Kent and Medway NHS and Social Care Partnership Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXY6Q	Priority House	Orchards Ward	ME16 9PH

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

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

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

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We carried out a focussed inspection of Orchards ward on 18 April 2018. We had received concerns through our intelligent monitoring, a Mental Health Act review visit and from families and carers of patients. Concerns raised included poor risk management, the ward environment and poor monitoring of patients' physical health. The ward was last inspected in January 2017 as part of a comprehensive inspection. At the comprehensive inspection, we rated the wards for older people with mental health problems as 'good' in all key lines of enquiry of safe, effective, caring, responsive and well led.

During this inspection, we found the following areas of good practice:

•Staff vacancies had reduced since the comprehensive inspection. The manager had recently recruited two qualified nurses who were deputy managers. Two nurses were available for each shift, other than in the event of staff sickness.

•There was a registered general nurse on the ward Monday to Friday who was not included in staffing numbers. This meant that they could dedicate their time to attend to patients' physical health needs. The registered general nurse was the physical health care lead for the ward and had oversight of patients' physical health care plans. A core physical health care assessment, which included food and fluid charts, was completed for all patients for the first 72 hours of admission.

•Staff completed a risk assessment as soon as possible and within 72 hours of a patient's admission. Risk assessments were regularly updated, including during ward rounds.

•The nurse in charge allocated observation responsibilities at the beginning of each shift. The manager issued staff with a laminated card which contained details of observation levels. A band four member of staff role modelled observations for new members of staff.

•Changes had been implemented following a serious incident in January 2018 to reduce the risk of future incidents. For example, how staff recorded certain medicines so that they were easily identifiable.

•All patients had a named nurse who was responsible for their care plans. Care records and progress notes were detailed and meaningful. Care plans reflected the individual needs of patients, for example, monitoring of diabetes or epilepsy.

•The ward used the dementia toolkit guidance. The toolkit provides practical advice and visual aids to help carers and families alike to support someone living with dementia. A member of staff was the lead for dementia care mapping.

•Staff completed detailed person centred support plans for patients with dementia. The support plans included information about the patient's life story, triangle of care, personality, social/occupation and physical and mental health. The care plans were colour coded to demonstrate proactive support and what staff should do if the patient becomes agitated.

•Staff completed detailed antecedent, behaviour and consequence (ABC) charts. The charts were analysed by a named staff member and psychologist, to better understand what the behaviour is communicating so that they could better meet the needs of the patient.

•The physical health lead had developed links with specialist services including the dietician, speech and language therapists, tissue viability nurses and urology team at the local general hospital.

•We observed staff treating patients with care, kindness, dignity and respect. Staff spoke about patients in a respectful manner and showed a good understanding of their individual needs. Staff were enthusiastic in their desire to improve patients' physical and mental health.

•The feedback from patients, families and carers was positive. Families and carers were invited to ward rounds and progress review meetings. Families and carers felt able to contact the ward at any time.

•Staff had decorated the family room and donated toys to make it a more welcoming and homely environment for patients and their families.

•Details of how to make a complaint were included in the patient and carer welcome packs. The patients and carers we spoke with all knew how to make a complaint.

Summary of findings

•The ward had a "you said we did" board. The board detailed the actions taken in response to suggestions, comments and complaints from patients and carers.

However, we also found the following areas for improvement:

•Anti-ligature door handles were still not in place despite inspectors raising this as a concern during our comprehensive inspection in January 2017 and the Mental Health Act reviewer visit in February 2018. The provider action statement dated 21 March 2018 said that this work would be completed by 8 April 2018 (which was ten days before this inspection).

•Repairs to the female garden area remained outstanding despite the Mental Health Act review provider action statement dated 21 March 2018, stating that immediate works would take place.

•The only de-escalation room was located on the male corridor. This meant that staff had to escort female patients onto the male corridor and may compromise dignity and respect and breach gender specific areas.

•There was little signage on the ward. The button to exit the male corridor was not obvious, and in a dimly lit corridor. This meant that some patients might struggle to locate the button and exit the ward.

•At the time of our inspection, staff did not have access to a secure camera so were unable to take a photograph of patients for medicine charts or of pressure ulcers to send with a referral to the tissue viability team. Senior managers assured us that actions had been taken to rectify this situation before inspectors left the service.

•The provider action statement from the Mental Health Act review visit in February said that privacy screens would be closed at all times. However, during this inspection we saw that staff continued to leave privacy screens on bedroom doors open for some patients.

•Menus were difficult to read and there were no pictures displayed in the dining room to remind patients of meal choices. Finger food was not routinely available for patients.

Summary of findings

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

Are services safe?

We found the following issues the trust needs to improve:

- Environmental risks identified during our comprehensive inspection in January 2017 and the Mental Health Act reviewer (MHAR) visit in February 2018 remained. The provider action statement in response to the MHAR visit stated that the trust would take immediate action to the risk posed by potential ligature anchor points. During this inspection, we were told that anti-ligature door handles had been ordered but were still not in place.
- The provider action statement in response to the MHAR visit in February 2018 recorded that the courtyard in the female garden area required immediate works to ensure patient safety and ability to exit in an emergency. However, during this inspection we saw that work remained outstanding.
- The only de-escalation room was located on the male corridor. This meant that staff had to escort female patients onto the male corridor.This may compromise the privacy and dignity of both men and women.
- At the time of our inspection, staff did not have access to a secure camera so were unable to take a photograph of patients for medicine charts or of pressure ulcers to send with a referral to the tissue viability team. This put patients at risk incorrect medicine being given to patients and not receiving timely and appropriate care. Senior managers assured us that actions had been taken to rectify this situation.
- There was little signage on the ward. The button to exit the male corridor was not obvious, and in a dimly lit corridor. This meant that some patients might struggle to locate the button and exit the ward.
- Staff told us that they placed symbols above bedroom doors to indicate patient needs and identify risk. For example, a falling star denoted that the patient was at risk of falls and a butterfly represented a diagnosis of dementia. However, we did not see any of these symbols, despite there being four patients with dementia on the ward.

However, we found the following areas of good practice:

- Two qualified nurses had recently been recruited as deputy ward managers. There were a minimum of two qualified nurses available for each shift. A registered general nurse was on the

Summary of findings

ward Monday to Friday. The general nurse was not included in staffing numbers other than in the event of staff sickness. This meant they could dedicate their time to the physical health needs of patients.

- Staff completed a risk assessment as soon as possible and within 72 hours of a patient admission. Staff regularly updated risk assessments including during ward rounds. Staff assessed patients' risk of developing pressure sores. We saw many examples where patients' risk of developing pressure sores had decreased.
- The manager maintained a log of all safeguarding concerns, which included details of patient name, date of referral and progress. A poster had been devised describing when staff should raise a safeguarding alert in the event of a patient falling.
- The nurse in charge allocated observations at the start of each shift. The ward manager had created a laminated card for staff with information about observations. A band four member of staff role modelled observations for new staff.
- We saw evidence of staff learning from a serious incident in January 2018. Changes had been implemented to reduce the risk of future incidents

Are services effective?

We found the following areas of good practice:

- All patients had a named nurse who was responsible for their care plans. Care records and progress notes were detailed and meaningful.
- A registered general nurse was the physical health care lead for the ward and had oversight of patient's physical health care plans. A core physical health care assessment, which included food and fluid charts, was completed for all patients for the first 72 hours of admission.
- Staff appropriately monitored patients' physical health care. There were corresponding care plans for patients with physical health conditions such as diabetes and epilepsy. We saw evidence of an improvement of patients' physical health.
- The ward used the dementia toolkit. A member of staff was the lead for dementia care mapping.
- Staff completed detailed person centred support plans for patients with dementia. The support plans included information about the patient's life story, triangle of care,

Summary of findings

personality, social/occupation and physical and mental health. The care plans were colour coded to demonstrate proactive support and what staff should do if the patient becomes agitated.

- Staff completed detailed antecedent, behaviour and consequence (ABC) charts. The charts were analysed by a named staff member and psychologist, to better understand what the behaviour is communicating so that they could better meet the needs of the patient.
- The ward was preparing to pilot the Newcastle model of patient centred care. The Newcastle Model provides a framework and process for staff to understand behaviour that challenges in terms of unmet patient needs, and suggests a structure to develop effective interventions that keep people with dementia central to their care.
- There was a multi-disciplinary staff team, which comprised; consultant psychiatrist, staff nurse, registered general nurse, health care assistants, occupational therapists, associate practitioners, student nurse and psychologist. Consultants followed patients through to discharge to community teams to ensure continuity of care.
- The physical health lead had developed links with specialist services including the dietician, speech and language therapists, tissue viability nurses and urology team at the local general hospital.

Are services caring?

We found the following areas of good practice:

- We observed staff treating patients with care, kindness, dignity and respect. Staff spoke about patients in a respectful manner and showed a good understanding of their individual needs. Staff were enthusiastic in their desire to improve patients' physical and mental health.
- Staff orientated patients to the ward and gave patients and carers an information pack.
- The feedback from patients, families and carers was positive. Families and carers were invited to ward rounds and progress review meetings. Families and carers felt able to contact the ward at any time.
- There was a family liaison worker on the ward, who actively kept families and carers informed of the care and treatment of their relatives.

Are services responsive to people's needs?

We found the following areas of good practice:

Summary of findings

- Toilets had red seats to support patients with dementia distinguish from their surroundings and avoid potential falls and spills.
- Staff had decorated the family room and donated toys to make it a more welcoming and homely environment for patients and their families. The ward had recently installed the internet and laptops had been ordered for patient use. A 'pets as therapy' team visited ward weekly.
- Details of how to make a complaint were included in the patient and carer welcome packs. The patients and carers we spoke with all knew how to make a complaint.
- The ward had a "you said we did" board. The board detailed the actions taken in response to suggestions, comments and complaints from patients and carers.
- Compliments and complaints were uploaded to datix and analysed by the trust complaints team.

However, we found the following issues the trust needs to improve:

- Staff told us that some patients had requested that staff left their privacy screens open at night to avoid disturbing them when opening and closing the screen. However, following concerns raised about patients' privacy and dignity during the Mental Health Act reviewer visit in February 2018, the provider action statement stated that the screens would be closed at all times.
- Menus were not easy to read and there were no pictures displayed in the dining room to remind patients of meal choices. Finger food was not routinely available for patients.

Summary of findings

Information about the service

The wards for older people with mental health problems provided by Kent and Medway NHS and Social Care Partnership Trust offer care both for those with organic mental disorders and for those with functional mental health problems.

An organic disorder has an underlying physical cause, for example Alzheimer's. Functional mental health problems include depression or schizophrenia.

Orchards ward is a 16 bed mixed gender ward for older people with organic and functional mental illness. There were 14 patients on the ward at the time of our inspection.

We inspected nine wards for older people with mental health problems during a comprehensive inspection in January 2017. We rated the wards for older people with mental health problems as 'good' in all key questions (safe, effective, caring, responsive and well led).

Our inspection team

The team that inspected Orchards ward comprised three inspectors, one specialist adviser with knowledge and experience of working on wards for older people with mental health and one expert by experience.

Why we carried out this inspection

We undertook an unannounced, focused inspection of Orchards ward following concerns we had received through intelligence monitoring, and from carers and relatives of patients. Concerns included poor monitoring of physical health care, poor risk management, the ward environment and lack of family and carer involvement. A recent visit by a Mental Health Act reviewer identified concerns, which included vulnerable patients who may be at risk from other patients, staff not treating patients with dignity and respect and the ward environment.

As this was not a comprehensive inspection, we did not pursue all key lines of enquiry. As we only focused on concerns raised with us, we have not reconsidered the rating of this service.

How we carried out this inspection

During this inspection we considered aspects of the following key questions:

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

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

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the manager for the ward
- spoke with four other staff members; including a nurse , health care assistant, an agency nurse and a psychologist
- attended and observed a hand-over meeting

Summary of findings

- reviewed 12 patient care records
- reviewed six risk assessments
- spoke with three carers and relatives
- observed a multi-faith activity delivered by the chaplain
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients, carers and families were generally positive about their experience. Patients said they felt involved in their care planning and staff explained about medicines when patients were able to understand.

Families and carers told us staff invited them to progress review meetings and ward rounds. Families and carers felt able to contact the ward any time of the day and night. They told us that their relative's health had improved since they had been admitted to the ward.

Good practice

The ward had a physical health lead who was responsible for patients' physical health care. The lead delivered training to staff and made sure that they were competent to carry out basic physical health checks and identify where more specialist help was required. There was evidence of improvement in various aspects of patients' physical health because of the assessment and monitoring completed by staff.

There was proactive use of the dementia care mapping toolkit and implementation of 'This is me' person centred support plans. The ward was preparing to facilitate a pilot involving a model of care specially designed to meet the needs of patients with dementia.

The ward had a family liaison lead who was the primary point of contact for families and carers. The lead provided information about the ward and made sure that families and carers were kept up to date with information when they had been unable to attend a ward round.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that they take immediate action to mitigate risks associated with urgent ligature points.
- The trust should take immediate action to carry out the repair works for the female garden area
- The trust should take immediate action to ensure that the ward has access to a secure camera to reduce any risk to patients and ensure timely and appropriate care.
- The trust should ensure that all staff are aware of the decision to keep privacy screens on patient bedroom doors closed at all times.
- The trust should ensure that patients are able to read menus and that appropriate food, in line with national guidance, is available for patients.

Kent and Medway NHS and Social Care Partnership Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Orchards Ward	Priority House

Mental Health Act responsibilities

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

As this was a focussed inspection, we did not inspect key lines of enquiry concerning the Mental Health Act.

A Mental Health Act reviewer had completed a visit to Orchards ward in February 2018. The reviewer found that some issues remained from their previous visit in August 2016. The trust has since submitted an action statement detailing how and when these and other concerns found during this visit will be addressed.

All staff except one had completed training in the Mental Health Act.

A representative from the Independent Mental Health Advocacy service was based on the ward, so was easily accessible for staff and patients.

The Mental Health Act administrator based on site scrutinised the detention paperwork and reminded the ward of their statutory duties under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

As this was a focussed inspection, we did not inspect key lines of enquiry concerning the Mental Capacity Act.

All staff except one had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Detailed findings

Care plans demonstrated that staff had involved patients and carers with their care and treatment as much as possible. Some patients did not have the capacity to fully engage with their care planning.

Are services safe?

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

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

Our findings

Safe and clean environment

- The environment contained a number of blind spots and ligature risks in the form of handrails and door and window handles. Staff told us that anti-ligature door handles had been ordered. Staff had identified ligature risks on the environmental risk assessment and mitigated risks by completing one to one observations if required.
- The ward was divided into three sections. There were two male only corridors with five bedrooms in each. The female corridor had six bedrooms. Male and female bedrooms were separated by locked corridors.
- All patients had their own bedroom, which contained wash hand basins. None of the bedrooms had en-suite facilities. Assisted bathrooms were available in both male and female areas. There were shared toilet and shower facilities on each corridor. All bedrooms contained call button alarms.
- Staff told us of plans to upgrade the ward environment, to include en-suite facilities by 2020. We received confirmation that the trust had signed off capital planning works the week before our inspection. The work included the removal of 93 ligature points on bedroom furniture and installation of two wet rooms for the male and female corridors by the end of August 2018. A full upgrade of the ward was planned to take place in 2019/2020.
- Bedroom doors had been designed to look like a 'front door' to help patients feel at home and create a non-institutionalised environment. Bedrooms were kept locked unless patients wanted to leave them open.
- Male and female patients had separate and shared lounge and dining areas. The spacious male dining room / lounge was also used for activities.
- The only de-escalation room was located on the male corridor. This meant that staff had to escort female patients onto the male corridor and may compromise privacy, dignity and respect and breach gender specific areas. The window in the room was frosted as it overlooked a public area. This meant that the room lacked warmth and let in little natural light.
- The outside area from the male ward contained raised beds and sensory plants. The female ward had a separate lounge and dining room, which led to a garden area. Staff had to accompany female patients wishing to access this garden, due to uneven paving and work required to fence. Staff told us that this had been reported and work was due to take place. A room used as a female quiet room was also located in the separate female corridor.
- There was little signage on the ward. The button to exit the male corridor was not obvious, and in a dimly lit corridor. This meant that some patients might struggle to locate the button and exit the ward.
- Staff told us that they placed symbols above bedroom doors to indicate patient needs and identify risk. For example, a falling star denoted that the patient was at risk of falls and a butterfly represented a diagnosis of dementia. However, we did not see any of these symbols, despite there being four patients with dementia on the ward.
- The environment was clean and tidy, although looked sparse in corridors and some communal areas. There was little stimulation on the walls and the laminated inspirational quotes were very small and fixed to the wall. A recovery tree mural on a corridor wall had nothing on it.
- All staff except occupational therapists wore uniforms. Uniforms were different colours to differentiate staff roles and responsibilities. Information about different staff uniforms was displayed on notice boards for patients and carers.

Safe staffing

- A consultant psychiatrist, a speciality doctor and a trainee doctor provided medical input to the ward. A duty doctor based at another site was available between 5pm and 9am. Staff called an ambulance in the event of an emergency.

Are services safe?

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

- Staffing consisted of two qualified nurses and five health care assistants during the day and two qualified nurses and four health care assistants at night. During night shifts, the qualified nurses identified tasks so that one was always available on the ward.
- Occupational therapists were not included in staffing numbers so that they could dedicate their time to providing activities for patients. On the day of our visit, the physical health lead nurse was on the ward in addition to the required levels of nursing staff, although the ward was one health care worker short for part of the morning.
- The manager had recently recruited two nurses who were deputy ward managers. Three new staff had recently been recruited and interviews for two health care assistant posts were due to take place the week after our inspection. An agency nurse was on a short-term contract to enable consistency. However, agency nurses were unable to access the electronic care record system because of trust policy.
- All staff, including bank and agency, completed mandatory training.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment as soon as possible and within 72 hours of a patient admission. Risk assessments were updated during ward rounds.
- We looked at six patients' risk assessments. Staff did not create new risk assessments but regularly updated existing risk assessments in response to incidents and changes in circumstances. We saw examples of patients, who had changes in their legal status, having their risk assessments updated to identify potential risks whilst on unescorted leave.
- Staff assessed patients' risk of developing pressure sores. They used the Waterlow score, which is a recognised tool, and carried out this assessment in line with identified risk and in line with individual care plans. We saw many examples where patients' Waterlow score had decreased whilst on the ward. This meant their estimated risk of developing pressure sores had decreased.
- At the time of our inspection, staff did not have access to a secure camera so were unable to take a photograph of pressure ulcers to send with a referral to the tissue viability team. This put patients at risk of not receiving timely and appropriate care. The manager had reported this on the trust electronic incident reporting system and contacted various teams within the trust but did not know when it would be resolved. Inspectors raised this as a concern and prior to leaving the ward; senior managers told us that immediate actions had been taken to resolve this.
- Medicine charts did not all have photos of patients because staff did not have access to a secure camera, since the trust had updated its information technology system. This meant that there was an increased risk of incorrect medicine being given to patients. Staff were mitigating risk by writing a description of the patient on the charts. Inspectors raised this with the senior management team who gave assurance that they would act on this immediately.
- All staff except one had completed safeguarding training. The manager confirmed that the member of staff would complete the training as a matter of priority.
- The manager maintained a log of all safeguarding concerns, which included details of patient name, date of referral and progress. A poster had been devised describing when staff should raise a safeguarding alert in the event of a patient falling.
- The nurse in charge or senior member of staff on shift allocated observations. Staff carried an observation folder at all times for patients on eyesight observations. The ward manager had created a laminated card with observation information for staff reference. A copy of the card was also in the observation folder. A band four member of staff role modelled observations for new staff to ensure best practice.

Track record on safety

- A serious incident in January 2018 involved a patient death. We saw evidence of learning and changes made to mitigate risk of future incidents. This included specific medicines training for staff and changes in the way staff recorded certain medicines on the patient 'at a glance' board.
- The ward had adhered to duty of candour responsibilities. The duty of candour is a regulatory duty

that relates to openness and transparency and requires providers of health and social care services to notify clients (or other relevant persons) of 'certain notifiable safety incidents'.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on the trust electronic incident reporting tool. Incidents were discussed during team meetings and handovers. The manager and psychologist had provided an initial formal debrief for staff immediately following the recent serious incident. Staff received monthly learning bulletins, which included results of investigations specific to the older person care group.
- The ward manager had attended a feedback session of the investigation into the serious incident the week before our inspection. A reflective session had been arranged for staff to discuss learning. However, we spoke with an agency nurse who was unaware of the nature and details of the incident.
- We saw evidence of changes made because of incidents. For example, staff had been asked to refresh their online modified early warning score (MEWS) training to better recognise deterioration in a patient's physical health.

Are services effective?

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 the care records of 12 patients and found that progress notes were detailed and meaningful. Staff wrote relevant information that related to individual patient care plans and recorded ongoing plans to support their colleagues continue care. The physical health lead had oversight of all physical health care plans.
- Staff monitored patients' physical health care appropriately. Staff used the modified early warning score (MEWS), which identifies deterioration in physical health and guides staff how to respond. All patients had their physical health observations checked daily or more regularly if identified in their care plans. Staff repeated checks appropriately, according to the MEWS score, until physical health had either improved, or required staff to contact medical staff.
- We found patients that had physical health conditions, such as diabetes and epilepsy, had corresponding care plans to support staff to manage these conditions. These care plans were clear and detailed and contained patient's views and areas they could maintain independence. For example, making informed choices about their diet. All patients had a folder in their bedrooms that contained their care plans so these could be easily viewed by patients and carers.
- The ward had access to pressure mats for patients at risk of falls and pressure relieving mattresses for patients at risk of pressure ulcers. A nurse completed an immediate and weekly review of falls.
- The ward manager had created an admission checklist for staff. The checklist identified actions for staff to complete immediately and within 24 and 72 hours of admission.
- All bedrooms except two contained a locked medication cupboard. Staff encouraged patients to self-administer medication, where appropriate.
- The manager completed regular audits, which identified areas for improvement. Audits were discussed twice a month during team meetings. Gap check audits identified areas of non- compliance for areas such as a patient's legal status, nutrition and risk.

Best practice in treatment and care

- A registered general nurse was the physical health care lead for the ward. A core physical health care assessment, which included food and fluid charts, was completed for all patients for the first 72 hours of admission.
- A nurse reviewed food and fluid charts to check for areas of concern. The charts were also reviewed during multi-disciplinary team meetings and a decision made whether to continue, if appropriate. weighed patients weekly.
- The ward used the dementia toolkit. There was one qualified member of staff for dementia care mapping who tried to complete a care map for at least one patient per week. Dementia care mapping was discussed during the weekly formulation meeting. The trust were investigating training more staff to complete dementia care mapping. The National Institute for Clinical Excellence (NICE) guidelines says that people with dementia should receive care from appropriately qualified staff.
- All patients had a named nurse who was responsible for care plans. Staff completed detailed person centred support plans for patients with dementia. The support plans included information about the patient's life story, triangle of care, personality, social/occupation and physical and mental health. The care plans were colour coded to demonstrate proactive support and what to do if the patient becomes agitated. This is in line with NICE guidelines, which state
- Although less detailed, patients with a functional mental illness had person centred care plans, which included information about their personality, social, family and hobbies.
- Staff completed detailed antecedent, behaviour and consequence (ABC) charts. The charts were analysed by a named staff member and psychologist, to better understand what the behaviour is communicating so that they could better meet the needs of the patient.
- The occupational therapists were included in the key working team for each patient. During our inspection, an occupational therapist was developing a daily structure plan for a new patient who said that they had found the move to the ward stressful.

Are services effective?

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.

- The ward was preparing to pilot the Newcastle model of patient centred care. The Newcastle Model provides a framework and process for staff to understand behaviour that challenges in terms of unmet patient needs, and suggests a structure to develop effective interventions that keep people with dementia central to their care. The psychologist was setting up 30 minute comprehensive training after each handover to upskill staff in this model.

Skilled staff to deliver care

- There was a multi-disciplinary staff team, which comprised; consultant psychiatrist, staff nurse, registered general nurse, health care assistants, occupational therapists, associate practitioners, student nurse and psychologist. Consultants followed patients through to discharge to community teams to ensure continuity of care.
- The ward had a physical health care lead nurse who was not counted in the staffing numbers, unless necessary. For example, in the event of staff sickness. This meant that they could focus on patients physical health needs.
- The psychologist completed one to one and group work with patients. They were involved in the formulation of the person-centred care plans and analysing the antecedent behaviour and consequence charts to better understand the needs of the patient.
- Staff routinely referred patients to the physiotherapist who provided support twice a week to assist patients with mobility issues.
- All new staff, including bank and agency, completed physical health care training with the physical health lead. Staff were aware to discuss patients' physical health care concerns with them.
- The physical health care lead carried out role modelling with staff to ensure competence and good practice. They completed competence assessments with staff to ensure understanding.
- Staff had completed a range of physical health training which included MEWS, physical health in mental health, sepsis, and cardio metabolic.
- The manager was attending a leadership course.
- There was a clinical housekeeper on the ward who was responsible for preparing breakfast. The housekeeper carried out additional responsibilities such as making patient beds so that the health care assistants were available on the ward for patients.

Multi-disciplinary and inter-agency team work

- Staff completed handovers at the start of each shift. A handover form provided patient information including legal status, observation level and physical health concerns. Staff referred to the patient 'at a glance' board, which contained key areas of patient information. A nurse reviewed handover forms and observation levels after each handover meeting.
- We observed a handover where staff discussed physical health concerns, legal status, observation levels, named nurse, CPR status, medication, hygiene, nutrition, food and fluid charts, risks, allergies, modified early warning scores and patient allergies. During the meeting, staff were informed of any new admissions and reminded of individual patient needs. Although comprehensive, the handover was nurse led with little input from the occupational therapy team.
- A full range of care disciplines attended the twice weekly ward rounds. Staff invited family and carers to attend ward rounds. The family liaison lead provided updates from meetings where carers and relatives were unable to attend.
- The physical health lead had developed links with specialist services including the dietician, speech and language therapists, tissue viability nurses and urology team at the local general hospital. The physical health lead could perform some physical health tasks including catheters.
- The ward had developed links with the local urgent medical assessment unit, which was located near the ward. Staff escorted patients for routine appointments, either walking or using a wheelchair. Staff called an ambulance in the event of an emergency.
- The manager attended monthly leadership and inpatient forum meetings. Topics discussed during the meetings included safeguarding, shared learning and finance. Meetings had been arranged so that information could be shared with staff during the team meeting.

Are services effective?

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

- Staff attended a weekly 'bug meeting' to encourage team problem solving and good practice. Examples included an improvement in the recording of patients' diet and fluid intake.
- Staff had good access to the Independent Mental Health Advocacy team whose office was based on the ward.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff treating patients with care, kindness, dignity and respect. When staff spoke about patients, they discussed them in a respectful manner and showed a good understanding of their needs.
- Staff demonstrated passion and enthusiasm in their role and a desire for improvement in patient's physical and mental health.

The involvement of people in the care that they receive

- Where possible, staff involved patients in their care planning and risk management. Patients we spoke with told us they had been involved in their care planning. Carers told us staff invited them to care planning meetings and ward rounds. The National Institute of Clinical excellence guidelines recommend that people with dementia, with the involvement of their carers, have choice and control in decisions affecting their care and support.
- Patients told us that they had received a welcome pack when they were admitted to the ward. Staff had orientated them to the ward and explained about their prescribed medicines.
- There were bi-weekly community meetings where patients could provide feedback about the ward.
- The ward had a family liaison lead who, where possible, met with families and carers prior to admission. Staff provided carers with a carer information pack and details of carers meetings.
- Carers told us that staff had a really good rapport with patients. They told us that they were able to contact the ward any time of the day or night.

Are services responsive to people's needs?

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

Our findings

The facilities promote recovery, comfort, dignity and confidentiality

- Patient privacy and dignity was compromised as the privacy screens on bedrooms doors were left open at night for some patients. Staff said that this was at the request of patients who had said that the noise of staff opening and closing the privacy screens during checks disturbed them. However, the provider action statement following the Mental Health Act reviewer visit in February 2018 says that privacy screens were to be closed at all times.
- There was a dining area on both the male and female wards. There was also a communal area where patients could eat and socialise together. Patients were able to make hot and cold drinks at any time of the day. Staff supported patients who were unable to make their own drinks.
- Patients chose their meals from a varied menu. However, the font size on the menu was very small making it difficult to read. Inspectors raised this with the ward manager who said that she would increase the size of the font so that patients could read the menu more easily.
- Patients ate a light meal at lunchtime and a hot meal in the evening. Finger food was not provided unless specifically requested by staff. However, the occupational therapists could make finger food with patients. The dementia toolkit guidance says that staff should make sure that suitable food is offered to patients and assistance provided where appropriate.
- Staff had decorated the family room and donated toys so that patients had a nice environment to meet their family and children away from the ward environment. However, the room was not entirely private as conversations could be heard in the corridor.

Meeting the needs of all people who use the service

- There was a 'peace' room for patients. The trust chaplain provided a weekly multi-faith service for patients who wished to attend.
- Toilets had red seats to support patients with dementia distinguish from their surroundings and avoid potential falls and spills.
- The ward had recently installed the internet and laptops had been ordered for patient use.
- A 'pets as therapy' team visited ward weekly.

Listening to and learning from concerns and complaints

- There had been one formal written complaint in the previous 12 months, which had been partially upheld.
- Staff tried to resolve complaints at a local level in the first instance. If this was not possible, complaints were escalated to the ward manager. Staff received feedback concerning complaints during supervision and team meetings
- Details of how to make a complaint were included in the patient and carer welcome packs. The patients and carers we spoke with all knew how to make a complaint.
- The ward had a "you said we did" board. The board detailed the actions taken in response to suggestions, comments and complaints from patients and carers.
- Compliments and complaints were uploaded to the electronic incident reporting system and analysed by the trust complaints team.