassionate.
- Patients and/or relatives told us they felt involved in deciding how their care should be provided. Relatives spoke highly of staff and the support they provided to patients and their carers.
- The service provided access to advocates that introduced themselves to each newly admitted patient.

Are services responsive to people's needs?

Good

We have rated responsive as **good** because:

- Patients were provided with a range of foods that met their cultural and religious needs.
- Patients were actively encouraged and supported to participate in a wide range of activities designed to promote their recovery.
- Activities were planned and delivered by a skilled team of therapists.
- Patients' diversity and human rights were respected.
- Patients were provided with a forum to raise issues as a group or individually and the trust responded positively to these.
- Patients were provided with a good range of information about the service and mental health.
- Staff were proactive in responding to patients concerns and complaints.
- Wards had sufficient equipment and resources to support patients' physical needs.

However:

- The environment on Irwell ward failed to promote patients' independence, and was not equipped to meet the needs of older people with dementia.
- Patients on Irwell ward were not provided with information in a format that suited their needs.
- There was a lack of psychology input across the wards.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

Summary of findings

- There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents.
- Wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust.
- Staff were felt well supported by their ward managers and modern matrons.
- Staff had a good understanding of the trusts vision and values.

However:

- There was a lack of effective governance in relation to Irwell ward.
- Staff across the wards were had no mechanism to feed into the trust's risk register.
- There was a lack of clarity around line management structures at Clock View Hospital.

Summary of findings

Information about the service

Mersey Care NHS Trust provides inpatient services for older people aged 65 and above with mental health conditions. These services are provided for people who are admitted informally and patients compulsorily detained under the Mental Health Act 1983. This reports looks specifically at all of the older people's inpatient wards provided by the trust. The services are based across five inpatient wards over four sites;

At Mossley Hill Hospital

- Oak, a 20 bed mixed sex assessment ward for people with functional mental health problems
- Acorn, a 15 bed mixed sex assessment ward for people with organic mental health problems

At Southport General Infirmary

- Boothroyd, a 20 bed mixed sex assessment ward for people with functional mental health problems

At Clock View Hospital

- Irwell, a 17 bed mixed sex assessment ward for people with organic mental health problems

At Heys Court

- Heys Court, a 16 bed mixed sex continuing care unit for people with enduring mental health problems

Our inspection team

Co-Chairs: Dr Paul Gilluley and Professor Jonathan Warren

Head of Inspection: Natasha Sloman

Team Leader: Serena Allen

The team included two CQC inspectors, two qualified nurses, and a consultant psychiatrist, an expert by experience, a quality manager, a Mental Health Act reviewer and a service manager.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited five wards at the four hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients.
- spoke with 15 patients who were using the service and collected feedback from two patients, using comment cards.
- spoke with six relatives of patients who were using the service at the time of our inspection.
- spoke with the managers or acting managers for each of the wards.

Summary of findings

- spoke with 22 other staff members; including doctors, nurses and social workers.
- interviewed the matrons and service leads with responsibility for these services.
- attended and observed three hand-over meetings and two multi-disciplinary meetings.
- looked at 31 treatment records of patients.
- carried out a specific check of the medication management on all wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

During the inspection we spoke with 15 patients and 6 relatives on all the wards. Overall they were positive about their experiences. Most patients told us they received the right level of care and support to meet their needs.

Most patients and relatives spoke positively about staff commenting on their kindness and compassion. Across all five wards we observed positive and caring interactions between staff and the patients. On the functional wards patients described staff as calm and supportive.

Good practice

- Acorn ward, led by the unit's dementia lead were trialling a human rights based approach to assessing and planning for the needs of older patients with dementia. The approach would provide a person centred and user friendly framework, for detailing how the service will provide care and treatment for older people. It would also ensure that the trust met its legal obligations in relation to human rights legislation.
- The trust had a well embedded falls management system in place. However inspectors considered that the multi-disciplinary approach and staff commitment to fall prevention that was evidenced on Acorn ward and Heys Court was outstanding.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve wards for older people with mental health problems.

The provider must ensure that:

- Irwell ward provides a safe environment that meets the needs of older patients with dementia.
- Irwell ward complies with the guidance on same sex accommodation.
- Irwell ward has adequately skilled and experienced staff to safely meet the needs of patients.
- Irwell ward assesses and meets the needs of patients properly.
- Staff on Irwell ward are adequately supervised or supported in their role.
- Patients on Irwell ward receive care and treatment that affords privacy during their admission.
- Irwell ward provides patients with food and drinks, in a manner that promotes their independence and dignity.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- Boothroyd ward must ensure there is an adequate call system that meets the needs of patients or staff seeking assistance.
- All wards should review staff's knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust should review governance arrangements and management oversight at Irwell ward to ensure the service is safe and effective.

Summary of findings

The trust should ensure that all wards have management representation at governance meetings.

Mersey Care 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
Acorn ward	Mossley Hill Hospital
Oak ward	Mossley Hill Hospital
Boothroyd ward	Southport General Infirmary
Irwell ward	Clock View Hospital
Heys Court	Heys Court

Mental Health Act responsibilities

Adherence to the MHA and the MHA Code of Practice

Staff on the wards had a good understanding of the Mental Health Act (MHA) and its Code of Practice (CoP). The documentation we reviewed in detained patients' files was generally compliant with the MHA and the CoP.

All wards had copies of patients' original detention papers on file. Approved Mental Health Professional reports were all present.

There was information on all wards, regarding the independent mental health advocacy service. We saw that Boothroyd ward and Heys Court documented very good evidence of discussions with patients about their rights and followed these up with referrals to IMHAs, when patients did not fully understand their rights.

We saw that there were good records maintained regarding patients Section 17 leave. Agreements and assessment around patients' leave were in place and we saw reviews of patients' leave recorded. Staff on Boothroyd ward provided additional support to patients and their carers by providing them with a "what to do if you are concerned when on leave".

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Good practice in applying the Mental Capacity Act 2005

There were valid authorisations in place for most patients to whom the deprivation of liberty safeguards (DoLS) applied. With the exception of Irwell ward where we found that one patient's DoLS had previously lapsed. For the same patient there was no mental capacity assessment in place in relation to dietary needs, wound care, personal care or medication. This concern was escalated to the trust.

We found that, on the whole the older people's inpatient wards were not applying the Mental Capacity Act 2005 (MCA) appropriately. We found that the assessments of capacity to consent to treatment were generalised. This was not in line with the MCA Code of Practice which states assessments must be specific to particular decisions.

We saw that issues around mental capacity were referred to the doctor for assessment. Patients' capacity assessments covered large general areas of their lives, such as their admission and treatment plan. There was a lack of specific decision capacity assessments, such as a patient's capacity to consent to the delivery of personal care and medication.

When staff made decisions for patients, there was generally poor documentation to demonstrate how and why the decision was made in the patients' best interests.

The capacity assessments also reflected a lack of information on which the assessor based their decision. For example assessments failed to detail the evidence of the patient's impairment or disturbance and why the patient could not retain or weigh up information. The recorded assessments did not detail what assistance the patient had been given to enable decision making.

We raised these concerns with the trust during our inspection and an alert was sent to all relevant staff. However when we returned on 16 June 2015, we reviewed a MCA assessment undertaken on a patient recently admitted. We found that there was no improvement in the assessment or recording of decisions.

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

Our findings

Safe and clean environment

- The wards did not all have clear lines of vision. The various design of the wards meant that there were blind spots where staff were unable to see patients easily. To mitigate risks the staff told us they undertook regular walks around the ward to check on patients. We saw records of staff undertaking regular zonal checks throughout the night.
- The design of the Boothroyd ward made observation difficult, particularly in the female bedroom area. There was a T shaped corridor, which had four single rooms. The ward manager said they managed the risk by zonal observation at night. However, there was no nurse call system in any of these bedrooms. The ward had some pull tag alarms that alerted a mobile hub. This identified which patient was activating the alarm but not their location. There were no spare alarms that could be issued should a patient require this or if a member of staff required assistance, for example, whilst on 1:1 observations. This left both staff and patients at increased risk.
- The design of Oak ward meant there was a long T shaped corridor with a conservatory at the end where patients liked to spend time. This was located out of sight of the communal areas and nursing office. We saw that there were convex mirrors in place to improve staff observation of patients.
- There were up to date environmental suicide risk assessments in place. These looked specifically at self-harm and ligatures. They considered ward layout, fixtures and fittings, staffing and observation levels.
- Ward managers told us that patients who were identified as a high risk of suicide would not be admitted to the dementia assessment wards.
- We looked at the number of incidents of use of ligatures that had taken place on the wards over the last six months and there had been none. Where previous incidents of ligature use had taken place on the wards, these were considered in the risk profile of each ward and the subsequent action plans were reflected in the environmental risk suicide risk assessment.
- There was a protocol in place that ligature cutters were checked on a daily basis. All staff that we spoke with knew where the ligature cutters were located. Oak ward had one bedroom that was suitable for patients who were at high risk of self-harm.
- We asked the trust to send us the environmental risk assessments for the older people's inpatient services, but were only provided with an environmental suicide risk assessment. So we were unable to judge how the trust had considered the environmental risks presented in the newly built Irwell ward at Clock View Hospital.

We identified a number of environmental risks on Irwell ward. There was a lot of glass throughout the ward. Corridor doors and panels were clear glass from floor to ceiling. There was a very small detail of discreet frosted leaves that would not be seen by patients or visitors with poor vision. We were informed by the ward manager and senior staff from the estates directorate that these doors were the cause of accidents within the ward where patients walked into the doors and then fell backwards. In the three months before our inspection there had been three accidents where patients "collided with walls or furniture" and a further six reports of unexplained injuries.

- The ward manager told us that the large viewing windows around the ward were a source of confusion for patients, particularly at night, as they were reflective and had a mirror effect. It appeared that some patients believed their reflections to be other people around them.
- There was a low use of colour throughout the unit. This meant that people with dementia were not afforded the support of well-defined fittings. For example a white toilet seat on a white floor, makes defining the toilet more difficult. There were white walls and flooring

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throughout with a black skirting, where the walls and flooring met. However staff told us that patients often perceived the black skirting as a step that they tried to "step-over" which was a potential falls risk.

- With the exception of the environmental issues contributing to accidents on Irwell ward, falls were robustly managed across older patients' wards. There was close monitoring of the incidents of falls at ward and senior management level. Inspectors considered falls management at both Heys Court and Acorn ward were outstanding. As part of the trusts 'perfect care strategy' Heys court had just been awarded with a 30 days no falls certificate. On Acorn ward we tracked the care arrangements and multidisciplinary team input for a patients who had a history of falls. We considered the approach to be at an outstanding level of practice. For one patient we counted 29 in-depth reviews as the service attempted to manage the patient's poor mobility, confusion and physical frailty. On Oak ward some patients had their own falls care plan called "My fall prevention plan". There was a reduction in the prevalence of all falls collected through the safety thermometer" (Trust Quality Account 2013/14).
- All wards, with the exception of Irwell ward complied with guidance on same-sex accommodation. Acorn ward had well segregated gender areas and three lounges for patients, one for male, female and a mixed gender lounge. Staff across the wards had a good knowledge of the importance of segregated areas and were able to describe individual patients' preferences, in relation to the areas where they sat.
- However on Irwell ward there were no gender segregated areas for patients in relation to lounge or dining areas. Patient bedrooms areas were not segregated. There were no gender designated toilets or bathrooms. All patient bedrooms had en-suite facilities. However, on our first day on the ward, we saw patients were locked out of their rooms during the day, leaving only one toilet for the entire ward. We escalated this as a concern to the trust and immediate arrangements were made for all patient bedrooms to be unlocked.
- The clinical rooms on every ward were fully equipped with accessible resuscitation equipment and emergency drugs. These were checked regularly. Emergency equipment, including automated external defibrillators and oxygen, were in place. The equipment was checked weekly to ensure it would be effective in the event of an emergency.
- On three of the wards patients told us that the wards were clean and that areas such as bathrooms and toilets were frequently checked by domestic staff. Most wards were cleaned and maintained to a high standard. This was reflected in cleaning schedules to guide domestic staff. Wards conducted audits of cleanliness and infection control to ensure that people who use the service and staff were protected against the risks of infection. We reviewed all five ward's infection control audits and found that any actions that needed to be implemented were followed up in a timely manner.
- However, on our first day on Irwell we found the ward to be unclean. Surfaces were dusty and soiled furnishings. Vacant bedrooms that had been prepared for admission of patients were unclean with soiled bathroom floors. Beds had not been properly cleaned following discharge. Check lists and audits had been completed but they did not reflect our findings. The trust responded promptly to our concerns and on our subsequent visits we noted an improvement in the level of cleanliness.
- Patient bedroom doors on Boothroyd ward patient bedroom doors, which were also fire doors, had been propped open with items such as bins. This was concerning as patients on the ward were not properly protected from the risks of fire or smoke inhalation. We spoke with the ward manager about this and the door props were removed.
- During the tour of Oak ward we found that products used in cleaning were not secured. Numerous products that would be harmful if ingested were found in unlocked cabinets in an unlocked store room. This was brought to the ward manager's attention and the store was secured.

Safe staffing

- We were provided with the individual staffing levels for all the wards over a three month period. Each ward had a 'safe staffing' reporting system which enabled staffing levels to be monitored by the trust.

Requires improvement

Are services safe?

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- In the 12 months up to December 2014 figures revealed that older people's inpatient services had the second highest turnover of staff in the trust at 14.5%.
- The wards displayed the expected and actual staffing levels on each ward entrance. The actual staffing levels matched or exceeded the expected staffing levels during our inspection visit. When we reviewed actual staffing levels in the months preceding our visit we saw this was not always the case. Wards managed to fill between 85% and 100% of all shifts, but there were areas of concern such as Acorn ward with only 59% of nursing day shift hours were filled in April 2015. These shifts had been covered by unqualified staff, bank and agency staff. However we were satisfied that there was always a qualified member of staff on duty at all times.
- There were deputy managers supporting the ward managers on all wards. Ward managers told us that there were a number of nursing staff vacancies across the older people's wards, which had led to an increased use of bank and agency staff. We checked three weeks, randomly selected staff rotas on Irwell ward. We saw that cover had been sought from agency or bank staff for an average 37 shifts per week. Ward managers tried to ensure that staff that were familiar with the ward and patients were booked to reduce the disruption. On Oak ward we spoke with a member of agency staff who had been block booked for 18 months, so that the input into the ward would be consistent.

Assessing and managing risk to patients and staff

Number of incidents of restraint in the last three months :

LOCATION MARCH '15 APRIL '15 MAY'15 TOTAL

Acorn ward 5 13 11 29

Boothroyd ward 3 2 8 13

Heys Court 0 1 3 4

Irwell ward 4 0 10 14

Oak Ward 0 16 1 17

Grand Total 12 32 33 77

(MC121 Restraints on OP wards 01/03/2015 to 31/05/2015)

- None of these restraints were in the prone position. Most of the restraints in the older patients' services were recorded as "arm hold" and "redirecting" However, we drew the ward manager's attention to a restraint of an older patient on Irwell that was recorded as "sitting position on floor". At the time of our visit the details of the restraint had not been reviewed by the manager or matron.
- 'No force first' was a trust initiative put in place to reduce the amount of restraint used within the inpatient wards. Information was visible about the scheme throughout the wards and staff were knowledgeable about what it meant. Patients on Oak, Boothroyd and Heys Court described the calm approach of staff and how they de-escalated incidents when other patients became agitated.
- Most staff across the wards were up to date with mandatory training. These included the management of violence and aggression, life support, manual handling, use of hoists and safeguarding vulnerable adults
- Staff had received training in safeguarding children and adults at risk. All staff we spoke with knew how to recognise a safeguarding concern. Staff were knowledgeable about the trust's safeguarding policy and could name the safeguarding lead and champions for their wards. They knew who to inform if they had safeguarding concerns. Safeguarding was discussed at ward team meetings and it was a standing item on the agenda for meetings. Safeguarding discussions with staff also took place during supervision, to ensure staff had sufficient understanding of safeguarding procedures.
- Appropriate arrangements were in place for the management of medicines on all of the older people's wards. We reviewed the medicine administration records of all patients on each ward we visited. Nursing staff carried out regular checks on medicine prescription and administration records to ensure these were accurate and to identify any medicines omissions. The medicines management team reconciled all patients' medicines on admission and assessed the suitability of patients' own medicines for use where necessary.
- There was a trust wide falls prevention strategy that was well embedded into each of the older people's wards. On Acorn ward we observed the appropriate footwear each patient was wearing in an aim to reduce the risk of

Requires improvement

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falls. Staff told us about the weekly falls management meetings that was held on the ward. The meetings included appropriate members of the multidisciplinary team.

Track record on safety

- We asked the trust to provide us with any serious untoward incidents (SUIs) that had taken place on the older people's ward over the last year. There were three incidents that were reported, each of these being a fall, occurring on Oak, Boothroyd and Acorn. Each incident investigation had an action plan, so that learning from the incident could take place. Staff were able to tell us about the learning from the incidents.
- Staff on Irwell ward told us that the trust was aware of the environmental issues that may be causal factors for some incidents. However they were unable to tell us what action was being taken provide a safer environment for patients.

Reporting incidents and learning from when things go wrong

- Staff we spoke with on all of the older people's wards knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the trust's clinical governance team, who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the progress of investigation. Ward managers told us how they maintained an overview of all incidents reported on their wards. Incidents were investigated and some managers told us they were made aware of incidents that had occurred on other wards. This happened at weekly meetings with the ward managers and the modern matron.
- Staff told us reporting incidents was encouraged. Incidents were investigated and the outcome shared with staff and more widely at local governance meetings. Staff told us incidents were discussed in team meetings and changes were made to care plans as a result of any learning identified. We found learning within the team took place. Staff told us, and we observed that safety and risk was discussed at handover. We saw also evidence of learning in recent team meeting minutes.

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

Our findings

Assessment of needs and planning of care

- Patients' needs were assessed and care was delivered in line with their individual care plans. The care records showed that people were assessed on admission to the ward and care plans implemented in response to their assessed needs.
- On most of the older inpatient wards, the risk assessments and care plans were robust. We saw that these were personalised and reflected patients' individual preferences and major life events.
- Patients in Heys Court had received primary health care from weekly GP visits to the ward. All wards had input from the trusts physical health care nurses along with district nurse support.
- On Irwell ward, patients' risk assessments and care plans were not properly reviewed. A patient who presented as a high risk of assaulting other patients and staff. Despite several assaults on others the patient's care plan failed to show the arrangements in place to manage the situation effectively and maintain patient and staff safety.
- On Irwell ward patients physical health care needs were not being met properly. We saw records for three patients, who were incontinent but their corresponding care plans failed to direct staff how to support them appropriately. One member of staff told us incontinence was a "problem on this ward". However they were unable to describe how to promote or maintain individual's continence.
- On a second patient's record, we saw that staff had not implemented the monitoring instructions of the medical doctor in relation to the person's physical health. The instructions given by the doctor were only recorded on a physical health plan after a second episode of the patient being unwell.
- On both Oak and Boothroyd wards there were some areas of very good practice reflected in care plans around issues such as covert medication and discussions with carers.

Best practice in treatment and care

- Throughout our visit to Acorn ward we observed examples of best practice in the care of older patients with diagnoses of dementia. Headed up by the dementia lead the ward had begun to introduce human rights based approach to assessment of people's needs and an emphasis on enabling people with dementia to live well. When fully and properly implemented, the approach should ensure that the care and treatment of patients with dementia would have a more person centred experience during their hospital stay.
- Across all the wards we found a good range of activities provided for patients such as art and music therapy. In Irwell ward we noted the good practice of several different small activity groups taking place in one large room at the same time. This ensured people could easily move between groups and exercise choice, regarding which activity they wanted to join.
- Nursing staff undertook a program of clinical audits on all the wards; these were reported to the modern matron and reviewed at monthly performance meeting. Any issues and concerns were promptly flagged to staff through a trust email circulation and newsletter.

Skilled staff to deliver care

- Care and treatment was provided by a multi-disciplinary team across all the wards we visited. The team consisted of consultant psychiatrists, medical doctors, nursing staff, occupational therapists, physio therapists, pharmacists, and dieticians. All the wards reported there was only limited access to psychology. On Heys Court each patient had access to a GP who visited the ward weekly
- The trust had not ensured that all staff, particulary health care assistants of Irwell ward were appropriately skilled and supervised or supported in their role.
- This was because the staff did not receive sufficient support and training to meet the needs of patients with dementia.
- On Irwell ward, some staff did not demonstrate sufficient skills to work with patients with dementia. We saw numerous examples of patients becoming distressed, frustrated and sometimes aggressive whilst staff failed to intervene to de-escalate the situation. On one visit whilst waiting to enter the ward we were told to

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.

wait whilst a patient repeatedly tried to push open a locked door with their walking frame. It took some time before staff intervened, at which point the patient had become agitated and upset. During another visit we saw a patient distressed and wanting to leave the ward, they told a staff that they had not done anything wrong and could not understand why they were in prison. The member of staff responded by saying they would "fetch a doctor" and walked away from the patient.

- Levels of individual supervision from line managers varied within wards. On Acorn ward all the staff we interviewed confirmed they received supervision and appraisals. The physiotherapist on Boothroyd ward was able to describe their arrangements for clinical and managerial supervision.
- On Irwell ward we checked some supervision records. On those records we checked, we found that the Band 5 and 6 registered nurses were receiving individual supervision. However, health care assistants who deliver the most 'hands on care' and interaction with patients were not receiving regular supervision.
- All the wards had input from an occupational therapist for group and individual therapy sessions. However, there was a lack of psychology input into the older people's wards.

Multi-disciplinary and inter-agency team work

- We observed two multi-disciplinary team meetings. The team members shared information and their specialist knowledge. All members contributed to the review and planning of each patient's care and treatment. We observed at these meetings that the team worked well together.
- Staff spoke positively about the multidisciplinary team and felt that everyone's contribution was equally valued. They felt listened to and could approach colleagues for advice when needed.
- In older peoples inpatient services the trust has embedded a robust multi-disciplinary team approach to falls management. There were weekly meetings on each of the wards that were attended by the range of disciplines, as required.
- We observed three shift handovers which, on most wards, were effective in sharing information about patients and planning the oncoming shift. The wards used a staff allocation sheet that clearly highlighted individual duties and responsibilities.

Adherence to the MHA and the MHA Code of Practice

- Staff on the wards had a good understanding of the Mental Health Act (MHA) and its Code of Practice (CoP). The documentation we reviewed in detained patients' files was generally compliant with the MHA and the CoP.
- All wards had copies of patients' original detention papers on file. Approved Mental Health Professional reports were all present.
- There was information on all wards, except Irwell, regarding the Independent Mental Health Advocacy (IMHA) service. We saw that Boothroyd ward and Heys Court documented very good evidence of discussions with patients about their rights and followed these up with referrals to IMHAs, when patients did not fully understand their rights.
- We saw that there were good records maintained regarding patients' Section 17 leave. Agreements and assessment around patients' leave were in place and we saw reviews of patients' leave recorded. Staff on Boothroyd ward provided additional support to patients and their carers by providing them with a "what to do if you are concerned when on leave".

Good practice in applying the MCA

- There were valid authorisations in place for most patients to whom the deprivation of liberty safeguards (DoLS) applied. With the exception of Irwell ward where we found that one patient's DoLS had previously lapsed. For the same patient there was no Mental Capacity Act 2005 (MCA) assessment in place in relation to dietary needs, wound care, personal care or medication. This concern was escalated to the trust
- When we interviewed staff, we found they were not all aware that DoLS only authorise an individual's detention in hospital and that the Mental Capacity Act 2005 should be followed regarding decisions relating to care and treatment.
- We found that none of the wards consistently applied the Mental Capacity Act 2005 (MCA) appropriately. We found that the assessments of capacity to consent to treatment were generalised. This was not in line with the MCA Code of Practice, which stated assessments, must be specific to particular decisions.

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.

- We saw that issues around capacity were referred to the doctor for assessment. Patients' capacity assessments covered large general areas of their lives, such as their admission and treatment plan. There was a lack of specific decision capacity assessments such as a patient's capacity to consent to the delivery of personal care and medication.
- When staff made decisions for patients there was generally poor documentation to demonstrate how and why the decision was made in the patients best interests.
- The capacity assessments also reflected a lack of information on which the assessor based their decision. For example, assessments failed to detail the evidence of the patient's impairment or disturbance and why the patient could not retain or weigh up information. The recorded assessments did not detail what assistance the patient had been given enable their capacity.
- We raised these concerns with the trust during our inspection and an alert was sent to all relevant staff. However when we returned on 16 June 2015 we saw that the trust had sent out an alert to all wards highlighting the need to improve mental capacity assessments. We reviewed a mental capacity assessment undertaken on a patient recently admitted onto Irwell ward. We found that there was no improvement in the assessment or recording of decisions.

Requires improvement

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- On Acorn, Boothroyd, Oak and Heys Court there were many examples of positive and appropriate interactions from staff. We saw staff on duty communicated with the patients effectively. They used different ways of enhancing that communication by touch, ensuring they were at eye level with those patients who were seated and altering the tone of their voice appropriately. We observed staff seek patients' consent to interventions when they required support with personal care.
- On Irwell ward many staff interacted positively with patients and we saw a kindness and empathy in their approach. However, the lack of dementia awareness, skill and knowledge was apparent on Irwell ward. Some staff failed to interact or intervene appropriately and did not meet the communication needs of people experiencing dementia.
- During our first visit to Irwell ward we observed the lunchtime routine and escalated concerns about our observations to the trust. This was because we saw that food was not being presented in a way that met the needs of the patients. For example, patients were served hot meals in disposable plastic dishes, with the plastic film lid only partially removed. Staff were putting food in front of people without engaging them or telling them what the meal was. We had been advised by the trust that action had been taken to address our concerns. However when we returned to carry out an unannounced visit, we saw that there had been no improvement. Patients were served food that was unpackaged and poorly presented. Drinks were not freely available and were only provided when patients asked for them.
- We observed some positive and compassionate interactions between patients and staff that showed staff were kind and supportive. For example on Boothroyd ward we saw a patient's birthday being celebrated with a cake and staff reminiscing with patients about their milestone birthdays.
- Patients on the Oak, Boothroyd and Heys Court wards told us they were involved in their care planning. Some had copies of their care plan recorded on a "my file" documentation.
- On the dementia assessment wards the patients were unable to provide verbal feedback about their experience. Therefore, we undertook three short observational framework for inspection (SOFI) on these wards. Two of these were on Irwell ward and one on Acorn ward. The three SOFIs were undertaken at lunchtimes, so we could observe the experiences of the patients having a meal. On both Acorn and Irwell wards the mealtimes appeared busy and task orientated. Patients were often outpaced by staff who were not communicating in a manner that suited the needs of patients. Patients were not provided with sufficient time to help them understand what was on their plate or what their food choices were. There was a particular lack of social interaction for patients who ate independently. This social isolation was further compounded when staff moved from one table to another to record what the person had eaten. We saw that some staff, whilst sitting at the dining table writing up their records often did not take the opportunity to have any interaction with the patient.

The involvement of people in the care they receive

- Patients on Acorn and Irwell wards were not able to tell us about their involvement because of the level of their cognitive impairment. However, we saw that Acorn ward was trialling a human rights based approach to assessing and planning care for older patients with dementia. We spoke to two relatives on Acorn ward who told us staff had involved them in assessing their relative's needs and creating care plans to meet those needs.
- On Irwell ward there little evidence to demonstrate family involvement in the assessment and care planning for patients. One relative stated they had not been informed about whether the patient had been detained under the Mental Health Act or was receiving care and treatment as an informal patient. They said they had not been told of changes the patients physical health. A second relative told us they had no involvement in the assessment or care planning arrangements or for a parent.

Requires improvement

Are services caring?

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

- The trust had in-house and externally provided advocacy services. Advocates visited the wards weekly and routinely introduced themselves to new patients. This meant that patients in need of the service did not have to seek it independently.
- On Irwell ward patients were not involved in planning the care they received. Relatives and families were not involved in assessing or planning how best to provide care for patients, who were unable to express their personal preferences. We spoke to two patients' families whom both reported minimal involvement or information sharing from the ward staff.
- On Acorn ward families said they felt involved in their relatives care and staff kept them informed of any changes. Patients on Oak and Boothroyd told us they were involved in their care arrangements and most knew their named nurse. Patients said nursing staff gave them information about their care and treatment whilst on the ward and we saw this information available in print. Some patients had copies of their care plans and others told us they chose not to hold their own plan.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access, discharge and bed management

- Clarence Ward had the highest level of delayed discharges across the trust. There were 26 delayed discharges in the six months up to February 2015. Clarence ward decanted into Irwell ward in early March 2015. The top three reasons for the delayed discharges were 'Awaiting nursing home placement or availability', 'Waiting Further NHS Non-Acute Care' and 'Public Funding'.

The ward environment optimises recovery, comfort and dignity

- There was a lack of privacy on Irwell ward. There was no film or screening on bedroom windows. Some patients' bedrooms were overlooked by an adjacent ward and there were unobstructed lines of vision into these bedrooms. Patients of either gender walked past other patients' bedroom doors on their journeys around the ward. They could see into each bedroom through the viewing panels, which were locked in an open position.
- The viewing panels could only be controlled by staff from outside the bedroom. We were told that a key was kept in the office. We randomly asked four individual nursing or care staff if they carried a key to close the panels. Three responded that they did not have a key but would be able to find it in the office. A fourth member of staff carried a key, stating this was because they had just "come off night duty". Two patients, who were able to give us verbal feedback, told us the viewing panels on their bedroom doors were never closed.
- On Irwell ward the en-suite bathroom doors closed back against the wall, the door handle was anti ligature in design. This meant that many patients were unable to release the door to close it when going to use the bathroom. One patient described to us how they had been embarrassed by a member of staff walking into their room whilst they were using the bathroom with the door fixed in an open position.
- The trust addressed our concerns about patients being locked out of their rooms after our first visit to Irwell ward. It confirmed that all bedroom doors were to be unlocked so people could access their private space. However, we found that patients were not provided with a key to their room. One patient told us they had to make a complaint to obtain a key, after they had asked for it on several occasions.
- Irwell ward lacked any signage to promote patients' independence and dignity. For example, toilets were not signposted. There was no artwork on the walls, which could include absence of textured objects to distract or engage patients. There was no consistent approach to the use of colour on the ward that would support patients' orientation and independence. We raised this as a concern to the trust and when we returned for our final visit we were informed signage had been ordered for the ward.
- The environment on Acorn ward was in complete contrast to Irwell ward. On Acorn ward patients were supported by good use of colour and signage. Patients had artwork to engage them as they moved around the ward.
- With the exception of Irwell, patients were provided with range of information across the wards for patients on noticeboards. Irwell ward had no patient noticeboards, and the guide to the ward was not presented in an easy read format.
- Mostly patients commented favourably on the quality and portions of the food. Patients were given choice of food, including vegetarian options. On Oak and Boothroyd wards patients could make hot drinks and snacks with any risks managed on an individual basis.
- Weekly activity programmes were advertised on all wards. Staff told us that planned activities were rarely cancelled because of a lack of staff available to run them. Patients were actively encouraged to participate in a wide range of activities. On the wards we visited we saw patients participating in various group and individual activities. There were a range of initiatives that patients could get involved in. Occupational therapy staff were effective in engaging patients across all wards.

Are services responsive to people's needs?

Good

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

- All the wards had communal areas and other quiet rooms which could be utilised as private interview rooms. There was a room for family visiting off the wards, in all areas, which were suitable for children. The wards had access to activities rooms.
- All the wards had equipment in place to help prevent pressure wounds such as pressure relieving mattresses and airflow cushions. Commodes were available for people with mobility or continence difficulties. Staff had access to moving and handling equipment such as hoists and had been trained in their use.

Meeting the needs of all patients who use the service

- Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. There were designated multi-faith prayer areas for the wards to access. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. Translation and interpretation services were available when required.
- The staff respected patients' diversity and human rights. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the wards. Local faith representatives visited people on the ward and could be contacted to request a visit.
- Translation and interpretation services were available when required. Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment. Leaflets explaining patients' rights under the Mental Health Act were available in different languages.

Listening to and learning from concerns and complaints

Total number of complaints in last 12 months

14

Total number complaints upheld

1 partially

Total number complaints referred to Ombudsman in last 12 months

0

Total number complaints upheld by Ombudsman in last 12 months

0

- Patients on the functional wards knew how to raise complaints and concerns. Most patients told us they felt they would be able to raise a concern should they have one and believed that staff would listen to them. With the exception of Irwell ward, information on how to make a complaint was displayed in the wards. Patients were also provided with information on the patient advice and liaison service and independent advocacy services.
- Staff told us they tried to address patients concerns informally as they arose. We observed staff responding appropriately to concerns raised by relatives and carers of patients. Staff were aware of the formal complaints process and knew how to signpost people as needed to PALS. Staff said that learning from complaints was discussed at team meetings and that as a result changes had taken place. Complaints and concerns were taken seriously and responded to in a timely way.
- Most wards provided patients with a forum of community meetings on Oak, Boothroyd and Heys Court to raise issues that affected them. We saw that on Oak ward, at community meetings, patients raised concerns about being administered their medication later than prescribed. We saw that this issue was escalated to the modern matron, who intervened and directed a change in medication round times.

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

Our findings

Vision and values

- The trust's vision and strategies for the service were evident and on display in some wards. Most staff told us that they understood the vision and direction of the trust. Staff were able to tell us about specific initiatives such as the 'staff compact', which was an agreement between staff and the trust to provide high quality care. Ward managers had regular contact with their modern matrons and divisional managers. Staff told us that senior trust managers sometimes came to the wards.

Good governance

- The wards were overseen by managers who led the quality and clinical governance agenda. Nursing staff on the wards had lead responsibilities for carrying out checks on various elements of clinical practice such as medicines management, Mental Health Act adherence, record reviews, environmental and security checks. Identified issues from these had been shared through team meetings and other forums.
- There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance systems were identifying and managing risks to patients using the service. However, the ward manager of Boothroyd ward told us that they did not attend these governance meetings.
- The wards had access to systems that enabled them to monitor and manage the ward and provide information to senior staff in the trust. However given the issues we found on Irwell ward we were not satisfied about the robustness of the monitoring in place. However, all the ward staff we spoke with confirmed there was no mechanism in place for staff to feed into the trust risk register. So it was unclear to staff what specific issues relating to older people's inpatient services were recorded on the risk register.
- A senior manager in the trust informed us that staff had been reporting incidents of patients injuring themselves on the doors on the ward. This had recently been highlighted through the trust surveillance group who monitored incidents on the ward.
- On our third visit to Irwell ward senior manager told us that they had secured funding to address some of the environmental risks on Irwell ward. However, without an environmental risk assessment, it was unclear how the improvements plans were going to be prioritised. The plans described to us appeared piecemeal and reactive. For example during our third visit to the ward contractors arrived and began to remove corridor doors. We were told that there were no plans to engage any specialist dementia advisors in this additional work.

Leadership, morale and staff engagement

- Across all the older people's inpatient services staff reported they felt well supported by their managers and modern matrons. They told us that they could raise issues with their managers and felt listened to.
- All the staff said they felt passionate about the patients and their teams and for the most part that was very evident. However, there was a high turnover of staff in the older people's wards. In the year ending May 2015 staff leaving their posts ranged from 15% on Irwell up to 23% on Oak ward.
- We were concerned about the transient management at Irwell, the manager had been acting up into the role for 8 months, and at the time of our visit had secured another post. The acting ward manager was supported by a modern matron who had only recently taken on the responsibility for the ward. When we returned for our third visit on 16 June 2015 senior staff were still unclear about the line management arrangements external to the ward.
- At the end of our first day of inspection on Irwell ward we raised with the trust our concerns about we had found on Irwell ward. The trust took immediate action to address these. For example, the ward had been cleaned, the cleaning schedule was revised, additional staff were deployed, there was an urgent review of a patient's legal status and patients were provided with access to their rooms during the day.
- When we returned two weeks later on 16 June 2015 we noted further plans in response to our feedback. We

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were told that dementia friendly signage had been ordered for the ward. We were advised a review had taken place of the design of the assisted bathrooms, and the anti-ligature handrails in ensuite bathrooms. The trust had begun to consider how to improve patient safety by addressing the environmental issues that appeared to be contributing to patient accidents.

- Staff on Irwell told us that the issues about the ward environment and its impact on patient safety had been raised with senior managers in the trust since the ward had opened. They told us these issues had not been addressed until we escalated our concerns.
- We saw minutes of three monthly meetings of the local divisional operational management team covering the period prior to the opening of Irwell ward at Clock View Hospital. The agenda items included updates on the progress at Clock view Hospital. We saw that the issue of ligatures had been discussed but there was no reference to the suitability of the environment for people with dementia. We also noted there was no workforce planning to ensure the ward would have the proper skill and knowledge base to safely meet the needs of the patients to be admitted to the ward.

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 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA 2008 (Regulated activities) Regulations 2014** **Dignity and respect** The provider had not ensured that patients were treated dignity and respect. This was because Irwell ward did not comply with the guidance on same sex accommodation. Patients of Irwell ward did not have their privacy promoted. Patients of Irwell ward were not provided with food and drinks in a manner that promoted their independence and dignity. This was in breach of Regulation 10

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 **Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014** **Safe care and treatment** Reg 12 (a) and Reg 12 (b) Reg 12 (c) eg 12 (d)

This section is primarily information for the provider

Requirement notices

The provider had not ensured that care and treatment was provided in a safe way for patients in terms of the risks presented by the environment.

This was because Irwell ward did not have action plans to mitigate against the risk of suicide that the environment may present.

Identified risks were not appropriately addressed in care plans on Irwell ward.

The trust had not ensured that all staff, particulary health care assistants of Irwell ward were appropriately skilled and supervised or supported in their role.

This was because the staff did not receive sufficient support and training to meet the needs of patients with dementia.

This section is primarily information for the provider

Enforcement actions

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.