

St Martha's







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location		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 and Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Overall summary

We rated St Martha's as **good** overall because:

- The service provided safe care. The ward environments were safe and clean. The service was staffed to establishment and shortages on shifts were filled with bank or agency staff to ensure a safe level of staffing on the wards. Staff assessed and managed risk well. They generally minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, person-centred care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice, including therapeutic groups such as mindfulness sessions, art therapy, music therapy and drama therapy.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards, for example occupational therapists, speech and language therapists, and a physiotherapist with a speciality in neurological disorders. Managers ensured that these staff received an induction and regular supervision. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare such as care co-ordinators and social workers.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Patients had their section 132 rights read regularly and patient's capacity to consent to treatment and admission was reviewed every three months.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved families and carers in care decisions and patients where possible.
- The service was well-led and the governance processes ensured that ward procedures ran smoothly. The service shared learning and knowledge with a local hospital of the same provider.

However:

- Patients were not able to openly access water in communal areas. Patients had to ask staff if they wanted a drink as they were locked away. Staff did not risk assess locking away drinks on an individual basis and this wasn't included in the service's blanket restrictions log for review.

Summary of findings

Our judgements about each of the main services

Service

Wards for older people with mental health problems

Rating

Good



Summary of each main service

St Martha's has five wards for older people with mental health. Two of these wards were open at the time of the inspection: Shamrock and Rose. These wards are single-sex and have 19 beds each. St Martha's three other wards are Thistle, which had 18 beds and is male-only, Daffodil, which has 18 beds and is female-only and, Iris, a five-bedded mixed ward.

Summary of findings

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Good 

St Martha's

Services we looked at

Wards for older people with mental health problems

Summary of this inspection

Background to St Martha's

St Martha's is a hospital for older people with mental health problems and is run by Oldercare (Haslemere) Limited. There is another hospital and nursing home in the neighbouring county, also run by the same organisation.

The service can admit patients with a functional or organic mental health disorder. Organic mental illness is usually caused by disease affecting the brain, such as dementia. Functional mental illness has predominantly a psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety. The service accepts patients with an organic illness aged 45 and above and 55 and above if they have a functional illness. At the time of the inspection, St Martha's were only accepting patients detained under the Mental Health Act 1983.

The service consists of five wards:

- Shamrock is a male-only ward with 19 beds.
- Rose is a female-only ward with 19 beds.
- Thistle is a male-only ward with 18 beds.

- Daffodil is a female-only ward with 18 beds.
- Iris is a mixed-sex ward with five beds. Iris ward will be for patients nearing discharge and who require a less supported environment.

At the time of inspection, two wards were open; Shamrock and Rose. There were nine patients on Shamrock ward and four patients on Rose ward. As the service admits more patients, the other three wards will be opened.

The service was registered with the Care Quality Commission in July 2019. At the time of the inspection there were two registered managers in place. The service is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

This is the first inspection the service has undergone since registering.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one nurse specialist advisor with experience of working on wards for older people with mental health

problems and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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?

Summary of this inspection

- 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 the location and requested feedback from relevant stakeholders of the service.

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment and observed how staff were caring for patients
- spoke with ten patients who were using the service and two relatives over the phone
- spoke with one registered manager,
- spoke with 13 other staff members; including five support workers, two nurses, one senior nurse, the medical consultant, a ward manager, the safeguarding lead, the head of therapies and the human resources administrator
- attended and observed a multidisciplinary team meeting
- attended and observed one patient group
- looked at eight care and treatment records of patients, as well as nine Mental Health Act files and 13 medication charts and
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Four patients provided feedback on the service they received.

The majority of comments were positive. Patients told us they felt safe and that staff were nice and looked after them. One patient told us they didn't like their mattress, and this was raised to the staff at the time of the inspection who were aware of the issue.

We also spoke to two relatives over the phone. Both felt their loved ones were receiving high quality care, that they were listened to and included in their loved one's care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as **requires improvement** because:

- Patients did not have open access to water in communal areas. Patients had to ask staff if they wanted a drink, which was locked away in the kitchenette. This was a blanket restriction and was not considered on an individual basis. Patients and staff were unable to feedback on this restriction as it was not included in the service's blanket restriction log, which was reviewed regularly at patient community meetings.

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. Staff had only used restraint during an incident once since opening and had recently re-evaluated how they were recording holds used during personal care. The ward staff were mindful of restrictive practices and regularly reviewed blanket restrictions with patients.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Requires improvement



Are services effective?

We rated effective as **good** because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Good



Summary of this inspection

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

We rated caring as **good** because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. The service held regular patient community meetings where patients were encouraged to voice their opinion on the service, raise any concerns or complaints and offer suggestions on how the service can improve. Staff also ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. Relatives told us that the ward manager in particular involved them in their loved one's care. For example, meeting with relatives and discussing their loved ones care needs and preferences at length.

Good



Summary of this inspection

Are services responsive?

We rated responsive as **good** because:

- Each patient had their own bedroom, which they could personalise, with an en-suite bathroom. Patients could keep their personal belongings safe as they had a fob key which only accessed their own bedroom. There were quiet areas for privacy.
- Staff had recently completed an audit using a recognised tool to assess the dementia friendliness of each of the wards and had developed an action plan to further improve the environment.
- The service met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. For example, a local chaplain had visited the service. Patients had access to a multi-faith room.

Good



Are services well-led?

We rated well-led as **good** because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

However:

- The leadership team did not recognise that locking away water in communal areas was a blanket restriction.

Good



Detailed findings from this inspection

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.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.






Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of the inspection no one was subject to a Deprivation of Liberty Safeguard.

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received training in the Mental Capacity Act and had a good understanding of the five principles.

Wards for older people with mental health problems

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are wards for older people with mental health problems safe?

Requires improvement 

Safe and clean environment

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand washing procedures. Hand washing sinks were available in the nursing station, where medicines were dispensed, and the GP suite. Staff checked, maintained, and cleaned equipment.

The ward complied with guidance and there was no mixed sex accommodation. Shamrock ward was for male patients only and Rose ward was for female patients only.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff completed a daily security check. The service had an up-to-date ligature audit that identified potential ligature points and actions taken to mitigate the risk to keep patients safe. A ligature point is anything which could be used to attach a cord, rope or other material for hanging or strangulation. The audit had recently been updated to include a ligature risk identified at another hospital.

Staff could observe patients in the communal areas with ease as they were wide, open spaces. Bedroom corridors were long and had a less clear line of sight, however staff

regularly walked these areas and were aware of which patients needed additional support when walking the corridors. There were also plans in place to install convex mirrors to improve visibility.

Staff had easy access to alarms and patients had easy access to nurse call systems. These were regularly tested.

Safe staffing

Managers accurately calculated and reviewed the number nurses and support workers for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Managers used a recognised tool for determining safe staffing numbers.

The service had enough nursing, support and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. We reviewed rosters on site for the previous month, including the Christmas period, and all shifts were fully covered by permanent, bank or agency staff. Managers limited their use of bank and agency staff and requested staff familiar with the service. The service was recruiting additional nurses and support workers to expand the staff team to cover all five wards when they are fully opened. The service's sickness rate was 2%.

Patients had regular one to one sessions with their named nurse.

Staff said patients rarely had their escorted leave or activities cancelled.

The service had enough staff on each shift to carry out any physical interventions safely. The provider did not allow staff to use prone restraint, which involves holding someone face-down on the ground. Staff were trained in appropriate de-escalation, breakaway and restraint

Wards for older people with mental health problems

training. All staff had completed level one, including administrative staff, which included breakaway techniques. Due to some staff undergoing induction, not all staff had completed all three levels however only staff trained to use the appropriate restraint techniques would restrain patients.

Staff shared key information to keep patients safe when handing over their care to others.

The service had enough daytime medical cover and staff had access to doctors out of hours. In the case of a physical health emergency, staff would contact emergency services. If a patient required a doctor for another reason out of hours, staff could contact doctors who were on the on-call rota. One doctor lived local to the service and could attend quickly and other doctors who worked at the local hospital run by the same organisation could also attend the service.

The mandatory training programme was comprehensive and met the needs of patients and staff. The training programme included, but was not limited to, basic life support training, health and safety, safeguarding, equality and diversity, radicalisation, administration of medication and relational security. However, some training had not been completed by all staff as they were still undergoing their induction. Staff were due to complete training as part of the 12-week induction.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on or soon after admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about patients' risks and acted to prevent or reduce risks. Staff discussed patient risks in handover meetings and in multi-disciplinary team meetings. Staff used observations therapeutically and in the least restrictive manner. For example, at the time of the inspection there were four patients that required staff to keep them in their eyeline whilst in communal areas, but we observed this being done discreetly.

Staff identified and responded to any changes in risks to, or posed by, patients. Each patient had a positive behaviour support plan in place.

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff made every attempt to avoid using restraint by using

de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Since registering, there had been one incident of restraint at the service. The service had recently changed the way holds were recorded during personal care to improve the way restraints were being recorded.

The service had a list of blanket restrictions and reviewed them regularly with patients and staff. However, there were two blanket restrictions identified that were not included the list. These were patients not having open access to water and patient snacks locked away. These restrictions were not considered on an individual basis. Patients had to ask staff for water as this was locked away in a kitchenette in the dining room. Some patients may have felt unable to ask for water or may forget.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. However, the provider's search policy did not state when patients would be searched. Staff reported that patients would not be searched unless risk assessment indicated a need.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe and the lead social worker in the team facilitated these visits.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service's lead social worker was responsible for making a referral to the relevant local authority.

Wards for older people with mental health problems

Staff access to essential information

Patient notes were comprehensive, and all nursing staff could access and update them easily using the electronic patient records system. At the time of the inspection the registered manager had just secured read-only access for the support workers to the electronic notes systems, although this had yet to be cascaded out. However support workers were unable to update the electronic patient records system. There was a paper record that all staff could access on the wards. These were up to date. This included risk assessments and care plans.

Medicines management

We reviewed 13 medicines charts. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure patients' behaviour was not controlled by excessive and inappropriate use of medicines. For example, the use of rapid tranquilisation was rare.

Track record on safety

Since registering, the service has had zero serious incidents.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients

honest information and suitable support. Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong. We saw an example of an apology being formally given to a patient following an incident.

Staff knew what incidents to report and how to report them using the service's electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service.

During team meetings, staff met to discuss the feedback and look at improvements to patient care.

Are wards for older people with mental health problems effective? (for example, treatment is effective)

Good 

Assessment of needs and planning of care

We reviewed eight patient care and treatment records.

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward by doctors and a visiting GP.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Wards for older people with mental health problems

Staff provided a range of care and treatment suitable for the patients in the service. There was a weekly ward activity timetable and each patient had a personalised timetable. There were activity coordinators employed to facilitate groups.

They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Each patient had a fluid and nutrition chart, and a food chart detailing what type of food the patient can eat. For example, if a patient was on a soft food diet.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients such as physiotherapy, speech and language therapy and occupational therapy. Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. They supported staff with clinical supervision and opportunities to update and further develop their skills. Staff received an induction programme over the first 12 weeks of their employment, this included attending mandatory training, reading policies and completing shadow shifts. As the service had not been open a year, staff were not due to complete an appraisal.

Managers made sure staff attended regular team meetings and staff who could not attend had access to the minutes from these meetings.

Managers made sure staff received any specialist training for their role, for example personality disorder, dementia training and suicide awareness. Due to a large number of new starters the overall training compliance for the service was below the providers target of 75%.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make

sure patients had no gaps in their care. The service had regular multidisciplinary team meetings. These meetings were well-attended, thorough and discussed all aspects of patient care. Minutes and actions from these meetings were clearly documented and staff were able to use these minutes to update patient records and other documentation efficiently. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff explained patients' rights to them. Patients had folders in their bedrooms with details of their section and their rights.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients were automatically referred to an independent mental health advocacy service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of

Wards for older people with mental health problems

Justice. For example, staff were liaising with the Ministry of Justice to seek approval for a patient's leave. We saw evidence that patients had taken leave for example going out on community day trips.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

At the time of the inspection there were no informal patients. An informal patient is someone who is not detained under the Mental Health Act and is able to leave hospital at any time.

Good practice in applying the MCA

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received training in the Mental Capacity Act and had a good understanding of the five principles.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff had access to the provider's policies online.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Patient's capacity to consent to treatment was reviewed every three months.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Are wards for older people with mental health problems caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. We observed staff engaging with patients in a meaningful way. Patients said staff treated them well, behaved kindly and relatives were assured their loved ones received good care.

Staff were discreet, respectful, and responsive when caring for patients. When patients became agitated, most staff spoke in a quiet and sympathetic manner. We observed a number of occasions when staff spoke calmly with patients who were agitated and used appropriate distraction techniques.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. All staff we spoke to, including senior staff, were aware of each patient and their needs. Relatives told us their loved ones were listened to by staff.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed the provider's policy to keep patient information confidential.

Involvement in care

Staff involved patients and relatives in care planning and risk assessment where possible. Both relatives we spoke with told us that the ward manager had taken the time to ask them about their loved ones and valued their input in care planning. The ward manager was passionate about involving patients in their care planning and encouraged staff to try different approaches with patients who were reluctant to engage or had cognitive impairments to ensure their views were taken into account.

Staff introduced patients to the ward and the services as part of their admission.

Wards for older people with mental health problems

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff held a monthly patient meeting and an agenda was attached to the wall so patients can add their own agenda items.

Staff made sure patients could access advocacy services. An advocate visited the service regularly.

Staff helped families to give feedback on the service. We saw feedback forms that had been filled in by relatives.

Staff gave carers information on how to find the carer's assessment.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good 

Access and discharge

There had been no patient discharges from the service as it had only been open six months at the time of inspection. The service was gradually accepting admissions to ensure the safety of the ward environment and to ensure quality of care remained high.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward supported patients' privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and had a fob worn on their wrist to unlock the door. There were quiet areas and a room where patients could meet visitors in private and large communal areas. Staff used a full range of rooms and equipment to support treatment and care.

Staff had recently completed an audit using a recognised tool to assess the dementia friendliness of each of the wards and had developed an action plan to further improve the environment. For example, the audit identified that signage was too high and the décor was the same colour throughout, making it difficult to distinguish different rooms and entrances.

The service also had a café, large gym, a games room and a hairdressing salon. There was also a multi-faith worship

room. The food was of good quality, but patients could not make hot drinks and snacks at any time as they had to ask a member of staff for access. Staff supported patients in the community to buy their own snacks, and these were also locked away in the kitchen. The service offered a variety of good quality food. Food menus were written on a chalkboard in the dining room and in communal areas. Paper menus were also provided to patients.

The service had an outside space that patients could access when requested by staff. Patients were risk assessed on an individual basis on whether they could access the garden with or without staff support. Patients who needed to smoke were able to access the garden every two hours.

Patients' engagement with the wider community

Staff supported patients with activities outside the service and had a dedicated driver to take patients into the community.

Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service

The service met the needs of all patients, including those with a protected characteristic.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff knew how to access interpreters however were unclear how to request a signer if required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. A local priest had recently visited the service and a leader of a local Sikh community visited the service to meet a patient.

Listening to and learning from concerns and complaints

At the time of inspection, the service had received no complaints.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Patients, relatives and carers knew how to complain or raise concerns.

Wards for older people with mental health problems

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. All staff knew how to handle complaints if they were delivered verbally or in writing. All staff felt that the senior management take all complaints seriously.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Are wards for older people with mental health problems well-led?

Good 

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. Managers and senior staff were visible in the service and staff said they were approachable and supportive.

Vision and Strategy

Managers and senior staff had a vision for what it wanted to achieve, and staff described a person-centred, high quality approach to care that echoed this vision. The service had a mission statement, that staff could access online. Due to the service being within its first year, the service was developing its strategy and plans to further develop its vision.

Culture

Staff reported high morale and were happy in their roles. We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging. This was confirmed by staff. Staff felt respected, supported and valued and described a positive culture in the service. Staff said there was low stress in the team despite the wards being busy. Staff we interviewed felt they were able to raise concerns without fear or repercussions and described a learning, rather than blame, culture.

Governance

Leaders met regularly to ensure there were structures, processes and systems of accountability for the

performance of the service. The service's multi-disciplinary team meetings were thorough, and minutes of these meetings were easily transferable to the weekly senior management team meetings to review all important matters for the safe and effective running of the hospital. The service had close links to a local hospital run by the same organisation and they held weekly calls to share learning and best practice. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However, leaders of the service did not recognise that locking away water in communal areas was a blanket restriction. This meant that a review of this restriction had not taken place and patients had been unable to provide feedback on the restriction.

The ward manager had completed care plan audits in the previous months however had not completed any since October 2019. However, during staff supervision meetings the ward manager went through care plans with staff to ensure they were a high standard and up to date.

Management of risk, issues and performance

The service had a local risk register which included appropriate items and concerns. The risk register was graded, and detailed actions taken to reduce risk. Some items had been closed but remained on the register to show a clear audit trail.

They ensured risks were dealt with at the appropriate level.

Information Management

The hospital used both electronic and paper records. Staff kept patient records securely. However, not all staff were able to update the electronic patient record system or had their own log-in to the computers.

Engagement

The service engaged well with patients and staff to plan and manage appropriate services. The service engaged well with patients by holding monthly meetings and by completing 'you said, we did' posters. For example, we saw that a patient had asked for more red cabbage to be added to the menu and this had been actioned. The service engaged well with staff by holding regular team meetings

Wards for older people with mental health problems

and staff told us they felt supported. Senior staff collaborated with partner organisations to help improve services for patients, for example by working closely with the local hospital run by the same organisation.

Learning, continuous improvement and innovation

All staff were committed to continually improving services but due to being a relatively new service, leaders had not yet started any quality improvement projects as they wanted to embed the basics and ensure high quality care first.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that patients have open access to water in communal areas. (Regulation 13)

Action the provider **SHOULD** take to improve

- The provider should follow through on its action plan to ensure the ward environments are dementia friendly where appropriate.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Patients were not able to access water in the communal areas without asking staff as drinks were locked away. Staff did not risk assess locking away drinks on an individual basis and this wasn't included in the service's blanket restrictions log for review. This blanket restriction may not be necessary or proportionate as a response to the risk of harm posed to the patient or another individual. This is a breach of regulation 13 (1)(4)(b)(c) and (5)