Requires improvement

Mersey Care NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW438	Mossley Hill Hospital	Acorn Ward	L18 8BU
RW438	Mossley Hill Hospital	Oak Ward	L18 8BU
RW449	Boothroyd Ward	Boothroyd Ward	PR8 6PH
RW435	Heys Court	Heys Court	L19 5NG
RW41E	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 Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Summary of findings

Where applicable, we have reported on each core service provided by Mersey Care NHS Foundation Trust and these are brought together to inform our overall judgement of Mersey Care NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
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

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Summary of findings

Overall summary

We rated wards for older people with mental health problems as requires improvement because:

- The service was not providing safe care and treatment in relation to medicines management. Allergies were not being recorded on medicine cards, which meant there was a risk of a patient being prescribed medicines they were allergic to. On Irwell ward, there was no guidance to staff of how to administer medicines to a patient covertly and medicine administration cards had several administration boxes left blank. We noted delays in treatment starting for up to three days.
- Training was a concern. Training levels for basic life support, immediate life support, Mental Health Act and Mental Capacity Act were low across the wards. Dysphagia training (to assist patients with swallowing difficulties) was not available to staff; this had been identified as being required in an action plan following the death of a patient.
- Staff were not receiving supervision and appraisal in line with trust policy. Staff reported morale as low, particularly following the closure of one of the wards caring for patients with dementia.
- Patient access to a variety of staff from different disciplines varied across the wards, especially in relation to psychology, occupational therapy, speech and language therapy and gerontology(a doctor specialising in old age and ageing).
- Accessible information was not available to patients to assist with orientation to the ward at admission.
- The service provision in some of the wards did not reflect national guidance in relation to the environment and activities available.
- There was no evidence that staff followed legal advice to review a patient's capacity pending the outcome of a Deprivation of Liberty Safeguards Application. Only one of the five wards notified CQC of authorised Deprivation of Liberty Safeguard applications.

However:

- Feedback from patients and carers was positive in relation to the care provided and we observed respectful, responsive and encouraging interactions from staff.
- Incidents and complaints were managed well and learning was shared with staff via team meetings.
- Staff had a good understanding of safeguarding and how to respond if safeguarding concerns were raised.
- Physical health was managed well, with assessments taking place on admission. Frailty reviews took place for all patients, which were multidisciplinary in nature and clear actions set and reviewed. The service provided ongoing physical health care.

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:

- Staff were not managing medicines safely at Irwell ward, Heys Court and Boothroyd ward. Allergies and section status were not recorded on all prescription cards. On Irwell ward, there was no guidance for staff of how to administer medicine covertly for a patient. On the medicine administration cards, we saw several administration boxes left blank. We noted delays in treatment starting for up to three days.
- The fridge temperatures for storage of medication were outside of the recommended range at Boothroyd ward.
- There were gaps in the records to show that staff had cleaned the equipment used for taking observations at Oak ward.
- Training levels for basic life support and immediate life support were low across the wards for older people with mental health problems.
- There were blanket restrictions in place at Heys Court and Boothroyd ward that were not individually risk assessed.

However:

- Each ward had a detailed environmental suicide risk assessment in place.
- All wards complied with guidance on same sex accommodation.
- Staff we spoke with regarding safeguarding were aware of their role in relation to safeguarding and how to respond to a safeguarding concern.
- Incidents were managed well, including the reporting and investigating of these and acting in accordance with the duty of candour requirements.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff were not receiving supervision and appraisal in line with the trust policies.
- Training attendance in Metal Health Act had a 56% average attendance and training in the Mental Capacity Act and Deprivation of Liberty Safeguards had a 57% average attendance.
- When there was a delay in the supervising body's processing of a Deprivation of Liberty Safeguards application, we could not find evidence of regular reviews of the patient's capacity to consent to their hospital admission at Heys Court.

Summary of findings

- Specialist training in dysphagia was not available to staff; this had been highlighted as an action following the death of a patient.
- The environments did not all reflect the recommendations for services caring for people with dementia.
- Psychology provision was not available on all wards we visited.
- Access to occupational therapy, speech and language therapy and gerontology was variable across the wards.

However:

- There were good systems for reviewing patients' physical health, with evidence of physical health examination on admission and then ongoing physical health care.
- Frailty reviews took place on all wards, which were multidisciplinary in approach.
- We saw well documented covert medicine care plans on Acorn ward and a care plan for a patient on monoamine-oxidase inhibitor antidepressant, including contraindicated food, at Boothroyd ward.
- Staff we spoke with had a good understanding of the Mental Health Act and Mental Capacity Act.

Are services caring?

Good

We rated caring as good because:

- We completed four short observations for inspection in communal areas of the wards. We noted that staff were responsive to the needs of patients, encouraging them with their eating, drinking, and facilitating the level of support needed.
- When staff arrived to monitor patients they introduced themselves and explained the reason for their visit in a calm and respectful way, offering reassurance to patients.
- Patients seemed relaxed in the wards and had a good rapport with the staff facilitating the activities.
- All wards had access to advocacy. There were posters on display advertising who the advocate was and how they could be contacted.
- Patients told us that they felt safe and staff were polite and respectful, the food was good and the ward was clean. They also reported the staff assisted them to receive care in relation to physical health needs.
- Carers told us that they felt involved in their loved ones' care; they were invited to meetings to review their care and were informed of any incidents that occurred.

Summary of findings

- Staff reported being interviewed for their jobs by experts by experience and patients being involved in facilitating training.

However:

- The records we reviewed did not show that all patients and/or their family were involved in the care planning process.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Family members were involved in the discharge planning process and multidisciplinary meeting we observed at Acorn ward.
- There was a variety of tactile items including in ward corridors to engage patients with dementia at Acorn and Irwell wards.
- There was a variety of rooms available to patients to pursue activities including outside space, which was well maintained.
- Feedback from patients was that the food was of good quality. We saw pictorial menus in use on Irwell ward to assist patients with decision making.
- Patients could access drinks and snacks throughout the day.
- Cultural beliefs were accommodated on the wards including dietary needs and a sacred space to worship.
- There were notice boards on each of the wards with important information on display. This included details on how to complain, the Patient Advice and Liaison Service and the advocacy contact details.
- Complaints were managed well and learning was shared with staff via team meetings.

However:

- On the day of inspection, activities were not taking place as advertised on the planners and patients were waiting for up to 90 minutes for the activities to start.
- Activities had reduced at Heys Court since the occupational therapist left and there was less of a focus on skill development and daily living tasks.
- There was no working patient phone on Boothroyd ward.
- Information given to patients about the service was not in an accessible format. Also, some information on display was not accessible for patients, including a handwritten menu on Boothroyd ward with small joined up writing.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

Summary of findings

- The governance systems in place did not ensure that staff received the training, supervision and appraisals required for their role.
- The service was not notifying CQC of all authorised Deprivation of Liberty Safeguards. Providers are required to submit notifications to CQC of any authorised Deprivation of Liberty safeguards under The Care Quality Commission (Registration) Regulations 2009. We reviewed our notifications systems and found that this was happening at Acorn ward, however not at all other older people's wards.
- At Heys Court, staff had not submitted the application for another Deprivation of Liberty Safeguard in a timely manner. We saw an example of an application submitted nine days before the previous authorisation expiring which did not allow the supervising body time to complete the necessary assessments.
- Heys Court was not fully implementing legal advice in relation to regularly reviewing a patient's capacity and their ability to consent to their hospital admission, while waiting for a Deprivation of Liberty Safeguards application to be processed.
- Sickness rates were particularly high on two wards. Information from the provider showed that in the 12 months leading up to our inspection the highest sickness rates were Oak Ward 23% and Heys Court 21%.
- Low morale was reported within wards, particularly the impact of Irwell ward closing for a period of time. This had resulted in the transfer of patients to other wards and the impact on the dynamics of the ward and challenge of supporting a patient population with increased observation levels.

However:

- Staff were aware of the trust's values.
- Senior managers were described as supportive.
- Team meetings were taking place and lessons learned were being shared.

Summary of findings

Information about the service

Mersey Care NHS Foundation Trust has five wards for older people with mental health needs.

The five wards were:

- Boothroyd ward, a mixed sex ward with 20 beds for older adults with a functional mental illness. However, at the time of the inspection there were some adults with an organic illness on the ward and some patients were aged between 50 and 60.
- Oak ward, a mixed sex ward with 20 beds for older adults with a functional mental illness.
- Acorn ward, a mixed sex ward with 15 beds for older adults with an organic mental illness.
- Irwell ward, a mixed sex ward with 17 beds for older adults with an organic mental illness.
- Heys court, a mixed sex ward with 16 beds for older adults with a functional mental illness.

Irwell ward, based at Clock View hospital had been used as a pre-discharge ward for adults of working age for several months in 2016 and 2017. The trust had moved the patients with dementia who were previously at Irwell ward to Boothroyd ward and Acorn ward. However, Irwell ward had re opened as a ward for both males and females with dementia in February 2017.

CQC last inspected the wards for older people with mental health needs in June 2015. We rated the core service as requires improvement overall. We rated the safe, effective, caring and well led key questions as requires improvement and the responsive key question as good. We issued two requirement notices for breaches of regulation 10 dignity and respect and regulation 12 safe care and treatment.

At this inspection, we found that Irwell ward was complying with the guidance on same sex accommodation and we completed a short observation for inspection and found that staff provided patients with their food and drinks in a manner that promoted their independence and dignity. The provider has met the requirement notice in relation to regulation 10 dignity and respect.

In relation to regulation 12 safe care and treatment, we found that Irwell ward had a detailed environmental risk assessment in place and individual patient risk assessments. Staff had received mandatory training relevant to their role with 90% attendance and were receiving supervision. The provider has met the requirement notice in relation to regulation 12 safe care and treatment at Irwell ward.

Mental Health Act reviewers had visited all older people's wards since January 2016. These reviews identified a number of themes. On Oak ward, staff overly restricted patients' access to certain items and did not give patients information as to how they could contact CQC. On Acorn ward, staff did not always assess patients' capacity to consent to treatment, or record carer involvement in planning care. At Heys Court, staff did not manage medicines well, did not plan discharge well and did not provide patients with a full programme of activities. We report our findings in relation to these in the detailed findings.

Our inspection team

The team was led by:

Head of Inspection: Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Team Leaders: Lindsay Neil and Sharon Marston, Inspection Managers Care Quality Commission

The sub team that inspected the wards for older people with mental health problems comprised two CQC inspectors, a pharmacist inspector, a specialist advisor who was a nurse with extensive experience of caring for older people with mental health needs and an expert by experience who has had experience of accessing services.

Summary of findings

Why we carried out this inspection

We undertook an announced focused inspection of Mersey Care NHS Foundation Trust because there had been a significant change in the trust's circumstances. The trust had acquired Calderstones NHS Foundation Trust on 1 July 2016.

We also planned this inspection to include high secure services (a new core service) and to assess if the trust had addressed some of the areas where we identified breaches of regulation at our previous inspection in June 2015 (published October 2015).

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all five of the wards at the four hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 20 patients who were using the service
- spoke with 11 carers of patients using the service
- completed four short observations for inspection
- spoke with the managers for each of the wards
- spoke with 19 other staff members including doctors, nurses and support workers
- attended a multidisciplinary meeting
- observed a variety of activities taking place on the wards
- reviewed 23 care records of patients
- carried out a specific check of the medication management on all wards, including reviewing 46 prescription cards and
- 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

We spoke with 20 patients and 11 carers of people being cared for by the service.

Patients told us that they felt safe and staff were polite and respectful, the food was good and the ward was clean. They also reported the ward assisted them to receive care in relation to physical health needs.

Carers told us that they felt involved in their loved one's care; they were invited to meetings to review their care and were informed of any incidents that occurred. They felt their relatives were well cared for by staff.

At Boothroyd ward, a patient felt that there was not enough staff available to assist with having a shower.

Other patients told us that Boothroyd facilities were limited for space, with the majority of patients spending time in the dining area and the lounge could be full on occasion.

Three patients told us that they did not have a care plan and did not know about the future plans for their care.

Two patients on Irwell ward told us that they would like to be able to lock their rooms, as they were concerned about their belongings.

Summary of findings

Patients and carers feedback in relation to Heys Court was that activities had reduced since the occupational therapist left and there was less of a focus on skill development and daily living tasks.

Good practice

Oak ward had access to a gerontologist who provided drop in sessions where staff could ask them to review any patients they were concerned about and staff felt their expertise was helpful.

Frailty reviews took place in all wards, either on a weekly or on a fortnightly basis. These were multidisciplinary meetings with attendees including the ward manager, doctor, nurse, frailty lead and moving and handling lead.

All patients were discussed in the frailty reviews in relation to falls, physical health conditions, infections and delirium, continence, modified early warning system score, weight, diet and fluid intake and dietary needs.

Activities included weekly visits from the Philharmonic Orchestra and a dance and movement organisation.

Several staff were also undertaking a Master's qualification in dementia, which the trust were funding and giving study time for staff.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that medicines are managed safely including the inclusion of allergies on all prescription cards for patients and the creation of covert medicines care planning and instructions to staff at Irwell ward.
- The provider must ensure that there is prompt action taken if the clinic fridge temperatures are not within range.
- The provider must ensure that staff clean all equipment according to policy and records are completed to reflect this has taken place.
- The provider must ensure that staff complete all training necessary to ensure they are able to deliver safe and effective care. Required training includes basic life support, immediate life support, moving and handling of people and dysphagia training.
- The provider must ensure that staff receive supervision and appraisal as per the trust's policy.
- The provider must ensure they submit notifications to CQC of Deprivation of Liberty Safeguards authorisations for patients.

Action the provider SHOULD take to improve

- The provider should review the blanket restrictions in place and ensure they are individually assessed.
- The provider should ensure that they reassess the capacity to consent to admission for patients at Heys Court and review their care plans to ensure the least restrictive practice is in place.
- The provider should review the activities available to patients, and communicate to patients when there are changes to the planned activities.
- The provider should review the arrangements for facilitating community and section 17 leave at Heys Court.
- The provider should review the information that is available to patients and ensure that it is in accessible format for patients.
- The provider should ensure that there is a working patient phone on Boothroyd ward.
- The provider should review the environment of the wards caring for people with dementia to ensure it is appropriate to their needs in accordance with current guidance.

Summary of findings

- The provider should review the disciplines working on each ward to ensure equity of access and provision to patients, including psychology and occupational therapy.
- The provider should consider the creation of a welcome pack or information available to patients and carers on admission to the ward to assist with orientation.
- The provider should ensure that they give the opportunity to the patient or their family to be involved in the care planning process.
- The provider should ensure they offer patients a copy of the care plan and document this within care records.

Mersey Care NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Acorn Ward	Mossley Hill Hospital
Oak Ward	Mossley Hill Hospital
Boothroyd Ward	Boothroyd Ward
Heys Court	Heys Court
Irwell Ward	Clock View Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

ELearning training in the Mental Health Act was part of the mandatory training offered to staff, with 56% average compliance across the wards for older people with mental health needs.

Information regarding the independent mental health advocate was on display in all wards.

Staff we spoke with regarding the Mental Health Act were aware of their role in relation to this including facilitating section 17 leave and ensuring legal paperwork was present and up to date. Staff felt well supported by the Mental Health Act administrators.

In the care records we reviewed, all Mental Health Act documentation was correct. However, we could not access the documentation at Heys Court due to the challenges of accessing the computer system and records.

At Heys Court and Irwell ward, we found that some of the prescription cards did not have the Mental Health Act status section of the card completed.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff completed eLearning training in the Mental Capacity Act and Deprivation of Liberty Safeguards with 57% average compliance across the wards for older people.

Staff we spoke to about Mental Capacity Act and Deprivation of Liberty safeguards had a good understanding of the Mental Capacity Act, however more limited understanding of the Deprivation of Liberty Safeguards.

There were patients where Deprivation of Liberty Safeguards had been authorised in Acorn ward, Boothroyd unit, Irwell ward and Heys Court. Providers are required to submit notifications to CQC of any authorised Deprivation of Liberty Safeguards under The Care Quality Commission (Registration) Regulations 2009. We reviewed our notifications systems and found that Acorn ward had been submitting the notifications however, the other wards had not.

When we reviewed the Deprivation of Liberty Safeguards paperwork at Heys Court, staff were unable to provide assurances of the application status of one patient whose previous authorisation had expired. Ward staff had submitted a further standard authorisation nine days prior to the authorisation ending. This did not allow the supervising body a sufficient amount of time to complete all necessary assessments. We asked the service what safeguards they had in place whilst waiting for the application to be processed and any legal advice sought. Since the inspection, the provider has submitted evidence of the legal advice sought which included that they should review the care plans and capacity to consent to admission while waiting for the supervising body to complete their assessments.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

We toured all wards and clinic rooms. Boothroyd ward and Heys Court were old buildings that were standalone and had several challenges in the environment including uneven floors. All wards were locked and required access via fob or key. There were blind spots on all wards, staff mitigated these by the use of zonal observations. A Mental Health Act reviewer visit at Acorn ward had highlighted that the wardrobes had been secured to the walls using a bolt, padlock and covered chain system, located on either side of the wardrobe. The aim of this was to remove the risk of patients pulling furniture down upon themselves. This posed a ligature risk, however when we visited the ward this had been addressed with alternative fixtures and fittings.

Due to the age and design of the buildings, there were several ligature points in all wards except Irwell ward. A ligature point is anything, which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Each ward had a detailed environmental suicide risk assessment in place, which identified the potential risks to patients and how staff would mitigate these, usually by the use of observations. The risk assessments included a floor plan to assist staff with orientation and identification of the risks.

All wards complied with guidance on same sex accommodation. There were female only lounges. All wards except Irwell ward had female and male corridors with a combination of single rooms and dormitories. Boothroyd ward, Oak ward and Acorn ward had one en-suite bedroom. Heys court had two en-suite bedrooms and Irwell ward had all single en-suite bedrooms.

The clinic rooms were clean and well stocked and included emergency resuscitation bags and emergency medicines, which were in date. Records showed that staff cleaned equipment regularly and were all up to date except on Oak ward. On Oak ward, there was no evidence that the equipment used to complete the medical early warning signs including thermometer and pulse oximeter had been cleaned since 27 February 2017. We raised this with the nursing staff, deputy ward manager and matron who resolved this and felt it was a training need in relation to record keeping. Fridge temperatures were checked daily and were all within range expect at Boothroyd ward. At Boothroyd ward we identified there was six occasions in March 2017 where the fridge temperature was not within range, and exceeded readings of eight degrees. We raised this with the pharmacist who resolved this including the disposal of medicines and ordering of replacements to ensure staff were not administering medicines that were compromised.

All wards were clean and furnished to a high standard. However, at Heys Court there had been problems with the drains, which had an odour, and some of the décor looked tired with scuff marks in parts. We saw staff cleaning the environment in all wards and that they used protective equipment for these tasks. We reviewed cleaning rosters, which were up to date.

Patient led assessments of the care environments (PLACE) are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. In relation to the environment, the 2016 PLACE data looks at cleanliness, condition, appearance and maintenance, dementia friendly and disability. At location level, Boothroyd Ward scored better than average in all four areas whereby a score of 99% was achieved for cleanliness. Clock View scored better than average in three out of four areas with the exception of 'dementia friendly' by five percentage points at 78%. Mossley Hill scored better than average in two areas, with 'cleanliness' scoring similar to the England average at 98% and 'dementia friendly' scoring worse than average by three percentage points at 80%. Heys Court scored lower than average in all areas with the exception of 'disability' (96%).

Staff adhered to infection control principles; there was antibacterial gel at the entrance to the wards. Where this was not available within the wards due to a risk to patients, there was hand gel available in clinic rooms for staff to cleanse their hands prior to and following any clinical intervention. Within the clinic rooms, there were sinks for

handwashing and a variety of personal protective equipment including disposable aprons and a variety of sizes of gloves. We saw staff wearing personal protective equipment when serving food and cleaning after meals.

Staff had personal alarms they used to summon assistance. Boothroyd ward used nurse call systems that were wrist bands that patients wore. This ensured that patients had access to the call button at all times; however, when a patient activated the call system it showed which patient had activated it but not their location. Oak ward had nurse call buttons on the wall or hand held attachments for use from the bed.

Safe staffing

Information provided by the trust showed that as of 07 February 2016 that there were 7.5 whole time equivalent qualified nurse vacancies, which was 14% of the posts. There were 8.2 whole time equivalent nursing assistant vacancies, which was 10% of the posts. Wards for older people with mental health problems also had a staff turnover rate of 13% in the 12 months between 01 January 2016 and 31 December 2016.

Sickness rates were particularly high on two wards. Information from the provider showed that in the 12 months leading up to our inspection the sickness rates were as follows: Oak Ward 23%, Heys Court 20%. Boothroyd Ward also had a sickness rate of 12%.

Staffing levels were calculated by the trust for each ward to include patients on general observations and one enhanced observation. If additional observations were in place or there were sickness and vacancies that needed covering the provider used bank staff and then agency staff if they could not fill shifts with regular bank staff. The ward managers were able to request additional staff via the bank when the needs of the ward warranted this.

Information from the provider showed that bank and agency staff had filled 6119 shifts across all wards in the period from 01 December 2015 and 30 November 2016. During this period, however, there were 2096 shifts not filled by bank or agency staff of which 1991 were nursing assistant absences and 105 nursing absences. This meant that at these times, shifts were not fully staffed, increasing the risk of harm to patients due to their needs not being met. We reviewed the safer staffing reports held on the wards and found the impact of being short staffed included ward managers working in the nursing numbers and supervision sessions being cancelled. This would mean the ward manager was not available to complete the managerial tasks of the ward and staff were not receiving their supervision as planned.

When planning for bank staff to cover the ward, ward managers had localised systems, which showed they tried to use regular bank staff where possible for consistency for patients. We reviewed the bank and agency induction checklist used to orientate staff to the ward and these included the location of emergency equipment, observation levels, summary of each patient and an introduction to them.

We reviewed the rotas for the last three months for each ward and found that the service used the same bank staff who worked several shifts per week on the ward.

We had feedback from carers and staff regarding the activities and availability of staff to facilitate community access for patients at Heys Court. We reviewed the section 17 leave folder and reviewed entries for four patients. We found that patients were authorised for one period of section 17 leave each day. One patient had been out four times in March 2017 with a family member. Another patient had not been out. One patient had been out six times since April 2016. Another patient had been out 15 times since June 2016. Several of the patients had been in Heys Court for several years and needed support to access their community leave; however, this did not seem to be happening. This meant patients were not accessing the community to aid their recovery and rehabilitation.

Mandatory training listed by the trust was conflict resolution, equality, diversity and human rights, fire safety, health and safety, infection control, Mental Health Act, Mental Capacity Act, moving and handling and moving and handling of people, safeguarding adults levels one to three, safeguarding children levels one and two. Mandatory training overall compliance was 86%. Moving and handling of people was low with 42% overall compliance. The trust's policy for "the support of service users who may present with challenging behaviour", dated May 2015 states "2.6.2 All staff who employ physical interventions must receive mandatory Basic Life Support training". We asked the trust for the compliance levels with basic life support and found overall compliance of 68% with attendance levels per ward of:

- Acorn 91%

Requires improvement

Are services safe?

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

- Boothroyd 43%
- Heys Court 55%
- Irwell 78%
- Oak 71%

Qualified nurses attended immediate life support training. All wards except Heys Court accessed this training for qualified staff with low overall levels of compliance of 45% and individual ward compliance of:

- Acorn 40%
- Boothroyd 56%
- Irwell 60%
- Oak 71%

This meant there may not be the staff available with the training to respond in an emergency or to safely complete the observations post rapid tranquillisation.

Assessing and managing risk to patients and staff

The wards for older people did not have seclusion rooms and did not segregate patients.

Between 01 January and 31 December 2016, there were 157 incidents of restraint. Overall, rapid tranquilisation was used with 23 patients.

We reviewed 23 care records of patients and found all 23 had a risk assessment present, 19 of which were up to date. At Irwell ward, a patient had fallen and sustained bruising; following the incident staff had reviewed the risk assessment and falls care plan. We reviewed the incident, which was captured on the electronic incident reporting system, and appropriate medical assistance and review had been provided, family informed and changes in support provided as a result.

The Mental Health Act Code of Practice defines blanket restrictions as "rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application." We found blanket restrictions in place at Boothroyd unit, including no plastic bags allowed and hourly smoke breaks. There was a poster on the front door of Heys Court advising of a list of items not allowed, including no tweezers, plastic bags, nail files, nail polish remover, cameras, computer games and lap tops. Other wards had individual arrangements in place that were specific to patients. We were advised that the topic of prohibited items was discussed at the Local Services Division Reducing Restrictive Practice Monitoring Group; we reviewed the minutes from 16 March 2017 and found that a prohibited items protocol had been created and was due to be discussed in other forums.

When discussing the detention status of patients with staff, several patients at Heys Court were informal. Staff advised although they could leave at will, their mobility and support needs meant they could only leave with carer or staff support or preferred to go out with staff support.

There were low levels of restraint within the service. We observed staff reassuring patients and offering alternatives or distracting patients away from areas or activities causing distress to reduce patients' agitation or distress levels. We could see that restraint was used as a last resort.

Staff attended safeguarding adults levels one to three and safeguarding children levels one to three training. Both safeguarding adults and children levels one to three was refreshed every three years with current compliance at 95%. Staff we spoke with regarding safeguarding were able to explain what constituted a safeguarding concern, how and where to report it including on their electronic incident reporting system and could give examples of current safeguarding investigations for patients on their wards.

We reviewed 46 prescription cards and found medicines were managed safely on most wards, with a pharmacist visiting weekly to complete audits. At Heys Court, two of the prescription cards had no allergies completed and three of the prescription cards did not record the Mental Health Act status of the patient. On Irwell ward, we were concerned about medicines management. On the medicine administration cards we saw several administration boxes left blank. We noted delays in treatment starting at up to three days, with cards marked as drug not available. This included antibiotic and antifungal treatments and an anticoagulant injection. Increasing regimes were planned for weeks in advance when good practice would be for reviews prior to each increased dose. We saw medication signed for which had been crossed off from the card and it was not clear if this had been given or when the prescription had stopped. One prescription card had no allergies completed, meaning there was a risk that the patient may be prescribed a drug they were allergic to. On one card, a medication had been

Requires improvement

Are services safe?

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

marked as not available the previous night but this was in the patient's drawer when checked that morning. One patient had covert medication written on the card, but with no care plan or advice about how to give the medicines they were prescribed covertly.

Facilities were available for children to visit the wards either within the ward or in a room off the ward, these had to be pre booked to ensure availability of space.

Track record on safety

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system and to the Strategic Executive Information System and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the National Reporting and Learning system does not collect information about staff incidents, health and safety incidents or security incidents.

Trusts are required to report serious incidents to Strategic Executive Information System. Between 01 December 2016 and 31 December 2016, wards for older people with mental health problems reported six serious incidents, which required investigation. Two were pending review, two were 'abuse/alleged abuse of adult patient by staff', one 'medication incident meeting serious incident criteria' and one 'accident for example collision/scald (not slip/trip/fall) meeting serious incident criteria'.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew what constituted an incident or an accident and how to report it on the electronic incident reporting system.

We reviewed incidents on Irwell ward and found they had been reported accurately and the appropriate action taken, with changes in practice as a result.

We reviewed team meeting minutes for the last six months for all wards and found they had a standard agenda item of adverse incidents and risks. Incidents that had occurred on the ward and learning from these were discussed and changes in practice noted. The minutes showed debriefs had taken place for staff following serious incidents.

The trust created quality practice alerts, which were emailed to staff summarising learning as a result of incidents. Most wards had these on display in staff areas and staff were encouraged to read and sign to indicate that they had read them.

At Boothroyd ward, we reviewed an action plan following a serious incident in 2016, which the ward manager had shared with the staff team, and the ward manager had started to make progress with achieving the actions set. However, one of the actions outstanding was dysphagia training for staff. This would increase staffs skills and understanding of supporting patients who had swallowing difficulties and may need their fluids thickened and food blended. Although contact had been made with the speech and language therapist in March 2017, who could facilitate the training, the training had not taken place. Lessons had been shared across the wards for older people, as the need for increased observation and knowledge regarding choking was also discussed at Heys Court team meeting in January 2017.

Duty of Candour

Ward managers we spoke with were aware of the duty of candour, the level of incident that would constitute meeting the duty of candour threshold and actions that would need to be taken. We reviewed an incident on Irwell ward that met the duty of candour threshold and found that staff had apologised to the patient and their family and had sought advice from senior managers and referred the incident to external bodies. We also found that the patient safety team had met with the family members to discuss the incident and had followed this up with a written summary of the meeting and an apology. The evidence reviewed showed the service were meeting the duty of candour requirements.

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.

Our findings

Assessment of needs and planning of care

We reviewed 23 care records and in all records, there were care plans in place, 19 of which were up to date. Care plans were not up to date and had not been reviewed in four of the five records reviewed on Oak ward.

We saw evidence of physical health examination on admission and then ongoing physical health care in 22 of the 23 records reviewed, including the modified early warning system of respiratory rate, heart rate, systolic blood pressure, conscious level, temperature and urine output being completed on a weekly basis. Frailty reviews took place in all wards, either on a weekly or on a fortnightly basis, which were multidisciplinary meetings including the ward manager, doctor, nurse, frailty lead and moving and handling lead. All patients were discussed in the frailty reviews in relation to falls, physical health conditions, infections and delirium, continence, modified early warning system score, weight, diet and fluid intake and dietary needs.

There was a variety of care plans in place for patients including mental health, physical health, mobility, section 17 community leave and other individualised topics dependant on patients' needs including diabetes and non compliance with medication. Care plans were holistic and personalised and included the views of carers and family members in 17 of the 23 care records reviewed. Records were on an electronic system, which worked well in all wards except Heys Court where there were operator challenges with accessing the system when we visited.

Best practice in treatment and care

National Institute for Health and Care Excellence: Dementia: supporting people with dementia and their carers in health and social care Clinical guideline [CG42] Published date: November 2006 Last updated: September 2016 advises that admission to inpatient services should be for people whose behaviour causes a challenge to others or they require assessment. Patients we saw and records reviewed showed they were appropriate admissions according to the guidance.

A range of tailored interventions for patients is suggested in the guidance. The only one that we found evidence of being delivered on the wards was exercise; a number of gentle exercise and seated exercise activities were taking place.

Psychologists were not employed on all older people's wards. There was one clinical psychologist at Boothroyd ward and one about to commence work on Irwell ward. Clinical guidance CG42 suggests for people with dementia who have depression and/or anxiety, cognitive behavioural therapy should be offered to patients. At the time of inspection, the trust was not able to provide cognitive behaviour therapy for patients due to the limited psychology provision.

The National Institute for Health and Care Excellence: Dementia: independence and wellbeing Quality standard [QS30] Published date: April 2013 recommends that consideration is given to the environment for people with dementia including lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment. We found Acorn ward, Oak ward and Irwell ward had good signage, floor coverings and colour schemes to best meet the needs of people with dementia. However, Boothroyd ward and Heys Court, did not. Both of these wards also cared for some patients with dementia.

Oak ward had access to a gerontologist who provided drop in sessions where staff could ask them to review any patients they were concerned about and staff felt their expertise was helpful.

Although we had concerns about the covert medicine care planning on Irwell ward, we saw well documented covert medicine care plans on Acorn ward. We also saw on Boothroyd ward a comprehensive care plan for a patient on an antidepressant that has adverse reactions to several foodstuffs. We saw that the staff supporting with the meal times were aware of the care plan.

Wards for older people with mental health problems had taken part in four clinical audits in the last 12 months, including a malnutrition universal screening tool audit, falls audit, Do Not Attempt Cardiopulmonary Resuscitation audit and a triangle of care audit.

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Requires improvement

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There were two items on the trust risk register relating to best practice in treatment and care. These included the patient misuse of substances within inpatients and gaps in prescription cards within the local division.

Skilled staff to deliver care

We saw nurses, doctors and support workers providing day to day care for patients. Staff from all wards could access the moving and handling coordinator. Pharmacists visited the wards weekly. Social workers contributed to the multidisciplinary meetings and future plans for patients.

Boothroyd ward had part time physiotherapy input and there was a vacancy for a full time physiotherapist and occupational therapist, which was being recruited to. A psychologist had just joined the team. Speech and language therapy provision was difficult to access as there was part time provision across the inpatient services. This affected the availability of training in dysphagia.

Oak ward, Acorn ward and Irwell ward had an occupational therapist, physiotherapist, and access to a dietician and speech and language therapist as part of the team. Oak ward also had access to a gerontologist. Irwell ward had a physical health lead and a psychologist was about to join the team.

Heys Court had a physiotherapist and access to a dietician and speech and language therapist. However, they did not have a psychologist or an occupational therapist. Feedback from patients and carers was that activities had reduced since the occupational therapist and activities worker had left the team.

Staff received eLearning training in dementia awareness with an average compliance of 70% across the wards. The lowest compliance was at Heys Court with 35%.

We were concerned that staff had not received training in dysphagia and how best to support patients with swallowing difficulties despite a number of the patients we observed requiring thickened drinks and liquidised food. There had been a serious incident where a patient had died at Boothroyd ward and one of the actions from the learning was that the trust should provide dysphagia training. In early March 2017, the ward manager had tried to arrange this with the speech and language therapist, however this was still in progress at the time of the inspection as the speech and language therapy had a limited resource. The trust has a "policy on the management of dysphagia" dated June 2014 which advises that "Different levels of training are offered for professionals, care staff, families and other agencies."

Staff received an induction to the ward including shadowing more experienced members of staff. There was also a bank and agency induction checklist used to orientate bank and agency staff to the ward and these included the location of emergency equipment, observation levels, summary of each patient and an introduction to them.

At the last inspection in June 2015, we were concerned about the level of training and supervision staff received particularly on Irwell ward. We reviewed the training figures and found all mandatory training courses to be at 100% compliance for Irwell ward, except basic life support, which was 78%, and immediate life support at 60%.

In terms of clinical supervision rates for non-medical staff, the trust was under performing in all five wards against the trust target of 90%. The average clinical supervision rate across all wards was 64% and wards with the lowest rates were Acorn ward and Heys Court at 40% and 45% respectively. The highest supervision rate was seen at Oak ward at 85%. This was followed by Irwell ward, which had a compliance rate of 83%.

The trusts "Clinical/Managerial supervision and reflective practice" policy dated March 2017 states that "all staff must have an individual supervision session with their line manager at least six times a year." We found in records reviewed that staff were not receiving supervision as the policy stated. We reviewed 12 records on site at three of the wards as Oak ward and Heys Court could not access the records. We found that from November 2016 staff had been receiving supervision every two to four months, prior to this there had been gaps for up to a year. In 2016 staff received between one and nine individual supervision sessions, with the most common frequency of two sessions per year.

Not all permanent non-medical staff received regular appraisal. Information provided by the trust showed that all five wards failed to achieve the trust's target of 95%. As at 26 January 2017, the overall appraisal rates for non-medical staff within wards for older people with mental health problems was low at 68%. The ward with the highest average appraisal rate was Irwell Ward with 88%, followed by Boothroyd Ward with 86%. The ward with the lowest

Are services effective?

Requires improvement

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appraisal rate was Oak Ward with only a third of permanent non-medical staff requiring an appraisal having received one (33%). Heys Court also recorded particularly low appraisal rates at 38%.The trust noted that the annual appraisal window is April to June and that clinical divisions have been given extended windows for completion for the last three years given that there were seven clinical areas where staff appraisal rates were lower than 75%. A review of the appraisal system, identification of barriers to performance and training for reviewers were some of the additional measures that the trust was taking to improve clinical appraisal rates.

Multi-disciplinary and inter-agency team work

Each ward had regular multidisciplinary meetings to review the progress of each patient. There was a different number of consultants for each ward as the model adopted by the trust was that the consultant overseeing the patient in the community would also oversee their care and treatment whilst an inpatient. This meant there could be up to nine consultants with patients on the ward. Although this provided continuity for patients, it meant that ward staff were required to coordinate up to nine wards rounds each week.

We observed a multidisciplinary review for a patient on Acorn ward. Family and professionals attended the meeting, the meeting was chaired by the consultant and we found the meeting to be patient centred and that all staff knew the needs of the patient well. The meeting was flexible and enabled family to have enough time and a break in the meeting to discuss as a family unit the proposals made. Staff interactions were polite and respectful.

Frailty reviews took place in all wards, either on a weekly or on a fortnightly basis. These were multidisciplinary meetings with attendees including the ward manager, doctor, nurse, frailty lead and moving and handling lead. All patients were discussed in the frailty reviews in relation to falls, physical health conditions, infections and delirium, continence, modified early warning system score, weight, diet and fluid intake and dietary needs.

Handovers took place at the start of each shift. Updates were provided to the community teams for patients. The consultants worked in both the community and inpatient teams and were mostly based at the hospitals, which meant they were accessible and this promoted consistency for patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

ELearning training in the Mental Health Act was offered to staff, with 56% average compliance across the wards for older people with mental health needs. The highest attendance was at Irwell ward with 100% compliance and the lowest at Boothroyd ward with 27%.

Staff we spoke with regarding the Mental Health Act were aware of their role in relation to this including facilitating section 17 leave and ensuring legal paperwork was present and up to date. Staff felt well supported by the Mental Health Act administrators.

The trust had polices relating to the Mental Health Act including: Leave for an informal inpatient and Equality & Human Rights Analysis, Seclusion and Section 117 - Aftercare under the Mental Health Act 1983 and a Mental Health Act 1983 Overarching Policy. The policies were available to staff on the trust intranet system and the public on the website. However the policies referred to the Mental Health Act Code of Practice 2008 and not the reviewed version, published 2015. Therefore, staff were not following the most recent guidance.

Information regarding the independent mental health advocate was on display in all wards. Staff were aware of the advocacy provision available to patients.

Mental Health Act reviewer visits had taken place for all older people's wards since January 2016. Themes from the reviews included overly restricting items and a lack of information for patients as to how they could contact CQC on Oak ward. Lack of assessments of capacity to consent to treatment, care plans not recording carer involvement and wardrobes bolted to the wall were issues raised on Acorn ward. Medicines management, discharge planning and lack of activities were raised at Heys Court. When we visited Oak ward they were aware of the actions following the most recent reviewer visit. They advised following the visit there had been agreement to remove the poster prohibiting items on the ward, which was replaced, by a poster to include restricted items that needed to be individually assessed, however this practice had not been shared with all wards, especially Boothroyd ward and Heys Court.

Are services effective?

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In the care records we reviewed, all Mental Health Act documentation was correct including staff explaining section 132 patients' rights. However, we could not access the documentation at Heys Court due to the challenges of staff being able to access the system and records.

At Heys Court and Irwell ward, we found that some of the prescription cards did not have the Mental Health Act status completed on the prescription cards. At Irwell ward there was a prescription card with a s62 form (Section 62 of the Mental Health Act allows for the emergency treatment of a detained patient, providing it is necessary to save life or prevent serious harm) still attached, which had been superseded by a T3 form. (A T3 form is a certificate of second opinion. It is a form completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.) We highlighted this to the nursing staff who removed the form.

Good practice in applying the Mental Capacity Act

Staff completed eLearning training in the Mental Capacity Act and Deprivation of Liberty Safeguards with 57% average compliance across the wards for older people. The highest compliance was at Irwell ward with 100% compliance and the lowest at Boothroyd ward with 27%.

The trust had a "Overarching Policy and Procedure of the Mental Capacity Act (MCA) 2005" dated January 2017 which referenced the Mental Health Act Code of Practice 2015. The "Management of the Deprivation of Liberty Safeguards (DoLS) within the meaning of the Mental Capacity Act 2005" policy, dated April 2014, reviewed February 2017, referred to the revised Mental health Act Code of Practice from 2015. Both policies were available on the trust website.

Staff we spoke to about Mental Capacity Act and Deprivation of Liberty Safeguards had a good understanding of the Mental Capacity Act. We observed conversations on Boothroyd ward where staff understood the difference between a Deprivation of Liberty Safeguards authorisation and a section under the Mental Health Act. Within the multidisciplinary review, we observed on Acorn ward, staff had a good knowledge of the Mental Capacity Act and making decisions in the patient's best interest and the patient's family were involved in the process. However, we found staff had more of a limited understanding of the Deprivation of Liberty safeguards in other settings, particularly at Heys Court.

When reviewing the Deprivation of Liberty Safeguards paperwork at Heys Court staff were unable to provide assurances of the application status of one patient. Their previous authorisation had expired and the ward had submitted a further standard authorisation nine days prior to the authorisation ending. This did not allow the supervising body a significant amount of time to complete all necessary assessments. Since the inspection, the provider has submitted evidence of the legal advice sought which included the review of care plans and capacity to consent to admission whilst waiting for the supervising body to complete their assessments. We reviewed data submitted by the trust following the inspection and found that the week after the Deprivation of Liberty Safeguards ended the consultant had recorded that they were waiting for a Deprivation of Liberty Safeguards review. The care plan had been reviewed six times since November 2016, however there was no evidence noted that the patient's capacity to consent to admission had been assessed or reviewed since November 2016. This meant that the provider was not reviewing capacity regularly and adhering to the requirements of the Mental Capacity Act.

The trust provided information around the number of Deprivation of Liberty Safeguards applications they have made between 01 January 2016 and 31 December 2016, which stood at 54. Acorn Ward (28) and Boothroyd Ward (21) made the most applications. The trust reported that of the 54 Deprivation of Liberty Safeguards applications made in the 12 month period, 26 were approved of which 18 were from Acorn Ward. There were patients where Deprivation of Liberty safeguards had been authorised in Acorn ward, Boothroyd unit, Irwell ward and Heys Court. Providers are required to submit notifications to CQC of any authorised Deprivation of Liberty safeguards under The Care Quality Commission (Registration) Regulations 2009. Acorn ward had been submitting the notifications, however, the other wards had not.

We reviewed 23 care records and found evidence in 21 of the records of capacity assessment, specifically in relation to consent to treatment. One patient had not had this completed at Oak ward. A patient at Heys Court had been assessed in 2016 as not having the capacity to consent to their admission and treatment however, at the time of inspection in March 2017, they were informal, with no evidence we could find that their capacity had been reviewed.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We completed four short observations for inspection in communal areas of the ward. A short observation for inspection is used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves. We noted that staff were responsive to the needs of patients, encouraging them with their eating and drinking and facilitating the level of support needed to eat their meals, for example opening sachets for condiments. Staff engaged patients in meaningful conversation, related to their interests and past experiences and were respectful of patients and understood the reason for behaviours presented. When staff arrived to monitor patients they introduced themselves and explained the reason for their visit in a calm and respectful way, offering reassurance to patients.

We also observed two meal times and five group activities, which included board games, a quiz and exercises. At Boothroyd unit, we saw that the menu was handwritten in small joined up writing which could make it difficult for some patients to read. Patients seemed relaxed in the wards and had a good rapport with the staff facilitating the activities.

Patients told us that they felt safe. They told us staff were polite and respectful, the food was good and the wards were clean. They also reported the staff on the ward assisted them to receive care in relation to physical health needs.

Carers told us that they felt involved in their loved one's care; they were invited to meetings to review their care and were informed of any incidents that occurred. They felt their relatives were well cared for by staff.

Patient led assessment of the care environment (PLACE) assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In relation to privacy, dignity and wellbeing, from the 2016 PLACE data, all wards achieved a score, which was higher than the England average at 91% or above. Boothroyd Ward scored highest of the four wards at 98%.

The involvement of people in the care that they receive

We viewed the information booklet for carers and relatives on Irwell ward which advised of visiting times, information about personal belongings, section status, ward rounds, discharge planning, how to give feedback and contact details for other organisations. In other wards, staff used the standard trust welcome to the ward booklet and letter with details of the advocacy service, discharge planning, patient experience and details of other organisations. These documents did not contain any pictures relevant to the ward, therefore it may be difficult for some patients to process the information.

We reviewed 23 care records and found 16 of the records involved the patient and/or their family in the care planning process. Eleven patients had been given a copy of their care plan. One patient had declined a copy of their care plan. Three patients told us that they did not have a care plan and did not know about the future plans for their care.

All wards had access to advocacy. There were posters on display advertising who the advocate was and how they could be accessed. Patient Advice and Liaison Services also visited the wards to assist with facilitating patients' meetings and receive feedback about the service.

Ward managers welcomed feedback from families about the ward. Formal carers meetings had taken place in the past however attendance was poor. Managers told us that informal feedback and asking family and carers for their views when they visited their loved ones seemed to be more effective. Family members were actively involved in the multidisciplinary meeting we observed and their views and opinions were listened to and taken into consideration by the consultant and wider staff team.

Patient meetings took place at Heys Court, facilitated by Patient Advice and Liaison Services. We reviewed the minutes of the meetings and found they discussed concerns about a lack of activities and not having an activity worker. Oak ward held weekly community meetings for patients to seek feedback on topics including activities and food. The trust carried out a monthly trust wide patient experience survey, which includes questions relating to involvement in their treatment and care. Oak ward used an electronic device to complete the questionnaire and if patients were able to they completed the feedback

Good

Are services caring?

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independently. The survey was reported through governance processes and was based on the National Institute for Health and Care Excellence standard for adult mental health.

Staff reported being interviewed for their posts by experts by experience and also patients being involved in facilitating training, however this was a pool of patients and experts that facilitated this and they were not current patients on the wards when we visited.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Over a 12 month period, between 01 January 2016 and 31 December 2016, all wards had an occupancy rate of 75% or above. Oak Ward had the highest bed occupancy rate at 94% compared to the service average of 88%. Boothroyd Ward had the shortest average length of stay of discharged patients on wards for older people with mental health problems with 60 days. Acorn Ward had the longest average length of stay for discharged patients at 125 compared to a service average of 74 days.

Two fully upheld complaints made in relation to Irwell Ward regarded access and discharge. The outcome of an investigation into one of the complaints found that discharge arrangements had not been clearly explained and nor was it clear if a carers assessment had been offered. A relative unhappy that a service user had been transferred to another hospital made the other complaint. Two complaints, one of which was still ongoing, regarded delays in admission due to bed availability at the Boothroyd Unit and also Mossley Hill Hospital. Both complaints were made in December 2016.

There were no out of area placements between 01 January 2016 and 31 December 2016 and only one readmission within 28 days at Oak Ward. The trust provided information in relation to any ward moves that patients made since being admitted and the greatest number of ward moves during the last 12 months were made at Boothroyd ward with 30 patients making between one and three ward moves. The trust highlighted that no patients had moved wards after 10pm in the same reporting period.

During the same period, there were 301 discharges and a total of 133 patients were delayed discharges, which accounted for 44% of all discharges. Boothroyd ward had the highest number of delayed discharges for this core service at 42 and Irwell ward had the highest proportion of delayed discharges at 40, which accounted for 98% of total discharges from this ward.

When Irwell ward changed its function to a pre discharge ward for adults of working age, the older patients were moved to the other older people's wards. Staff on the other wards told us that the increase in patients, including having several admitted on the same day, with an organic illness presented challenges in relation to orientating them to the ward, managing observations of patients and providing more intensive support in relation to personal care. Although the wards were for older people with mental health needs we found adults of working age had been admitted, especially on Boothroyd ward. Staff also highlighted difficulties in planning activities that were appropriate and accessible to both patient populations. Irwell ward reopened as a ward for patients with dementia in February 2017 and we found that five patients were admitted on one day and three the following day, which would have presented the same challenges, when assisting with orientation and settling into the ward.

We found evidence of discharge planning and the involvement of family in the process at the multidisciplinary meeting we observed at Acorn ward.

The facilities promote recovery, comfort, dignity and confidentiality

Each of the wards had a variety of rooms available for patients' use, which included dining rooms, lounges and activity rooms. Acorn ward had rummage baskets available for patient use with a variety of tactile objects in including knitted items with buttons on, which were all age appropriate. Both Acorn and Irwell wards had interactive tactile boards in the walls in the corridors to engage patients. However, at Boothroyd and Oak wards the dining rooms had 18 chairs. Both wards accommodated 20 patients so they could not all sit down to eat at once. At Boothroyd ward, the main communal area was the dining room. Visitors spent time with their family members in this area too and we observed that it was cramped on occasion.

Lounges were used on most wards to facilitate visitors. Arrangements could be made for children to visit but this needed to be arranged in advance to ensure there was a designated room available.

Patient phones were available on all wards however, the phone at Boothroyd ward was broken and patients used the ward mobile phone.

All wards had access to outside space, which was well maintained; patients who smoked used the outside space for this.

Feedback from patients was that the food was of good quality, we saw pictorial menus in use on Irwell ward to

Are services responsive to people's needs?

Good

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

assist patients with decision making and we saw patients choosing their meal from a trolley, therefore they could make informed decisions about meal options as they could see what they were choosing.

Patient led assessments of the care environment are self-assessments undertaken by teams of NHS and private/ independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. In 2016, two out of four wards were rated worse than the England average with Heys Court scoring lowest at 88%. Clock View was the only ward to better the England average for food at 96%. The England average score was 92%. All wards saw improvements in their scores since 2015 results in line with an increase of the overall England average.

At Heys Court and Boothroyd ward, snacks were available for patients in the communal areas and included fruit, biscuits, crisps and crackers. Patients could access drinks freely.

At Oak ward, there was a hot drinks trolley for patients to make their own drinks and cold drinks were available in the dining room.

At Irwell and Acorn ward staff made drinks for patients regularly and staff were aware of patient preferences. Snacks including fruit and biscuits were available and we saw staff offering these to patients and assisting and encouraging them to eat where needed.

Patients were able to personalise their bedrooms and bring items in from home, carers we spoke to also confirmed this. Bedrooms that patients showed us had photographs and other personal items in their rooms.

We saw that Heys Court had wall-mounted safes for patients to keep their valuables.

We reviewed activity planners that were on the wards. Activities included weekly visits from the Philharmonic Orchestra and a dance and movement organisation. Feedback from patients was that they enjoyed the sessions. We found that activities on the planner did not always go ahead as advertised. At Heys Court on the day of our visit the afternoon activity should have been arts and crafts, however the activity provided was board games. The game chosen was one that only two people could play, excluding other patients.

During the inspection, we observed five group activities, which included board games, a quiz and exercises. However, we noted that patients were waiting for a significant amount of time prior to the activities starting on Oak and Acorn ward and Heys Court. At Oak ward, patients waited 60 minutes for a quiz to start without any explanation from staff. Patients waited 90 minutes for games to start at Acorn ward although a member of staff did advise they were delayed starting. At Heys Court the activity was a different activity than advertised which started 85 minutes after the proposed time, with no explanation from staff.

The gentle exercise and dance at Irwell ward was well received and the activities were tailored to the ability of the patients, for example seated exercises. Patients seemed relaxed in the wards and had a good rapport with the staff facilitating the activities.

Feedback in relation to Heys Court was that activities had reduced since the occupational therapist left. This meant there was less of a focus on skill development and daily living tasks.

Meeting the needs of all people who use the service

The Equality Act 2010 includes nine protected characteristics of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. Services must have regard for, make reasonable adjustments and ensure discrimination does not occur on these grounds.

We were given examples of how on Boothroyd ward family members assisted the patient to wash in line with the patient's cultural beliefs. Staff also ensured that the patient did not eat in the communal dining room and family brought food in for them, which the ward facilitated.

The catering department could accommodate patient's specific dietary needs including halal and kosher meals. Acorn and Oak ward shared a sacred space, which patients could use to pray and practice their faith. A chaplain visited the wards.

Are services responsive to people's needs?

Good

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

Staff on Oak ward gave an example of accessing documents in a patient's specific language that they could read during their admission.

All wards were on one level. For standalone services, there was ramped access to the building for people with mobility difficulties. Mobile hoists were available on the wards for patients that required assistance with moving and handling. We saw patients using aids and adaptations to mobilise including frames and walking aids.

Information on display was in written form and we saw hand written menus on Boothroyd ward, which may be difficult for some people to read. Leaflets available to patients and carers regarding the wards were in written English and the font was quite small. Large font or condensed versions would be helpful for some people to assist with their understanding.

There were notice boards on each of the wards with important information on display. This included details on how to complain, the Patient Advice and Liaison Service and the advocacy contact details. There were leaflets about the advocacy service, helplines, and how to complain, different treatments and medications that patients could take and read in their own time.

Listening to and learning from concerns and complaints

In the 12 month period from 01 January 2016 to 31 December 2016, the wards for older people received 16 complaints, which is an additional six compared to the number reported at the previous inspection carried out in 2015. Five complaints were upheld and none were referred to the ombudsman. Reasons for complaints varied, but of those upheld, three related to the care and treatment of service users and two were regarding access to services or transfers.

Of the 20 patients we spoke with, nine knew how to complain. Seven of the 11 carers we spoke to knew how to complain and advised information was available on the wards.

Staff we spoke with were aware of the complaints procedure, which included capturing details on the electronic recording system and managers being involved in investigating complaints.

Complaints and compliments were standard agenda items at team meetings and learning from these was shared with staff in these forums.

The service received five compliments in the same period of which four regarded Boothroyd Ward and one Oak Ward. The trust noted that this reflected only formal letters received by the trust and excluded cards received at ward and team levels.

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.

Our findings

Vision and values

The trusts vision is "to be recognised as the leading organisation in the provision of mental health care, addiction services and learning disability care."

The trust has four values which are:

- Continuous improvement
- Accountability
- Respect
- Enthusiasm

Staff we spoke with regarding the vision and values were able to tell us what the values were.

Staff told us that their matrons visited the ward and they felt supported by them. There were notice boards on display in each ward with photographs of senior members of staff including the chief executive and the chairperson. Following concerns raised at the last inspection, staff on Irwell ward reported the trust investing time and resources into improvements within the ward.

Good governance

Feedback from staff and training attendance records showed that it had been difficult to release staff to attend training, although the overall average compliance at mandatory training was 86%. Moving and handling of people was low with 42% overall compliance and basic life support overall compliance of 68% .

Supervision and appraisal did not take place as per trust policy. The average clinical supervision rate across all wards was 64% and wards with the lowest rates were Acorn Ward and Heys Court at 40% and 45% respectively. As at 26 January 2017, the overall appraisal rates for non-medical staff low at 68%. The trust target was 95%.

Managers were aware of their teams training compliance rates, however reported challenges with the electronic system. Managers had created localised systems to store the information regarding their ward including supervision and training. Managers did not have access to a system to oversee their usage of bank and agency staff.

We found team meetings took place in all wards and a regular agenda item of sharing learning from incidents was discussed. The trust also distributed quality practice alerts to shares learning with staff across the whole organisation with the aim of improving practice and care delivered.

The service was not notifying CQC of all authorised Deprivation of Liberty Safeguards. Providers are required to submit notifications to CQC of any authorised Deprivation of Liberty Safeguards under The Care Quality Commission (Registration) Regulations 2009. We reviewed our notifications systems and found that this was happening at Acorn ward, however not at all other older people's wards. There did not seem to be the oversight in place across all wards for older people to ensure this was happening; it was dependent on the knowledge and localised management of individual wards.

The service, particularly at Heys Court, were not fully implementing the guidance issued by their solicitors in relation to regularly reviewing a patient's capacity and their ability to consent to their hospital admission, while waiting for a Deprivation of Liberty Safeguards application to be processed.

Ward managers told us of a variety of key performance indicators that they were measured against. This included the completion of malnutrition universal screening tool for all patients, smoking and the cessation of this, admission documentation including the completion of physical health observations within patients first 72 hours of admission, physical and capacity assessments at admission and completion of supervision with staff. These were managed by an online portal, which showed ward managers their levels of compliance and areas they needed to improve.

Ward managers were assisted by ward clerks. They took the lead in the administrative tasks for the ward and supported the ward managers.

Ward managers were able to escalate concerns and potential risks to their matrons who were then able to add items to the risk register. An identified concern of the inspection team, in relation to Immediate life support, was on the risk register. The risk was identified 6 July 2015 and relates to the 'Lack of staff trained in Immediate Life Support. There is a risk that service users will not receive timely care for cardiac or respiratory arrest due to staff not receiving appropriate training'.

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.

Staff's understanding of the Mental Capacity Act was also included on the risk register. Staff completed eLearning training in the Mental Capacity Act and Deprivation of Liberty Safeguards with 57% average compliance across the wards for older people. Staff we spoke with about Mental Capacity Act and Deprivation of Liberty Safeguards had a good understanding of the Mental Capacity Act, however more limited understanding of the Deprivation of Liberty Safeguards.

The trust identified two risks on their board assurance framework relating to wards for older people with mental health problems and inpatient wards more generally, including delays in access to beds and a risk that the trust would be unable to provide staffing on wards. In addition, the trust also highlighted one item on the risk register specific to this core service relating to the inadequate wound care provision on Boothroyd ward.

Leadership, morale and staff engagement

From the 2015 trust wide staff survey results, the trust reported an improvement in overall staff engagement, staff motivation and staff recommending the trust as a place to work and receive treatment. Areas for improvement for the trust as a whole included staff feeling that there were equal opportunities for progression and that they were able to influence decisions and make improvements to their role. In addition, the quality of staff appraisals also required review and improvement.

Information provided by the trust showed that as of 07 February 2017 that there were 7.5 whole time equivalent qualified nurse vacancies, which was 14% of the qualified nurses. There were 8.2 whole time equivalent vacancies, which was 10% of the nursing assistants. Wards for older people with mental health problems also had a staff turnover rate of 13% in the 12 months between 1 January 2016 and 31 December 2016. The service were actively recruiting and ward managers told us that several staff were going through recruitment checks and due to start in post soon.

Sickness rates were particularly high on two wards. Information from the provider showed that in the 12 months leading up to our inspection the highest sickness rates were Oak Ward 23%, Heys Court 21% and Boothroyd Ward 12%. Ward managers knew the reasons of staff sickness, these included work related issues and incidents.

Staff who had had long periods of sickness reported the trust were supportive. They had had a review of their role and requirements and had reasonable adjustments made and were supported on a phased return to work.

There were no bullying and harassment cases. Staff told us they felt able to discuss concerns with their managers.

Low morale was reported within the service, particularly the impact of Irwell ward closing for a period of time. Factors included the transfer of patients to other wards and the impact on the dynamics of the ward and challenge of supporting a patient population with increased observation levels. Staff and carers told us that activities had reduced at Heys Court and patients did not go out very often. This was a particular concern as patients were at Heys Court for long admissions and for a number of patients they had been there for several years. Impact of staff sickness and suspension meant staff worked more shifts or there was an increase in bank and agency staff usage. However, staff did report that the teams were supportive of each other and did work extra shifts to provide cover.

Ward managers were offered leadership training opportunities, this included prior to becoming ward managers when they were team members. Managers reported the leadership training called "DRiVE, THRiVE and STRiVE" was instrumental in their career development.

Ward managers we spoke with were aware of the duty of candour and the level of incident that would constitute meeting the duty of candour threshold and actions that would need to be taken. We reviewed an incident on Irwell ward that met the duty of candour threshold and found that the service were meeting the duty of candour requirements.

Commitment to quality improvement and innovation

Two of the five wards had registered with the Accreditation for Inpatient Mental Health Service (AIMS), which is a quality improvement programme led by the Royal College of Psychiatrists. We were shown the final report for Oak ward from October 2014. Both Acorn and Oak wards had been assessed by the Accreditation for Inpatient Mental Health Service in December 2016 and their reports were in draft form. The accreditation lasts for three years. The other three wards were considering applying for accreditation.

Are services well-led?

Requires improvement

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The wards had student nurses on placement and reported this as a good experience, as it was helpful to have people with current knowledge on the ward that could highlight areas they were doing well and possible areas for development.

Acorn ward had participated in a trial of innovative lighting, which simulates daylight to assist orientation and improve the experience of a hospital admission for people with dementia.

Several staff were also undertaking a Master's qualification in dementia, which the trust were funding and giving study time for staff.

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 Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not being managed safely. Staff had not given or recorded accurately the administration of medicines on medicine cards at Irwell ward and there was no guidance in place for staff of how to give medicines covertly, including in a care plan. Not all medicine cards included allergies of patients at Heys Court and Irwell ward. Fridge temperatures were out of range for the medicine fridge at Boothroyd ward, meaning the integrity of medicines in the fridge could be compromised. The physical observation monitoring equipment had not been recorded as being cleaned at Oak ward. This meant the provider was not providing safe care and treatment. This was a breach of Regulation 12(2)(g)

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 (RA) Regulations 2014 Staffing Staff had not received training in dysphagia. There was a death of a patient and learning from that was for staff to have dysphagia training; a number of patients we observed had thickened drinks and liquidised food. This meant staff may not have had the knowledge and skills to support patients effectively. Training levels of basic life support was 68% and moving and handling of people was 42% and for immediate life support 45% across the older people's wards. This meant there may not be sufficiently skilled staff able to respond in an emergency.

This section is primarily information for the provider

Requirement notices

The average clinical supervision rate across all wards was 64%. We reviewed managerial supervision records on site and found that staff were not receiving supervision as per trust policy.

The overall appraisal rates for non-medical staff within wards for older people with mental health problems was low at 68%.

This meant staff were not receiving the training and support required for their role.

This was a breach of Regulation 18(1)(2)(a)

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 CQC (Registration) Regulations 2009 Notification of other incidents

There were patients where Deprivation of Liberty Safeguards had been authorised in Acorn ward, Boothroyd unit, Irwell ward and Heys Court. The provider was not submitting the notifications to CQC as required. We reviewed our notifications systems and found that Acorn ward had been submitting the notifications, however, the other wards had not.

This meant the provider was not informing CQC of patients who were deprived of their liberty under the Deprivation of Liberty Safeguards.

This was a breach of Regulation 18(1)(2)(c)