Inadequate

Derbyshire Healthcare NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Kingsway Site
Kingsway
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Cubley Court tel: 01332 623713
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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)
RXMF4	London Road Community Hospital	Wards 1 & 2	DE1 2QY
RXM14	Trust HQ	Kingsway Hospital - Cubley Court	DE22 3LZ

This report describes our judgement of the quality of care provided within this core service by Derbyshire Healthcare 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.

Where applicable, we have reported on each core service provided by Derbyshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Healthcare NHS Foundation Trust We rated wards for older people with mental health problems as inadequate because:A safeguarding alert was made in 2015 regarding the alleged theft of an individual patient's belongings. Local and senior staff within the trust had not

Summary of findings

investigated the possible links of this alert with other reported alleged thefts and losses of patients' belongings over a four-year period. There was a failure by clinical leads and staff at board level to investigate possible links between incidents to prevent further possible abuse of patients and learn lessons from the incidents.Risk management plans were basic in formulation and lacked identification of strategies to reduce risk.New electronic patient records records were incomplete and sometimes the back-up paper record was unavailable to clinical and medical staff. This meant that essential information to patient care was sometimes not available to clinical staff, putting patients at risk.Discharge planning was not clearly recorded in the patient recordsStaff did not have a full understanding of the MCA and decisions made in the best interests of patients were not adequately recorded, meaning there was no means of retrospectively assessing whether patients were being correctly treated in law.Structured therapies were not available or detailed in care records and there was insufficient emphasis on evidence based therapeutic interventions.However:All wards were clean, well maintained, decorated to a good standard and had well maintained outdoor spaces for patients to relax in. clinic rooms were clean and tidy and contained the necessary emergency equipment and drugs.Comprehensive physical health checks were made in line with National Institute for Health and Care Excellence guidelines for older peopleStaff treated patients with sensitivity and patience, listened to their concerns, and were caring. Patients welcomed on admission to the wards reported that they felt safe and able to feed back any concerns or compliments to staff.Occupational therapy treatments were high quality. Activities on the wards included social events, drama groups and one-to-one activities..

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	Inadequate 
Are services safe?	**Inadequate** 
Are services effective?	**Inadequate** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Inadequate** 

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.

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- A safeguarding alert made was made on 25 August 2015 regarding the alleged theft of an individual patient's money. Local and senior management within the trust had not investigated the possible links of this alert with alleged thefts and losses of patients' belongings over a four-year period. There were 22 incidents of alleged thefts and losses between late 2010 and May 2016.
- The inspection team examined care records and saw that risk management plans were basic in formulation and lacked identification of strategies to reduce risk.
- All of the bedrooms in Cubley Court had ligature points (fixtures and fittings that can be used for tying or binding as a means of hanging oneself). Other rooms on the wards also had ligature points. Risk assessments did not contain plans to mitigate the risk to patients.
- There was no administrative support for the transfer of care records and monitoring of the transfer of clinical records to the trust's new electronic patient record system (EPR). New EPR records were incomplete and sometimes the back-up paper record was unavailable to clinical and medical staff. On call doctors also reported not being able to access the EPR system. This increased the risk to patients, as important clinical information was not available to staff at crucial times.

However :

- Wards were clean, maintained and decorated well
- All wards complied with guidance on same sex accommodation meaning that the dignity and privacy of patients was respected.
- Wards 1 and 2 at London road had anti-ligature fittings such as door handles, clothes and curtain rails fitted in all bedrooms. These are designed to limit the potential for a ligature tobe fastenedto them. Staff on all wards were able to locate the whereabouts of ligature cutters immediately meaning they could respond to emergencies quickly.
- All staff were trained in the management of violence and aggression and used de-escalation techniques wherever possible.

Summary of findings

Are services effective?

Inadequate

We rated effective as inadequate because:

- We looked at 25 care records for the purposes of checking whether staff followed the Mental Capacity Act. In all the care plans we reviewed, there were no reasons given for making decisions in the patient's best interests. There was also limited evidence available to demonstrate the reasons patients had an assessed lack of capacity.
- We reviewed six Do Not Attempt Resuscitation orders. The inspection team found that in all except one case it was unclear why these orders were in place.
- Structured therapies were not available or detailed in care records. Inpatient wards did not follow recognised guidance on access to psychological therapies for older people.
- There was no clear evidence that audits in relation to the application of the Mental Health Act or Mental Capacity Act were in place
- There was limited evidence that patients were regularly having their rights explained under Section 132 of the Mental Health Act
- There was no clear evidence that patients were being risk assessed prior to utilising Section 17 leave

However:

- We saw evidence of comprehensive physical health checks on the wards and staff used National Institute for Health and Care Excellence guidelines to inform physical health care plans.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with sensitivity and patience and listened to their concerns. They used their expertise and creativity in a caring way and were thoughtful in approach
- Patients and carers reported that they felt safe on the wards and were able to feed back any concerns or compliments to staff whenever they wished. The inspection team observed staff to treat patients as individuals and to be sensitive to their concerns and needs
- Nurses took care and attention to detail in the care of their patients by being clinically creative in engaging patients in a meaningful manner.
- There were variety initiatives to support carers and wards ran carers groups.

Summary of findings

- Staff were alert to opportunities for patients to make choices even when the patients had limited capacity to do so by making lists with them and identifying what their likes and dislikes were

However we also found:

- Staff were inconsistent in involving patients in their care. Evidence from care records demonstrated that it was mainly family members involved in care planning and multidisciplinary team reviews.
- Independent advocacy was available to patients but information on how to access it was not always readily available across the wards.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Discharge planning was not recorded clearly in clinical notes and lacked detail. This meant that other clinicians were not always aware of the discharge plans for individual patients
- There was no information on display about how patients and carers could complain or any literature relating to how patients could access advocacy services.

However:

- Occupational therapy treatments were high quality and staff had developed engaging activities on the wards such as social events, drama groups and one-to-one activities. These activities helped people interact and build confidence. Wards were lively and happy with good staff interaction.
- An initiative to use staff as local interpreters to break down language barriers and to take advantage of the knowledge and familiarity nurses had with patients had been piloted.
- Inpatient wards for Older Peoples Mental Health (OPMH) services did not hold waiting lists meaning referrals were responded to promptly and their needs were met quickly.
- The admission processes for the wards were managed in a caring manner and staff were aware of the difficulties patients and their families faced. The welcome to the wards was orientated to helping patients and carers adapt to the care environment.
- Delayed discharges were minimal and if they did occur, it was due to clinical reasons

Summary of findings

Are services well-led?

Inadequate 

We rated well-led as Inadequate because:

- Staff did not have a full understanding of the Mental Capacity Act. Care records did not adequately record the reasons for decisions made in the best interests of patients. Reasons for assessing patients as lacking capacity to make their own decisions were also not clear within care records. The leadership of the trust had not addressed the issues despite there being evident gaps in the recording of capacity assessments.
- Managers on wards 1 & 2 at London road hospital had failed to link a safeguarding alert made in 2015 with other reported allegations of theft and loss made dating back four years. There had not been an investigation into this series of alleged thefts and losses of patient belongings and money. Staff at all levels of the trust failed to investigate possible links between incidents to prevent further possible abuse of a patients and learn lessons from the incidents.
- Staff had lost a degree of faith in the trust leadership team as a result of a high profile employment tribunal in 2015 that had criticised individual staff within the trust board

However:

- Staff were aware of the trust's vision and values and all staff demonstrated the core value of aspiring to deliver excellence.
- The ward 1 staff team won a Delivering Excellence Every Day award for putting the patient at the centre of clinical practice while making them feel valued.

Summary of findings

Information about the service

Wards 1 and 2 at the London Road Community Hospital are mixed sex wards; both with16 beds for assessment and treatment of people over the age of 65 with functional mental health problems such as depression, schizophrenia, mood disorders or anxiety.

Cubley Court is a 36-bedded assessment and treatment unit for both men and women with an acute organic illness who require a period of assessment. The two wards at Cubley court provide single sex accommodation.

Our inspection team

A four-person team inspected the wards for older people with mental health problems at Derbyshire Healthcare NHS Foundation Trust. The team included one CQC inspector, one Mental Health Act (MHA) reviewer and three specialist advisors with a nursing, occupational therapy and consultant psychiatry background.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited London Road community hospital, wards 1 and 2, Cubley Court, Kingsway, male and female wards and looked at the quality of the environment and observed how staff were caring for patients
- spoke with three patients and one carer who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 10 other staff members; including doctors, nurses and occupational therapist
- attended and observed one multi-disciplinary meeting and one occupational therapy activity session.
- looked at 50 sets of treatment records.

What people who use the provider's services say

Patients felt safe on the wards, said that staff were pleasant and polite and that the wards were clean and tidy. They also said that that staff were very friendly and helpful and that there were good activities on the wards.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that learning from incidents and safeguarding alerts is captured in a way that allows for managers to identify themes and trends in order to keep people who use the service safe.
- The trust must ensure that potential themes or hot spots that relate to patient safety are captured on the trust risk register in order for the executive team to be fully aware.
- The trust must ensure that Mental Capacity Act documentation and assessments are fully completed and filed correctly in patients' records. The provider should also ensure that staff apply the Mental Capacity Act correctly and that they fully understand how it relates to the patient group that they are caring for.
- The trust must ensure that documentation relating to section 17 leave is completed, up to date and filed correctly.
- The trust must ensure that detained patients are reminded of their rights under Section 132 of the Mental Health Act on a regular basis.
- The trust must ensure that the discharge process is properly documented and that it demonstrates that planning begins at the point of admission.

Action the provider SHOULD take to improve

- The trust should ensure patient involvement in their care is consistent and well documented in care plans.
- The trust should ensure information on how to access independent advocacy is publicised across older people's mental health wards.
- The trust should ensure structured psychological therapies are available to all patients and detailed in care records.
- The trust should ensure that room & fridge temperatures are consistently checked to ensure that medicines are stored in correct conditions.
- The trust should ensure that regular audits are carried out to minimise the risk of gaps on medicines charts not being picked up.
- The trust should ensure that information is available to people who do not speak English as a first language.
- The trust should ensure that information on how to complain is clearly displayed.

Derbyshire Healthcare 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
Wards 1 & 2	London Road Community Hospital
Cubley Court	Kingsway 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.

We looked at 25 care records for the purposes of checking adherence to the Mental Health Act (MHA) and the MHA code of practice

- Overall compliance for mandatory training for Older Peoples Mental Health wards was 75%. The staff attendance rate for Mental Health Act training was 80% with the highest being 100%
- Staff on Cubley Court female told us that an automatic referral was made to an independent mental health advocate, where patients lack the capacity to access these themselves.
- Each ward had a checklist in place to review MHA documents on admission and old and unnecessary paper work was routinely removed
- Staff demonstrated their knowledge of the different MHA sections and told us that people had their rights under the MHA explained to them on admission and at regular intervals throughout their stay on the wards.

Mental Health Act Reviewers (MHAR) visited older Peoples Mental Health (OPMH) wards in January, March, September and October 2015. At these Mental Health Act reviews:

- Care plans looked at by MHARs were found to be comprehensive and individualised and specific to the needs of the individual patients
- Staff told MHARs that patients signed their own care plans.
- Care plans covered issues such as the locked doors, and consideration of Deprivation of Liberty Safeguards (DOLS)
- Patients appeared to be aware of their care plans. Some patients told the MHARs that staff had gone through the care plans with them.

- Where a patient lacked capacity to engage in their care plans, the family's views were sought.
- There was clear evidence of reminders being sent from the Mental Health Act office regarding the rights of patients under Section 132.
- Wards did not have any seclusion facilities

However:

- Patients on one ward had not signed their care plans.
- While reminders were being sent from the Mental Health Act office regarding the rights of patients under Section 132, the rights forms had not been completed in the files the MHARs looked at. They were therefore unable to find evidence that patients were aware of their rights of appeal and their rights to advocacy.
- Tribunals and hearings documentation, clearly designed to facilitate the explanation of rights, was not completed in the files looked at by the MHARs. They were therefore unable to locate firm evidence that patients were aware of their rights of appeal.
- Whilst capacity and consent decisions were recorded on the statutory paperwork, this was not concurrently recorded in the notes
- Section 17 leave of absence from the ward was authorised by the Responsible Clinician (RC) on standardised forms. Some were completed for specific periods while others had no end date.
- The MHAR found no evidence of patients being given copies or of episodes of leave being reviewed
- One file reviewed had no evidence of rights being explained to a detained patient on admission or within a few days of their admission.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at 25 care records for the purposes of checking adherence to the Mental Capacity Act (MCA)
- Observance of the five statutory principles of the MCA (presumption of capacity, support to help patients make their own good and unwise decisions, making decisions in the patient's best interests and that decision making was proportional) were not evident in the care plans we looked at. The patient records indicated a lack of capacity but there was limited evidence available to demonstrate why this was. There was no justification of patients' best interests in all of the plans reviewed by the inspection team. Plans did not include patient's opinions of treatment and were not inclusive of different facets of a patient's care focusing almost exclusively focused on physical health

Inadequate

Are services safe?

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

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

Our findings

Safe and clean environment

- The ward layout allowed staff to observe all parts of ward and had detailed procedural descriptors of patient observation at six levels. These ranged from general observation to intensive management of high-risk patients.
- All OPMH wards had rooms and areas with ligature points (fixtures and fittings sometimes used for tying or binding as a means of hanging oneself). However, anti-ligature fittings, designed to limit the potential for a ligature to be fastened to it, such as door handles, cloths and curtain rails were fitted in all bedrooms on wards 1 and 2. Bedrooms on both Cubley Court wards did not have fully anti-ligature fixtures and fittings
- Risk management and care plans did not clearly document mitigation against ligature risk. This meant that assessments of individual risks to patients were not available to temporary or medical staff unfamiliar with the wards or patients. However, the inspection team spoke to ward managers and regular staff who had a high awareness of individual patient risks. Staff also described a commonly understood policy of supportive day and night observation that regarded the patient attentively, whilst minimising the extent to which they felt they were under surveillance. Supervision of patients took place when they visited the bathroom and all doors to bathrooms were locked when not in use. Staff on all wards were able to locate the whereabouts of ligature cutters immediately. This meant that they would be able to cut a patient away from a ligature point quickly in an emergency. There had been no incidents related to ligatures in the 12 months prior to the inspection.
- Both wards at London road complied with guidance on same sex accommodation and had a spacious layout with various rooms available to patients. Cubley Court wards were single gender and so complied with guidance on same sex accommodation.
- The clinic rooms contained accessible resuscitation equipment and emergency drugs. All equipment checks were up-to-date. Logs for medical equipment showed that all clinics were well maintained and cleaned regularly. However, we found gaps in the daily checks of room and fridge temperatures which could have an adverse effect on the efficacy of medication stored in that area.
- No Patient-Led Assessments of the Care Environment (PLACE) data was available for wards 1 and 2. Derby Teaching Hospitals NHS Foundation Trust rented the London road community hospital building housing wards 1 and 2 to Derbyshire Healthcare NHS Foundation Trust. On occasion, this caused difficulties regarding equipment and building repairs. PLACE data relating to the cleanliness of the environment for Cubley Court was 98.5%; this was in comparison with the trust average of 99.1% and the average for England which was 97.6%. All equipment cleaning schedules were up to date.
- Staff were aware of infection control principles, having knowledge of how to prevent cross transmission from recognised and unrecognised sources of infection. The infection control mandatory training compliance rate for all OPMH ward staff was between 79% and 100%.
- An environmental risk assessment was undertaken regularly across all older people's wards
- All bedrooms had a nurse call button near to the bed. However, staff did not carry personal alarms.

Safe staffing

- Ward managers did not use a safer staffing tool to calculate the numbers of staff required on each shift. However, they did use electronic rostering to make sure there were qualified nurses present for essential monitoring of communal areas of wards and to carry out physical intervention such as restraint.
- Shift data for December 2015 to February 2016 showed that ward 1 had 17.5 whole time equivalent (WTE) qualified nurses. Ward 2 had 15.3, Cubley Court female had 17.3 and the male ward had 17.8.
- There were 10.7 vacancies across all wards for the 12 months up to 31 January 2016. Staff percentage vacancies for ward 1 were 11.2% and for ward 2, they

were 2.8%. Cubley Court male had 9.3% percentage vacancies and Cubley Court female had 8.9%. Cubley Court male had the highest nursing assistant vacancy rate of 30%, as at March 2016.

- The staff sickness rate for the 12 months up to 31 January 2016 for Ward 1 was 9%, for ward 2 it was 10.8%, for Cubley Court female it was 4.4% and for the male ward, it was 8.4%.
- The wards employed staff from the nurse bank to fill duties not filled by the substantive team and shift requests were sent to the nurse bank using the electronic rostering system. The system has a facility to request preferred staff. In the 12 month period prior to the inspection, wards 1 and 2 filled 333 shifts with agency and bank staff and Cubley Court filled 539. For continuity, ward managers tried to book bank and temporary staff known to the wards. This was to allow staff to understand ward procedures, become familiar with the patients and manage risk effectively. Ward managers reported that the trust bank system would often not be able to fill shifts. This meant there was frequent movement of staff between wards, mostly from wards 1 and 2, to Cubley Court where staff shortages were more common due to registered nursing staff taking sick leave. An incident report, completed every time there was a staff shortage made sure senior management was aware of how often this was happening. The ward 2 manager worked closely with all wards in maximising the efficiency of the e-rostering system to cover sickness absence and redeployment of staff.
- Shifts and ward activities were always covered. However, activities at weekends were sometimes limited.
- There were enough staff to allow patients to have 1:1 time with their named nurse.
- Medical cover for wards 1 and 2 comprised 6 “junior doctors”, of varying grade, allocated between the two wards from 9am to 5pm, Monday to Friday. One speciality grade doctor on each ward covered Cubley Court male and female wards with an additional foundation level doctor on Cubley male ward. All doctors had commitments off the wards during the working day but cross cover was arranged between them to ensure a constant medical presence. A consultant was present on wards at regular ward rounds and at other times as required. The inspection team were informed that out of hours, on call doctors responded by telephone to requests from OPMH wards within 20 minutes. Doctors made a decision whether to provide telephone advice, an active visit or, in an emergency situation, a direct call to 999. On call doctors had the opportunity to contact an on call consultant older adult psychiatric consultant at any time.
- Staff had received mandatory training; the compliance rate for Cubley Court female ward was 91%, Cubley Court male ward was 92%, ward 1 was 96% and ward 2 was 94%. The overall compliance rate for OPMH inpatient services was 94% for all mandatory courses; this was in comparison to the trust target rate of 95%. The inspection team noted that clinical risk management training for all wards, except Cubley Court female ward, was at 82%. Cubley Court female’s risk management training compliance was less than 50%.

Assessing and managing risk to patients and staff

- There was only one recorded incident of restraint across all the OPMH wards. This was not conducted in the prone position. All staff were trained in the management of violence and aggression and used de-escalation techniques wherever possible.
- There was no seclusion room on OPMH wards and as such there were no incidents of seclusion or long-term segregation in the 12 months prior to the inspection.
- The inspection team examined sets of 25 care records. Staff undertook risk assessments on admission and these were regularly reviewed and up to date in all but two cases. Risk management plans completed by staff were basic in formulation and in their identification of strategies to reduce risk.
- There were few blanket restrictions on patients and independence was encouraged on all wards. Blanket restrictions in place related to access to certain areas of the garden on wards 1 and 2 and there were also locked doors due to detained patients being on the ward. All patients were informed of these restrictions and the reasons for them. All informal patients could leave at will.
- None of the wards had cause to use rapid tranquilisation in the 12 months prior to the inspection

Inadequate

Are services safe?

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

(medicines given to patients who are very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others and allow them to receive the medical care that they need.). However, appropriate protocols were in place and in line with National Institute for Health and Care Excellence guidelines.

- All staff were trained in safeguarding and wards had met trust targets on safeguarding adults Level 3 training except for Cubley Court male ward, which had achieved only 67% compliance. All staff interviewed at inspection could explain how to make a safeguarding referral.
- There were good medicines management processes in place and good links with pharmacy services. Wards used a medicines management tool, however, a recent audit of this tool on ward 2 found that there was no clear audit trail relating to the receipt of medicines and there were administration gaps on medicines cards. There was an action plan in place to remedy these errors. A plan was also in place with pharmacy staff to provide awareness training to staff on medicine management standards. Patients' own medicines were accepted onto the ward in line with the hospital medicines code.
- Staff were aware of outlier issues such as falls or pressure ulcers and liaised appropriately with the tissue viability nurse.
- Procedures for children to safely visit the wards were in place.

Track record on safety

- There were four serious incidents from 1 January 2015 – 31 December 2015. None of these were 'never events', that is, medical mistakes so serious they should never happen. The incidents included an unexpected death, alleged neglect of a patient and a patient fall. Ward managers informed the inspection team of procedures for investigating these and learning lessons from the incidents.
- All staff that we interviewed understood how to report incidents and felt able to be open and transparent with colleagues and patients.
- There was evidence of debriefing staff after incidents. Ward 1 had a very recent incident relating to the trust's new electronic patient record system and the attempted suicide of a patient. The inspection team were shown minutes of a debriefing meeting that had taken place and a record of the lessons learned from the incident. However, lessons were not learned after incidences of alleged thefts and losses of patient's belongings. During the inspection, the inspection team became aware of several alleged incidents of theft and loss of patients' money and belongings, dating back to 2010 on wards 1 and 2. The inspection team were informed that nursing and security staff made a safeguarding alert regarding an individual patient in 2015. This alert related to an alleged theft. Further to this, there were another 22 reported incidents of alleged thefts and losses between late 2010 and May 2016. A safeguarding alert made at the time of inspection, on 8 June 2016, summarised the possible exposure of patients to this safeguarding risk. The inspection team found that staff at director level, despite being aware of the incidents, had failed to link the events together in a systematic approach to safeguarding. This was despite having an awareness of local attempts, made by the trust health & safety manager, to investigate the alleged thefts and losses. The inspection team were informed that the police had not investigated due to lack of evidence. There was also no evidence of a safeguarding plan to protect vulnerable patients from further loss of their belongings.

Are services effective?

Inadequate

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 saw evidence in 25 care records of timely assessments on admission to the wards. These assessments included comprehensive physical health checks measuring blood pressure, height, weight, pulse, checks for diabetes and other health conditions. There was regular monitoring of physical health problems throughout patients stay on the ward. All staff followed protocol for the trusts early warning system for the assessment of acute illness, the detection of clinical deterioration and the initiation of timely clinical responses. These also assisted in the formulation of individual care plans for patients. Care plans that the inspection team looked at were comprehensive, individualised, and specific to the needs of the individual patients.
- We found that paper information needed to deliver care was stored securely and available to staff. There had been some difficulties in the co-ordination between the new system of electronic patient records (EPR) and the paper based clinical records. Electronic clinical information was therefore less accessible during the transition of information to the EPR. On-call doctors described difficulty in accessing the EPR as they had not been issued log in details such as passwords. Doctors complained that safeguards should have been in place to make sure of quick access to clinical information. In addition, partially inputted new patient information and slow migration of patient data affected patient care and the timeliness of the delivery of patient care. There had been support from the EPR technical team and they remained responsive to any difficulties brought to their attention. There was also nowhere on the EPR to record that a patient had been offered a copy of their care plan. It was also difficult to locate where MHA information was within the EPR system. Nurses transferred risk assessments to the trusts new electronic patient record (EPR) system. The inspection team identified one risk assessment that had not transferred to the EPR but it was readily available in the paper care record. Nurses reported that there was no administrative support for the transfer of care records and no information was available on the local monitoring of the transfer of clinical records to the EPR. The ward manager of ward 2 described an occasion when a nurse had not been able to provide next of kin information to the local accident and emergency department. This was because the EPR record was incomplete and the paper care record was not to hand. In addition, the nurse concerned was unfamiliar with the EPR system. This incident may have been indicative of an inherent risk within the process of clinical record transfer to the new Electronic Patient Record (EPR) system.

Best practice in treatment and care

- The inspection team were satisfied that wards were monitoring their adherence to NICE guidance when prescribing medication. An audit of medicine code standards on ward 2 found prescription dates were accurate and that prescriptions were signed appropriately. However, the same audit found there were frequent administration gaps on medicines cards. An action plan was in place to remedy this.
- Inpatient wards did not follow Joint Commissioning Panel for Mental Health guidance on access to psychological therapies for older people on inpatient wards. Structured therapies were not available or detailed in care records. When interviewed, a doctor said that they would have liked a psychologist attached to the team to undertake case formulation with staff. Staff carried out low-level therapeutic verbal treatments but were unable to describe what these were. The inspection team observed that there was limited emphasis on evidence-based interventions. This potentially disadvantaged older people on the wards who should have had access to the same interventions as patients of a younger age.
- There was a system in place to monitor fluid charts and alert doctors if a patient did not drink more than 800ml of water in 24 hours. Patients could eat in private and, if necessary, arrangements could be made for referral to a dietician to assess and treat a wide range of nutritional issues or concerns. Staff used the Malnutrition Universal Screening Tool to identify patients who were malnourished, at risk of malnutrition or obese. Once assessed patients had a choice of dining rooms and places to sit and could eat with dignity if they had special dining requirements. Choices of food were also

Are services effective?

Inadequate

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.

available for people from different religions or those with specific dietary requirements. Protected mealtimes offered opportunity for socialising and various food choices were available such as pureed and liquid foods.

- Patients on the ward had both mental and physical health problems and received services primarily focussed on physical health care. Staff stated that they used Health of the Nation Outcome Scales (HoNOS) recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health. These scales measure behaviour, self-injury, cognitive problems and activities of daily living and are designed to help build up a picture of a patients responses to nursing and medical interventions. However, the inspection team did not find HoNOS ratings or findings substantially incorporated into the care plans of patients on OPMH wards.
- Patients had good access to physical healthcare and specialists when required
- In March 2016, clinical staff had participated in an audit of inpatient ward records. This audit measured against standards of legibility, completion of data, full completion of assessments, discharge planning and other standards for clinical notes. The results and the outcomes of the audit were not available to the inspection team at the time of inspection.

Skilled staff to deliver care

- The staff team included doctors, nurses and health care assistants, occupational therapists, speech and language therapists and pharmacists. Staff also had access to a local tissue viability nurse.
- Staff received regular one to one supervision, group supervision or both. The overall appraisals rate for the wards was 76.5% as of 31 january 2106; this was in comparison to the trust overall appraisal target of 85%. Only Cubley Court male ward met this target with 91.4%.
- There were two instances of performance management, both dealt with in accordance with trust policy and procedure.
- All staff received a full induction on transfer to OPMH wards. Two ward managers interviewed said they were aware of concentrating their managerial efforts on staff that relocated under stressful circumstances from other wards. They approached this positively and provided a full workplace induction and an individualised action plan tailored according to training requirements and development needs. These plans included objectives, regularly discussed and reviewed with each staff

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary meetings, which comprised senior and lead nurses, nursing assistants, bank and student nurses, occupational therapists and assistants, ward doctors and consultant psycho-geriatrician. Multi-disciplinary meetings took place weekly when ward teams reviewed care and treatment plans. These meetings sometimes included patients and carers. . In the multi-disciplinary meeting, inspectors observed there was good representation from all disciplines of staff who all contributed to the meeting. The consultant spoke of a holistic approach to care and about the importance of physical health.

Each multi-disciplinary team meeting documented evidence of a discussion of a patient's capacity to consent to treatment

- Staff had regular handover meetings where staff discussed patients' physical health, safeguarding concerns, staffing levels and patient observation levels.
- There were effective working relationships with other teams both internally and externally of the organisation such as the dementia care liaison team based at the Royal Derby Hospital as well as liaison with Community Mental Health teams. Links with the local authority were well established and OPMH wards adhered to joint multi-agency policy on referral and joint work. Staff we spoke to said that there were good working relationships with local authority safeguarding colleagues.

Adherence to the Mental Health Act and the Mental Health Act (MHA) Code of Practice

- Cubley court female had a 100% MHA training compliance rate. Cubley Court male ward achieved 81%, ward 1 attained 94% and ward 2 had a 93% compliance rate. Mental Capacity Act (MCA) training compliance figures for Cubley Court female ward were 100%, Cubley Court male were 69% compliant, ward 1 was 94% and ward 2 achieved 93%. However, nursing practices observed at the inspection showed that staff did not have a full understanding of the MCA.

Are services effective?

Inadequate

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.

- Staff had good knowledge of the Mental Health Act, the code or practice and the guiding principles.
- Consent to treatment forms were in place and were attached to medication charts where applicable. Records of detention of patients were completed correctly, up to date and stored correctly.
- The 25 sets of care notes the inspection team reviewed did not always clearly state that patients had been informed of their rights under the MHA.
- Access to an independent mental health advocate was available but not clearly publicised on all wards.
- When looking at Section 17 leave forms, the inspection team saw that there was no evidence of a clear risk assessment, on the forms or in the case files, relating to granting of leave from the responsible clinician.
- Staff were able to liaise with the central Mental Health Act office for any advice or support

Good practice in applying the Mental Capacity Act

- Staff had received mandatory MCA training for which there was an overall compliance target of 85%. Cubley Court female ward achieved 100% compliance with this training, Cubley Court male ward 69%, ward 1 achieved 94% and ward 2 attained 93%.
- Despite the high compliance rate in staff training on mental health legislation and the MCA, good practice in applying the MCA was not apparent. There was no evidence of best interest decision processes or discussion in the 25 care plans we looked at. This was the case even when the care plan stated that the patient had capacity. Staff had not followed local MCA policy in recording this information in the trust risk assessment or in the nursing notes. Do Not Attempt Resuscitation orders (DNAR, a legal order not to perform emergency resuscitation on a patient) also lacked evidence of best interest discussion and decisions being made for the patient. This did not comply with section 4 of the MCA. In all cases, there was no rationale in care plans of the reasons why these orders were in place for patients. In one case, the clinical note stated that the DNAR order was a continuation. The order in this case was not lawful as best interest decisions must take place when transferring patients between wards or when readmitting to a ward. On Cubley Court female ward, we looked at 16 MCA assessments. In nine cases, patients were assessed as lacking capacity and in five of these, a DNAR was also in place. The capacity assessment entered on to the EPR for each patient was the same. This demonstrated an impersonal approach to these decisions. Only one patient had an alert on the EPR that a DNAR was in place. The others had a yellow sticker on the paper notes. The inspection team were not clear on the measures in place to ensure this information was placed on to the EPR.
- The inspection team did not have sight of any MCA audits.
- Older people's mental health inpatient services made 45 DoLS applications during the period 1 August 2015 and 31 January 2016. Cubley court female ward made 21, Cubley Court male ward made 18 and wards 1 and 2 at London road made 2 and 4 applications respectively. Staff were aware of their DoLS policy and knew that advice on the MCA was available to them corporately and from their ward manager.
- Staff we spoke to understood that the MCA stated capacity to consent was done on a decision specific basis with regards to significant decisions, and that people should be given every possible assistance to make decisions for themselves before they were assumed to lack the mental capacity to make them. However, there was limited evidence of compliance with the MCA. The inspection team could not find one capacity assessment for best interest decisions in three sets of notes on ward 2. There was no demonstration in the notes of patient capacity assessed on a decision specific basis. Patients were assumed to lack capacity regarding significant decisions in some cases and there appeared to be a presumption of capacity relating to patients ability to consent to admission. In six sets of notes, we looked at; capacity assessments were completed after best interest decisions had been made. There was also limited detail in all assessments using the MCA functional test and the sections focusing on how patients made their decisions and how they understood and retained information was scant.
- Staff we talked to understood that restraint of patients lacking capacity, though rarely used, may be applied if a patient might cause harm to themselves or others and it is believed to be in the patient's best interests. All staff agreed that restraint should be least restrictive option and used for the minimum amount of time.

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

- The inspection team observed staff treating patients as individuals, recognising that they needed time, patience and sensitive responses to their concerns and needs. Occupational therapy interventions on the wards were discreet and respectful in providing practical and emotional support.
- The inspection team spoke to patients on wards and were told that staff were pleasant and polite and that the wards were clean and tidy. They also said that they enjoyed the activities on the wards. However, one or two patients said that they were bored. Others said they enjoyed their stay and felt safe on the wards. Observations of patients were that they were well cared for and treated with sensitivity. Staff adopted and promoted a kind and caring attitude. This was evident on all wards and clearly embedded in the culture of the care provided to older people
- The knowledge and expertise that each nurse had for the patients on the wards was evident as was the care and attention to detail. This meant they had a good understanding of patients' individual needs. For example, a nurse we observed sat with an elderly patient who did not speak English. The nurse spent time searching for songs on the internet in the patient's language so she could sing along to then with him. This and other examples of sensitive and creative care demonstrated the dedication staff had to their patients on all of the wards the inspection team visited. Staff sought to maximise patients' opportunities for choices even when the patients had limited capacity to do so. This was done through 'I like' lists where nurses spent time with patients finding out what they did and did not like. This included information on music and food. Patient-centred care was important to staff and they made every effort to make the patients stay on the ward as physically and emotionally comfortable as possible.
- Cubley Court had a Patient-Led Assessments of the Care Environment (PLACE) data score for privacy, dignity and well-being of 94.0%; the average for the trust was 94.7%. Both these scores are above England's average score of 86%. No PLACE data scores were available for wards 1 or 2 at London road hospital.

The involvement of people in the care they receive

- Active involvement and participation in care planning and risk assessment was encouraged but staff commented on the difficulty of verifying how patients were involved in their own care.
- Independent advocacy was available to patients but information on how to access it was not always readily available across the wards.
- There were variety initiatives to support carers and wards ran carers groups. These had mixed success in terms of attendance and did not therefore achieve what staff wanted to in terms of delivering high quality carer support. Enhancements made to how the named nurses engaged with carers specifically focussed on understanding the 'ripple effect' that illness and a hospital stay could have on a family. A student nurse gave the inspection team an eloquent, passionate overview of her time on the ward and of her family experience as a relative of an older patient. She described how this had affected her career choice and learning, and the support she gave to carers. A carer we spoke to observed staffs interactions with patients closely. They confirmed that staff were caring and approachable and that this included doctors who had made time for them. Family members were mainly involved in care planning and multidisciplinary team reviews. Staff commented that it was difficult to involve some patients due to their limited capacity.
- All patients could have access to their care plans on request.
- Patients' community meetings, chaired by nursing assistants, offered the opportunity for patients to be included in decisions about the service if they wished. However, due to the often-limited capacity of patients, they were not routinely involved in such decisions.
- Advanced decisions were in place for patients but not always recorded in the notes and when they were, they did not detail the decision clearly enough. This was particularly the case with do not attempt resuscitation orders, a legal order not to perform emergency resuscitation on a patient.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Referral and discharge was managed well by staff and they described good working relationships with the dementia care liaison team. This team assessed patients in acute settings, usually accident and emergency. Roughly 30% of referrals came from liaison team. Where appropriate the OPMH wards also worked with the rapid dementia response team to support patient referrals back home to divert patients away from hospital admissions where appropriate. All referrals were discussed at MDT.
- Admissions to OPMH wards depended on the availability of an approved mental health practitioner. Wards also took out of hours emergency admissions. Staff told us that all patients had an assessment by a doctor or a community mental health team (CMHT) and had their admission discussed with a consultant psychiatrist specialising in older peoples mental health problems. These discussions included consideration of alternative treatment such as CMHT support at the patient's home address, day hospital assessment or respite care as a nursing residential placement.
- At the time of the inspection, there were no patients placed out of area because of bed shortages.
- The average bed occupancy from 1st August 2015 to 31st January 2016 across all older people's wards was 73%. Cubley court female ward had average bed occupancy of 100%, cubley court male ward with 70%, ward 1 with 91% and ward 2 with 89%.
- No patients were moved between wards during their admission at the time of inspection.
- The average length of stay for discharged patients for older people's wards was 101 days. The average Length of stay for discharged patients for Cubley Court female ward was123.7 days, Cubley Court male ward with 92 days, ward 1 with 87.1 and ward 2 with 80.5 days. There was no trust target for average length of stay on OPMH wards.
- Discharges were conducted in consultation with carers, the local authority and private residential care homes and were completed at an appropriate time of day. Discharge planning, written in the 25 sets of clinical notes the inspection team looked at, lacked detail. Staff told us that they discharged all patients with the support of social workers, community mental health nurses and private residential homes. All of whom they had excellent working relationships with but this was not evident in the records that were viewed.
- Delayed discharges across the wards were only due to clinical reasons
- Occasional referrals for assessment, of patients with particularly unstable mental health, were made to the enhanced care service at the Radbourne unit rather than a psychiatric intensive care unit.

Facilities promote recovery, comfort and dignity and confidentiality

- There were rooms available for therapeutic activity and patients had access to a well-maintained outdoor space including a garden. All patients were able to access their bedrooms during the day.
- There were also quiet areas on the wards and rooms where patients could meet visitors.
- Patients could make telephone calls in private on all wards, subject to an individual risk assessment.
- There was no Patient-Led Assessments of the Care Environment score available for food on OPMH wards. However, snacks were available whenever patients wanted them and every effort was made to accommodate patient's individual tastes.

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Patients could personalise their bedrooms. A memory box was also in some patients rooms. This was a box of memorable items collected together by friends and family.

- There were arrangements in place on all OPMH wards to secure patients personal belongings.

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- All patients had access to activities. Support from occupational therapy staff was of high quality and the inspection team met a member of the team who had developed new approaches to activities. These included organising social events, drama groups and providing one to one activities if required. All activities were designed to help people interact and build confidence. We were informed that activities were more restricted at weekends.

Are services responsive to people's needs?

Requires improvement

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

Meeting the needs of all people who use the service

- All wards had adjustments for people requiring disabled access including shared disabled toilets.
- There was an initiative to use staff as local interpreters. Recognising that non-English speakers were at risk of having unmet need due to language barriers and that staff have knowledge and familiarity with the patient, it was decide to pilot a project which used staff as interpreters. This recognised staff's individual skills and reassured carers that the patient had an opportunity to communicate and inform staff of any concerns. The project, which had not been evaluated, did not replace access to interpreters through the normal channels.
- Patients of all faiths had access to spiritual support.
- The inspection team did not see information leaflets for people in languages spoken by those using the service.
- There was easily accessible information about mental health problems on the notice boards and a poster located in the patient's dining room informed detained patients of their rights. An information booklet about the service was given to all new patients.

Listening to and learning from concerns and complaints

- Older Peoples Mental Health wards received eight complaints, from February 2015 to January 2016. Seven of these were upheld. One complaint referred to concerns about medication, four related to worries about nursing and care. The remaining two referred to concerns about staff attitude. No complaints were referred to the parliamentary and health services ombudsman.
- Patients said they knew how to complain but information on how to do so was not available on all notice boards on OPMH wards. Staff we spoke to were familiar with the complaints procedure and trust information on the outcomes of investigations was discussed at team meetings.
- All complaints investigated had documented outcomes on the lessons learned from mistakes. These included recommendations on medication management and involving family members more in care and treatment to improve communication.

Are services well-led?

Inadequate

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

Our findings

Vision and values

- Staff were aware of the trust's vision and values and all staff demonstrated the core value of aspiring to deliver excellence.
- Staff were aware of who their most senior managers were and said that they had visits from them on occasion. Cubley Court's manager had met the acting chief executive of the trust several times. In addition, ward mangers agreed that the service manager for OPMH wards was a supportive and proactive colleague.

Good governance

- Older Peoples Mental Health (OPMH) wards were 82% compliant for compulsory and mandatory training. Overall compliance for the trust was 94%.
- The staff supervision target was for a minimum of 10 hours per annum. Compliance with this target was between April 2015 and March 2016 was from 44% and 85%, the lowest compliance rate being for staff at Cubley Court male ward.
- The grades of staff were appropriate to the work on OPMH wards and there were experienced staff to manage common challenges of working with the patient group.
- Staff time was focussed on direct care but the transfer of clinical records to the new Electronic patient Record (EPR) and the associated on the job learning required meant that this time could be restricted. Night staff mainly completed the transfer of clinical notes.
- Lessons learned from complaints included recommendations, discussed at team meetings for implementation. However, managers did not learn from significant incidents. There was a failure at a senior level to link the safeguarding alert made by staff in 2015 regarding an alleged theft, with 22 other incident reports of possible financial abuse of patients. The health and safety security manager had informed the trust safeguarding lead, the nursing director, the finance director and NHS fraud of their findings regarding the alleged thefts and losses of patients' belongings. This included preliminary investigations with evidence and requests for support and guidance. However, there was no senior management direction, in response to the information and evidence provided, to suspend and investigate suspects under trust disciplinary procedures. This poor and inadequate management of the risks, at director level, meant there was no management plan in place to prevent further potential abuse of vulnerable patients. Personnel at director level did not act on the meticulous documentation, provided to them, of the possible connection between the historical alleged thefts and losses. The police had made it clear that they did not have enough evidence to pursue an investigation. However, the trust did not require the same burden of proof as the police and could therefore have investigated fully. There was enough clear and reliable evidence to warrant such an investigation under trust disciplinary procedures. This episode cast doubt on the trust's ability to manage safeguarding incidents in a systematic manner to prevent further incidents. Since the inspection, the local CCG have commissioned an investigation in order to explore how the run of thefts and abuse of patients was not identified at senior level via trust reporting and assurance systems.
- Procedures for the Mental Health Act & Mental Capacity Act were not consistently followed
- Staff participation in clinical audit was evident
- Staff were aware of key performance indicators at a local and national level and ward managers communicated these well through team meetings.
- Ward mangers had sufficient authority and administrative support to direct and supervise staff on these matters. However, staff shortages on the Cubley Court wards sometimes placed pressure on the manager's time to supervise staff.
- Staff were aware of the trust risk register and how to submit concerns that would be fed into a directorate wide register

Leadership, morale and staff engagement

- Some staff we spoke with said morale was low and affected by recently made public problems in the leadership of the trust.Staff we interviewed had made the decision to remain professional and support each other to do a good job.

Are services well-led?

Inadequate

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.

- All staff returning from long term sickness received a work place risk assessment by the moving and handling advisor, a managerial referral to occupational health services and a phased return to work.
- Older People's Mental Health wards had higher staff turnover rates compared to the rest of the trust and Cubley Court male and female wards had sickness rates of 16.5% which were higher than the trust and national averages of under 6%
- There were no reported bullying and harassment cases at the time of the inspection
- Opportunities for leadership development had been taken by band 6 nurses who had formed a group dedicated to coaching in management skills and research and journal feedback. This was a model that the ward managers were considering developing for themselves.
- Staff understood their duty of candour, to inform and apologise to patients if there had been mistakes in their care that had led to significant harm.

Commitment to quality improvement and innovation

- Ward 1 staff team, nominated for a Delivering Excellence Every Day (DEED) award, by a local community mental health nurse, also won the award for putting the patient at the centre of clinical practice while making them feel valued.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Mental Capacity Act documentation and assessments were not fully completed and filed correctly in patients' records. Staff did not apply the Mental Capacity Act correctly or fully understand how it related to the patient group that they were caring for. Assessments of capacity were not followed with recorded best interests meetings. This was a breach of Regulation 11(1) (3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The trust had failed to investigate the links between alleged thefts and losses on wards 1 and 2 under its disciplinary procedure. The provider did not ensure that learning from incidents & safeguarding alerts was captured in a way that allowed for managers to identify themes and trends in order to keep people who use the service safe. Managers did not ensure that potential themes and hot spots that relate to patient safety were captured on the trust risk register in order for the executive team to be fully aware This was a breach of Regulation 13 (1) (2) (3)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not ensure that the discharge process was properly documented or demonstrate that planning began at the point of admission. This was a breach of Regulation 17 (2) (C)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not ensure that detained patients were being reminded of their rights under the Mental Health Act on a regular basis This was a breach of Regulation 17 (2) (C)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not maintain accurate and up to date records relating to service users utilising section 17 leave This was a breach of Regulation 17 (2) (C)