Good

North Staffordshire Combined Healthcare NHS 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)
RLY88	Harplands Hospital	Ward 6 Complex Care	ST4 6TH
RLY88	Harplands Hospital	Ward 7 Assessment	ST4 6TH

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated wards for older people with mental health problems this service as good because:

- During this most recent inspection, we found that the services had fully addressed two of the four issues that had caused us to make recommendations for improvement following the September 2015 inspection.
- The trust had followed the recommendation of the CQC inspection of September 2015 and employed a clinical psychologist to work on the two wards. By providing access to psychology, a patients recovery could be enhanced.
- Staff recorded that they had offered patients' copies of their care plans and attempted were possible to include individual patients in discussion of and planning their own care and goals.
- Through a programme of audit and education trust managers had reduced the number of medication administrations that went unrecorded. Although there continued to be some omissions manager were taking action to meet the target of all prescribed medication that is given, omitted or refused was always recorded.
- Staff had excellent practice around supporting patients to make decisions independently. If a patient lacked the mental capacity to make specific decisions staff followed the best interests' checklist to make decisions on their behalf.
- Staff carried out excellent physical healthcare assessments that covered a wide range of physical health issues. Nursing staff responded quickly to any changes in physical health conditions and took appropriate action.
- Both wards offered patients a wide range of activities that were person centred seven days a week including evenings. Activity workers on both wards, had knowledge of individual patient's needs, and developed personalised plans of care and materials to help relieve their distress.
- Managers had provided a clear policy on the application of the Mental Capacity Act. Staff were aware of this policy and where to find it for reference. In addition, the trust had developed information leaflets for patients and carers on aspects of the MCA including making best interests decisions.

However:

- The wards did not have an up to date rapid tranquillisation policy. Staff did not record, in line with the Mental Health Act Code of Practice, when they used rapid tranquilisation and they did not always carry out physical observations following its use.
- Staff on ward 7 gave one patient covert medicine (this is medicine given to a patient in a hidden way without the knowledge or consent, for example in food or drink) for physical health problems without any legal authority. They did not follow the proper procedures related to the use of the Mental Capacity Act or the national institute for health and care excellence (NICE) guidance on managing medicines in care homes, which also informs hospital practice.
- Not all ward staff had received specialist dementia training; this was at 60% and below the trust target of 100%. Following the inspection of September 2015, the CQC told the trust it should ensure all trust staff working with dementia patients are fully equipped for the role by having undertaken appropriate dementia training.

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:

- The wards did not have an up to date rapid tranquillisation policy available at the time of inspection. Staff did not record effectively in line with the Mental Health Act Code of Practice when they administered rapid tranquilisation. Staff did not carry out physical observations to monitor the effects of the medicine following rapid tranquilisation.
- On ward 7, staff administered physical health medicines covertly (hidden in food or drink) to one patient without any legal authority to do so and so failed to safeguard the patient.
- Ward 6 did not always store medicines within safe temperature ranges. The fridge temperature was above the recommended temperature 48 times between June 2016 and September 2016. Staff did not complete an incident form or report the discrepancies to pharmacy. The potential impact of these failings was that the effectiveness of medicines stored in the fridge may have been affected putting patients at risk

However:

- The environments were clean and well maintained. The ward managers had assessed all potential ligature points and developed individual management plans to reduce risks to patients.
- Staff completed individual risk assessments and they regularly reviewed and updated them at the multidisciplinary team meetings.
- The wards had enough staff to meet the needs of patients. Staff reported incidents appropriately and the managers provided staff with the opportunities to learn lessons. Staff had good awareness of safeguarding procedures.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments that the multidisciplinary team regularly reviewed and updated. Staff also carried out excellent physical healthcare assessments that included the monitoring of hydration and nutrition.
- Care plans were personalised, holistic with clear recovery orientated goals and staff clearly recorded patients' involvement. Staff adjusted care to reflect the changing needs of patients.

Summary of findings

- Staff had excellent practice around supporting patients to make decisions independently. If a patient lacked the mental capacity to make specific decisions staff followed the best interests' checklist to make decisions on their behalf.
- The wards worked well in partnership with other teams within the trust and outside organisations to ensure that patients got the right support.

However:

- Staff had not been receiving supervision regularly in line with the trust's policy and staff did not have regular team meetings on the ward 7.
- Not all ward staff had received specialist dementia training; this was at 60% and below the trust target of 100%.
- The wards did not use recognised outcome measures to monitor the severity of mental health problems. Physical health needs and well-being were closely monitored.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with respect and dignity, and were polite and supportive. Patients and families were complimentary about the support they received from the staff.
- Staff involved patients and carers in their care and treatment planning. Staff had a good understanding of patients' needs, their personal histories and preferences. Staff supported patients with access to advocacy when needed.
- Patients were able to share their views in decisions about their service and staff gave feedback in patient meetings.

However:

- The inspection team received mixed feedback from carers regarding lack of information about their relatives and difficulties in communication with medical staff.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The multidisciplinary team discussed discharge plans in advance, involved carers and outside organisations to ensure that they had planned to support all patients' needs.

Summary of findings

- Staff provided patients with different information about their treatment and care and on how the service was managed. Interpreting services or information in different languages was made available when needed.
- Staff offered patients a wide range of activities that met their individual needs seven days a week.
- Staff offered patients good quality food that met their dietary needs and preferences.
- Patients knew how to make complaints, and staff dealt with complaints in line with the trust's complaints procedure.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew and agreed with the vision and values of the trust that promoted safe, personalised, accessible and recovery-focused services.
- The managers were knowledgeable and provided good leadership. Staff reported good morale within the teams and they felt supported by their line managers
- Staff felt confident to raise concerns with managers and that managers would act upon them.
- The trust used key performance indicators and other measures to gauge the performance of the wards.

Summary of findings

Information about the service

The service provides treatment and short-term inpatient care for older people with mental health problems in order to discharge them to suitable community settings. This could be to their own homes, supported living or residential or nursing care. Ward 7 was primarily for older people with functional mental illnesses, while ward 6 was primarily for older people with organic mental disorders such as dementia.

Our previous report also included an assessment of ward 4. This was a 'shared care' ward jointly run with the University Hospital of North Staffordshire NHS trust. This ward was for older patients with physical health problems and dementia needs who were treated at that hospital and need additional support prior to 'stepping down' to community, nursing or residential settings. The ward closed in July 2016 and so did not form part of the inspection reported below.

Ward 6 had 15 beds and ward 7 had 20 beds available for use.

On our last inspection, we rated the service as good overall and in answer to each of the five questions, the CQC asks. However, the report also included recommendations to the provider on how the service should be improved in four areas:

- The provider should consider whether better access to psychology by wards could benefit the recovery of particular patients.
- The provider should make copies of treatment and care plans available to patients and/or relatives.
- The provider should ensure all trust staff working with dementia patients are fully equipped for the role by having undertaken appropriate dementia training.
- The provider should ensure any prescribed medication that is given, omitted or refused is always recorded.

We inspected the progress the trust had made at this inspection and discuss our findings below.

Our inspection team

The North Staffordshire Combined Healthcare NHS Trust comprehensive inspection was led by:

Chair: Beatrice Fraenkel, Chair, Mersey Care NHS Foundation Trust.

Head of Inspection: James Mullins, Head of Hospital inspections (Mental Health), Care Quality Commission (CQC).

Team Leader: Kathryn Mason, Inspection Manager (Mental Health), CQC.

The team inspecting the two older adult wards comprised of one CQC inspector, a CQC pharmacy specialist, one mental health nurse specialist advisor, one expert by experience and one Mental Health Act reviewer. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether North Staffordshire Combined Healthcare NHS Trust had made improvements to their inpatient mental health services for older people since our last comprehensive inspection of the trust in September 2015.

When we last inspected the trust in September 2015, we rated wards for older people with mental health problems as **good** overall.

We rated the core service as good for safe, effective, caring, responsive and well-led.

Summary of findings

Following the September 2015 inspection, we told the trust it should make the following actions to improve wards for older people with mental health problems:

- The trust should consider whether better access to psychology by wards could benefit the recovery of particular patients.
- The trust should make copies of treatment and care plans available to patients and/or relatives.
- The trust should ensure all trust staff working with dementia patients are fully equipped for the role by having undertaken appropriate dementia training.
- The trust should ensure any prescribed medication that is given, omitted or refused is always recorded.

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 at three focus groups.

During the inspection visit, the inspection team:

- visited both wards at Harplands hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service (two on ward 6 and seven on ward 7)
- spoke with five carers on ward 6 and on ward 7
- spoke with the manager and charge nurse on ward 7 and the acting manager on ward 6
- spoke with two staff nurses, two healthcare support workers, an occupational therapist two activity workers and the assistant practitioner on ward 6
- spoke with two staff nurses, a healthcare support worker, activity worker and the assistant practitioner on ward 7
- spoke with a consultant psychiatrist with responsibilities on both wards and with junior medical staff on each ward
- interviewed the modern matron, clinical psychologist and social worker who all worked across the two wards
- attended and observed one team hand-over meeting and one multidisciplinary meeting on ward 6
- attended and observed one nurse hand-over meeting and one multidisciplinary meeting on ward 7
- spoke with domestic staff on each ward
- looked at 20 treatment records of patients
- carried out a specific check of the medication management on both wards reviewing 30 prescription 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

We spoke with nine patients during our inspection visit. Patients on both wards were very positive about the standard of care they received. They commented on the cleanliness of the ward environments and praised the quality of food. Only one patient on ward 7 complained of about boredom on the ward. The other patients reported that many activities were available. Patients on both wards said the activity workers were very good and helpful.

Patients gave mixed opinions about their involvement in care planning and receiving copies of care plans. On ward 7, two patients told us they had not been involved in discussions with staff about their care. The remaining five patients said staff involved them in meeting, consulted them on their care plans, and informed them about their care.

Summary of findings

Good practice

We found good practice in the following areas where the wards were demonstrating innovative or very good evidence-based practice:

- Staff carried out excellent physical healthcare assessments that covered a wide range of physical health issues. This included careful monitoring of hydration and nutrition. The wards used a prompt sheet for staff to show all the cups and glasses used on the ward and the volume of fluid they contained to make recordings accurate and consistent.
- The wards had activity workers that ensured patients were always engaged in meaningful activities. Staff offered patients a wide range of activities that were person centred seven days a week including evenings. They had a range of dementia friendly equipment available to support particular patient's needs.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that their policy on rapid tranquillisation is consistent and in line with current prescribing guidance from national institute for health and care excellence (NICE).
- The trust must ensure that clinical staff have a consistent approach to the use of rapid tranquillisation, understand its risks and record its use and follow up care as detailed in the NICE guidelines [NG10] 'Violence and aggression: short-term management in mental health, health and community settings'.

Action the provider SHOULD take to improve

- The trust should ensure that staff follow appropriate procedures in line with the Mental Capacity Act and national institute for health and care excellence (NICE) guidance on managing medicines in care homes where nurses administer covert medication for physical health issues.
- The trust should ensure that when the multi-disciplinary team transfers patients between wards, they clearly document clinical reasons for doing so.
- The trust should ensure that a pharmacist is regularly involved clinical multidisciplinary team meetings to review patients' medication.

North Staffordshire Combined Healthcare NHS 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
Ward 6 Complex Care	Harplands Hospital
Ward 7 Assessment	Harplands Hospital

Mental Health Act responsibilities

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

The wards had 90% of staff that had received training in the Mental Health Act (MHA). Staff had a good understanding of the MHA, the code of practice and the guiding principles.

The wards had appropriate treatment forms in place to support the administration of medicines to detained patients. However, nursing staff carried out capacity to consent to medication assessments rather than the patient's responsible clinician. All detention paperwork appeared correct and was available for scrutiny on the wards.

On ward 7, two patients out of the ten detained had not received information about their rights at admission. All seven of the patients detained on ward 6 had received this information. After admission, staff routinely informed patients of their rights weekly.

Staff knew how to contact the Mental Health Act administrator for advice when needed. The wards carried out audits to check that they were correctly applying the MHA.

Patients had access to independent mental health advocate services (IMHA) to support them in appeals and ward rounds.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust provided staff with training in Mental Capacity Act (MCA) and deprivation of Liberty safeguards (DoLS). All wards were above the trust target of 90%. Staff showed a good understanding of the principles of the act and their responsibilities.

Staff were aware of the MCA policy and knew where to find it for reference. Staff knew the MCA lead for the trust and how to contact the lead when they needed support and advice.

Where staff had assessed patients as lacking mental capacity to consent or refuse treatment, they clearly recorded the assessment and specific decision. Staff considered what they knew of a patient's past preferences, wishes and culture in developing care decisions in their best interests and included families and others involved in care.

Staff made applications for deprivation of liberty safeguards (DoLS) authorisations appropriately when required. The trust had developed protocols to manage delayed deprivation of liberty safeguards (DoLS) applications and regularly reviewed the need for and potential alternatives available to protect vulnerable older adults on the wards.

The trust monitored its adherence to the Mental Capacity through regular audits.

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

- Ward 7 was laid out as a cross with one corridor leading from the entrance containing the offices and communal areas of the ward. The other three arms contained bedroom areas and some smaller meeting rooms. This design allowed unobstructed observation of the majority of the ward from the centre of the cross and staff would sit at this point at night to maintain their general observations of patients. Ward 6 had a more complex layout with the entry corridor leading onto a larger corridor, which looped around a central square. This allowed patients and staff to walk uninterrupted by any barriers or doorways around a circuit. This was a positive design feature in a ward for people with dementia where locked doors can cause frustration. Emergency doorways were decorated to look like bookcases to distract from their becoming focuses for attempts to leave the ward. There were some smaller rooms used for therapy or relaxation where patients could sit out of direct lines of sight of staff in the main ward. However, a member of staff maintained regular observations of all patients on the ward and could report on the location of a patient on request.
- The trust had a policy to address the potential risk of ligature points on the wards through annual audits and action plans. Each ward had a ligature risk assessment completed in the 12 months prior to the inspection. On ward 6, staff had last completed the audit in February 2016 and on ward 7 staff had reviewed the audit in light of an external review completed in August 2016. This led to some immediate actions to remove all handles that could support a ligature. Managers had also introduced a requirement that all staff on ward 7 complete a ligature walk around on the ward to inform them of risks. When staff assessed patients at potential risk of using a ligature, they were managed using person centred care plans, risk assessments and clinical observations. The trust had discussed the need to balance the potential for a ligature risk incident against a fall or other potential harm on the two older adult wards. The wards provided services for people with mobility issues associated with their physical and neurological health problems that included a range of equipment and disability aids such as hand and grab rails. These are reasonable adjustments in line with the Equality Act requirements to meet the needs of the patient group. As such, trust managers were aware that these wards had a higher level of ligature risk than the working age adult acute wards. Staff mitigated the risks through risk assessment, care planning and clinical observations.
- The managers on both wards displayed information on the trust's approach to single-sex accommodation which explained ways in which they met the government's requirements. On ward 7, staff organised accommodation to separate male and female bedrooms to different wings of the ward. Shared bathroom and toilets were used that were dedicated to male or female only use. Staff re-allocated the bedrooms and bathrooms in line with the gender mix on the ward while ensuring that patients had en-suite facilities or close access to same-sex bathrooms and toilets. The ward had a female-only lounge to provide a private and secure space for female patients. On ward 6, staff could separate male and female sleeping areas if required. However, the design of the ward allowed easy circulation around the internal circular pathway to benefit patients with dementia who liked to walk freely without obstruction. Separating the sleeping areas meant closing doors and creating obstructions that might give rise to frustration. The trust felt that a high level of observations and thorough risk assessments mitigated effectively against any risk. Women on the ward had a separate lounge available for their sole use and all bedrooms were single occupancy. Staff allocated the shared toilets and bathrooms for single-sex use based upon the ratio of male to female patients on the ward.
- Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that nurses checked weekly. We examined the records for the weekly checks on the emergency equipment and found that on ward 6, staff had missed two checks (10%) since the beginning of May 2016 (in a 19-week period). On ward 7, staff missed one check (5%) in the same time period. The potential impact of not

making these checks was that equipment may not be present or no longer suitable to use, compromising resuscitation efforts on the ward. Ligature cutters were available as an additional piece of equipment to the main emergency bag. These are hooked knives designed to allow staff to remove any material tied to a patient without harming the person. Staff completed daily checks on the ligature cutters on both wards.

- The wards did not have a seclusion room. Ward 6 had one room designated as a breakout room to provide a low-stimulus environment for the de-escalation of patients in distress.
- The wards were clean and well maintained. Corridors were free from clutter that presented a trip or falls risk. Each ward had allocated domestic staff that cleaned their wards on a daily basis. Cleaning schedules were available on each ward. We reviewed cleaning checklists and audits and found they were completed and up-to-date. The domestic staff were aware of the risks associated with the cleaning products they used and stored them securely when not in use.
- Patient led assessment of care environments (PLACE) assessments are self-assessments undertaken by teams of NHS and private/independent health care providers and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided. In relation to cleanliness, the 2015 PLACE score was 98.7% for ward 6 and 100% for ward 7. The overall score for the trust was 99.6%, around 2% above the England average of 97.6%. For condition, appearance and maintenance ward 6 scored 100% and ward 7 scored 98.7% against a national average of 93.4%.
- Clean stickers were visible on clinical equipment. Clinical nursing staff were responsible for the weekly cleaning of equipment and checking that it worked properly. They recorded their checks and the ward manager reviewed the records. We found that staff had missed 33% of daily checks on the fridge in the activity kitchen on ward 6 since the beginning of June 2016 (35 out of 105 days). The impact of these omissions was low as only a small amount of food was stored in the fridge, which staff had labelled and dated appropriately.
- Training rates for infection prevention and control were 94% for ward 6 and 95% for ward 7. Managers monitored ongoing compliance with infection control procedures, including handwashing through monthly audits.
- Domestic staff on each ward maintained cleaning schedules. We reviewed cleaning checklists and audits for the previous month and found they were completed and up-to-date.
- Each ward undertook monthly environmental risk assessments. Each ward had a dedicated member of staff assigned to undertake audits on health and safety, fire, workplace equipment and control of substances hazardous to health (COSHH). Housekeepers maintained a log of work requests sent to the facilities department and risk assessments to manage short-term environmental problems.
- There were two alarm systems in operation on the wards. The first was a nurse call alarm operated from fixed points on the walls of bedrooms and communal areas, bathrooms and toilets. Patients used this system as a non-urgent call for nursing aid and an urgent call for assistance in an emergency. When we activated the non-urgent call alarm from a bedroom on ward 7, the response arrived within a minute. In addition, the nursing staff on the ward carried alarms that linked to a hospital-wide system that would pinpoint the location of the alarm when activated. There was delay of one minute before the alarm would escalate to other wards to give time for an initial ward response and cancellation of any false alarms. After that delay, a response team made up of members of staff from each ward in the hospital would attend to support.

Safe staffing

Establishment levels: qualified nurses (Whole Time Equivalent)

- Ward 6 had 14 qualified nurses, a ward manager, a deputy ward manager and 12 staff nurses. Ward 7 had nine qualified nurses, a ward manager, a deputy ward manager and seven staff nurses.

Establishment levels: nursing assistants (WTE)

- Ward 6 had 17 nursing assistants (healthcare support workers) and ward 7 had 13.

Number of vacancies at the time of inspection: qualified nurses and nursing assistants (WTE)

- Both wards had no vacancies

Number of shifts filled by bank or agency staff from May to July 2016

Requires improvement

Are services safe?

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

- Ward 6 had 56 shifts and ward 7 92 shifts filled by bank staff in this three-month period.

Number of shifts not filled by bank or agency staff from May to July 2016

- Ward 6 had not been able to fill 63 shifts and ward 7 38 shifts in the three-month period.

Staff sickness at the end of February 2016

- In the year to the end of July 2016, the sickness rate for permanent staff in the older adults inpatient service was 4.6%.

Staff turnover for the year until the end of July 2016

- In the year to the end of July 2016, eight full-time staff left the older adults inpatient service, which equated to a turnover of 11%.
- Following the requirements of NHS England in implementing the Francis Report, the trust managers had completed a review of staffing levels in June 2014. In addition, they committed to ongoing reviews every six months, monthly discussions at board meetings and publication of safe staffing data on the trust's website. On ward 6, managers had set a minimum staffing level for three shifts (a 24-hour period). This was three staff nurses and three support workers for early and late shifts during the day and one staff nurse and three healthcare support workers for night shifts. Managers expected this planned level of staffing to manage two patients on one-to-one clinical observation levels Managers could request more staff if there were more patients receiving one-to-one observation. On ward 7, the minimum staffing levels planned over three shifts was two staff nurses and three support workers on early and late shifts during the day and one staff nurse and two healthcare support workers on nights. If clinical needs increased, the nurse-in-charge could request extra staff from the trust staff bank.
- Managers monitored any additional clinical needs that could have an impact on staffing levels. Although there was no direct use of an assessment of the acuity of patient needs staff daily recorded other indicators such as number of clinical observations, missed staff breaks or unplanned overtime. Ward managers in liaison with the modern matron assessed if there was a need for additional short-term staff resources to manage increased demand for clinical care and supervision.

However, we found that the wards did not always achieve the planned numbers of staff, particularly on day shifts. In the trust data for June, July and August 2016, ward 6 reported an average fill rate for qualified nurses on day shifts of 77.2%. For nursing assistants the fill rate was better at 83%. On night shifts in the same period, the ward had at least 100% of the qualified nurses planned on duty each month and an average fill rate of 93% for nursing assistants. On ward 7, night shifts were filled at a rate of 100% or more of the qualified and nursing assistants planned in each month. On days there were shortfalls of qualified nurses in two months (June 97.2 % and July 95.4%) and nursing assistants in all three months (an average fill rate of 87.2%).

- The ward manager for ward 7 told us they rarely cancelled escorted leave or ward activities because there were too few staff. Staff felt that they were able to maintain the safety of the ward because in emergencies, they could they could call on staff from other parts of the hospital to help. Where a 100% fill rate was not achieved, safety was maintained on inpatient wards by the use of additional hours, cross-cover between wards and ward managers and multidisciplinary team members supporting clinical duties.
- Agency and bank nurses completed an induction to orientate them to the ward and received a specific handover on risk management from permanent staff members. Managers made block bookings for agency or bank staff to achieve consistency in care and familiarity with patients and ward systems.
- Trust data for August 2016 showed that overall 91% of staff on ward 6 and 89% of staff on ward 7 were up-to-date with their mandatory training. However, for training in in-hospital resuscitation, ward 6 achieved 86% and ward 7 achieved 80% compliance rates, below the trust's target of 90% compliance with mandatory training. The potential impact of this shortfall was a lack of trained staff to respond immediately to a medical emergency on the wards. Another element of mandatory training that fell below the trust's goal with a potential impact on patient safety was compliance with safer people-handling training. At end of August 2016, 70% of staff on ward 7 and 77% staff on ward 6 were up-to-date with this training. This meant that not all staff could safely support patients with mobility problems and increased the risk of falls. Here the potential impact would be to increase the falls risk for patients dependent on staff to aid their mobility.

Requires improvement

Are services safe?

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

- Three consultant psychiatrists provided medical cover to both wards. They provided clinical leadership and acted as responsible clinicians. The consultants were community based and attended the wards for a weekly review of their patients and when requested by ward staff. The consultants managed caseloads on the wards made up of patients from the locality for which they had responsibility. On each ward, two junior medical staff (a GP trainee and foundation year one doctor in training) supported the consultant psychiatrists. They reported that the consultants were very good at responding to any enquiries. None of the junior doctors had chosen psychiatry as a speciality and appreciated the knowledge and experience offered by the senior staff. Out-of-hours medical cover was provided by an on-call junior doctor based on site and a duty consultant rota, which allowed staff to get telephone advice as required.

Assessing and managing risks to patients and staff

- There were 15 episodes of seclusion across the service reported by the trust in the six months between 1 March 2016 and 31 August 2016. Ward 6 recorded using seclusion 12 times and ward 7 three times in that period. In addition, eight episodes of long-term segregation were reported; six on ward 6 and two on ward 7.
- The trust had questioned these figures as part of their reviewing of the seclusion and long term segregation policy in line with the Mental Health Code of practice. They concluded that incidents of intensive care were being recorded as seclusion and long term segregation.The reason that teams were doing this was because of a lack of clarity on the definitions of seclusion and long term segregation. Intensive care is a strategy used to de-escalate a patients distress in allow stimulus environment with at least on to one support from staff.
- The CQC had observed staff supporting a person with behaviours that challenge in this way in the 'break out' area on ward 6 during our previous inspection. We did not consider it seclusion on that occasion but a proportionate response to managing distress whilst maintaining privacy and dignity. In reviewing the incidents reported between 1 March 2016 and 31 August 2016 that had been coded as seclusion or long term segregation we found no evidence to suggest that the care approach used to de-escalate amounted to the seclusion or long term segregation of patients.
- The trust had implemented a new policy in relation to the use of seclusion and long-term segregation in August 2016. This policy defined the use of seclusion and the procedures required to safeguard patients in line with the revised Mental Health Act Code of Practice published in 2015. Managers had organised training in the new policy for ward staff to clarify understanding and improve future incident reporting.
- Since the trust's updated policy has been issued and clinical teams trained on the definitions now to be used there had been no incidents of seclusion or long term segregation recorded.
- There were 81 episodes of restraint in between 1 March 2016 and 31 August 2016. These were highest on ward 6 with 66 episodes involving 11 patients. Ward 7 had 15 episodes of restraint involving six patients. The trust reported only one episode of prone restraint in this six-month period from ward 7; that episode had not led to rapid tranquillisation. Ward 6 reported no incidents of prone restraint in that time.
- We examined 20 clinical records, ten on each of the two wards. Every patient had a risk assessment completed at admission. The risk assessments were comprehensive including mental health and social risks. For each identified risk, nursing staff completed management plans on admission, which identified how they planned to support patients. Staff recorded the risk assessment and plan on the electronic patient record system. Managers had provided training on the completion of risk assessment for qualified nursing staff. By the time of our inspection, 100% of the nurses on ward 6 and 86% of the nurses on ward 7 had completed the training.
- Ward policies imposed reasonable restrictions on patients to manage identified risks. Staff did not allow patients to hold restricted items such as cigarette lighters. However, staff would provide a light and support to staff who wished to smoke on request.
- On both wards there was clear notice at the exit to the ward that told informal patients they were free to leave but asked them to inform staff if they wished to do so.

Staff gave any informal patient an information leaflet regarding their rights on admission. This presented a clear summary of a patient's rights when informal and reasonable requests that patient should inform staff of any leave they planned to take and when they expected to return.

- Staff were aware of the trust policy on supportive clinical observations. They kept records of observations and activities participated in with patients during periods of close (one-to-one) observation. Due to the size of ward 6, there was a protocol that if more than two patients required intermittent observations, the task may was allocated to multiple members of staff to allow the time required to make the observation meaningful.
- Staff were trained in the use of restraint and maintained their skills through annual updates. As of August 2016 97% of staff on ward 6 and 78% on ward 7 were up to date in this training. Managers had also provided additional training in positive behavioural support to increase the skills and confidence of staff in de-escalation and distraction. We found examples of personalised approaches to reducing a patient's distress that emphasised de-escalation before the use of restraint.
- We found that staff did not attempt to monitor patients' physical health following rapid tranquillisation in line with the national institute for health and care excellence (NICE) guidelines [NG10] on Violence and aggression: short-term management in mental health, health and community settings (2015)'. Rapid tranquilisation is the treatment of patients with sedatives to manage episodes of agitation when other calming or distraction techniques had failed to work. In one case on ward 7, over the course of five days, staff used eight doses of lorazepam (four by intramuscular injection) and an intramuscular dose of an antipsychotic drug to treat a patient. The clinical record described the patient in a high degree of distress, who had barricaded themselves in their room and refused medicines and staff support implying that sedation was required. However, staff had failed to record that they had used these medicines as rapid tranquillisation. We found that staff had not completed incident reports or attempted to monitor the physical health of the patient post--tranquillisation. On only one occasion, staff recorded attempting to talk with the patient (debrief them) following the incident. On ward 6, we found two incidents of the use of rapid tranquillisation. Staff had completed incident forms describing the level of restraint used. However, there was no evidence that staff attempted any physical health monitoring in line with the NICE guidance and the Mental Health Act Code of Practice. The ward manager had allocated a member of staff to support patients following any use of restraint or rapid tranquillisation. The trust used the incident reporting data to monitor the use of rapid tranquillisation, as it did not carry out a specific audit. The failure to submit incident reports, as found on ward 7, led to a risk of an under-reporting of its use and a lack of oversight of the use of restrictive practices required by the Mental Health Act Code of Practice.
- Neither ward had a seclusion room. On occasions, where staff removed a patient from the main ward area to a quiet area of the ward to reduce stimulation or distract, staff treated this as an episode of intensive nursing care. Incident reports for these episodes included evidence of the level of supervision given to patients and the treatment options considered.
- Staff had received training in safeguarding adults and children. Ward 6 had completion rates of 89% and ward seven 86%. All staff that we interviewed knew the name of the trust safeguarding lead and where to contact her. The safeguarding lead provided feedback to teams about the outcomes of incidents they had raised at the end of investigations.
- A specialist CQC pharmacist inspector attended both wards, inspected the clinic rooms, and reviewed prescription charts. In total, 30 prescription charts were reviewed (15 on each ward). On both wards, we saw staff completed medicine reconciliation on all prescription charts and recorded when patients had allergies to any medicines. Prescription charts had pharmacist interventions documented on them, where appropriate. We found the wards stored medicines securely and the pharmacy technician visited the ward to complete monthly audits for safe storage. Access to medicines was good from the onsite pharmacy and medicines for discharge were readily available. Staff reported medicine errors using the incident reporting system. We found that medicines on ward 6 were not always stored within safe temperature ranges. Record charts showed

the fridge temperature exceeded the recommended temperature 48 times between June 2016 and September 2016. The only action recorded by staff against these incidents was resetting the thermometer. Staff had not completed incident forms to alert maintenance to repair the fridge. Staff had not requested that the pharmacy department review the medicines stored in case the high temperatures had affected their performance. Two patients on ward 7 received covert medication. However, staff gave one patient all of their medication, including that for physical health, with reference only to the authority of the Mental Health Act. The Mental Health Act only allows the covert administration of mental health medication. Only when a person regularly refuses their medicine and lacks the capacity to understand why they need to take the medicine is this practice acceptable. Staff need to consider medicines for physical health problems separately under the Mental Capacity Act.

- On our previous inspection, we found gaps in patients' prescription charts. There was no signatures against administration or reasons noted to explain why staff had not given the medicine. The report recommended that recording should be more robust to ensure that staff properly recorded all medicines given or omitted. In response, the modern matron for the service and ward managers had provided education to staff on how to fully complete medication records and introduced regular audits and weekly spot checks to ensure compliance. The modern matron had given the CQC assurance that she and the ward managers had addressed this problem. Staff had achieved completion rates near the goal of 100% across both wards (99.5% on ward 6 and 98% on ward 7) in June 2016. However, we found a number of missed medication doses on ward 6. These records were unable to show that patients received their medicines when they needed them. In the 15 prescription charts we examined, staff failed to record whether they gave or omitted a medicine on 39 occasions. The trust provided information that this would represent and overall rate of 1.37 % of doses not recorded. On ward 7, we found the prescription records fully completed.
- The trust had addressed this issue across all inpatient areas in an ongoing programme of audit and thorough the use of caseload and performance management to support any individual clinical practitioners where underperformance identified. We were able to see other audits from ward 6 in the weeks before inspection and found in the week ending 5 September records were 100% complete and for the week ending 16 August 97% complete. Overall, the trust was able to demonstrate robust procedures to minimize these errors. We found that their omitted dose clinical audit programme had led to improvement at ward level.
- Patients received ongoing assessments of physical health risks relevant to older people. These included the risks of falling, pressure ulcers, osteoporosis and continence problems. Staff supported patients with a known history of falls with a preventative package of care that included, for example, a review by a physiotherapist, provision of non-slip footwear and other measures to reduce the risk of falls. There were pressure sensors available on ward 6 to make staff aware if someone got out of a chair or their bed. This allowed staff to attend patients who were potentially at risk and in need of support. The staff's use of these sensors protected patients from potential falls without requiring physical restriction or intrusive levels of observation.
- There was a room available at the entrance to the hospital shared with the younger adult wards where patients could meet family with staff supervision, if required. If there were no significant risks evident, both wards would allow children to visit their relatives with prior agreement.

Track record on safety

- The trust as a whole reported 56 incidents to the NHS Strategic Information System (STEIS) that had occurred between 1 April 2015 and 31 March 2016. Of the 56 incidents reported four (7.1%) STEIS incidents related to older people's inpatient wards. These related to slips/ trips and falls; three on ward 7 and one on ward 6.
- In the period 1 April 2015 to 31 March 2016, the trust reported only one serious incident requiring investigation related to the wards for older people with mental health problems. This related to an infectious outbreak of diarrhoea on one of the wards.

Reporting incidents and learning from when things go wrong

Requires improvement

Are services safe?

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

- All grades of staff completed incident reports on an electronic incident recording system used on both wards. Ward managers and service leads received copies of all incident reports for review.
- We found that staff on ward 7 had not recorded any restraint used in incidents requiring the use of intramuscular rapid tranquillisation. The degree of psychological distress recorded and refusals of the patient to accept oral medication implied that restraint had occurred.
- All senior nursing staff interviewed knew of their duty to be open and transparent with patients when things went wrong.
- We saw feedback to staff from investigations of incidents documented in the minutes of the monthly staff meetings held for staff on ward 6. The ward manager requested that staff prioritised attendance at these meetings. The manager informed other staff of the discussion and outcomes by email and the minutes. They also circulated the minutes to senior staff within the service for their information. On ward 7, the ward manager told us she gave staff feedback from investigations individually and by email. The staff on ward 7 did not meet regularly to review a standard agenda that including investigation results. However, the minutes of an away day for ward 7 staff in August 2016 showed that the introduction into the team of a social worker and psychologist came about as a result of feedback to the service managers about shortfalls in the provision of multidisciplinary expertise on the wards.
- There were opportunities for staff to receive support after serious incidents on both wards. Senior nursing staff supported individual staff and the ward-based psychologist supported staff individually or in small reflective practice groups.

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 reviewed 20 care records and found that staff had completed comprehensive assessments consistently soon after admission.
- The wards used the trust's integrated care pathway designed specifically for older adults this included a record of a physical health examination at admission, details of previous medical history and a list of medications reconciled with the patient's primary care records. This included recognised screening and assessment tools to assess relevant risks such as falls, pressure areas and nutrition and hydration risks. Ongoing monitoring of physical health problems was care planned for, according to the individual needs of the patient.
- Care plans reflected a personalised and holistic approach to care. Managers had introduced training in care planning following feedback from our last inspection, which examined the underlying principles of a personalised approach. By the end of August 2016, all staff nurses on both wards had completed this training.
- Where possible, staff wrote care plans in close partnership with patients and staff reflected this in the use of the first person to describe the care they had agreed upon. When that had not been possible, staff had regard to what they had found out about patients preferences but used the third person to describe care they would give. Care plans were up to date, reviewed regularly (with patients where possible) and recovery focussed with clear goals to be achieved.
- Patient records were divided between paper based system of individual care notes and electronic patient record. On our last inspection, staff maintained paper care records. This had raised concerns that they were accessible to staff on wards but not easily accessible to community staff when a patient left the ward. During this inspection however, we found that risk assessments, care plans, Mental Health Act information and clinical reviews were available on the electronic patient record. This allowed community staff to access the information remotely to assist in discharge planning. Access to this system also allowed ward staff to get information already entered by community staff at the point of admission.

Best practice in treatment and care

- The trust policy covering rapid tranquilisation available on the wards during our inspection, was based on the previous National Institute of Clinical Excellence (NICE) guidance dated February 2005. After the inspection, the trust provided a new rapid tranquilisation policy document based on the current NICE guidance dated May 2015. It advised on how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. We found the body of the new policy to be in line with the current NICE guidelines; however, the appendices and references within this new policy continued to reflect the old guidelines and this might result in confusion.
- We reviewed 30 prescription charts and found other areas of prescribing including the use of antipsychotics for people with dementia fell in line with NICE guidance with no polypharmacy and doses prescribed within the BNF limits. With the appointment of a clinical psychologist the full range of therapies recommended by NICE for people with dementia was available on the wards.
- A recently appointed clinical psychologist gave support to both wards. The CQC had highlighted the need for access to psychological therapies in our previous report, as there was no dedicated psychology input onto the wards. Managers had advertised a full time post in February 2016 and the new worker had started work in July 2016. The psychologist had started to engage with patients on the wards and was developing a work-plan for psychological therapies to support patients and staff across both wards.
- Managers had appointed a registered general nurse at the hospital to support the physical health skills and knowledge of the mental health nurses on site. Staff could access specialist physical healthcare through referral to the acute hospital trust.
- Staff assessed the nutritional and hydration needs of all patients on admission. Staff used the malnutrition universal screening tool to identify particular risk of being malnourished. Ward staff could request support

of a dietician to support in developing individual care plans for nutritional needs. The clinical team considered medical conditions such as diabetes or kidney disease that could limit the type and amounts of food and fluids an individual patient could eat or drink. Staff would then discuss these considerations with patients and agree a care plan with them. There were fluid and nutrition charts in place for all patients assessed as requiring these. Staff regularly updated this information throughout shifts and checked by nurses on each shift in order to note any areas of concern and take necessary actions. One staff member had prepared a prompt sheet for staff clarifying all the cups and glasses used on the ward and the volume of fluid they contained to make recordings accurate and consistent. During the two days of our inspection, there was a significant change in the weather and the wards were very warm. In response to this, the clinical team on ward 6 had adjusted the amount of fluids available to two patients who had their drinking closely monitored and controlled for medical reasons. Staff had raised the maximum limits of fluids allowed to account for the hot weather and compensate for fluid lost through perspiration. Housekeeping and nursing assistants were aware of individual needs, such as swallowing difficulties and gave extra support at mealtimes to those patients with difficulty in eating or drinking independently. We observed a lunchtime meal service on each ward. On ward 6 staff supported patients to eat where they would feel most at ease. We observed at one mealtime staff supporting patients across four rooms with their meals and drinks. Staff members supported some patients to support their eating and drinking through direct help to feed or by supporting a small group of patients with individual prompts. If a patient refused the initial choice of food, staff offered them an alternative and sandwiches were available on request if hot food declined. On ward 7, most patients chose to eat together in the main ward dining room with staff available to support individual needs.

- Clinical outcome scales to measure the severity of mental health problems were not in regular use on the wards. Staff completed the health of the nation outcome scales for older adults (HoNOS) on admission as part of the care cluster allocation tool. They did not repeat this assessment at discharge or at any points during the stay to demonstrate any change in the psychological and social needs of the patients. The newly appointed psychologist was trialling the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) on ward 7 but it had not been embedded into practice at the time of our inspection.. Staff monitored all patients for changes in their physical well-being through use of the modified early warning scores (MEWS) and other condition specific measures such as a pressure ulcer risk rating scale. We found evidence of two incidents where changes in a patient's physical health and scoring on MEWS had triggered an escalation response. In one case from ward 7, a doctor had reviewed the patient within an hour and nurses had completed a repeat set of observations in line with the guidance. In the other example from ward 6, nurses had referred to the rise in MEWS score in the clinical notes. However, there was a separate entry to confirm that a medical review had taken place.

- We saw that clinical staff managed audits to assess local compliance with trust standards for aspects of care. For instance, the deputy ward manager on ward 7 had audited the completion of care plans and risk assessments on the electronic patient record on a monthly basis. In September 2016, both wards were 100% compliant on this audit and this was in line with our own findings on reviewing case notes.

Skilled staff to deliver care

- Ward teams included occupational therapists, a psychologist and social worker as well as nursing and medical staff.

- Support from pharmacists and physiotherapy staff was available within the hospital. Staff could request further specialist support from a dietician and speech and language therapist.

- Clinical supervision provides staff members with support to review and reflect on their clinical practice and plan their personal development. The local trust policy states staff should attend clinical supervision at least once every two months. The average supervision rate for ward 6 in the six months between March and August 2016 was 83% and for ward 7 61%. Both wards had substantially improved supervision rates in August with ward 6 up to 97% and ward 7 up to 91%. However, we heard concerns that managers delivering supervision focused on performance and information

Are services effective?

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sharing (management supervision) rather than reflection and personal development (clinical supervision). There were no supervision contracts completed to define the terms of these sessions. In September 2016, completion rates for appraisals (personal development reviews) in the last year were recorded as 100% for each ward on the service quality dashboard.

- Staff on ward 7 were able to access regular monthly staff meetings that were minuted for the information of staff not able to attend. Staff on ward 6 met less regularly. We saw minutes from a staff away day in August 2016 at which staff had an opportunity to discuss plans for the development of the ward and lessons learnt from incidents and feedback from audits. In addition, the psychologist supported staff by leading a weekly reflective practice group meeting on ward 6. They had recently introduced these meetings and we heard positive feedback about their usefulness from medical and nursing staff.
- On our last inspection, we found that staff working in the service had little or no specialist training in working with people with dementia. All staff within the trust had received a one hour session on basic dementia awareness training. The last inspection report requested the provider should ensure all trust staff working with dementia patients were fully equipped for the role by receiving appropriate dementia training. The trust submitted an action plan to the CQC explaining how they would meet this and other requests for action made in the last inspection report. After consultation with the regional NHS dementia specialist, managers had agreed a two day training package for the education of all older adult ward and community clinical staff. The learning outcomes were for staff to develop their understanding of a person centred approach to behaviours that challenge and other aspects of the lives of people with dementia. The initial rollout of this training started in May 2016. By the beginning of September 2016, 57% of inpatient staff had completed the two day course. Further training dates had been identified to raise that number to 100% completion rate the trust had initially set to be completed by the end of July 2016. The directorate had now revised this target to have training completed by the end of November 2016. In addition to core clinical staff on the wards, the two ward housekeepers had been included in the higher level dementia training that the directorate had introduced.
- Managers submitted evidence to demonstrate that when they had identified poor staff performance they addressed it promptly.

Multi-disciplinary and inter-agency team work

- Each ward admitted from three locality-based catchment areas covered by a consultant psychiatrists and community mental health teams. This meant that the consultant psychiatrist, who led on a patient's care on the ward, would also be responsible for them in their community practice. This provided for some continuity of care between hospital and home. There were three consultant led multi-disciplinary meetings a week on each ward. All professional disciplines, based on the ward, attended the ward reviews that we observed. We found that the team on ward 6 were welcoming of carers and community workers joining the meetings. Staff listened to family members and offered information and support from the team. Where patients lacked family support, the team would involve an appropriate advocate to meetings to represent the patient's interest in decision-making. On ward 7, we observed patients attending the review meeting and were given time to explain their feelings and express their opinions about their care. The consultant offered patients choices about treatment and gave them the information necessary to make an informed decision. The consultant always asked the patient if they had any questions for the team and offered information to them about their Mental Health Act status, leave and medication.
- We found on both wards that the clinical pharmacists were involved in patients' individual medicine requirements, however their involvement in multidisciplinary meetings was limited to when requested and depended on their availability. Following NICE guidance on medicines optimisation a pharmacist regularly attending these meetings given the complications of long-term physical health conditions and polypharmacy in the patient group would be good practice.

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- Each ward had a handover for staff at the end of each shift. The nursing staff usually attended these shift handovers. We attended a nursing handover on ward 7 and found that the nurse leading the meeting covered current risks for all patients. We noted the positive language used to describe all patients.
- Staff from community mental health teams regularly visited the wards. Representatives of the outreach team of care home liaison team would be involved in discharge planning and received updates from the wards about the progress of patients. Staff believed that the use of a common electronic patient record had helped improve communication between ward and community teams.
- The appointment of a ward based social worker for the city of Stoke had improved the effectiveness of the working relationships between the ward and local social services. Staffordshire county council who covered the remainder of the catchment area for the wards did not have a regular representative on the wards. This resulted in some delays in response to planning discharge and requests for social assessments.
- Staff on ward reported good working relationships with local GPs and the local acute general hospital. The wards had also developed good working relationships with local voluntary organisations and nursing homes.

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

- On both wards, training records evidenced that 90% of staff were trained in the MHA in September 2016. Staff were able to demonstrate a good understanding of the mental health act and its guiding principles.
- We found that treatment forms were in place as required to support the administration of medicines to detained patients. However, nursing staff carried out the capacity to consent to medication assessments rather than the patient's responsible clinician.
- On ward 7, two out of 10 detained patients had not received information about their rights at admission. All seven of the patients detained on ward 6 had received this information. However, in an example of good practice, we found that the approved mental health professional routinely provided rights information during the detention process. They also provided the patients with a detention summary. After admission, staff informed patients of their rights weekly.
- A central trust team supported the wards in the administration of the mental health act. The MHA team could provide information to ward staff and also managed the timetables for reviews, hearings and tribunals on the wards
- All detention paperwork appeared correct and was available for scrutiny on the wards.

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- We reviewed audits completed for both wards in August 2016. The auditor had highlighted issues of assessing, recording, and reviewing capacity and consent to treatment as failings.
- Files demonstrated independent mental health advocate involvement with patients on the wards, including at appeals and ward rounds.

Good practice in applying the Mental Capacity Act (MCA)

- As of September 2016, training rates for staff in the Mental Capacity Act were 97% for ward 6 and 95% for ward 7. Staff demonstrated in practice and during interview a good working knowledge of the principles of the mental capacity act and respect for the principles of supporting autonomy and wishes in decision making.
- Managers had provided a clear policy on the application of the Mental Capacity Act. Staff were aware of this policy and where to find it for reference. In addition the trust had developed information leaflets for patients and carers on aspects of the MCA including making best interests decisions.
- In cases where staff had assessed patients as lacking mental capacity, they had clearly documented the assessment and specific decision considered. Staff had a clear understanding of the principles of the act and their responsibilities. In one ward multidisciplinary team meeting we witnessed a thorough discussion on why a particular decision about future care of a patient would require an application to the court of protection.
- We saw that staff considered what they knew of a patient's past preferences in developing care decision in

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their best interests. Staff followed the best interests checklist, consulted interested parties such as family members and referred to the patients past preferences when possible.

- Staff were aware of how to access advice and support regarding deprivation of liberty safeguards (DoLS) and best interests' assessments. In the six months until the end of August 2016, ward 6 had made 21 DoLS applications, the relevant local authority had approved only three. Ward 7 had made ten application in the same time with only one approved. For those applications not approved, there was variety of outcomes; patients had been detained under the Mental Health Act, discharged or had regained capacity and become able to consent to care as informal patients. There had been significant delays in the response of Staffordshire county council to these applications. For Stoke residents, the trust had a joint arrangement with the local authority to host a specialist team that contained best interests' assessors able to process DoLS applications from care settings in the city. Ward staff contacted the Staffordshire DoLS team weekly for updates on the progress of applications. The trust had raised concerns about delays with the local authority safeguarding lead and the safeguarding board. In August 2016, the trust's medical director wrote to the county council regarding five individuals who were currently inpatients in Harplands hospital requiring assessments. The chief executive had followed this up in her own letter requesting early dates for assessment and had raised concerns with the safeguarding board and Staffordshire safeguarding lead. At the time of our inspection, ward 7 had two patients and ward 6 three patients awaiting assessment from Staffordshire. Ward 6 had one patient protected by an authorised DoLS application and one patient on an urgent authorisation awaiting assessment from Stoke. The trust had developed protocols to manage delayed DoLS applications and regularly review the need for DoLS and the potential alternatives available to legally protect vulnerable older adults on the wards. This included the trust developing and implementing a DoLS scrutiny process, which tracks the individual's progress through the application process. All files reviewed contained copies of the applications for authorisation. In addition, the trust had developed a DoLS rights process. This required staff to regularly engage with and provide information to patients for whom they had applied for, or received an authorisation to deprive a patient of their liberty
- The trust monitored its adherence to the Mental Capacity through regular audits and bi monthly review by the mental health law governance group.

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

- On the wards, we observed the interactions between staff and patients, spending time in social areas and also making observations in activity groups and at mealtimes. We observed a particularly warm response from patients to the activity workers on both wards. All three staff had an easy and respectful rapport with the patients and used humour and personal knowledge of patients' preferences to engage them in activities.
- We spoke with nine patients on both wards; they were very positive about the standard of care they were receiving. They commented on the cleanliness of the ward environments and praised the quality of food. Only one patient on ward 7 complained of being bored on the ward the other patients reporting that they found there to be many activities available. Patients on both wards mentioned the activity workers as very good and helpful.
- In our discussions, we found that all staff, including regular bank, had some knowledge of patients' history and could give examples of how they used that knowledge in their approach to care.
- According to patient led assessments of care environment (PLACE) survey in relation to privacy, dignity and wellbeing, the ward scores were 93.8% for ward 6 and 100% for ward 7. The score for the trust as a whole was 97.5% and the national average for mental health and learning disability hospitals was 89.7%.
- We observed staff react quickly to patients in distress or to help restore their dignity or privacy. For example, we saw a member of staff breaking away from another task to help a patient dress herself. We heard from one carer that staff on ward 6 respected their relative's wishes to have personal needs attended to by female members of staff only.

The involvement of people in the care they receive

- On admission, staff orientated patients to the ward and provided information on ward routines and details of the care team. In addition, the wards asked patients and their carers to complete a booklet on admission that provided staff with information about their preferences and some personal history. Staff used this information to develop an individual approach to patients by understanding the personal strengths of a patient that could contribute towards their recovery.
- A recommendation of our previous inspection was that staff should offer all patients a copy of their care plan. The introduction of an electronic patient record in February 2016 allowed staff to print copies of care plans and record directly into the electronic record their offer of a copy to the patient. An initial audit in April 2016 found that staff had made this offer to 100% of patients on the wards at that time. Patient opinion about involvement in care planning and receiving copies of care plans was mixed. On ward 7, two patents told us that they had not been involved in discussions with staff about their care whereas the remaining five had positive experiences of staff involving them in meetings, consulting them on care plans and informing them about their care. We heard from one patient on ward 6 that staff looked after them very well but had not informed him about his care plan and that he was given too many tablets without explanation. A carer for a different patient on ward 6, told us that they had received a copy of their parent's care plan but did not believe that the patient had a copy.
- Staff knew how to access advocacy services appropriate to the needs of individual patients. Advocacy workers visited the wards regularly to support individual patients at care planning and discharge meetings.
- We spoke with 12 carers and family members visiting the wards over two days, five on ward 6 and seven on ward 7. On ward 6, we heard positive comments about the standard of care and staff communication from three carers and concerns from two others. They had in common frustrations that staff did not know detail about the care of their relatives and questions went unanswered between formal meetings. More positively, another carer told us of the very positive support given to her parent and said, 'diabetes care here is absolutely unbelievable'. Staff had supported their parent to regain weight lost, after a period of physical illness and a long acute hospital stay, whilst effectively managing the sugar content of their diet and fluid intake. On ward 7, the visitors that we met were overwhelmingly positive about the staff offering support and the communication they received from the ward.
- Staff told us that carers and family members were encouraged to attend the weekly review meetings. The

Good

Are services caring?

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assistant clinical practitioner was also available to help support families and keep them informed of and involved in discharge arrangements. The ward manager on ward 6 offered a monthly drop in sessions to meet with carers to discuss any questions around diagnosis, treatment and discharge planning.

- Each ward had arrangements in place to allow patients to give feedback on the service they received. On ward 6 the nurses had gathered feedback from patients and carers together into a folder called 'Our journey on ward 6' and this contained copies of cards and other messages sent to ward staff after discharge. Staff hoped that be sharing these experiences with current patients it could help build hope for the future.
- The activity workers were also responsible for managing the patient community meetings on each ward. On ward 6, the activities co-ordinator facilitated patient meetings weekly. They communicated the decisions of these meetings on a notice board with the "you said, we did" format to highlight how staff had responded to the suggestions made. On ward 7, staff organised fortnightly community meetings with patients. They asked a regular series of questions to understand levels of patient engagement with staff and ward routines on and their experience of care. Minutes had not been made of decisions of these meetings and feedback was not available to the patients attending.
- No patients had advance decisions in place. These are decisions made beforehand to refuse a specific type of treatment at some time in the future.

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

- The average bed occupancy over a six-month period from March 2016 to August 2016 was 98% on ward 6 and 89% on ward 7.
- There were no out of area placements for older adult inpatients in the same period.
- There were four patients on ward 7 whose primary care needs identified through the use of the care cluster allocation tool (CCAT) at the time of admission indicated an organic illness (dementia). They had been placed on ward 7 as there were no beds available on ward 6, the specialist dementia ward. The ward managers and modern matron reviewed these placements at weekly bed management meetings. However, there was no record kept of the individual discussions supporting these moves. We examined the records of one patient who had moved from ward 7 to ward 6 on the day before our inspection. This patient was a person with dementia who had become more unsettled and presented staff with behaviours that challenged. Their needs were reviewed and the supportive specialist environment of ward 6 was agreed on as a more suitable placement. Clinicians had authorised this move on clear clinical grounds.
- Discharges were always organised in advance if possible and at a time to support the involvement of carers and the care services or placement identified. Ward staff told us that if a discharge was organised as a result of a physical health problem or emergency, they would seek to accompany the patient to the acute hospital to provide support and a handover to receiving staff.
- On ward 6, we saw evidence of a very thorough approach to discharge planning with arrangements delegated to a specific staff member to organise transport and liaise with community carers and relatives. A comprehensive discharge pack containing summary information about the patient was prepared. This included the personal information gained on the ward about the patient, their likes and dislikes and personal history to inform new carers. The ward occupational therapists had a major role in assessing the functional needs of patients on the ward in preparation for discharge. They did use through assessments using facilities on the ward such as the activity kitchen and taking patients home to assess abilities in a familiar environment. Their assessments were included in the discharge pack for the information of future carers.
- Delays in discharge were reported from both wards. The trust stated that they knew the number of delayed days but not the number of patients involved. Ward breakdown was not available. Between 1 March and 31 August 2016, the trust reported that 85 days of occupancy on the wards as the result of a delay in discharge due to a non-clinical reason.
- The ward social worker covered patients living with the boundaries of Stoke city only and was a recent appointment to the team. In collaboration with the city council, managers had created this post to reduce unnecessary delays in discharges from the wards awaiting allocation of a community social worker. Staff could refer patients requiring support from Staffordshire county council to that council's duty system.
- If a patient became unwell during their admission and risks increased, the clinical team would attempt to manage that patient's developing needs on the ward rather than through transfer to a more secure setting. Ward managers could request additional staffing or other resources to support the patient until their needs reduced again.

The facilities promote recovery, comfort, dignity and confidentiality

- Each ward had an examination room with a couch to allow physical reviews by medical staff. The wards had quiet lounges for women. There were good facilities for occupational therapy activities and group sessions available on and off the wards. There was a sensory room on ward 6 where patients could relax in a supportive and calm atmosphere.
- Visitors were concerned about limited space to visit their relatives in private on ward 7. Staff used the ward dining room to accommodate all visitors and patients whilst patients without visitors remained in the main lounge. This meant that at peak times the visiting room/dining room became very crowded and noisy. We observed this difficulty during our visit to the ward.

Are services responsive to people's needs?

Good

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

- Patients had access to a phone from which to make private calls.
- Both wards had access to outside spaces that consisted of well-maintained gardens with seating areas. On ward 6, the activity workers used the garden to grow a small selection of fruit and vegetables that patients could pick and use in the cooking groups held on the ward.
- Food quality scored 100% for Harplands hospital in the 2016 patient-led assessment of the care environment (PLACE). This was higher than the trust average of 92.9%, and the national average of 86.6%.
- Patients had a choice and catering staff were able to meet a range of dietary requirements and cultural preferences. Staff involved patients in planning their meals and simplified copies of the menus were available to help patients make a decision. In our observations of mealtimes, we noted the food being well presented and patients giving positive feedback. For instance, one patient when asked said their meal was 'very good'.
- Drinks and snacks were available on request from staff. There was access to a small assessment kitchen in which under the supervision of an occupational therapist or other staff member patients could make drinks and snacks. This was part of a therapeutic approach to maintain and develop independent living skills..
- Patients were encouraged to bring in family photos and other decorations to personalise their rooms. Staff believed that having personal items with them helped patients to feel more at ease in a strange environment. Patient names were also displayed on doors; sometimes alongside photographs to help patients find their way. Bedroom doors had been painted different colours to distinguish them from one another. One patient had a record player in his room which staff encouraged him to use as music brought him comfort.
- On ward 6, staff made use of creative resources and selected hobbies (CRASH) boxes, which contained materials to support activities known to calm an individual patient. This could include family photos, or objects with a personal association to use as talking points and distraction. Staff had asked family carers, "what helps calm your relative down?" to help inform the contents of each box.
- Patients had access to secure storage for personal items they had brought onto the ward.
- The ward 6 timetable of activities covered seven days a week and included evenings. They included a mixture of social, exercise and recovery focused activities from groups and supplemented by individual activities. Both wards employed activity co-ordinators. Ward 6 had two staff in post who worked shifts and seven days a week to provide activities. Where possible, staff organised activities for individual patients based on their known hobbies or work history. They had a range of dementia friendly equipment available to support particular patient needs. This included an iPad to play music or play games. Visitors were encouraged to involve themselves in activities on the ward and 'inter active visiting' was promoted at the entrance to both wards. This involved taking a word game or colouring outline to complete on the ward with the patient visited to help engage them in a cognitively stimulating activity and maintain social skills through co-operative effort.

Meeting the needs of all people who use the service

- Each ward had level access from the main hospital entrance. Handrails were available on the main corridors to assist patients and visitors with mobility problems. There was equipment available for patients with mobility difficulties to allow bathing, showering and safe transfers between areas of the wards. Occupational therapists carried out assessments for those patients requiring such aids during their admission. Staff allocated any wheelchair users one of the assisted bedrooms available on each ward, where the toilet and bathing facilities were ensuite and adapted for their use.
- Dementia friendly signage was in use on ward 6 and the purpose of rooms was clearly identified by words and symbols. Staff had made use of high colour contrast in providing equipment to improve identification by patients with dementia.
- The PLACE assessment scores for the ability of the wards to meet the need of people with dementia or a disability were all higher than the national average. Ward 6 scored 93.9% and ward seven 97% against a national average of only 75.3% for dementia. Both wards scored 93.8% against the national average of 82.9%.

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- Each ward had very wide range of information leaflets available for patients and visitors. In addition, there were numerous notice boards and display cases presenting information on patients' rights, treatments and the performance of the wards
- Information that managers had made immediately available on the wards was in English only. Staff could, on request, source copies of the information in a range of other languages. There was a lot of information available about local support services in the voluntary sector and from community based health services.
- Staff on both wards could access signing and interpreting services on the assessment of patient need.
- The variety of choice in menus allowed staff to meet the dietary requirements of religious and ethnic groups on request. Patients, who commented, were all positive about the choice of food available.
- Neither ward had a designated multi-faith room. We saw patients attending an act of worship in an activity room shared between the two older adult wards and ward 5. The hospital chaplain led this service every Tuesday. Spiritual support was available through a request to nursing staff and hospital chaplains made regular visits to both wards.

Listening to and learning from concerns and complaints

- Patients knew how to make complaints and we found that staff gave them information on the trust' patients advice and liaison service.
- Staff on both wards had knowledge of the complaints process. They emphasised that the approach they would use was to deal with matters of concern immediately and at ward level.
- Staff on ward 6 had a regular agenda item at staff meetings to discuss incidents & learning lessons, which included the investigation of complaints.
- The trust received 65 complaints between April 2015 and March 2016 and of these, three related to older adults inpatients. Ward 4 received one complaint related to clinical issues and ward 6 two complaints; one concerning discharge arrangements and the other clinical issues. Neither ward had received any further complaints since March 2016.
- Older adults' inpatient received 27 compliments over the 12-month period from 1 May 2015 to 30 April 2016. Twenty-one (77%) of these were for Harplands ward 6, four for ward 7 and two for ward 4 which was now closed.

Are services well-led?

Good

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's values of safe, personalised, accessible and recovery-focused services (known as SPAR) was promoted in posters and leaflets visible throughout the hospital. Staff knew these values and agreed with them. Each ward team had completed local action plan on how to deliver the trust's values against the five key lines of enquiry used by the CQC. A summary of their reflections and goals was displayed prominently on each ward. For example, on ward 7, the poster displayed recognised strengths as 'experienced and passionate' staff and their challenge to 'improve carer/family involvement'. Each ward had also displayed a copy of their ward vision presented as a mission statement to emphasise their commitment to personalised care and recovery.
- Staff on the wards knew the names of senior managers of the service and the trust. Trust executives maintained regular communication with ward staff through emails and newsletters and a blog. Staff also positively reported that one executive member had worked a shift on the wards to understand their work.

Good governance

- The trust had set a target of 90% compliance with mandatory training. Across both wards training rates fell below these levels for inpatient resuscitation training, safer people handling, safeguarding children and safeguarding adults. Both types of safeguarding training were just below target at 88% on ward 6 and 85% on ward 7. On ward 7 the training levels for the management of actual or potential aggression (MAPA) was 78%.The 90% target had been met for fire, health and safety, manual handling theory, information governance and infection control training on both wards.
- Supervision completion with staff on ward 6 was 97% and 91% on ward 7. These rates had improved during the year as permanent staffing levels increased.
- High staffing turnover and vacancy levels had been a challenge for the service at our previous inspection. However, the trust had taken measures to fill the vacancies and had new staff coming into post. The wards used regular bank staff and block-booked agency staff to fill shifts.
- Staff participated in clinical and environmental audits.
- All staff knew the process to report incidents using the electronic incident reporting system. We saw that serious incidents were investigated and recommendations were acted upon and then lessons learnt information was shared with staff.
- The trust had presented an action plan to the CQC in advance of this inspection dated 19th August 2016 giving assurance that they had addressed all four concerns raised in our previous inspection. The appointment of a psychologist was complete and ward staff were recording that they had offered patients copies of their care plans. Both items had been rated green on a traffic light monitoring system indicating that managers had successfully implemented these changes. Specialist dementia training was rated at amber, accurately reflecting that progress had been made and recognising the goal of 100% compliance had not been reached. The fourth aim was to ensure that the medication records included no gaps and that nurses recorded all prescribed medication given, omitted or refused. Managers had rated this as green based on earlier checks; however, we found some gaps on ward 6. Ward 7 had complete records in line with the assurances previously given. However, overall the trust's quality governance team assured us that there was an effective system to audit and take action on any omissions.
- There had been no complaints received by the service since March 2016. Patients attended community meetings on both wards and were able to raise any issues within these. Staff displayed feedback and actions on both wards although minutes were not available for review on ward 7.
- Managers monitored overall effectiveness of the two wards against a series of key performance indicators that reflected how effective and safe care was on the wards. Ward staff and managers could access up to date reports on aspects of the wards performance through

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the trust's digital pathway programme. This created a portal to a ward specific database that included clinical information, links to policy and other trust wide resources.

- Ward managers, supported by the modern matron, provided strong and visible clinical leadership on the wards. They had authority to make decisions about the development of the wards and to manage resources. The ward managers could access only limited administrative report.
- Each ward maintained a local risk register that managers used to inform the service level document and reviewed at trust level. Highlighted risks on ward 6 were ligatures and staff workforce in July 2016. By September 2016, staffing issues had been resolved and only the ongoing monitoring and mitigation of ligature risks was an active item. In September 2016, Ward 7 registered the management of ligatures, the challenge of providing care for patients with dementia on that ward and not being able to reach the trust target for mandatory training (95%). There were plans to remove or mitigate these risks. Staff discussed the local content of the risk register at monthly staff meetings on ward 6.

Leadership, morale and staff engagement

- Staff knew how to use whistle-blowing process and the confidential 'Dear Caroline' route to contact the chief executive directly with any concerns.Staff consistently told us they felt able to raise concerns without fear of victimisation. They felt confident in being able to raise any issues with ward managers.
- No concerns were raised regarding bullying and harassment.
- Staff reported high morale and high levels of job satisfaction within the teams. On ward 6, we heard from two staff members who had transferred from ward 4 after its closure. They spoke very positively about how existing staff had integrated them into the team and the positive attitudes that they had found on the ward.
- Staff reported positive examples of team working and the support they had received from other team members.
- A development pathway was available for nursing staff to undertake leadership training at Aston University.
- Staff understood their duty of candour and were open and transparent in explaining to patients if and when something went wrong.
- Both wards organised regular away days for staff to have time away from clinical practice to discuss the effectiveness of their work and develop plans for future service development.

Commitment to quality improvement and innovation

- Both wards were participating in the Royal College of Psychiatrist Accreditation of Inpatient Mental Health Service – Older People (AIMS-OP). Neither ward had yet received accreditation but they were actively preparing for their assessments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The wards did not have an up to date rapid tranquillisation policy available at the time of inspection. Staff did not record effectively in line with the Mental Health Act Code of Practice when they administered rapid tranquilisation. Staff did not carry out physical observations to monitor closely the effects of rapid tranquilisation. One patient was administered medicines covertly outside of the authority of the Mental Health Act. This was a breach of Regulation 12(2)(g)