Requires improvement

Humber NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV938	Maister Lodge	Maister Lodge	HU8 0RB
RV942	Millview	Millview Lodge	HU16 5JQ

This report describes our judgement of the quality of care provided within this core service by Humber 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 Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber 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?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Humber NHS Foundation Trust's wards for older people as requires improvement because:

- The recording of medicines at Maister Lodge required improvement.
- There continued to be higher use of agency staff at Maister Lodge and issues with the deployment of experienced staff /more senior clinical staff being limited especially at evenings and weekends and despite escalation these had not been addressed.
- Systems were not fully in place to ensure all incidents of restraint were recorded appropriately.
- Ward staff and operational managers had highlighted that staffing levels on Maister Lodge required review particularly at nights and weekends. The trust produced a plan to deal with staffing levels in June 2015. These actions were still being addressed.
- The ward based audits did not pick up on issues we found on inspection such as medicines management issues.
- Whilst there were plans to develop the environment of Maister Lodge, these plans had been in place for some time and, in the meantime, the quality of the environment had deteriorated.

However

- Each ward provided safe environments to care for patients. There were good patients' risk assessments in place so the risks were well managed. Patients' physical health was monitored. Each ward was meeting same sex guidance. Patients told us that they felt safe. There was evidence of lessons learnt.
- Staff wrote care plans that were of good quality; including those for people with dementia. There was effective multi-disciplinary working with daily care reviews taking place. Staff were adhering Mental Health Act. Best interest decisions were well recorded where decisions were made about incapacitated patients.
- Patients were complimentary about the care they received. Patients were actively involved in their care and had access to advocacy input. Where patients could not be involved due to cognitive impairment, records showed that families were involved.
- Patients could access a bed in their locality and staff were working towards helping patients on Mill View Lodge to be discharged home with the correct support. Patients' individual needs were met. Patients had access to a range of activities. Complaints were well managed.
- There were plans to improve the environment of Maister Lodge and dementia care across the trust. Teams had their own objectives. Internal changes within the trust were helping ward staff to have better links with allied health professionals involved in the care of older people.

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:

- There were significant gaps in the medicine records for the majority of patients at Maister Lodge and these were not picked up by audits. We have issued a requirement notice stating the trust must improve the recording of medicines at Maister Lodge.
- There was higher use of agency staff at Maister Lodge and issues with the deployment of experienced staff /more senior clinical staff being limited especially at evenings and weekends and despite escalation these had not been addressed.
- Incidents of restraint were not always recorded appropriately.
- The environment of the seclusion room used at Mill View lodge (shared with the adult mental health acute ward) was not fully fit for purpose.
- The environment of Maister Lodge was tired and not dementia friendly but there were well developed plans to address this

However

- Mill View Lodge was piloting a programme for patients to administer their own medication self administration with removable medication lockers for their bedrooms.
- Staff undertook good assessments of patient risks.
- Each ward was meeting same sex guidance and patients felt safe.

Are services effective?

Good

We rated effective as good because:

- There were detailed care plans and effective multi-disciplinary working with daily care reviews.
- Staff produced good 'all about me' records and formulation of care records which followed good practice in dementia.
- Patients' physical health was promoted by staff on the wards.
- There was good adherence to the Mental Health Act and the Mental Health Act code of practice in relation to detention papers, leave and consent to treatment rules.
- Staff were recording best interest decisions including when significant decisions were made for patients who lacked capacity including decisions around minimal restraint to provide care and covert medication.

Are services caring?

Good

We rated caring as good because:

Summary of findings

- Patients were complimentary about the care they received and we observed positive interaction.
- Patients were involved in their care and had access to advocacy input.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients could access a bed in their locality and bed occupancy levels were within recognised levels to allow responsive care.
- Staff were working towards helping patients on Maister Lodge to be discharged soon after admission with proactive involvement from the intensive home treatment team.
- Patients' individual needs were met.
- There were a range of rooms and activities to promote dignified care to older people.
- There were systems in place to manage complaints.

However

- The environment of Maister Lodge was looking tired but there were well developed plans to improve this.
- There were some delays in discharging patients on Maister Lodge.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Staff morale was reported as being low on Maister Lodge.
- Ward staff and operational managers had highlighted that staffing levels on Maister Lodge required review particularly at nights and weekends but there was no timely or specific plans to address this.
- The ward based audits did not pick up on issues we found on inspection such as medicines management issues.
- Maister Lodge had not been properly recording incidents
- Whilst there were plans to develop the environment of Maister Lodge, these plans had been in place for some time and, in the meantime, the quality of the environment had deteriorated.

However

- There was an older people's strategy to improve dementia care across the trust.
- Teams had their own objectives.
- The move to community and older adult care groups were felt to be a positive move to better meet needs of the service whilst maintaining links with the mental health care group

Summary of findings

- Mill View Lodge had received an initial assessment for peer accreditation and had developed its systems and locally based audits in anticipation of this.

Summary of findings

Information about the service

Humber NHS Foundation Trust provides assessment, treatment and care for people aged 65 years and older who have a functional mental health problem (such as depression, schizophrenia or bipolar disorder) or organic mental health problems (such as dementia).

It has two wards for older people with mental health problems who live in Hull and East Riding:

• Maister Lodge. A 16 bed inpatient unit that provides inpatient services for older men and women who are experiencing predominantly organic mental health problems.

• Mill View Lodge. A nine bed inpatient unit that cares for older men and women with functional mental disorders.

The wards offer a range of assessment and treatment including nursing care, medical input, occupational therapy, psychological interventions and physiotherapy and a range of recovery focused therapeutic interventions to aid patients' recovery as far as possible.

We have inspected Maister Lodge three times. We visited in October 2012 and May 2014 and on both these occasions, Maister Lodge was meeting the essential standards we inspected. We carried out a further focused inspection to Maister Lodge to look at staffing and the arrangements for managing risk in March 2016 following concerns being raised with us. We found the provider had not ensured there where sufficient numbers of suitably skilled staff on duty to provide safe care and treatments. We issued a requirement notice following the inspection. At the time of this comprehensive inspection, the provider had not been provided with our findings.

We have inspected Mill View Lodge once in May 2014. Mill View Lodge was meeting the essential standards we looked at on that inspection.

We carried out Mental Health Act monitoring visits to Maister Lodge in May 2015 and to Mill View Lodge in January 2016. Following these visits, the trust provided an action statement telling us how they would improve adherence to the Mental Health Act and Mental Health Act Code of Practice

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Gilluley, head of forensic services at East London Foundation Trust and Care Quality Commission national professional adviser

Head of Hospitals: Jenny Wilkes, Care Quality Commission

Team Leaders: Patti Boden (mental health) and Cathy Winn (community health), Inspection Managers, CQC

The team that inspected this core service included a Care Quality Commission inspector, a Care Quality Commission pharmacist inspector and a variety of specialists: a nurse manager, a social worker and an Expert by Experience. Experts by Experience are people who have experience of using health and care services.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

We inspected both older people's wards on the 12 and 13 April 2016.

During the visit, the inspection team:

- looked at the quality of the ward environment on both wards
- observed how staff were caring for patients
- carried out a short observational framework for inspection which is a tool to capture the experiences of patients who may not be able to express this for themselves
- spoke with 14 patients
- spoke with two carers
- collected feedback from patients using comment cards
- spoke with the modern matron and ward managers for each of the wards
- spoke with 17 other staff members; including doctors, nurses, nursing assistants, and the occupational therapist
- attended and observed two clinical review meetings where patients were discussed
- attended and observed two hand-over meetings
- looked at 13 care and treatment records of patients
- carried out a specific check of the medication management on each ward where we checked all the medicine charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

During our inspections, the Expert by Experience spent time talking to patients and observing the environment. They spoke with 14 patients and two carers.

On Maister Lodge we carried out a short observational framework for inspection which was a tool to capture the experiences of patients who may not be able to express this for themselves. This was because patients at Maister Lodge had dementia or related illnesses. We saw staff attend to patients' needs in a timely manner, engage with them warmly and attempt to support and comfort patients when they became distressed. Staff attempted to anticipate patients' needs and patients were observed and staff intervened appropriately to prevent patients from causing distress to other patients.

We received 23 comment cards relating to mental health older people wards.

At Mill View Lodge, we received 18 positive comments and one mixed comment. The positive comments included several stating that staff were friendly, caring, understanding and helpful. The mixed comment included the high temperature in bedrooms, few activities to occupy patients and not enough opportunities for exercise.

At Maister Lodge, we received three positive comments and one mixed comment. Patients were complimentary about staff stating that staff were very professional, treated patients with dignity and respect and were

helpful and kind. Comments also reported that Maister Lodge provided a safe and hygienic environment. The one mixed comment stated that the environment was not stimulating enough and personal items were disappearing.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

The trust must ensure that staff at Maister Lodge properly code and record the administration of medicines on the patients' medication cards.

The trust must ensure that the clinical governance arrangements are improved at Maister Lodge to include more robust audits of management of medicines, improved incident recording and reporting, timely action is taken on known issues or shortfalls and staffing levels and grades are considered and reviewed in a timely manner according to known and reported risks.

The trust must continue to address the requirement notice issued following the March 2016 focused inspection which identified that there must be sufficient numbers of suitably trained staff deployed on Maister Lodge ward.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The trust should ensure that Maister Lodge remains fit for purpose until major refurbishment is carried out.

The trust should ensure that there is a privacy curtain in both bathrooms in Mill View Lodge.

The trust should continue to address the shortfalls identified following the March 2016 focused inspection which were that:

- The trust should ensure staff report when they use restraint on a patient as an incident.
- The trust should ensure staff fully understand how to use the supportive engagement policy to support patient observations.

Humber 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
Maister Lodge	Maister Lodge
Millview Lodge	Millview

Mental Health Act responsibilities

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

We carried out routine Mental Health Act monitoring visits in May 2015 to Maister Lodge and in January 2016 to Mill View Lodge. We found overall good adherence to the Mental Health Act but highlighted a small number of areas for improvement. The trust sent us an action statement telling us how they had or would address the issues we found.

On this inspection, the wards adhered to the Mental Health Act and Mental Health Act Code of Practice. There were systems in place to support the operation of the Mental Health Act:

- Detention paperwork was orderly, up to date and stored appropriately.
- There were good checklists and proformas provided by the trust to ensure the correct papers were available on the ward for each detention episode.
- Patients received treatment with the proper authorisation of medication for mental disorder when detained.
- Records showed that patients had been told about their rights under the Mental Health Act in a timely manner. Where patients did not understand their rights, there had been appropriate consideration whether patients would benefit from an independent mental health advocate to support them to understand their rights.
- The section 17 leave forms were well completed with clear conditions.

Detailed findings

- Nursing staff felt supported in ensuring they adhered to the Mental Health Act and Mental Health Act Code of Practice through regular support and contact with Mental Health Act administrators based at the trust's headquarters.

However:

- The wards did not keep a local copy or register of seclusion episodes when seclusion was used to monitor the use of seclusion and benchmark any episode against the Mental Health Act code of practice requirements and safeguards.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found the services were adhering to the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards and the associated Codes of Practice:

- There was a record of mental capacity and consent, when significant decisions were made.
- Staff ensured health decisions were made based on mental capacity or in the best interest of the person.
- Staff had a clear understanding of their responsibilities in undertaking mental capacity assessments and the processes to follow should they have to make a decision about or on behalf of an incapacitated patient.
- There were comprehensive best interest decision records around decisions arounds minimal restraint to provide personal care, covert medication and do not attempt resuscitation orders.
- There were twenty Deprivation of Liberty Safeguards applications made between

  June 2015 to October 2015 for patients on the older adult mental health wards, with twelve on Maister Lodge and eight on Mill View Lodge.
- The trust was notifying us of Deprivation of Liberty Safeguards applications as they were required to do.
- There was no-one subject to a Deprivation of Liberty Safeguards authorisation when we inspected.

However the uptake of formal refresher training around the Mental Capacity Act was low, especially on Maister Lodge.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Staff had identified a number of ligature risks within Maister Lodge and Mill View Lodge. They managed risk with the use of high engagement, observation levels and ongoing risk assessments as well as a ligature risk register. Some ligature risks were clearly necessary for the patient with mobility difficulties to get around such as handrails and grab rails in disabled bathrooms. Maister Lodge had a higher level ligature risk management tool when temporarily caring for patients with functional mental health needs (such as schizophrenia or depression) who may present with higher levels of self harm. This meant that whilst there were ligature points on both wards, the risks were adequately mitigated.

At Mill View Lodge, there were four bedrooms for women and four bedrooms for men on opposite ends of the communal lounge/dining area. The ninth bedroom was on the corridor near the nursing office and could be used for either gender where they required more intensive nursing. All bedrooms on this ward were ensuite with toilet, wash basin and shower. There was a women only lounge off the dining area.

Mill View Lodge had two separate bathrooms which could be used by both men and women, one of which was an assisted bath. Both bathrooms also led out onto the communal lounge dining area. Any disabled patient would be supported by a member of staff to use the assisted bath. We heard that the assisted bathroom was rarely used. We highlighted that one of the bathrooms did not have a privacy curtain beyond the door to ensure patients' privacy and dignity. As the bedrooms opened directly onto the communal lounge area, staff were considering erecting partition walls around patient bedrooms to further enhance patients' privacy but any partition would restrict the use of restricted communal space on the ward.

On Maister Lodge, there were clearly designated male and female bedroom corridors either side of a large communal atrium area. There were doors on the corridor to separate the bedroom area from the communal area. We saw staff were vigilant to prevent patients wandering down the wrong designated corridor. Each corridor had two larger bedrooms that were more suitable for patients who required mobility support. These bedrooms had en suite wet room areas. All of the other bedrooms had en suite toilet and sink. There was a communal bathroom and a wet room on each corridor.

Each ward had a well equipped clinic room. Medicines were stored securely with access restricted to authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Medicines requiring refrigeration were stored appropriately and temperatures were monitored in accordance with national guidance. The resuscitation equipment was checked regularly to ensure it was safe to use.

Nursing staff at Mill View Lodge had access to a seclusion room within Millview which could be used if patients presented with seriously challenging behaviour which posed risks to others. The seclusion room was off the ward within a small suite between Mill View Lodge and Mill View Court (an adult acute mental health ward) and was used by both wards. The suite consisted of a seclusion room which contained a bed, a small foyer where staff could sit and observe patients and a separate lockable toilet area accessible from the foyer area.

The seclusion room contained no blind spots so patients could be observed from the window in the door to the seclusion room. There was no natural light into the seclusion room. There were no two way intercom facilities so staff either opened the door if it was safe or communicated by a small hatch in the door. There was a clock adjacent to the seclusion room so that patients could see the time.

The toilet was located outside of the seclusion room. It had not been adapted for use in a seclusion facility as the toilet and sink were china and they did not have anti-ligature fittings. Patients were therefore risk assessed to check whether they could use the toilet safely. If it was not safe, patients would be given a disposable bowl to use instead.

Managers told us that the trust recognised that the seclusion room did not meet the Mental Health Act Code of Practice requirements on the environment of the seclusion

Requires improvement

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facility (especially as there was no natural light). Staff were therefore required to alert senior managers when it was used so that senior staff could monitor its use until a longer term solution had been arranged. If seclusion for more than four hours was likely, then staff were required to look at conveying the patient to the psychiatric intensive care unit or another seclusion room within the trust so that patients were not secluded for long periods in a room which was not fully fit for purpose.

Maister Lodge did not have a seclusion facility. If patients presented with seriously challenging behaviour which posed risks to others, they would be managed for the shortest period of time in their own bedroom or in one of the large communal rooms on each of the corridors.

The wards were clean. There was dedicated domestic support and appropriate cleaning schedules. The cleaner on Mill View Lodge felt part of the team and took pride in the ward environment. Patients commented favourably on the cleanliness of the ward. There were alcohol gels on the entrance to the wards for staff and visitors to use to prevention infections being carried onto the ward. The furniture across both wards was in good condition and comfortable. Mill View lodge was well maintained. However, the ward environment of Maister Lodge whilst clean, was looking tired with scuffed walls, some broken furniture and work surfaces and fixed cabinets requiring repair. Maister Lodge was awaiting major refurbishment.

Appropriate health and safety checks had been carried out on equipment such as checks on the fire extinguishers throughout the wards and appropriate electrical testing.

There were nurse call systems in patient bedrooms. Staff attended quickly when we tested these on an unannounced basis. Staff on Mill View Lodge responded quickly to a pressure sensor alarm going off in a patient bedroom to check whether the patient at risk of falls had fallen.

Safe staffing

We undertook a Mental Health Act monitoring visit in May 2015 to Maister Lodge and identified staffing levels not being sufficient and impacting on the care of detained patients. The trust provided a high impact action plan telling us how they were going to address the staffing difficulties. This recognised that there were insufficient staff numbers per shift to fulfil all patient needs and to meet required observation levels. In particular more support was required to provide assistance at mealtimes and activities with patients were limited. The establishment did not represent the staffing levels recommended to the trust's board in June 2014 based on nine beds. The trust identified the difficulties of recruiting and retaining staff at Maister Lodge due to the geographical isolation and rural nature of the trust footprint.

The trust had produced an action plan to address the difficulties with a slight increase in staffing and improved e rostering to help plan patient care. The observation policy had also been superseded by the engagement policy which looked to free up staff. At the time of this inspection, the action identified in the action plan to address the staffing levels was still being addressed.

In March 2016, we carried out a focused inspection to Maister Lodge as a result of further and ongoing concerns raised with us that the staffing levels were still insufficient to meet patients' needs. We saw that there had been some improvements but saw that there was heavy reliance on agency qualified staff including a number of occasions where the agency qualified member of staff was the only nurse on duty. In addition the trust were not assured that when this happened that the agency nurse in charge of the ward had received training in caring for patients with dementia. There were also a number of unfilled shifts. We issued a requirement notice relating to staffing levels as a result of the March 2016 inspection. At the time of this comprehensive inspection, the provider had not been provided with our findings and had not produced an action plan. Since the focused inspection, there had been a further three night shifts led by agency nursing staff between 15 March 2016 to 31 March 2016.

The establishment levels for Maister Lodge comprised 15.6 whole time equivalent qualified nurses and 7.2 whole time equivalent support workers. On 29 February 2016, Maister Lodge had 3.6 whole time equivalent nursing vacancies. In March 2016, the ward had one nurse vacancy and three nurses undergoing preceptorship, which meant qualified nurses supervised them. The manager used regular bank staff that were familiar with the ward to cover sickness levels, vacancies and leave. In addition, the ward also used a small core group of regular agency staff. Maister Lodge had a need for increasing staffing levels above the core numbers on a very regular basis due to the acuity of

Requires improvement

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patients and the need for increased observations for individual patients. In January and February 2016, there were 35 shifts which had not been staffed or filled by bank or agency staff. Maister Lodge has a sickness rate of 5.2%.

The trust monitored staff levels and managers submitted monthly safer staffing information. The required staffing level for Maister Lodge for the eight-hour day shift and late shift comprised of two qualified nurses and four support workers. Staffing levels at night shift were one qualified nurse and four support workers. In addition, there was a twilight shift worker when needed.

We asked the trust about the impact of staffing on Maister Lodge and specifically requested the numbers and details of incidents categorised as occurring due to short or critical staffing levels as a primary or secondary factor including the grading of the incident, brief details and the time of the incident for period 1 September 2015 to 31 March 2016 at Maister Lodge. The trust told us that they had been four such incidents; of these, one incident prevented staff from completing the required ongoing paperwork, another prevented staff from completing admission paperwork in a timely manner and a further incident requiring an agreed later admission of a patient from the community.

The staffing of Maister Lodge was highlighted on the trust's risk register following our Mental Health Act monitoring visit in March 2015. This risk remained on the trust's risk register at the time of our comprehensive inspection in April 2016. Despite the controls in place to reduce or mitigate the risks, the trust identified that the residual risk score remained the same. This was mainly due to staffing the unit with bank and agency staff due to low staffing levels of substantive staff.

We saw that the risks of not having sufficient staff on Maister Lodge was escalated at recent community services and older people's care group meetings such as the March 2016 community services and older people's mental health clinical management meeting.

In Spring 2016, the community older people's mental health team staff left the Maister Lodge site and relocated. The led to staff at Maister Lodge being more isolated. At evenings and weekends there was a band 5 nurse in charge of Maister Lodge ward with on-call arrangements from more senior staff. Managers told us that there had been no further formal review of staffing following the further isolation of the unit with the community mental health teams relocating. This was corroborated by information we requested from the trust of details of any meetings or formal consideration of reviewing staffing levels, including weekend or night time staffing levels at Maister Lodge occurring over the 6 months prior to 31 March 2016.

We therefore judged that the staffing issues at Maister Lodge continued and there were not sufficient numbers of suitably skilled staff deployed to provide safe care and treatment to patients at Maister Lodge.

The establishment levels for Mill View Lodge comprised 10 whole time equivalent qualified nurses and 14.4 whole time equivalent support workers. Mill View Lodge had no nursing vacancies. In January and February 2016, there were 15 shifts which had not been staffed or filled by bank or agency staff. Mill View Lodge had a sickness rate of 4%. Staff from Mill View Lodge were able to receive assistance from the adjacent adult acute ward where there were shortfalls in staffing. Staff and patients on Mill View Lodge told us that there were sufficient staff to meet patients' needs.

The mandatory training levels across the community older people's mental health care group was 79% which was above the trust's required level that over 75% of staff should receive training.

Staff working within older people's mental health wards exceeded the trust's target for mandatory training in some areas. For example, 85% of staff on the older people's wards had completed fire safety training, and 91% of staff had completed health and safety training. There were some mandatory training that fell below the trust's target of 75%, including safeguarding training. Staff had access to clinical supervision rate with an uptake rate of 75% on Mill View Lodge and 98% on Maister Lodge.

Assessing and managing risk to patients and staff

We looked at 13 care and treatment records of patients including their risk assessment and management plans. Staff completed a comprehensive risk assessment for each patient using a nationally recognised tool was completed for all patients. The risk assessments were compiled on the trust's risk assessment documentation called GRIST. GRIST stands for the Galatean Risk Screening tool. This was a structured risk assessment tool designed to help clinicians assess risk of suicide, self harm, harm to others, self neglect and vulnerability. There were good risk assessments and management plans in place for all the risk assessments we

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saw. Twelve out of 13 risks assessments were fully up-to-date having been completed recently and included all the risks identified across the patient's care record formulated into an up-to-date risk management plan.

Risk assessments included ongoing monitoring of likely physical health risks faced by older adult patients. For example, the risks of developing pressure ulcers was assessed and managed through regular assessment using the waterlow pressure ulcer risk assessment tool. Patients were assessed for the risk of developing venous thromboembolism as part of their admission assessment process. Venous thromboembolism was the collective term for deep vein thrombosis or a blood clot that forms in the veins of the leg which can cause strokes or other health conditions. This meant that patients received routine and ongoing assessments to ensure they did not acquire further physical health problems whist in hospital.

Staff had made efforts to remove or reduce blanket restrictions on the wards. Patients were allowed mobile phones and access to computer on the wards. Patients could access their bedrooms throughout the day. Patients had continual access to fresh air and there were currently no restrictions on smoking. Entry to and exit from Mill View Lodge was controlled by a keypad. Patients who had capacity were given the code to leave the ward but were asked to let staff know that they were leaving.

Patient levels of observations were reviewed daily at clinical review meetings. The trust introduced a supportive engagement policy in May 2015 to manage observations of patients. This allowed staff to use zonal observations to monitor patients in a given area. The policy stated that all patients at Maister Lodge would be nursed within the zonal engagement model and therefore would be within sight at all times. If this was not required for a patient due to their specific needs or when the patient was asleep then this would be supported by their care plan, which would outline the engagement required. The zonal model aimed to ensure appropriate observation of individual patients without the need to assign a particular nurse to be in close proximity to any patient for long periods. Identified nursing staff were responsible for observing all patients within a particular area (zone) of the ward.

When we carried out a focused inspection in March 2016, we heard that staff on Maister Lodge found the use of the policy confusing and contradictory with the same staff managing zonal observations as well as one to one observations. In the report from the March 2016 inspection, we said that the trust should ensure staff fully understand how to use the supportive engagement policy to support patient observations. When we carried out this inspection in April 2016, managers were continuing to work with staff to fully understand and implement the observation policy on the ward to manage patient observations and risk.

Staff understood their responsibilities in reporting safeguarding concerns. Training in safeguarding adults and safeguarding children was mandatory and required staff to attend initial and regular refresher training. At Maister Lodge only 38% of staff were up-to date with their safeguarding adults training and 65% were up-to-date with safeguarding children training. At Mill View Lodge only 65% of staff were up-to date with their safeguarding adults training and 70% were up-to-date with safeguarding children training. Despite this low level of staff uptake of safeguarding training, staff we spoke to had a good understanding of safeguarding procedure and what to do when faced with a safeguarding concern.

We looked at the systems in place for medicines management. We assessed all prescription records and spoke with nursing staff who were responsible for medicines. At Maister Lodge, medicine administration records were not always completed fully. We checked 12 records and found that in 10 cases there were gaps across several days for several patients, including for some critical medicines. There was no code or record to explain why there were gaps on these 10 charts. For example an explanation whether the patient had refused, whether the nursing staff had been unable to give medicines covertly or whether the patient was in another hospital or on leave. Staff including managers could not explain the gaps. The ward did not have a proper system in place to monitor or assess whether records were completed correctly. At Mill View Lodge, the medicine administration records were well completed.

We saw four examples of medicines given covertly (this is where medicines were disguised in food or drinks when patients lack capacity). In all cases, the decisions to give medication covertly was in accordance with the Mental Capacity Act as we saw corresponding records of best interests decisions in patient's notes.

Mill View Lodge had arrangements in place to support patients to be self medicating. The ward had removable medicine cabinets which could be slotted into a cavity

Requires improvement

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within patients' wardrobes. There were appropriate phased assessment and risk assessments in place to ensure that any decision for patients to be permitted to self-medicate had been properly considered. There was one patient self medicating at Mill View Lodge when we inspected. The decision was supported by well completed assessments. We checked the removable medicine cabinet and found the bedroom and the cabinet unlocked whilst the patient was on unescorted leave. We brought this to the attention of the ward manager who took steps to ensure the cabinet was locked.

Across Maister Lodge and Mill View Lodge, there were eight recorded episodes of patients being restrained on seven different patients between 1 November 2015 and 31 March 2016. None of the restraint episodes resulted in the use of prone restraint or rapid tranquilisation.

Managers gave assurances that the safeguards for seclusion were met when patients were in the seclusion room or prevented from leaving any area to manage their behaviour. The wards did not keep their own record of seclusion episodes so we could not corroborate this on inspection. We asked for information on the use of seclusion and any benchmarking against the safeguards of seclusion prescribed in the Mental Health Act Code of Practice. In the period, between 1 October 2015 and 31 March 2016, there were twelve episodes of seclusion across the older patients wards; nine of which occurred at Maister Lodge and three at Mill View Lodge. There were no uses of long-term segregation.

Most of the seclusion episodes were recorded as lasting less than an hour with one notable exception where a patient on Mill View Lodge was recorded as being in seclusion for nearly 21 hours. All of the seclusion episodes on Maister Lodge occurred after 5 March 2016. The trust did not provide details of any benchmarking such as ensuring that the rationale for seclusion was recorded, observations occurring, initial and ongoing medical reviews and ongoing nursing reviews. Mental Health Act administrators were beginning to receive details of seclusion episodes in order to benchmark against the safeguards.

There were rooms off the ward that could be used for visitors including children who were visiting patients. This meant that patients could see their young family members without having to go on the ward.

Track record on safety

We looked at the incidents that had occurred recently at this trust. All NHS trusts were required to submit notifications of incidents to the National Reporting and Learning System. Serious incidents known as 'never events' are events that were classified as so serious they should never happen. In mental health services, the particular relevant never events was suicide of an in-patient from a fixed ligature point. There had been no never events on the older people's wards.

There had been a reported recent incident of severe dehydration of one patient on Maister Lodge. The trust had carried out an incident review which identified that fluid monitoring paperwork used at Maister Lodge had been reviewed and major adjustments had been made. Staff were also informed of the importance of recording appropriately and the process of escalating concerns. When looking at staffing levels on the wards, we saw that there had been four incidents of staff not having enough time to meet their duties on recordkeeping due to there not being sufficient staff on duty.

In the last year on Maister Lodge there had been an increase in adverse incidents and injuries to staff from patients, two of these resulted in staff having to take sick leave to recover. As a result of the staffing issues, the trust had placed Maister Lodge on the risk register and had produced an action plan to address the staffing levels.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to report incidents on the electronic risk management system used by the trust. Staff were able to describe what should be reported. The system escalated notification of incidents to ward managers, and if appropriate to senior managers, dependent upon the severity. This ensured appropriate investigation.

When we inspected in March 2016, we identified that staff on Maister Lodge were not always recording all restraint episodes when staff placed hands on patients to prevent them from harming patients or where they had to significantly hold a patient for a sustained period to provide basic care in their best interests. On that inspection we found episodes of restraint that had not been recorded as an incident. On this inspection we asked what the trust had done to better prescribe the thresholds for recording restraint for patients with significant cognitive impairment. The trust told us that a group has been set up led by the

Requires improvement

Are services safe?

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

Deputy Director of Nursing and Patient Safety which was looking specifically at restraint. The staff had been reminded of the need to complete a restraint form when this intervention was required and the patient was seen by a doctor for a review as per the policy.

Staff were debriefed after serious incidents. Staff at Maister Lodge has weekly reflective practice sessions supported by a clinical psychologist. Team meetings were used to discuss incidents and lessons learned from these. This meant that staff learnt from incidents in order to improve future practice.

Staff knew about the requirements placed on them to meet the duty of candour requirements. Duty of candour regulations ensured that providers were open and transparent with patients and people acting on their behalf in general in relation to care and treatment. It also set out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff were aware of the need for openness and transparency if there was an incident. Staff encouraged patients and their carers to complain if there was something they were concerned about.

We saw that managers met with the relatives of one patient following a significant incident. The relatives were given an explanation of the incident including the identified shortfalls. Records showed that managers apologised for this and had learnt lessons to try and prevent it happening again. This included ensuring that fluid monitoring paperwork used at Maister Lodge have been reviewed and major adjustments have been made. Staff were also informed of the importance of recording and the process of escalating concerns.

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Are services effective?

Good

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 13 care and treatment records of patients across Maister Lodge and Mill View Lodge. Patients had well-documented assessments and care plans that described how their needs would be met on admission and at each stage of in-patient care. Assessments included both medical and nursing assessments including a physical examination to consider any physical health problems that require treatment of further investigation. There were appropriate investigations to rule out a physical health cause when people were admitted with confusion or suspected early stages of dementia.

Care plans were recovery focused and identified support to address the symptoms of mental disorders. Care plans covered a range of needs including patient's medical needs (physical and mental health needs and medication), nursing needs and interventions, social needs (accommodation, finance, employment and leisure needs), legal status and discharge progress. Feedback from patients on Mill View Lodge confirmed they felt involved in assessments and planning of their care. Patient needs and care were reviewed on a daily basis at multi-disciplinary clinical review meetings.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward and regular weekly physical health checks.

Best practice in treatment and care

Staff on Maister Lodge worked with patients, relatives and carers to receive accurate information about patients' life stories which was then translated into a summary 'all about me' document. This ensured staff provided care and treatment to patients with dementia which was individualised and respected patients' personhood in line with recognised research into providing quality dementia care. We saw care provided took account of patients' histories. For example some of the male patients had previous interest in cricket and bowling. We observed these activities occurring on the ward led by enthusiastic staff.

Staff had completed malnutrition universal screening tool for relevant patients with corresponding care plans. Staff used the modified early warning system tool to help monitor patients' physical health care needs.

Staff were following National Institute for Health and Care Excellence guidance. For example, safe prescribing was considered resulting in most patients only being given one anti-psychotic. Where it was clinically necessary to give more than one anti-psychotic, this followed rules for the prescribing and ongoing monitoring of high dose anti-psychotics.

Some patients received electroconvulsive therapy which was a psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric illnesses. Staff followed National Institute for Health and Care Excellence guidance on treating patients with electroconvulsive therapy including limiting the electroconvulsive therapy episodes, ensuring physical checks pre and post electroconvulsive therapy and ensuring appropriate consent has been obtained from the patient or a second opinion appointed doctor.

Staff on Mill View Lodge were working towards resubmitting their application to be accredited with the Royal College of Psychiatrists' accreditation scheme for wards for older people.

The trust had developed an overall three year strategy which included a local dementia strategy in line with the national dementia strategy document 'Living Well with Dementia'. The aim of this was to deliver quality improvements to dementia services and address health inequalities faced by people with dementia.

The environment of Maister Lodge did not meet with current good practice around providing dementia friendly environments due to a dark central courtyard, poor utilisation of space and limited use of colour or other markers to help patients find their way around. The trust's three year strategy included improvement to the environment at Maister Lodge to provide an environment better suited to caring for people with dementia in line with good practice. This included plans to have improved natural light, landscaped outdoor areas, improved zoning, colour being used to differentiate different spaces and corridors and the installation of memory boards on doors. This meant that there were plans in place to provide an

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environment which provided appropriate levels of stimulation and which better helped patients orientate themselves around the ward. The plans had been timetabled to be completed by the end of January 2017.

Skilled staff to deliver care

We spoke with a number of staff including the consultant psychiatrists, the modern matron, charge nurses, registered and student nursing and non-registered nursing staff and other professionals including the occupational therapists. Staff we spoke with were largely positive and motivated to provide high quality care.

Staff received appropriate training, supervision and support. Staff told us that they received supervision which consisted individual management supervision.

Training for staff consisted of mandatory and more specialist training. Staff at Maister Lodge were ensuring that staff on the ward completed formal dementia training to better understand patients with dementia.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input from medical staff, registered nursing and non-registered nursing staff and other professionals including psychologists and occupational therapists.

Access to other professionals were via referral, for example dietician or speech and language therapy. We heard that since older people's services had joined with community health services into one care group, access to these allied health professionals had improved.

Multi-disciplinary meetings occurred on a daily basis, through care reviews. At Mill View Lodge, older adults' intensive home treatment teams proactively attended daily care review meetings to

consider whether patients could be discharged from hospital earlier with input from the staff of the intensive home treatment teams. Attendance and involvement from care co-ordinators from the older people's community mental health teams and the intensive treatment team for patients with dementia on Maister Lodge was more sporadic and tended to be when patients were considered ready for discharge.

We observed a care review and a handover. Discussions occurred with comprehensive information on each patient to ensure that all members of the nursing and multidisciplinary team were kept up to date on current issues with patients and to inform decisions about future care and treatment

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

We carried out routine Mental Health Act monitoring visits in May 2015 to Maister Lodge and in January 2016 to Mill View Lodge. We found overall good adherence to the Mental Health Act but highlighted a small number of areas for improvement including patient rights recording and section 17 leave recording on Mill View lodge and staffing and environmental issues and variable quality of care plans affecting detained patients on Maister Lodge. The trust sent us an action statement telling us how they had or would address the issues we found.

On this inspection, we reviewed care and treatment of patients detained under the Mental Health Act. We found the wards adhered to the Mental Health Act and Mental Health Act Code of Practice. We found there were systems in place to support the operation of the Mental Health Act.

Detention paperwork was orderly up to date and stored appropriately. There were good checklists and proformas provided by the trust to ensure the correct papers were available on the ward for each detention episode. Detention papers showed that there had been appropriate medical and administrative scrutiny to ensure that where patients were detained under the Mental Health Act, each detention was supported by a full set of well completed detention papers. The section 17 leave forms were well completed with clear conditions.

There were records relating to consent and capacity to consent to treatment for decisions around treatment for mental disorder given to detained patients. This meant that detained patients received treatment with the proper authorisation of medication for mental disorder. On Mill View Lodge, treatment prescribed for mental disorder for a patient who had their community treatment order revoked was authorised under urgent treatment rules (section 62) whilst awaiting a second opinion appointed doctor decision. Legal certificates in the form of T2, T3 or section 62 forms were attached to patient's medication charts where appropriate. This meant that the Mental Health Act rules around consent to treatment and capacity requirements were adhered to.

Are services effective?

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On the last inspection to Maister Lodge and Mill View Lodge in May 2014, we highlighted the need to improve the recording of patients' rights to ensure adherence to the Mental Health Act. On this inspection, records showed that patients had been told about their rights under the Mental Health Act in a timely manner. Where patients did not understand rights, staff continued to attempt to support patients to understand their rights on regular occasions. Records showed that there had been appropriate consideration whether specific patients would benefit from the services of an independent mental health advocate to support them to understand their rights. Where patients would benefit and were unable to instruct the independent mental health advocate themselves, staff automatically referred the patient to be seen by the independent mental health advocate.

Mental Health Act training updates were not mandatory within the trust. Mental Health Act administrative managers had offered Mental Health Act training updates including updates on the most recent revisions to the Mental Health Act Code of Practice. Training data from the trust showed that only one member of staff from the older people's wards had taken up this offer. We did not identify any deficits in staff understanding of the Mental Health Act. Nursing staff felt supported in ensuring they adhered to the Mental Health Act and Mental Health Act Code of Practice through regular support and contact with mental health act administrators based at the trust's headquarters.

Good practice in applying the Mental Capacity Act

We found the ward staff were adhering to the requirements of the Mental Capacity Act. There was a record of mental capacity and consent, when significant decisions were made. For example, when decisions were made whether to admit a patient into hospital, when patients were being considered for discharge from hospital to residential care, or if covert medication was being discussed.

Staff ensured health decisions were made based on mental capacity or in the best interest of the person. We observed staff seeking informed consent prior to giving care, for example, when moving people. Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible.

Fifty per cent of the staff on the older people's wards had received recent training on the Mental Capacity Act including the five statutory principles. This broke down further to 84% of staff of Mill View Lodge were formally trained and up-to-date; whereas only 26% of staff on Maister Lodge were formally trained. Staff we spoke with had a good understanding of the Mental Capacity Act and its' principles. Whilst the uptake of formal refresher training was low especially on Maister Lodge, staff had a clear understanding of their responsibilities in undertaking mental capacity assessments when they were the principle decision maker. Staff understood the processes to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

There was a policy flowchart on the Mental Capacity Act and Deprivation of Liberty Safeguards on each ward which staff were aware of and could refer to. There was information for patients and relatives on the Mental Capacity Act and Deprivation of Liberty Safeguards on the ward and in the reception areas of both wards. The trust had employed a band 8 nurse across the trust to provide advice and clinical leadership regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards, within the Trust.

Where people were assessed as having possible impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions. People were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. When patients' were deemed to lack capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. We saw completed best interest decisions for a number of decisions for several patients including comprehensive best interest decision records around minimal restraint to provide personal care, covert medication and do not attempt resuscitation orders.

All of the patients on Maister Lodge were detained under the Mental Health Act. Treatment decisions for mental disorder were made under the legal framework of the Mental Health Act. Staff understood the limitations of the Mental Health Act. For example, they were aware that the Mental Health Act could not be used for treatment decisions around treatment for physical health issues for detained patients.

The trust stated there were twenty Deprivation of Liberty applications made between

Are services effective?

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June 2015 to October 2015 for patients on the older adult mental health wards, with twelve on Maister Lodge and eight on Mill View Lodge.

The trust was notifying us of Deprivation of Liberty Safeguards applications, as they were required to do. However, the numbers of Deprivation of Liberty Safeguards applications reported to us did not match the number of applications the trust stated they had made. This discrepancy may be because the trust tell us when the outcome of the application was known and there were frequently delays in the local authority (the supervisory body) processing applications as a result of the increase following recent court judgements (for example, in a case called the Cheshire West judgement).

There was no-one subject to a Deprivation of Liberty Safeguards authorisation when we inspected; all of the patients on Maister Lodge were detained under the Mental Health Act, and on Mill View those that weren't detained were giving informed consent to stay as an in-patient. We did not identify any concerns around significant restrictions for any patient that would amount to a deprivation for any patient. Staff had a good understanding of the requirements for Deprivation of Liberty Safeguards.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated with dignity and respect in all the interactions we observed. We observed staff participating in activities, engaging and speaking with patients and providing care and support in a calm, kind, friendly and patient manner. Patients made positive comments about the quality of the care and treatment they received. The patients we spoke with were complimentary about staff attitude and engagement.

On Maister Lodge we carried out a short observational framework for inspection. The short observational framework for inspection was a tool to capture the experiences of patients who may not be able to express this for themselves. During our observations, we saw staff attended to patients' needs in a timely manner, engaged with them warmly and attempted to support and comfort patients when they became distressed. Staff attempted to anticipate patients' needs and patients were observed and staff intervened appropriately to prevent patients from causing distress to other patients.

Staff we spoke with felt that patients received good quality care on the wards. They told us they felt patients were given hope with regard to moving on and recovering.

We observed two daily clinical review meetings and two multi- disciplinary handover meetings; patients' needs were discussed and considered with dignity and respect at these meetings.

We received 23 comment cards relating to mental health older people wards. At Mill View Lodge we received 18 positive and one mixed comments. The positive comments included an excellent service with wonderful staff, and several comments stating that staff being friendly, caring, understanding and helpful. Patients told us that they felt listened too and were treated with dignity and respect Patients also commented favourably on the nutritious food and clean and safe environment. The mixed comment included the high temperature in bedrooms, few activities to occupy patients and not enough opportunities for exercise.

At Maister Lodge, we received three positive and one mixed comments. Patients were complimentary about staff stating that staff were very professional, treated patients with dignity and respect and were helpful and kind. Comments also reported that Maister Lodge provided a safe and hygienic environment. The one mixed comment stated that the environment was not stimulating enough and personal items were disappearing.

The involvement of people in the care that they receive

Patients on Mill View Lodge were given a comprehensive information pack telling them about the ward and practical matters about being a patient. The pack was well presented and clearly written.

The care plan documents across the trust were found in the paper notes. On most of the care records, we saw recorded involvement of patients in their care where staff could meaningfully engage with them. This was usually as part of the recovery star outcome tool where patients were encouraged to identify their strengths, needs and goals. Patients told us that care was usually planned and reviewed with them.

Quality circle meetings were held regularly on Mill View Lodge where patients had an opportunity to comment on the running of the ward including the environment, cleanliness, activities and catering amongst other things. We looked at the minutes from recent meetings. The meetings were attended by patients using the service, staff from the catering service and staff on the ward. We saw examples where patients had requested specific activities or raised issues; staff had responded to these requests and made changes where possible. Due to patients' cognitive impairment, staff on Maister Lodge were unable to meaningfully involve patients in their care or on the running of the ward. Patients' relatives were consulted and involved where this was appropriate. The charge nurse was hoping to reinstate the carers group to receive feedback and consult with relatives.

Patients felt that they were involved in their care. However patients were not always able to participate fully in daily reviews due to the ways that the multi-disciplinary team meetings operated. Patients' views and wishes were requested prior to the daily reviews and were considered in the daily clinical reviews. Patients and relatives could request a separate meeting with their consultant psychiatrist to raise issues and multi-disciplinary meetings were business meetings without patients being seen.

Good

Are services caring?

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

Patients had regular access to advocacy, including specialist advocacy for patients detained under the Mental Health Act known as independent mental health advocates. Staff informed patients about the availability of the independent mental health advocates and enabled them to understand what assistance the independent mental health advocate could provide. Patients we spoke with were aware of the independent mental health advocacy service. Patients were referred to the independent mental health advocacy service if they would benefit from advocacy input but lacked the capacity to instruct an advocate. The independent mental health advocate worked with these patients using non-instructed approaches.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

When patients required admission into the older person ward bed, the admission was gate kept by staff within the crisis and home treatment teams or out of hours team, or by approved mental health professionals following a Mental Health Act assessment. This ensured that there was proper consideration whether people required treatments as in-patients or whether there were any alternative options to admission such as patients staying at home with more intensive support.

The wards were operating within safe bed numbers at the time of our inspection. The average bed occupancy levels of the two older people's wards from 1 September 2015 to 29 February 2016 stood at 75%. This was reflected in Maister Lodge having an average bed occupancy of 77% and Mill View Lodge having an average bed occupancy of 72%. This meant that there were usually beds available for patients to be admitted or when they returned from leave and helped to ensure patients received improved quality care.

The trust also reported that there were no out of area placements during the period 1 September 2015 and 29 February 2016. Managers of Maister lodge and Mill View Lodge worked together and they were overseen clinically by the same modern matron. Occasionally, patients with functional mental health needs were initially admitted to Maister Lodge due to bed availability issues on Mill View Lodge but they would be moved as soon as a more suitable bed became available. This meant that patients received treatment as an in-patient in a suitable bed close to their home.

Patients on Maister Lodge were staying much longer on the ward. The average length of stay of the current patients on Maister Lodge at 29 February 2016 was 102 days and the average length of stay for discharged patients across the 12 month period from 1 March 2015 to 29 February 2016 was 97 days. The reasons for these longer stays were complex but included patients presenting with more challenging behaviour due to their organic mental health problems (such as dementia), the lack of available residential care home and nursing care home beds in the community and delays in agreeing funding packages where this was local authority funded or jointly funded between the local authority and continuing healthcare. There was an independent hospital in the locality which accepted patients who presented with ongoing challenging behaviour and patients had been transferred there if they required this level of support.

In contrast, patients on Mill View Lodge were staying for much shorter periods on the ward. The average length of stay of the current patients on Mill View Lodge at 29 February 2016 was 27 days and the average length of stay for discharged patients across the 12 month period between 1 March 2015 to 29 February 2016 was 11 days. Patients on Mill View Lodge were frequently discharged home once their mental health crisis had been treated.

The older people's home intervention team worked with patients on Mill View Lodge on admission to consider and support them proactively on discharge. The older people's home intervention team only worked with patients on Maister Lodge when people were ready for discharge.

There were a small number of readmission of patients back to the wards with only four readmissions across the older people's wards in the period between September 2015 and February 2016 – all four of these were from Mill View Lodge.

Only 7% of patients on Mill View lodge suffered delayed discharges in the period between September 2015 and February 2016. However, 19% of patients were delayed discharges on Maister Lodge in the same period. The primary cause of patient delays or delayed days was due to public funding, followed by patients awaiting care packages in patients' own home and then patients awaiting care or nursing home placement.

The facilities promote recovery, comfort, dignity and confidentiality

The ward environment of Mill View Lodge was clean and comfortable. There was a meeting room with a digital reminiscence therapy machine for patients to use and a patients' phone. There was a large lounge with a TV and a smaller female lounge. Patients on Mill View Lodge had open access to a small secure outdoor space which included a smoking shelter, seating, bird feeders and raised beds which patients helped to tend.

The furniture across Mill View Lodge was in good condition and comfortable. However patients on Mill View Lodge complained about the new chairs which had been placed in the women's only lounge. They felt the chairs were not very comfortable. We raised this with the ward manager

Are services responsive to people's needs?

Good

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

who agreed to ensure there was a range of chairs of varying comfort in each of the lounges. There were a pleasant assortment of murals and pictures on the walls which made the ward feel homely.

The ward environment of Maister Lodge was looking tired with scuffed walls, some broken furniture and work surfaces and fixed cabinets requiring repair. Patients on Maister Lodge had open access to a large open outdoor space which included a smoking shelter and seating. Most of the outdoor space was grassed and uneven making it unsuitable for those with impaired mobility. The planned changes to the ward environment were looking to address the internal and external ward spaces.

All the wards were mixed gender. Sleeping accommodation was in single rooms which promoted patients' dignity. Each ward had communal areas and other quiet rooms which could be utilised as private interview rooms. There were interview rooms and family visiting areas off the wards but these spaces had not been adapted to provide an appropriate for children and family visiting.

Patients had access to activities throughout the day. Whilst we visited, we saw patients engaging in a varied range of activities that included floor ten pin bowling, model making and cooking. There was an occupational therapist on each ward who led on activities and functional assessments. At weekends and evenings, activities were led by nursing staff.

Patients had access to snacks and hot drinks. Each ward had an equipped kitchen so patients could make drinks or, if they required assistance, staff could help them or make drinks for them. Patients could also select healthy snacks from the fridge. The kitchen was equipped so that patients could prepare meals as part of their assessment or care plan under the supervision of an occupational therapist. During our formal observations of care on Maister Lodge, staff offered and supported patients to have a hot drink or cold drink so that they kept hydrated. Managers at Mill View Lodge were arranging for a water cooler to be installed in the main lounge area so patients could have access to cold water at all times of the day or night. In the lounge on Mill View Lodge we saw an uncovered jug of water being used for patients' drinks. We raised this with the ward manager who addressed it.

Patients had access to a ward telephone and were also permitted to keep their mobile phone. Mobile phone chargers were kept by staff as these posed a ligature risk but were available on request.

Patients at Mill View Lodge had secure storage to lock valuable possessions and also a removable lockable medicine cabinet for those patients who were self medicating. Maister Lodge did provide any facilities to lock patient belongings away in patients' bedrooms so relatives or patients could not lock significant items such as photos or keepsakes or valuables away. The planned changes to the ward environment were looking to change this.

Meeting the needs of all people who use the service

Patients and relatives received a welcome pack when they were admitted onto the ward. This had a range of information including information on the running of the ward, visiting times, treatments, local services, patients' rights, and how to complain. There was a range of information on noticeboards in the foyer and ward areas for patients and relatives to refer to.

The wards were on the ground floor with level access to outside garden space and access throughout the ward areas. There was clearly designated disabled parking close to the ward entrances for people with disabilities to park nearby. There were disabled toilets and showers adapted for the people with limited mobility and at least one assisted bathroom with appropriate equipment on Maister and Mill View Lodges. This meant that each ward was equipped to care and treat people with significant mobility issues.

The doors across Maister Lodge had picture symbols as well as writing to help patients with dementia understand the function of each room and help them find their way around the ward. The future plans for Maister Lodge included much improved environments for treating patients with dementia including improved zoning, better use of colour, memory frames on each patient's door and other refurbishments.

At Maister Lodge the food was cooked on site and staff worked to ensure that patients with dementia could eat food which met their individual needs, for example finger food, high protein enriched food and soft mashed foods for those patients who found swallowing difficult or who were at risk of malnutrition. At Mill View Lodge, patients were

Are services responsive to people's needs?

Good

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

encouraged to help ensure meal times were positive and social experiences which promoted their recovery, for example patients were encouraged to be involved in setting the tables and arranging water to be available. There were options available at mealtimes including vegetarian options. Halal food for Muslim patients and kosher food for patients of Jewish faith could be arranged on request.

Information in other languages and interpreters could be sourced via the trust head office. Staff told us that the catchment area for the trust did not include significant non-white or non-English speaking communities. Whilst there was a growing eastern European population in the locality, they tended to be adults of working age moving into the area rather than older people. On the rare occasions that translation and interpreting service had been requested, there had not been any problems.

Patients could access spiritual support. At Mill View Lodge patients could access a multi-faith prayer room in the main hospital on the Castle Hill Hospital site. The prayer room was always open for prayer and once a week there was a holy communion service. Patients at Maister Lodge could access spiritual support through utilising escorted leave or through requesting a specific faith leader to attend the ward.

Listening to and learning from concerns and complaints

The wards did not receive many complaints – Maister Lodge only had two complaints and Mill View Lodge ward had no complaints in the 12 months up to February 2016. Of the two complaints raised, one was fully upheld and one was partially upheld. Where complaints had been raised, we saw that the trust had worked to resolve these complaints.

The trust also formally collated compliments with Mill View Lodge receiving 17 compliments and Maister Lodge receiving 1 compliment in the 12 months up to February 2016.

Patients who were able to express an opinion told us they knew how to complain if they wanted to. We saw posters on the wards about how patients could complain and how patients could offer suggestions or compliments.

There was information in the ward welcome pack in patients' bedrooms about how to complain and the support available from the patient advice and liaison services in raising complaints informally or formally. The complaints form also signposted patients to the availability of local independent advocacy services to provide independent support to help raise and progress complaints. The welcome pack included a specific information page explaining that detained patients had the right to raise complaints about the Mental Health Act directly with the Care Quality Commission. This meant that patients were properly informed about the available support to raise and progress complaints.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust had developed a service transformation programme for older people's mental health services to face the challenges of rising demand. The aim of the programme was to provide high quality and cost effective care and configure services which were designed to meet the needs of the local people.

The transformation programme plan for 2016 was described under three broad headings:

- Productivity: Recognising the need for efficiency by introducing productive ways of working; reducing waste and duplication.
- Quality and sustainability: Building a sustainable business and work to retain our existing business through the development of responsive local plans.
- Improved outcomes: Developing care pathways and partnerships to support people to achieve better health and improved quality of life.

When we spoke with staff on the older people's wards they showed professional commitment to providing high quality care and signed up to the trust's values. Staff had begun to see the benefits of being under the same care group directorate as the community health arm of the trust with improved contact and alliances with nursing colleagues and other allied health professionals with special experience in physical health promotion. Patients gave positive comments about the good quality care they felt they received which showed staff were working within the stated values of the trust in their day to day practice.

Good governance

We found the wards were well managed. There was a modern matron across Maister Lodge and Mill View Lodge and a charge nurse on each of the wards. Staff had clear roles and a management structure that was understood by all staff. Managers were usually aware of the shortfalls we identified and were trying to address these but many of these issues had been ongoing for some time without properly being resolved. For example, the staff capacity issue of Maister Lodge was on the trust risk register. Ward staff and operational managers had highlighted that staffing levels on Maister Lodge required review particularly at nights and weekends due to the grade of staff left in charge of the ward at these times being insufficient to meet the complex needs of patients on an isolated unit. There was no timely or specific plans to address this despite it being raised in formal meetings and the staffing issues remained. Since the removal of the community older people's mental health team from Maister Lodge, it had become even more isolated as a stand-alone unit with no nearby ward or staff to call on . There had been no proper review of staffing at Maister Lodge to take account of its further isolation as a result.

Whilst the environment of Maister Lodge was due to be addressed through the older people's mental health strategy, these plans had been in place for some time and, in the mean time, the quality of the environment had deteriorated. The environment of the seclusion room at Mill View was not fit for purpose due to the lack of natural light. Whilst a policy was put in place to oversee its' use, there were no detailed specific plans to reprovide the seclusion room available to the older people's ward at Mill View.

The ward based audits did not pick up on issues we found on inspection such as medicines management issues. Staff and managers had not identified the basic shortfalls in the recording of medicines administration at Maister Lodge which themselves.

The trust had recently changed its quality assurance reporting and accountability processes with the older people's mental health services going from mental health directorate to a community health and older people's care group. Managers reported into governance meetings monthly. Senior nurses felt that the service quality assurance provided better integration into community health services with allied health professionals from community health teams (such as physiotherapists and speech and language therapists being more responsive) to their needs because there were no better links and liaison between services.

There were audits in place to monitor the Mental Health Act. Senior nurses on the wards also carried out local audits such as care planning and care records audits. The manager of Mill View Lodge in particular had developed a range of checks and evidence which had been prepared for the Royal College of Psychiatrists' peer accreditation process. Managers had very good clinical oversight and were aware of the pressures on the service.

Are services well-led?

Requires improvement

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

Staff mostly reported they had been appraised and supervised by their immediate line managers and that they were supported by them as well as by their peers.

Leadership, morale and staff engagement

Staff told us that they felt supported by their immediate line manager and more senior managers.

Staff morale was generally good at Mill View Lodge with staff showing a commitment to providing quality care which responded to patients' needs. Staff felt able to raise concerns and were aware of the trust whistleblowing policy. Staff at Maister Lodge showed poorer morale detailing the quality of the environment, the geographical isolation of the unit, acuity and increasing challenging behaviour of the patients and the staffing difficulties as some of the reasons. Nevertheless staff continued to be committed to providing quality care.

Charge nurses felt well supported and were optimistic that the change in care group reporting and accountability would lead to improved stability, better responses for patients and more visible director level involvement. The charge nurse was complimentary about the director level support received following the initial decision of the quality peer assurance process.

Staff had access to regular individual clinical supervision as well as weekly reflective practice sessions led by psychologists.

The trust had a risk register from December 2015 which detailed a total of 26 risks scoring 12 or higher. Of these one related specifically to older people's mental health wards which was the Maister Lodge staffing issue.

Commitment to quality improvement and innovation

Maister Lodge was soon to close for major refurbishment. This meant that capital investment was occurring to improve the quality of the older people's ward environment.

Maister Lodge was not currently accredited with the Royal College of Psychiatrists' accreditation for in-patient mental health services for older people's wards (AIMS-OP). Managers at Mill View Lodge were looking to address a small number of shortfalls identified prior to resubmitting their application to be accredited under the same scheme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Location – Maister Lodge** We found that the trust's systems or processes were not operating effectively to ensure compliance with good medicines management and to monitor the risks of patients not receiving their medication in a timely manner. The trust had not maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. There were gaps in the clinical governance arrangements that meant that although issues were identified, appropriate action was not taken to mitigate the risks or act on feedback for the purposes of continually evaluating and improving the service. **How the regulation was not being met:** We found numerous examples of gaps in the medicines administration charts where staff at Maister Lodge did not properly record or code the administration of medicines across a number of patients' medication records. The audits of medicines management arrangements were not sufficiently robust or regular to ensure that the gaps in the medicines administration charts were identified and addressed. We found appropriate action was not taken to mitigate the risks or act on feedback for the purposes of continually evaluating and improving the service. For example action was not taken in a timely manner to address the known evening and weekend staffing issues at Maister Lodge or to review staffing levels once the community team departed from Maister Lodge.

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Requirement notices

This was a breach of Regulation 17 (1) and (2) (b) (c) (e) and (f) of the HSCA (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was also one ongoing requirement notice from the focused inspection of Maister Lodge in March 2016. **Regulation 18 HSCA (Regulated Activities) Regulations 2014** **Staffing** We found the provider had not ensured there where sufficient numbers of suitably skilled staff on duty to provide safe care and treatments. **How the regulation was not being met:** 26% of shifts did not meet the minimum establishment required level. There was no senior nurse in charge on 23 out of 42 occasions on the day shift. This included every weekend. We were not assured the agency nurses used to supervise the night shift where trained in dementia care. This was a breach of Regulation 18 (1) of the HSCA (Regulated Activities) Regulations 2014.