Requires improvement

Somerset Partnership NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Tel: 01278 432000
Website: 8 – 11 September 2015

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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)
RH572	Magnolia Ward	Older people's mental health ward	BA20 2BN
RH576	Pyrland 2	Older people's mental health ward	TA2 7AU
RH576	Pyrland 1	Older people's mental health ward	TA2 7AU

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership 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 Somerset Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Somerset Partnership 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.

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Overall summary

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

- We identified issues in relation to the safety of the environment at the three wards. Although some of these issues had also been identified by the trust's staff, they had not been effectively addressed by the provider at the time of inspection.
- Each of the wards had a range of different rooms and equipment to support treatment and care, and there was access to attractive and well maintained outdoor spaces. However, we identified a number of problems in relation to the design and layout of the wards which impacted on staff's ability to promote recovery and maintain patient comfort, dignity and confidentiality at all times. For example, meeting rooms were inadequately sound proofed and not all bedrooms had ensuite bathrooms.
- There were high occupancy rates at each of the three wards inspected. Although largely beyond staff's control, this resulted in a number of issues including delays to discharge and not being able to keep beds free for people to return to following leave from the ward.
- We identified a number of instances where the trust had failed to meet its legal obligations under the Mental Capacity Act 2005 (MCA). Staff had not identified when a patient should have had the input of an independent mental capacity advocate (IMCA) to support them through the process of a long term move. In relation to do not attempt resuscitation (DNR) forms, we were concerned that for some patients the DNR decision appeared to have been reached without discussion with the person or their relatives and that the DNR decisions were also not being regularly reviewed.

However:

- The 20 care records we viewed were complete, up to date, person-centred and in most cases contained evidence of people's involvement in planning their own care.
- We saw good evidence of changes having been made by staff and improvements to safety as a result of feedback and learning following incidents. We saw examples of good practice in relation to staff assessing and managing risk to patients. Care plans, for example, contained detailed and up to date risk assessments.
- There were appropriate processes and procedures in place for the effective management of medicines.
- Patients and their carers were treated with kindness, dignity and respect. Without exception the staff we met were conscientious, professional and committed to doing the best they could for the people in their care.
- Morale was good among staff at a local team level. Staff told us they were unaware of any issues with bullying, that their managers and peers were supportive, and that they enjoyed their jobs. They knew how to use the trust's safeguarding and whistle-blowing processes and felt able to raise concerns without fear of victimisation. Staff demonstrated openness and 'duty of candour' when communicating with relatives following incidents.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We identified concerns in relation to the safety of the environment at each of the wards. This included ligature points and poor lines of sight. Although some of these risks had also been identified by the trust's staff, they had not been effectively addressed by the provider at the time of inspection.
- We identified a risk with the doctor on-call system which meant it was not always easy for staff to access adequate medical cover day and night and that a doctor might not always be able to attend the ward quickly in an emergency.
- Staff told us the training they received was inadequate for learning how to safely respond to aggressive, physically fit and strong older adults.
- Staff took appropriate steps to ensure wards complied with relevant national guidance on same-sex accommodation; however, a lack of bedrooms with ensuite facilities put pressure on staff's ability to meet those requirements.

However:

- Wards had been well maintained and staff ensured they were kept clean.
- Although there were nursing staff shortages, shifts were generally covered by sufficient numbers of staff of the right grades and experience.
- We saw examples of good practice in relation to assessing and managing risk to patients and staff. Care plans, for example, contained detailed and up to date risk assessments.
- We saw good evidence of change having been made and improvements to safety as a result of feedback and learning following incidents.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- We identified a number of instances of the trust failing to meet its legal obligations under the Mental Capacity Act 2005 (MCA). Staff had not identified an instance when a patient should have had the input of an independent mental capacity advocate to support them through the process of a long term move. In

Summary of findings

relation to do not attempt resuscitation (DNR) forms, we were concerned that for some patients the DNR decision appeared to have been reached without discussion with the person or their relatives and that the DNR decisions were also not being regularly reviewed. However, staff spoken with otherwise demonstrated a good understanding of the MCA and awareness of requirements regarding mental capacity and consent. Wards had followed correct procedures in relation to applications for authorisations to lawfully deprive people of their liberty under the deprivation of liberty safeguards (DoLS).

However:

- The 20 care records we viewed were complete, up to date, person-centred, and in most cases contained evidence of people's involvement in planning their own care.
- There were appropriate processes and procedures in place for the effective management of medicines.
- Patients had good access to physical healthcare and we saw evidence of regular physical examinations and ongoing monitoring of physical health problems. People's nutrition and hydration needs were assessed and met effectively.
- We saw evidence that the wards inspected adhered to the Mental Health Act (MHA) and the associated Code of Practice. Patients had access to independent mental health advocacy (IMHA), and staff were clear how and when to access and engage with the IMHA service to obtain independent support for patients.
- Staff received annual appraisals and regular supervision.

Are services caring?

Good

We rated caring as good because:

- Patients and their carers were treated with kindness, dignity and respect. Without exception, the staff we met were conscientious, professional and committed to doing the best they could for the people in their care.
- We saw evidence of how people were involved in planning their own care, and patients corroborated this. However, patients' involvement in care planning was not always reflected in the care plans and patient records.
- Carers told us they were kept up to date and involved in assessments and decision making processes.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There was a wide range of information provided for patients. This included information on different conditions and treatments, patients' rights, local support projects including advocacy, and how to make a complaint if they were not satisfied with the service they received. Each of the wards had been adapted to ensure accessibility for disabled people.
- People's different dietary requirements, including for religious and ethnic reasons, were catered for. People had access to appropriate spiritual support in line with their needs and wishes.
- Each of the wards had a range of different rooms and equipment to support treatment and care. There was access to attractive and well maintained outdoor spaces, in particular at Magnolia and Pyrland 2 wards.
- There was access to lots of different activities and outings, including on weekends.

However:

- There were a number of problems with the design and layout of the wards which impacted on staff's ability to promote recovery and maintain patient comfort, dignity and confidentiality at all times. For example, meeting rooms were inadequately sound proofed and not all bedrooms had ensuite bathrooms.
- There were high occupancy rates at each of the three wards inspected. Although largely beyond staff's control, this resulted in a number of issues including delays to discharge and not being able to keep beds free for people to return to following leave from the ward.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff spoken with were largely aware of and agreed with the organisation's values, but did not necessarily share or feel engaged with the organisation's vision. Somerset Partnership NHS Foundation Trust had been through a period of considerable change since 2011 when it had merged with Somerset Community Health, the community health service provider of NHS Somerset. Many of the staff we spoke with felt

the process of change following the merger had not been effectively managed. They felt there had been a shift of focus, that the main emphasis was now on physical care and that they were losing the identity of being a mental health service.

- A lack of emphasis on recovery and rehabilitation, particularly in regard to care planning, suggested the model of care was in some ways outdated and that the trust had not kept fully abreast of developments in older people's mental health care.

However:

- Although there were issues related to the management of change, there was evidence of effective governance and strong local leadership of the wards for older people with mental health problems. Morale was good among staff at a local team level. Staff told us they were unaware of any issues with bullying, that their managers and peers were supportive and that they enjoyed their jobs. They knew how to use the trust's safeguarding and whistle-blowing processes and felt able to raise concerns without fear of victimisation. Staff demonstrated openness and 'duty of candour' when communicating with relatives following incidents.

Summary of findings

Information about the service

The wards for older people with mental health problems are part of Somerset Partnership NHS Foundation Trust's core services. The services work alongside other statutory health and social care providers, voluntary and private organisations, to provide inpatient support to older people who have mental health needs. There are three wards specifically for older people with mental health needs; Pyrland wards 1 and 2 in Taunton in the west of the county, and Magnolia ward at Yeovil in the east.

Our inspection team

The comprehensive inspection was led by:

Chair: Kevan Taylor, Chief executive Sheffield Health and Social Care **NHS** Foundation Trust

Team Leader: Head of Inspection Karen Bennett-Wilson, Care Quality Commission

The team that inspected this core service comprised an inspector team leader, a psychiatrist, a mental health services manager, a Mental Health Act reviewer (MHAR) and an expert by experience. An expert by experience is someone who has had either direct experience of receiving mental health services and / or caring for someone who does. A specialist pharmacist inspector also visited Magnolia ward and reviewed the management of medicines at that location.

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 three of the inpatient mental health services for older people, based at two locations
- Looked at the quality of the environment at each location.
- Spoke with eight patients and seven carers.
- Spoke with the managers or acting managers for each of the teams.
- Spoke with 18 other staff members made up of consultant psychiatrists, psychologists, team leaders, occupational therapists, mental health nurses and nursing assistants, and administrators.
- Attended and observed three multidisciplinary team meetings, three handover meetings and two patient involvement meetings.
- Looked at care records of 20 patients.
- Looked at medication records for every patient at the three wards visited.
- Looked at a range of policies, procedures and other documents relating to the running of the services.
- Carried out Mental Health Act reviews at two of the wards.

Summary of findings

What people who use the provider's services say

People told us they were kept safe and their different care needs were met on the wards. They told us they were treated with kindness, dignity and respect. One person told us that staff were polite and compassionate, and that they cared about them. They told us how staff respected their privacy. One person told us that staff were always willing to help them, were respectful and polite, were caring and that they looked after them. Relatives of people who used the services all spoke positively about the kindness and respectfulness of staff and how caring they were. One told us staff always made them feel welcome and that they delivered a very high standard of care. Another told us the way staff had looked after their relative had been been brilliant, that they had gone the extra mile and that they didn't have a bad word to say about them.

Areas for improvement

Action the provider MUST take to improve

- The provider must assess and address in full the risks associated with the physical ward environments. Until the necessary changes are made to make the environments as safe as possible, appropriate measures must be implemented to mitigate effectively the risks to people using the service.
- The provider must ensure that the training staff receive is adequate to be able to safely manage aggressive, physically fit and strong older adults.
- The provider must take the appropriate steps to demonstrate that care and treatment are provided with the consent of each patient or other relevant person, and be able to demonstrate that they act in accordance with the Mental Capacity Act 2005 (MCA) in all instances where a patient lacks mental capacity to make specific decisions and to consent to their care and treatment. Specifically, the provider must ensure they act in accordance with the MCA in all instances where a formal instruction to not attempt resuscitation (DNR) is in place..

Action the provider SHOULD take to improve

- The provider should make every effort to recruit nursing staff to identified vacancies in order to address issues in relation to the lack of qualified permanent staff. If unsuccessful in recruiting the necessary nursing staff, the provider should take further steps to ensure the workload for existing staff is manageable and safe.
- The provider should ensure all front line staff have updated Mental Capacity Act training in order to help ensure teams work in line with statutory requirements at all times
- The provider should assess, clarify the purpose and monitor the use of the de-escalation rooms.
- The provider should ensure staff's understanding and practice in relation to de-escalation and seclusion are in line with the trust's own policy and procedures.
- The provider should consider how to better provide staff with all of the specialist training they require to carry out their roles effectively.
- The provider should review the provision of on-call and out of hours support to ensure ward staff are able to receive medical support promptly at all times.
- The provider should increase focus, through effective and holistic care planning and joined up MDT working, on patients' recovery and rehabilitation.
- The provider should review the provision of psychological therapies and psychosocial interventions to ensure it meets people's treatment needs.
- The provider should involve ward staff fully in any future redesign and refurbishment of the ward environments.
- The provider should engage effectively with staff and ensure their views and concerns are included in the future shaping and structure of this core service.

Somerset Partnership 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
Older people's mental health ward	Magnolia Ward
Older people's mental health ward	Pyrland 2
Older people's mental health ward	Pyrland 1

Mental Health Act responsibilities

We reviewed adherence to the MHA during our inspection and found the following:

- We saw evidence in records viewed that the wards inspected as part of this inspection adhered to the Mental Health Act (MHA) and the associated Code of Practice. All front line staff spoken with told us they had received up to date training in the MHA. We were told by staff that the trust's central MHA team were effective in supporting them and ensured process and protocols were being followed; for example, in relation to people who were detained under section. We saw evidence in patients' records that their rights under the MHA were explained to them on admission and then as appropriate thereafter.
- At Pyrland ward we found that staff managed admission to the ward well, section papers were present and correct, and approved mental health professional reports were on file as required. We did identify a specific issue in relation to the decision making and recording of leave under section 17 of the MHA at Pyrland ward. This is covered in full in the separate mental health act reviewer (MHAR) reports for Magnolia and Pyrland wards, in which the provider has been required the to take action to address this and several other issues in respect of adherence to the MHA.
- Patients had access to independent mental health advocacy (IMHA) and staff were clear on how to access and support engagement with the IMHA service to obtain independent support for all patients on the wards as required. We saw evidence that all patients detained under section were accessing or referred to the advocacy service for support. We were told that the IMHA contract had been taken over by a new organisation earlier in the year, and that the service had

been reorganised to be referral only since then. Staff told us they thought patients' advocacy needs would be better met by a proactive service on the ward rather than by one that was referral only.

- A number of issues in relation to mental capacity and consent were identified in the MHA reviews which were conducted as part of this inspection, and those are covered in detail in the separate MHAR reports for the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

- According to figures supplied from the trust, none of the ward staff had been required to complete, as part of their mandatory training, a module in consent. However, 89% of staff on the Pyrland wards had received MCA training but only 37% of staff on Magnolia ward had received this training. Some of the staff spoken with, including the ward managers and senior staff, told us they had received training in the MCA through other training they had received. We found there was mixed practice in relation to wards meeting their obligations under the MCA.
- At Pyrland 2 ward we saw little evidence that the responsible clinician reviewed mental capacity regularly or that there was a systematic, structured approach to this. There was little reference to mental capacity within the progress notes of detained patients. Also, staff had not identified that a patient who was due to be moved to a new long term placement, but who was 'unbefriended' and potentially lacked mental capacity in relation to this decision, should have had the input of an independent mental capacity advocate (IMCA) to support them through this process. The MCA Code of Practice explains that an 'unbefriended' person is one who has no family or friends who are appropriate to consult in relation to specific important decisions including changes of accommodation and long term moves.
- We identified an issue in relation to do not attempt resuscitation (DNR) forms which were in place for some patients. In the case of one person, there had been no family to liaise with but also no liaison with the independent mental health advocate (IMHA) who was involved with this patient. The form suggested that as the patient had dementia they had not expressed their views. However, again there was no mental capacity assessment to clarify this. We reviewed four other DNR forms, one of which was for a patient who had themselves requested a DNR form be put in place, and this included good evidence of involving the patient's relative and GP in the process. We were concerned that for the other three patients the DNR decision seemed to have been reached without discussion with the person or their relatives and that the DNR decisions were also not being regularly reviewed.
- We spoke with ward managers and senior staff who demonstrated a good understanding of the MCA and awareness of requirements regarding mental capacity and consent. For example, one senior staff member explained to us that all patients who were not detained under the MHA were free to go as they wished and if requested. We observed another senior member of staff demonstrate a sound working knowledge of key mental health legislation, including the MHA and MCA. A colleague in another team tried to make a referral to the ward, for a person currently in a care home who was being very aggressive and was not able to do their own personal care or eat and drink for themselves. The member of ward staff correctly told the referrer they could not just admit the person to the ward at that time as they likely did not have mental capacity to agree to come to the ward informally or to consent to it being a locked ward. They explained to the referrer that the person would need to be admitted under MHA section or following an assessment of mental capacity and with relevant MCA deprivation of liberty safeguards (DoLS) in place.
- We also saw some evidence that, in line with legal requirements, mental capacity was assessed and recorded appropriately on a decision-specific basis with regards to significant decisions affecting people who potentially lacked mental capacity. Care records viewed contained mental capacity assessments and records of consent to treatment or care. Care records for patients at Magnolia ward, in particular, contained good evidence of decision specific mental capacity assessments and subsequent 'best interests' decision

making processes. This covered areas where decisions were required such as medication, hospital admission, and personal care. We saw there had been consultation with key professionals and family members and were then able to track this through to patients' care plans where best interests decisions were recorded. In line with key principles of the MCA, the care plans contained the least restrictive steps that staff should take to support the best interests decisions.

- There had been 24 applications for deprivation of liberty safeguards (DoLS) authorisations in the six months from December 2014 to the end of May 2015. This consisted of 11 applications from Magnolia ward and 13 from the Pyrland wards. We saw evidence that applications for DoLS authorisations continued to be made when appropriate. For example, we were shown applications for DoLS standard authorisations which had recently been submitted for two patients whose detention under MHA section was due to expire. The DoLS applications had been made appropriately because the people had been assessed as lacking mental capacity and there were continued 'risks posed to self and others if they were not within a safe care environment.' The applications had gone in and ward staff were awaiting the response from the local authority MCA team who processed and oversaw DoLS applications. We found that although staff had followed correct procedures, they had not subsequently been sufficiently proactive in monitoring the progress of those submitted applications or prompting the supervisory body for updates.

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 ward environment

- The layout of wards did not allow staff to observe all parts of the wards. This presented different degrees of risk to patient safety, according to the ward and patient group. At Magnolia ward we found the whole section of a far end of the ward was unused, not visible to staff but also not closed off to patients. This section of the ward was not constantly monitored, had no viewing mirrors and was not easily visible to staff unless they were actually in the area. This section of the ward included bedrooms, toilet facilities and a de-escalation room. This was a bare room, painted in a drab grey and without a window, which had previously been used for the purpose of de-escalating agitated patients. It was open and accessible to patients at the time of inspection. Staff assured us the room was no longer in use. Regardless of whether that was the case, we found it to be a depressing space and potentially even distressing to patients who entered that area of the ward. Other rooms in this section of the ward also had obvious ligature points. A ligature point is an environmental feature or structure which is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. Patients had unsupervised access to rooms with ligature points. Staff spoken with confirmed that people on the ward did, understandably, like to wander. We saw that staff made a check of this area during our inspection. However, we also observed that at another time during the day a patient wandered, unmonitored and unwitnessed by staff, into this unused part of the ward. Magnolia ward is primarily for elderly people who have an organic mental health condition, such as Alzheimer's disease or dementia. As such, their patients were likely to be less at risk of deliberate self harm. However, those patients were potentially more at risk of accidental injury, such as injuries caused by falling. Such risk was increased when people at risk of falling were able to access parts of the ward which were unmonitored The risks posed by the unused section of the ward were not effectively mitigated at the time of our inspection.
- At Pyrland 2 ward there were blind spots and lines of sight were not clear to all sections of the ward, including some of the bedrooms. Staff measures to mitigate the risks this posed included walk arounds during the night and alarm pads in bedrooms. These pads were used to alert staff to people's night time movements if they were identified as being particularly at risk. At Pyrland 1 ward there were blind spots, including an arm of the ward which was out of staff's line of sight. Staff explained to us that there were two bedrooms available that were much more visible to them and where they were able to monitor people very closely. They sought to reduce the risks associated with the layout of the ward by putting people who were identified as a significant risk in either of those two rooms.
- We identified multiple ligature risks at the three wards we inspected. At Magnolia ward, we found that curtain rails in bedrooms were not collapsible, so presented a potential ligature risk. Adaptations and fittings in bathrooms were also identified as potential ligature risks. At Pyrland 2 ward we identified similar ligature points, such as hinges on wardrobes. At Pyrland 1 ward we identified multiple ligature points; including handles on bedroom windows, fittings in ensuite bathrooms, and call alarms with long cables. In addition to the ligature risks, most of the bedroom doors on the three wards inspected were not anti barricade. Staff on Pyrland 1 ward gave an example of how this had been an issue previously when a patient had barricaded themselves behind the door and staff had to go through the bedroom's external window, which thankfully had been unlocked and had allowed them timely access in that instance.
- Although many of the ligature risks had been identified by ward staff through health and safety checks and risk assessments, we found the trust had not taken steps to effectively mitigate or address those risks at the time of inspection. The latest local risk assessment for ligatures, carried out by the Pyrland wards' manager in August 2015, identified clearly 'Potential ligature points on both wards which patients can use to self harm, such as door handles on all doors, beds, call bells, equipment.' The assessment contained a current control measures statement that, 'due to the physical care needs of many

older persons on the ward and the need to meet these needs, older person's mental health wards have been excluded from the trust's ligature assessments, staff assess each new admission as per trust policy and any patients with high or significant risk will be assessed and placed on appropriate nursing observations to prevent self harm.' Pyrland 1 ward is a ward for older people whose primary needs relate to functional mental health conditions. As explained on the provider's own website, functional mental illness has a predominantly psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.' Consequently, as confirmed by staff and demonstrated in specific serious incidents, Pyrland 1 ward cared for many physically fit older people who were at increased risk of self harm due to their prevalent mental health condition. As such, the trust was required to take swift and necessary steps to ensure the risk control and safety measures on this particular ward are to the same standards as the trust's other mental health inpatient services.

- The wards complied with relevant national guidance on same-sex accommodation. In line with the 2015 revision of the Mental Health 1983 (MHA) Code of Practice, sleeping and bathroom areas were in the main segregated, and patients did not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms were provided, as were women-only day rooms. The Code also states that a patient should not be admitted to mixed-sex accommodation. However, it may be acceptable, in a clinical emergency, to admit a patient temporarily to a single, ensuite room in the opposite-gender area of a ward. This was the case on Pyrland 2 ward, where a lack of bedrooms with ensuite facilities had meant a male patient who required such facilities had to be admitted to the female area of the ward. This was beyond staff's control, due to a lack of ensuite bedrooms. Staff assured us that they had carried out a full risk assessment to mitigate any risks this posed and also that the person would be moved as soon as a more suitable room became available.
- We found an appropriate standard of hygiene and cleanliness at each of the three wards, and regular cleaning rounds took place during our visits to each ward. The wards were generally in a good state of repair and had been well maintained.

Safe staffing

- The majority of staff spoken with at the three wards inspected told us that they thought the staffing level on the wards was usually sufficient to safely and effectively meet the different needs of patients. Staff at each of the three wards told us there were sufficient numbers of health care assistants (HCAs) available to cover each shift. However, staff spoken to on Magnolia ward told us that the ward sometimes had only one qualified nurse working during day time shifts, instead of the planned two, as a result of nurse vacancies. The ward manager confirmed the ward was 45% down on staffing for bands 5 and 6 nursing staff, which equated to 4.2 whole time equivalent nursing staff. The manager confirmed that the vacancies for permanent qualified nursing staff had been a significant challenge for over 12 months and did put pressure on to existing staff. Although the manager was able to access nursing support through the trust's own bank staff and an external agency, existing permanent nursing staff had been affected. It had resulted in some nursing staff working back to back shifts to provide cover, and additional nursing cover had been provided by the ward manager and deputy manager. Another senior member of staff told us the issue of nurse vacancies had caused stress to the existing nurse team on the ward. This issue had been clearly identified by appropriate senior staff and was on the trust's corporate risk register. The ward manager had also been innovative and they had recently employed a registered general nurse (RGN) in order to fill some of the gaps caused by registered mental nurse (RMN) vacancies. Although limited in terms of what they were able to do under mental health legislation due to a lack of appropriate qualifications and registration, it was anticipated the RGN would bring with them additional knowledge of physical care and treatment, which would in turn help to lessen the workload of existing nursing staff.
- We found a similar situation on the Pyrland wards. A local risk assessment for staffing carried out in July 2015 reported 'Low, potentially unsafe registered nurse (RN) staffing levels'. There had been a 56% or 12.7 whole time equivalent band 5 hours vacancy out of an establishment of 22.7 for most of July. The assessment also identified appropriately a number of risks in relation to nurse vacancies. These included: 'low staffing levels can increase risk of harm to patients as use of

bank and agency increases who are unfamiliar with trust protocols, systems and mandatory training'; and 'Low staffing can increase workplace stress and sickness rates'. The assessment contained current control measures, such as existing band 6 staff providing additional cover, additional use of bank and agency staff and close monitoring of sickness rates as an indicator of staff stress. Further actions to potentially be taken included raising the issue on the corporate risk register, reducing the number of beds or closing one of the two Pyrland wards.

- Although the trust was finding it difficult to recruit permanent staff to fill nurse vacancies, wards were usually able to get essential cover through either the trust's own staff bank, an external agency or with the good will and commitment of existing permanent staff members. We were told that some staff missed annual leave to make sure shifts got covered, or occasionally worked long hours to cover back to back shifts. When agency staff were used, managers requested regular staff who were familiar with the wards and patients. We were assured by senior staff at each of the wards that they were also able to request additional staff at short notice if, for example, several patients on the ward required one to one observation.
- As a result of the efforts of existing staff members to ensure their wards were kept safe and people's care needs were met, patients and relatives remained fairly positive in response to our questions about staffing levels. People told us they thought the wards were sufficiently well staffed, although one thought there were sometimes less staff at weekends. One person told us they thought a high turnover of staff on Pyrland 2 ward made continuity of care difficult, because staff didn't always know their relative and so potentially weren't totally familiar with their relative's needs. In contrast, a relative of another patient on the same ward told us that although there were lots of different staff, staff knew about their relative and were able to update them as to their progress and condition.
- Staffing figures supplied to us by the trust did not break down agency and bank usage per ward or team. However, we reviewed a sample staffing roster for Pyrland wards for the week prior to our inspection which confirmed that almost half of the nursing staff who worked were from an agency. For Pyrland 1 ward, seven of the 13 RMNs who worked during the week were from an agency. Also, the rosters showed that on the weekends there were often no permanent qualified nursing staff working at nights and that cover was provided solely by agency nursing staff.
- We were able to identify potential risks to staff well-being and therefore also to patient safety and the quality of care. These risks were likely increased as a result of staffing pressures faced by the wards. Staffing figures supplied to us by the trust confirmed there had been a relatively high rate of staff sickness at both the Pyrland wards and Magnolia Ward in the 12 months from April 2014 to the end of March 2015. Magnolia ward, in particular, had a sickness rate of almost 10% over that period, which was the fourth highest sickness rate of over 100 different teams or units across the trust. Following the NHS wide 'safer staffing' review in November 2014, the number of beds at Pyrland 2 ward had been reduced from 21 to 15. Staff spoken with on Pyrland 2 ward told us this had made a considerable difference to ward safety, patient care and to staff stress levels. Magnolia ward had also reduced their beds from 14 to 10. The provider subsequently informed us this had led to similar improvements in patient care and that staff stress and sickness levels had improved since this reduction. In light of our findings in relation to ongoing staffing issues at the time of our inspection, we were encouraged to learn from staff that the trust was due to carry out a further major review of staffing at each of the older people's mental health wards.
- The majority of staff were up to date with their mandatory training, with an average completion rate of 95% across each of the different elements of training. This training included areas of learning essential for safe practice such as safeguarding vulnerable adults, risk assessment and management, moving and handling, and fire training.
- We identified a risk that it was not always easy for staff to access adequate medical cover day and night, and that a doctor might not always be able to attend the ward quickly in an emergency. Several different staff at Pyrlands ward raised with us that there wasn't a reliable rota for on-call doctor support and that it could sometimes take between 45 minutes to an hour for the on-call emergency doctor to arrive. As the on-call doctor was no longer resident on-site, the response time was

dependent on where the doctor lived. Staff were concerned that there were times when they didn't know who the on-call doctor was or when they were unable to get hold of them quickly.

Assessing and managing risk to patients and staff

- We looked at 20 patients' care records across the different wards we inspected. We found that risk assessments were present in each of the records inspected and were clear and up to date. They detailed the specific risks and outlined steps staff were to take to mitigate those risks and support people more safely. The risk assessments were carried out at or soon after admission to the ward, and that assessments were updated following any incidents.
- Staff carried out broader general risk assessments which covered key areas of risk on wards. For example, we saw the results of Pyrland ward's latest quarterly risk assessment for falls, carried out in July 2015. This identified potential risks due to the layout and fabric of the building, such as different floorings and rooms far away from visible areas. It qualified more specific elements of risk, such as risk of increased wandering due to people's agitation and risks related to specific furniture on the ward. It listed current control measures such as intentional rounding (checks) and movement of high risk patients to high visibility room at the earliest opportunity. Finally, it included further actions to be taken to mitigate risks, including a request for additional staffing and encouraging people to eat their meals in the dining room where they could be monitored.
- We saw examples of good practice in relation to assessing and managing risk to patients and staff across the wards we visited. For example, risk and safeguarding were discussed in detail at ward handover and multidisciplinary team meetings we attended. We saw evidence of sharing best practice across teams in response to key risks. For example, it was recorded in minutes to falls local action group meetings, which were attended by representatives from each of the wards, that sensor mats had been found to be helpful in reducing falls. The sensor mats activated when people shifted their weight in bed, so that staff were alerted before they actually got out of bed. Staff had identified that some people were particularly vulnerable to falls just after they had got out of bed. This learning was then shared with other teams.
- According to figures supplied by the trust prior to the inspection, there had been no episodes of seclusion across the three wards in the 12 months from April 2014 to the end of March 2015. Staff spoken with told us there had been no episodes of seclusion in the following period from April 2015 to the time of inspection. However, we were concerned there may have been episodes of seclusion that were not recognised or recorded as such by staff. At Magnolia ward a member of staff told us of a recent incident where a newly admitted patient had been taken to their room and the door had been shut on them, with the intention being they could be contained there due to their presentation at that time. This sounded very much like seclusion, but it was not necessarily recognised as such by the staff member. The trust's own policy on seclusion and de-escalation quoted the Mental Health Act (1983) Revised Code of Practice (2008) definition of seclusion: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.'
- At Pyrland 1 ward the purpose and use of the de-escalation room was not clear. This was a cream painted room which contained a simple couch and nothing else. We discussed this with staff and they assured us the room was no longer used for de-escalation and was never used for seclusion. However, staff did tell us it was used and had been used recently to keep a person safe when they were agitated and at risk of hurting themselves. Again, this seemed to fit within the statutory and the trust's own definition of seclusion, but it was not recognised as such by the staff member. Staff also told us this room's use was not recorded or audited formally. This meant we were not able to assess or confirm the frequency or specific nature of its use.
- According to figures supplied by the trust prior to the inspection there had been 24 recorded episodes of restraint across the three wards in the 12 months from April 2014 to the end of March 2015. This involved 17 different patients. Magnolia ward recorded 15 episodes of restraint involving 10 patients, which indicated restraint had been used more than once on at least one patient on the ward.
- According to figures supplied by the trust prior to the inspection, there had been three episodes where prone restraint had been used by staff across the three wards

in the 12 months from April 2014 to the end of March 2015. Staff assured us that, in the period from April 2015 to the time of inspection, there had been no further use of prone restraint in response to incidents. This was in line with the NHS-wide drive to reduce the use of restraint in inpatient settings and to stop the use of prone restraint altogether. Prone restraint is where a person is restrained face down for a period of time. It is widely acknowledged that this form of restraint is dangerous and can lead to serious injury or even death of patients, particularly if carried out incorrectly.

- The trust's records indicated that most staff were up-to-date with their mandatory prevention management of violence and aggression (PMVA) training. This training teaches staff about de-escalation, conflict management and also safe and correct use of restraint or holding. Staff spoken with on each of the wards were able to give good examples of how they used de-escalation techniques, such as changing people's environment, calming, diversion and distraction. All staff spoken with told us restraint was only ever used when absolutely necessary and if all attempts at de-escalation had failed. Staff on Pyrland 1 ward did, however, tell us they had received insufficient specialist training to be able to respond effectively in all instances. This was a particular issue on Pyrland 1 ward where they cared primarily for people with functional mental health conditions. They felt the PMVA training they received concentrated on staff breakaway techniques, which was positive and in line with trust policy; but that the training was inadequate for learning how to safely restrain aggressive, physically fit and strong older adults.
- The trust's records indicated that over 90% of staff were up-to-date with their mandatory safeguarding training. Staff spoken with demonstrated a good understanding of safeguarding processes and were able to give examples of when they had intervened and taken action to safeguard people on the ward after identifying potential abuse. Staff told us they had a good working relationship with the local authority and police. Alerts were raised centrally through a safeguarding lead, who decided whether an incident or information of concern needed to be raised formally as a safeguarding alert. However, staff were clear that they would also take further action to escalate their concerns if they ever believed an alert should be raised but central office said not.
- We reviewed processes and systems related to the management of medicines. We looked at medication charts for each patient on the three wards visited. We identified a number of minor issues which we raised with ward staff at the time of inspection. However, overall, we found there were effective processes and systems in place to ensure the safe management of medicines.

Track record on safety

- Information provided by the trust reflected that there had been six reported serious incidents requiring investigation over the 12 month period from April 2014 to the end of March 2015 across the three wards. These six incidents were all falls, four of which were unwitnessed and two witnessed, and which had resulted in a broken bone for each of the patients concerned. We saw evidence of actions ward staff were taking in response to these incidents, including better risk mitigation and sharing of best practice in relation to the prevention of falls.

Reporting incidents and learning from when things go wrong

- Staff spoken with gave us examples of different incidents they recorded and reported. This included any accidents or injuries, falls, pressure sores, instances of restraint, and attempts at self harm or suicide.
- Staff spoke positively about the support they got from their line managers and colleagues following incidents. They told us they received appropriate debrief and that learning was shared following incidents and investigations. There had been a serious incident at one of the wards during our inspection. Staff were able to talk us through the subsequent reporting and investigation process. We also saw first hand that appropriate support was put in place for staff on the ward and the process of debrief and investigation began. We were assured that further debrief would follow as and when it was appropriate, and that the formal investigation would look at what happened and determine what could have been done differently or better.
- We observed how staff responded effectively following a serious incident. We saw that appropriate senior staff were involved immediately, and that extra staff were brought in to provide additional cover on the ward and

Requires improvement

Are services safe?

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

to support additional observation levels for patients. We also saw how senior staff made contact with care and nursing staff who were affected by the incident to give their support. Staff demonstrated openness and family members were appropriately informed and involved, in line with the statutory requirement for 'duty of candour'.

- There was evidence of staff having made improvements as a result of feedback and learning following incidents. On one ward we were shown a serious incident investigation report, which followed a patient fall. The investigation had identified a need for additional training, so that staff would be able to identify signs of deterioration sooner. We were shown the minutes to the falls local action group meeting from August 2015, where the action was identified that all inpatient staff were to receive falls training, and training in identifying deterioration and reviewing levels of observation. Similarly, a patient on one of the wards had recently died from a specific medical condition. This had resulted subsequently in all staff receiving training in the condition and a new measure whereby all patients were physically observed weekly for signs of the condition. The value of the training had been proven as staff had been able to identify a colleague who had been at risk, and they were then admitted to hospital immediately for vital emergency medical care.
- Staff spoke positively about the trust's response following incidents, including serious incidents. They described an open and supportive atmosphere; one in which focus was put not on finding or directing blame, but instead on learning lessons and making required improvements.

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 looked at 20 people's care records across the three wards we inspected. The care records we viewed were complete, up to date, person-centred, and they contained some evidence of people's involvement in planning their own care. Although care plans were effective for supporting staff to meet people's immediate physical and mental health needs, they had insufficient focus on patients' recovery and rehabilitation.
- Timely and comprehensive needs and risk assessments had been carried out at or soon after people's admission to wards. Referral folders were used to collect information on people on admission, and these covered medication and physical needs, malnutrition assessment, and physical assessments including weight and blood pressure. On Magnolia ward, an occupational therapist was involved in carrying out mobility and falls risk assessments at admission.
- Care records contained evidence of regular physical examinations and effective ongoing monitoring of physical health problems. Weekly updates were sent through from the trust's central monitoring team identifying which patients had outstanding physical checks. We reviewed care plans and saw that regular physical checks and monitoring were taking place at all of the wards inspected. We observed staff carrying out physical checks, including blood pressure checks, during the inspection.
- All care plans and confidential records were stored securely, electronically, and only staff with security clearance were able to access the system. None of the staff spoken with raised concerns as to difficulties or specific issues with completing and updating care records.

Best practice in treatment and care

- Processes and systems for the management of medicines were looked at in detail by both a specialist pharmacist inspector and a consultant psychiatrist during our inspection. We found that wards generally worked within National Institute for Health and Care Excellence (NICE) guidelines in respect of medication. A specialist pharmacist inspector carried out a detailed review of the medication processes and procedures at Magnolia ward. An electronic prescribing system was used on the ward. Staff told us they liked the system because prescriptions were much clearer and it reduced the risks of mistakes being made. We saw that appropriate safeguards were in place to protect patients who were given medication covertly and to ensure this was in their best interest. The pharmacy technician visited the ward once a week and checked the prescription records, they then informed staff of any issues that needed addressing. Staff told us they could speak to pharmacy staff for advice whenever they needed it. Trust medicines policies were available on-line for staff to refer to. Medicines were stored safely and suitable arrangements were in place for the ordering of medicines.
- We saw further examples of how staff operated to NICE clinical guidelines. For example, an occupational therapist on one of the wards assessed each patient according to a pool activity level checklist, which was contained in NICE guidelines. This assessment determines a patient's functional level, identifies suitable activities and interests and ensures the detail is in the care plan, and assesses a person's ability to carry out essential day to day living activities to ascertain whether they are fit and safe enough to return home.
- Availability and provision of psychological therapies varied across the three wards. A senior member of staff spoke enthusiastically about improvements they wanted to see at Magnolia ward to support better psychosocial interventions. This included making the ward a more stimulating environment, with sensory walkways and sensory room. At Pyrland 1 ward staff told us they wanted to provide more psychosocial interventions, but that the amount of psychological therapies or interventions they could offer patients was limited by a lack of appropriate specialist training. Staff did not have the capacity to routinely offer interventions such as cognitive behavioural therapy (CBT). This was because they had to receive specialist CBT training internally from the trust's own psychology team as and when they had the capacity to deliver it, and were not able to go to external training providers. Ward staff told us they were able to refer people to a psychologist, and that they got good support from psychology colleagues. However, the amount of psychological intervention

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available was potentially limited as a result of what one member of staff described as being spread too thinly, covering both community and inpatient services for example.

- Care records contained evidence that patients had good access to physical healthcare, including the intervention of specialists, when needed. Patients told us their physical health needs were met effectively, and this was also corroborated by relatives. One person, for example, told us how the chiropodist had been brought in to the ward to see their relative since they had been admitted.
- Patients' nutrition and hydration needs were assessed and met. Senior staff at each of the wards confirmed that dieticians and speech and language therapist were available to support in the assessment and planning of care as required. We saw nutrition and hydration assessments were carried out on or soon after admission for all patients. These covered the patient's history of eating, diet, and whether any supplements were taken. In conjunction with the physical assessment, staff could flag up anything requiring further investigation. People who had specific requirements or who were identified as being at risk nutritionally, were monitored more closely on food and fluid charts. We saw people were provided with different cutlery to suit their needs and given support with feeding when necessary. We saw that patients were provided with a good variety of tasty and nutritious meals, and hot and cold drinks were provided to meet people's hydration needs throughout the day.
- Clinical staff took an active part in a range of clinical audits. These included audits of length of stay and delays to discharge, infection control, nursing standards, falls and controlled drugs.

Skilled staff to deliver care

- Staff at each of the wards visited received regular supervision and all staff had had a recent annual appraisal. Senior clinical staff told us they had monthly old age and peer supervision, while junior doctors usually received weekly clinical supervision with the consultant psychiatrist. Nursing staff generally received supervision every four to six weeks. Due to a senior team member being on long term sick on Pyrland ward and their role not being covered, other staff were acting up to cover the necessary responsibilities. We were told this impacted on their ability to carry out some of their own tasks when the ward was busy, including supervision of more junior staff who occasionally went two to three months between supervision. All staff spoken with were happy with the level of support and supervision they received.
- Although most staff were fully up to date with their mandatory training, many of the staff spoken with across the three wards highlighted a lack of more specialist training to be an issue. For example, one member of staff told us they received good training in physical care, but had received little specialist dementia or mental health training which would have helped them to carry out their role more effectively. Another member of staff raised lack of specialist dementia training to be an issue, particularly as they worked on a ward where most of the patients had dementia. Staff all said their managers were very supportive in response to requests for additional training, but were only able to agree to additional training if it was available internally in the trust.

Multi-disciplinary and inter-agency team work

- We observed three handovers at the three wards visited. Each handover was well attended, with five or six staff including senior nurses, occupational therapists and nursing assistants. Patients were presented and discussed in a systematic and comprehensive way. All staff present were attentive and engaged with care. Behaviour, physical care needs, risks and medication were all discussed. In addition, people's observation level and status were discussed. Each handover was effective for enabling staff to meet the ongoing and changing care and health needs of patients. However, we felt there could have been more emphasis on recovery and rehabilitation interventions to be used on each shift. This would have helped to keep the attention on interventions to improve independence and self care. We also saw there was limited focus on psychosocial needs, or investigation of triggers and patterns around disturbed behaviour and possible plans to modify these.
- We found a similar situation in the three multi disciplinary team (MDT) meetings we attended. Again, these were well attended and patients were presented and discussed in a systematic and comprehensive way. At Pyrland ward MDT meeting we observed in depth

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discussion of three different patients waiting for placements. Discussion covered patients' progress, their likes and dislikes, what was working and what was not, medical status and results of physical checks. There was also discussion about patients' legal status, whether they were detained under the mental health act or under the mental capacity act deprivation of liberty safeguards. We found behavioural problems were not linked effectively in with the care planning and there was insufficient focus on recovery and rehabilitation. It was also noted that neither the patients or their next of kin were present at any of the MDT meetings, and so were not able to be fully involved in those discussions.

Adherence to the MHA and the MHA Code of Practice

- We saw evidence in records viewed that the wards inspected as part of this inspection adhered to the Mental Health Act (MHA) and the associated Code of Practice. We were told by staff that the trust's central MHA team were effective in supporting them, and ensured process and protocols were being followed; for example in relation to people who were detained under section. We saw evidence in patients' records that their rights under the MHA were explained to them on admission and then as appropriate thereafter.
- At Pyrland ward we found that admission to the ward was well managed, section papers were present and correct, and approved mental health professional (AMHP) reports were on file as required. We did identify a specific issue in relation to the decision making and recording of leave under section 17 of the MHA at Pyrland ward. This is covered in full in the separate MHAR reports for Magnolia and Pyrland wards, in which the provider is required to take action to address this and several other issues in respect of adherence to the MHA.
- Patients had access to independent mental health advocacy (IMHA) support and staff were clear on how to access and support engagement with the IMHA to obtain independent support for all patients on the wards as required. We saw evidence that all patients detained under section were accessing or referred to the advocacy service for support. We were told that the IMHA contract had been taken over by a new organisation earlier in the year, and that the service had been reorganised to be referral only since then. Staff told us they thought patients' advocacy needs would be better met by a proactive service on the ward rather than by one that was referral only.
- A number of issues in relation to mental capacity and consent were identified in the MHA reviews which were conducted as part of this inspection, and those are covered in detail in the separate MHAR reports for the wards.

Good practice in applying the MCA

- According to figures supplied from the trust, none of the ward staff had been required to complete, as part of their mandatory training, a module in consent. However, 89% of staff on the Pyrland wards had received MCA training but only 37% of staff on Magnolia ward had received this training. Some of the staff spoken with, including the ward managers and senior staff told us they had received training in the MCA through other training they had received. We found there was mixed practice in relation to wards meeting their obligations under the MCA.
- At Pyrland 2 ward we saw little evidence that the responsible clinician reviewed mental capacity regularly or that there was a systematic, structured approach to this. There was little reference to mental capacity within the progress notes of detained patients. Also, staff had not identified that a patient who was due to be moved to a new long term placement, but who was 'unbefriended' and potentially lacked mental capacity in relation to this decision, should have had the input of an independent mental capacity advocate to support them through this process. The MCA Code of Practice explains that an 'unbefriended' person is one who has no family or friends who are appropriate to consult in relation to specific important decisions including changes of accommodation and long term moves.
- In relation to do not attempt resuscitation (DNR) forms, we found that for one person there had been no family to liaise with but also no liaison with the independent mental health advocate (IMHA) who was involved with this patient. The form suggested that as the patient had dementia they had not expressed their views; however, again there was no mental capacity assessment to clarify this. We reviewed four other DNR forms, one of which was for a patient who had themselves requested a DNR form be put in place, and this included good

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evidence of involving the patient's relative and GP in the process. We were concerned that for the other three patients the DNR decision seemed to have been reached without discussion with the person or their relatives and that the DNR decisions were also not being regularly reviewed.

- However, ward managers and senior staff spoken with demonstrated a good understanding of the MCA and awareness of requirements regarding mental capacity and consent. For example, one senior staff member explained to us that all patients who were informal and not detained under the MHA were free to go as they wished and if requested. We observed another senior member of staff demonstrated a sound working knowledge of mental health legislation, including the MHA and MCA. A colleague in another team tried to make a referral to the ward for a person currently in a care home who was being very aggressive and was not able to do their own personal care or eat and drink for themselves. The member of ward staff correctly told the referrer they could not just admit the person to the ward at that time as they likely did not have mental capacity to agree to come to the ward informally or to consent to it being a locked ward. They explained to the referrer that the person would need to be admitted under MHA section or following an assessment of mental capacity and with relevant MCA deprivation of liberty safeguards (DoLS) authorisation in place.
- We also saw some evidence that, in line with legal requirements, mental capacity was assessed and recorded appropriately on a decision-specific basis with regards to significant decisions affecting people who potentially lacked mental capacity. Some of the care records viewed contained mental capacity assessments and records of consent to treatment or care. Care records for patients at Magnolia ward, in particular, contained good evidence of decision specific mental capacity assessments and subsequent 'best interest' decision making processes. This covered areas where decisions were required such as medication, hospital admission, and personal care. We saw there had been consultation with key professionals and family members, and were then able to track this through to the patients' care plans where best interests decisions were recorded. In line with key principles of the MCA, the care plans contained the least restrictive steps that staff should take support the best interests decisions.
- There had been 24 applications for deprivation of liberty safeguards (DoLS) authorisations in the six months from December 2014 to the end of May 2015. This consisted of 11 applications from Magnolia ward and 13 from the Pyrland wards. We saw evidence that applications for DoLS authorisations continued to be made when appropriate. For example, we were shown applications for DoLS standard authorisations, which had recently been submitted for two patients whose detention under MHA section was due to expire. The DoLS applications had been made appropriately because the people had been assessed as lacking mental capacity and there were continued 'risks posed to self and others if they were not within a safe care environment.' The applications had gone in and ward staff were awaiting the response from the local authority MCA team who processed and oversaw DoLS applications. We found staff had followed correct procedures, but they had not subsequently been sufficiently proactive in monitoring the progress of those submitted applications or prompting the supervisory body for updates.

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

- People using services and their carers told us they were treated with kindness, dignity and respect. One person told us that staff were polite and compassionate, and that they felt they cared about them. They told us how staff respected their privacy and made sure no one could see them when they were getting dressed. A person on another ward told us staff were always willing to help them, were respectful and polite, were caring and that they looked after them. They gave us a recent example of how staff had bought them some soothing linctus as they had a cough.
- We spoke to seven carers of patients and they all spoke positively about the kindness and respectfulness of staff and how caring they were. A relative of a person on Magnolia ward told us staff always made them feel welcome and that they delivered a very high standard of care. A relative of a person on Pyrland 1 ward told us: "Staff have been absolutely brilliant, the way they've looked after [their relative], they go the extra mile, I can't put in words what they do for [them], I haven't got a bad word to say."
- On visits to the three wards we inspected, we observed that all staff treated people with compassion and were sincere and caring in the way they interacted and gave support. We saw an activities coordinator thoughtfully sought different activities for people to do according to their interests. Other staff commented to us how the coordinator adapted activities according to people's needs and abilities, and prompted patients sensitively. During observation of lunch time at Pyrland 2 ward we saw numerous positive interactions between staff and patients. Staff referred to each person by name. When people were offered a choice of meals and drinks, a member of staff clearly knew well people's likely preferences and offered them choices or extra portions accordingly. The attentiveness of staff contributed to a positive dining experience for all patients. When supporting a person with eating for example, a member of staff explained what food was on the fork while gently feeding them. After the meal was finished, staff gave reassurance when talking to people, supporting them gently with a hand on their arm or shoulder if they needed support to move from the dining room. One person who had an injured arm was supported to move to another area of the ward where the member of staff could put a cushion underneath their arm to make them more comfortable.
- Without exception, the staff we met were conscientious, professional and committed to doing the best they could for the people in their care. We attended three multi-disciplinary team (MDT) meetings and three shift handover meetings for the wards we inspected. During these meetings we observed that patients were discussed in a respectful manner and that each patient was given due attention from a range of people supporting them.

The involvement of people in the care they receive

- Although people were discussed in a very positive and respectful way at the meetings we attended, it was noted that neither the patients nor their next of kin were present at any of the MDT meetings and so were not able to be fully involved in those discussions. We were subsequently informed by the provider that patients would not ordinarily attend MDT meetings on Magnolia ward due to their level of cognitive impairment; however, they assured us that patients on Magnolia ward and their carers were involved and engaged through a number of other meetings and review processes. Care plans did not always reflect how people were fully involved in the planning of their own care. The care records we inspected at Magnolia and Pyrland 2 wards contained good evidence of involvement of patients and relatives, but less so at Pyrland 1 ward. Needs and risk assessments were present and up to date and they contained good evidence of assessment and ongoing monitoring of physical health; but they did not contain clear record or evidence of patients' involvement.
- Care .The care records we inspected at Magnolia and Pyrland 2 wards contained good evidence of involvement of patients and relatives, but less so at Pyrland 1 ward. Needs and risk assessments were present and up to date and they contained good evidence of assessment and ongoing monitoring of physical health; but they did not contained clear record or evidence of patients' involvement.

Good

Are services caring?

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- However, we did see how each of the wards had additional systems in place to gather patients' input to the planning and delivery of care and the feedback of relatives. We attended a family liaison meeting on Magnolia ward. The staff member who facilitated the meeting was compassionate and supportive throughout, allowing family members to talk freely and to ask questions. They discussed the person's history and what specific support was needed. Information about the ward was given to the family and the staff member explained how the person had settled in to ward life in the days since their admission. The family were given a timeline for assessment of six to eight weeks, and two further progress meetings were to be scheduled in that time. Afterwards we spoke with the family, who told us they felt a lot better as a result of the meeting because it had given them confidence their relative would be looked after on the ward.

- Patients who were able to told us they were involved in the planning of their own care and treatment and that the care they received was in line with their wishes. One person, for example, told us staff regularly checked with them about how they wanted to be treated. We spoke to seven relatives of people who use the services and they told us they were kept up to date and involved in decision making processes concerning their family members who use services. They told us that they were involved in assessments and initial care planning. For example, they had been requested to fill in 'this is me' documents in order to provide detailed information about their relative's history, their likes and dislikes, and any specific wishes.

- We saw positive ways in which staff made effort to ensure people were involved in the day to day running of the wards. We attended two separate ward 'have your say' meetings, which were were set up specifically to gather the input and feedback of patients and were very well attended. At one such meeting on Pyrland 2 ward, food was discussed and people got the opportunity to say what they liked and also what they were not so keen on. For example, a patient confirmed they were happy with the variety and quality of vegetarian food options. The meeting was facilitated by the ward's activities coordinator, who we saw engaged with every patient and made sure everyone gave their opinion. We saw minutes to previous meetings, where people had made requests and it was recorded that staff had responded accordingly to meet those requests. For example, people had wanted wanted mugs to drink from and then mugs had been ordered; and people had wanted tai chi sessions, and staff had a planned date for starting up those sessions again.

- Staff told us that people were supported to access independent advocacy services if and as needed. Independent advocacy is a valuable tool which can help to safeguard and give a stronger voice to potentially vulnerable people who use services. Ward managers and senior staff were able to tell us what advocacy services were available, including statutory independent mental health advocacy. Leaflets publicising local advocacy services were on display on each of the wards, and advocacy workers were present carrying out their scheduled regular visits to the wards at the time of our inspection.

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, discharge and bed management

- The average bed occupancy across the wards between October 2014 and March 2015 was 94%. Both Magnolia and the two Pyrland wards had bed occupancy rates of more than 85%, and Pyrland wards had a particularly high occupancy rate of 98%.
- The high bed occupancy rate impacted on access and bed management in a number of ways. For example, although Magnolia ward staff told us they were usually able to keep a bed space for a person to return to from a period of leave, this was rarely the case for Pyrland wards. Senior staff at Pyrland 1 ward, for example, told us that bed pressures meant that beds were usually filled immediately when people went on leave from the ward.
- Additional pressure was put on the inpatient mental health services for older people as a result of delays to discharging patients. According to figures supplied by the trust, in the 6 months from October 2014 to March 2015 there were delays in discharges from older person's mental health inpatient facilities totalling 449 days. Magnolia ward had the highest number of delayed discharges with 283 days and Pyrland wards had delayed discharges of 166 days. Staff at each of the wards inspected told us there were sometimes delays to discharge due to circumstances largely beyond their control, such as lack of suitable residential care places and delays in obtaining home care packages. We were also made aware of changes to admission criteria at other wards that impacted further on staff's ability to discharge people. We were told that St Andrews ward for example, one of the trust's mental health inpatient services for adults of working age, previously admitted people who were over 65 years old, but such people were now not being admitted due to strict age criteria. The issue with delayed discharge was confirmed by family members, one of whom, for example, told us that Magnolia ward staff had wanted, but been unable to discharge their spouse due to a lack of care home places. This was also a problem at the Pyrland wards, and staff at those wards told us delays to discharge were frequent. At Pyrland 2 ward, for example, staff told us a patient's discharge had been delayed for two weeks at the time of our inspection because there was no home care package available to enable them to be safely discharged back into the community.
- Managers and senior staff explained to us how, in an effort to overcome the difficulties achieving timely discharges, they worked effectively and creatively with colleagues in other teams and services to ensure people were found places when needed. The manager of Magnolia ward, for example, told us about creative joint working between different in-patient services and how they spoke regularly with other ward managers to find out vacancies and gaps. Similarly, staff at Pyrland 1 ward explained how they worked well with other inpatient teams if an older person with a functional mental health condition needed a bed and they had didn't have space. They also had links with community hospitals who were able to help in limited circumstances.
- We found that a bed was not always available in a psychiatric intensive care unit (PICU), even if a person required more intensive care and support. At the Pyrland wards, for example, we were told there had been a small number of instances when a PICU bed had not been available when it was really needed. This had been a significant issue on at least one previous occasion, when they had not been able to transfer a very aggressive person to the PICU. We were told it had taken five staff on the ward to manage the aggression of the person. Staff told us that although they only needed to transfer people to the PICU very occasionally, it was a particular risk when they were unable to transfer because they had not themselves received sufficient specialist training to be able to deal effectively with physically able, aggressive and challenging people.

The facilities promote recovery, comfort, dignity and confidentiality

- Each of the wards had a range of different rooms and equipment to support treatment and care. This included rooms for interviews and therapy, clinic rooms for physical examinations, quiet rooms and larger communal rooms for group activities. We found that the inside ward space at the Pyrland wards was more conducive than that of Magnolia ward for promoting recovery and comfort. Pyrland 1 ward had an activities of daily living kitchen, which was very useful for promoting recovery of independent living skills such as

Are services responsive to people's needs?

Good

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

laundry and food preparation. Pyrland 2 ward had a bright and cheerful lounge and activities room, brightly decorated and with pictures on all walls and lots of items to aid reminiscence. It also had a salon for hairdressing, which we were told was very popular with patients There was access to attractive and well maintained outdoor spaces, in particular at Magnolia and Pyrland 2 wards. Dining areas were big enough to allow patients to eat in comfort and to encourage social interaction.

- However, we did identify a number of issues in relation to the facilities at each of the wards visited. At Magnolia ward, we were concerned to find an unused section of the ward was left open and accessible by any patients who chose to wander into that area. This unused section consisted of bedrooms and bathroom and a de-escalation room. The de-escalation room was of particular concern to us. The room was depressing, was painted grey and it had no windows. It was not a space conducive to calming or de-escalating distressed older people. Although we were told this room was no longer in use and had not been used for more than 12 months, it was left open throughout our visit and was accessible to patients who we observed wandered into the unused section of the ward. We felt the presence of this disused room was inappropriate and potentially unsettling to patients on the ward. Although this aspect of the ward's environment was of particular concern to us, we also felt the ward's décor and general appearance was somewhat drab, in comparison to the Pyrland wards. This was echoed by the relative of a patient on the ward, who told us they thought it was 'a bit grim', 'dreary', and likened it to an institution.
- At Pyrland 2 ward, some of the bedrooms did not have ensuite bathrooms. Staff raised with us that they thought this was an issue. Aside from the possible impact on people's dignity of having to share bathing facilities, we found that due in part to bed pressures on the ward, the fact that some bedrooms were not ensuite made it more difficult for staff to segregate effectively separate sleeping areas for men and women. This in turn made it difficult at times for the ward to comply with regulations concerning mixed sex accommodation.
- We identified an issue in relation to soundproofing of meeting rooms at the Pyrland wards. It was possible to hear the conversations taking place between people in the closed interview rooms when passing in the communal reception area outside. The rooms were used for family liaison meetings, discharge planning and memory clinics. The issue with soundproofing meant that patients' confidentiality and privacy could not be effectively maintained when other people were in the communal reception area near to those meeting rooms.
- We were told by staff that the trust had plans for the renovation and remodelling of their wards in the next 12 months or so. Staff spoken with at each of the wards were enthusiastic and gave us good suggestions for how the environments and physical layouts of their wards could be improved for the benefit of their patients. For example, with regard to improving or redesignating the different or unused spaces such as the de-escalation rooms. A member of staff at Magnolia told us they thought people would benefit greatly from the addition of a sensory room. A member of staff at Pyrland 2 ward suggested that if all bedrooms had ensuite facilities it would improve people's dignity and allow for better sex segregation. Another member of staff suggested sensor lights in bathrooms would support people's independence and also decrease the risk of falls. At Pyrland 1 ward, staff had good ideas for a specific family room or space for meetings with families. They explained how it would make it more friendly and less intimidating when families with younger children visited relatives on the ward.
- There was good access to different activities, including on weekends. We saw lots of different activities taking place at each of the wards visited during our inspection. These included group activities such as baking, bingo, exercise and 'have your say' patient feedback meetings. Patients and their relatives told us there were usually lots of activities to take part in, which people enjoyed. We also saw that people got to go out regularly on trips to places such as the park or the shops, accompanied by staff. The variety and quantity of different activities was due in a large part to the work of the specialist activities coordinators who staff, patients and relatives all spoke highly of. However, we also saw staff of different roles taking part enthusiastically in activities with patients and were assured that other staff made sure activities took place on weekends when the activities coordinators did not work.

Meeting the needs of all people who use the service

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Good

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- At each of the wards we visited, we saw there was a wide range of information provided for people who used services. This included information on different conditions and treatments, patient's rights, local support projects including advocacy, and how to make a complaint if they were not satisfied with the service they received. Staff told us they were able to obtain information in different formats and languages if needed, so as to support people's different communication needs. They were able to get outside interpreters very quickly when needed, but also had access to a list of trust staff who spoke different languages.
- Each of the wards had been adapted to ensure accessibility for disabled people. This included flat surfaces and ramps for wheelchair users and disabled adapted toilets. Bathrooms had necessary hoisting equipment and adapted baths. Outdoor spaces were flat and pathways wide enough for wheelchair access. Flower and vegetable beds were raised to enable easier access for patients.
- Staff confirmed that a choice of food could be provided at immediate notice in order to meet the dietary requirements of different religious and ethnic groups. People had access to appropriate spiritual support. Representatives from the Christian church made weekly visits to the wards to meet with patients and conduct Communion. We were told people of different faiths would be supported to access similar spiritual support as necessary and whenever required.

Listening to and learning from concerns and complaints

- According to figures supplied to us by the Trust, the older person's mental health inpatient services had received just three separate formal complaints overall in the 12 months between April 2014 and March 2015. Of those complaints, all three had been upheld following investigation.
- Patients and carers we spoke with told us they felt able to complain. People told us they had been taken through the trust's complaints process, but most said they would speak directly to ward staff if they were unhappy about anything and they believed their concerns would be effectively addressed. There were leaflets at each of the wards about how to make a complaint, along with details of the patient advice and liaison service. Staff told us they tried to answer any concerns immediately, before they became more formal complaints. They said the family liaison meetings had helped in this respect as they improved communication and gave people a forum to raise any questions or concerns on an ongoing basis.

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

- Staff spoken with were largely aware of and agreed with the organisation's values, but did not necessarily share or feel engaged with the organisation's vision. Staff on one ward told us they had been visited by the senior team, who had wanted to meet with them. Staff at another ward told us they knew who the senior team were, but that they had cancelled visits to the ward and weren't really visible to the ward team. Another member of staff told us the trust's values and vision were not shared in full by the ward's staff who, they said, concentrated simply on providing safe and compassionate care. They questioned how an inpatient service fitted in with the trust's vision to improve community based care.
- Somerset Partnership NHS Foundation Trust had been through a period of considerable change since 2011, when it had merged with Somerset Community Health the community health service provider of NHS Somerset. It was clear that many of the staff we spoke with felt the process of change following the merger had not been effectively managed. One of them told us they felt "a bit bombarded" as a result of constant new directives and changes. Ongoing changes to teams and structures had led, according to a senior clinician, to a lack of clinical and non clinical leads for older adults; which, they said, was a significant issue. Other staff described feeling angry and upset as a result of being "segregated" under the community umbrella, and distanced from the other mental health teams. They told us that it felt to them like the trust's senior management team saw them as an older person's service, primarily, and not as a mental health inpatient service for older people. Other staff said there had been a shift of focus, that the main emphasis was now on physical care and that they were losing the identity of being a specialist psychiatric unit. We did find evidence to substantiate staff's concerns during our inspection. Many of the staff spoken with told us they were unable to access the specialist training they needed to deliver a truly effective and up to date mental health inpatient service. Ward environments were not designed and laid out to the same safety standards as other inpatient wards, but were geared more towards caring for elderly people. Although we found wards were very caring and met effectively people's day to day and physical care needs, the lack of emphasis on recovery and rehabilitation suggested the model of care was outdated and that the trust had not kept fully abreast of developments in older people's mental health care.

Good governance

- We found although there were issues related to the management of change, there was evidence of effective local governance of the wards for older people with mental health problems.
- The majority of staff were up to date with their mandatory training, had been appraised and received regular supervision. Although there were issues as a result of nursing staff shortages, shifts were generally covered by sufficient numbers of staff of the right grades and experience. Staff told us they were able to spend more time with patients as a result of the national 'safer staffing' initiative. The reduction in beds had led to a decrease in staff stress, and given them what one staff member described as extra "time to care." Staff participated actively in clinical audits. Incidents were reported appropriately, and the investigation process following incidents allowed staff to learn and improve without feeling blamed or victimised. We saw examples of how ward staff were able to submit items to the trust risk register. At a local level, ward managers were highly thought of by their staff teams and were able to lead with appropriate authority.

Leadership, morale and staff engagement

- We found evidence of strong local leadership of the older persons inpatient mental health services.
- A member of clinical staff told us how local management openly encouraged feedback from staff and wanted to know from them what improvements were needed. Although there was a feeling among staff that they were able to contribute to development and changes on a local level, they told us there was less opportunity to shape policy or contribute to change at a more senior level. They told us there had been a lack of engagement opportunities, which had resulted in them feeling out of touch with the wider trust.
- Sickness rates had been high in the 12 months from April 2014 to the end of March 2015, averaging at almost

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10% across the three wards inspected. We were aware of staff being on long term sick leave at the time of our inspection. There was also an issue at each of the wards in relation to vacancies for qualified permanent nursing staff. These factors were having a negative impact on other nursing staff, whose workloads had been increased as a result. Despite that, we found there was good morale among staff teams at a local level. Staff told us they were unaware of any issues with bullying, that their peers were supportive and that they enjoyed their jobs.

- Staff knew how to use the trust's safeguarding and whistle-blowing processes and felt able to raise concerns without fear of victimisation. They told us they were prepared to whistle-blow if they thought it necessary, but that they felt confident raising concerns openly. One member of staff told us how the trust's 'see something, say something' project had added to the open atmosphere. We saw a similar openness during our inspection in staff communication with patients and relatives following incidents, which showed how staff worked to meet the new 'duty of candour' requirement.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment** The registered person did not demonstrate that they had fully assessed all the risks related to the health and safety of service users receiving care or treatment and had not done all that was possible to mitigate those risks. They had not ensured the premises were safe for their intended purpose and used in a safe way. Risks associated with the physical ward environment, such as ligature points, had not been fully assessed and addressed. The provider had also not ensured that persons providing care or treatment to service users had the competence and skills to do so safely at all times, as staff had not received adequate training to be able to safely manage fit and able patients who were physically aggressive. This is a breach of regulation 12 (2) (a)(b)(c)(d)

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA (RA) Regulations 2014: Need for consent** The registered person did not demonstrate that care and treatment were provided only with the consent of the service user or other relevant person. The registered person could not demonstrate that they had acted in accordance with the Mental Capacity Act 2005 in all instances where a service user lacked mental capacity to consent to their care and treatment.

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 11(1) & (3)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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