Requires improvement

Lincolnshire Partnership NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP7CG	Witham Court	Langworth ward	LN6 8UZ
RP7CG	Witham Court	Brant ward	LN6 8UZ
RP7LP	Manthorpe Centre	Manthorpe Centre	NG31 8DG
RP7LA	Pilgrim Hospital	Rochford Unit	PE21 9QS

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated wards for older people with mental health problems as requires improvement because:

- Patient safety and dignity was compromised. Langworth ward did not meet the Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the arrangements for mixed sex accommodation. Brant ward and Rochford unit dormitories lacked privacy and dignity, with some beds separated by curtains. This did not provide privacy and dignity.
- We found some ligature risks withinBrant ward, which were not effectively managed. Rochford ward had limited outdoor space and was located on the first floor by a stair case or lift.
- Langworth and Brant wards, and Manthorpe ward were covered by CCTV in communal areas, but patients, carers and their relatives were not informed of this.
- Some wards had what were described as comfort rooms. Patients were cared for away from others and could not leave the room. These rooms appeared to be used for the purposes of seclusion.When patients used the comfort rooms for de-escalation these incidents were recorded on an electronic recording system. We sampled these records on Langworth ward and found staff had difficulty locating and tracking these incidents. There were gaps in recording. This meant risks for individual patients with challenging behaviour using the comfort room was not well managed.
- There was a heavy reliance on agency staff on Langworth, Brant and Manthorpe wards.
- Medication was not managed effectively on Manthorpe ward and Rochford Unit. We found errors when we looked at medication records and a wound swab was found in the drugs fridge. Staff had not accurately recorded in medicines charts for patients being discharged. Staff did not know how to obtain medicines if they did not stock them.
- Access to nurse call systems was limited in the dormitories on Brant ward. One nurse call bell was shared between four patients and was not easy to locate. This meant patients would not find them accessible in an emergency.
- Staff were unable to access safeguarding or dementia awareness training at the time of the inspection. Staff told us this was booked up until 31 March 2016. This service provides care, treatment and support for older people with dementia and other health difficulties. The trust had not identified this training need. Training figures showed that 87% staff had attended adult safeguarding training over the past year.
- Shift working patterns impacted on staff capacity to attend team meetings and undertake training. Staff told us that working a 12 hour shift impacted on their wellbeing.
- Patient discharges were delayed because of limited places to move patients on to.
- The multidisciplinary team meetings on Rochford unit were often short and did not allow sufficient time for full discussions of patients' needs.
- Patients were unable to make phone calls in private in the Manthorpe centre. There was no payphone at the Manthorpe centre and patients would ask staff to use the office phone.
- Two patients from Langworth ward and the Rochford unit did not receive required follow up for eye care.
- Staff did not respond with meaningful feedback from community meetings on Brant ward.
- Staff felt a disconnect with the senior management team. Staff told us that senior managers within the trust had not visited the wards.

However:

- The service employed sufficient numbers of staff. There was a good ratio of qualified staff to unqualified staff.
- Clinical areas and ward environments were clean and hygienic.
- We reviewed 13 care records and found comprehensive assessments. Care plans were holistic with evidence of patient involvement. There were effective physical health care assessments with good access to health screening and follow ups.
- Staff responded to patient needs, showing discretion and respect.
- A weekly timetable of on-site occupational activities was provided by a range of therapists, occupational therapists and activity coordinators.

Summary of findings

- Carers and family members were regularly invited in for special events with patients.
- Effective and appropriate signage on wards provided information to patients in a way they could understand.
- Staff felt supported to raise concerns without fear of victimisation and told us that morale and job satisfaction was good.
- Staff were provided with opportunities for leadership training at ward management level.
- Ward managers had sufficient authority to run the ward and administration support to help them.
- Staff sickness and absence rates were low on the Rochford unit. We saw a positive working culture within this team.

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:

- Langworth ward did not meet the Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the arrangements for mixed sex accommodation.
- We found some ligature risks withinBrant ward, which were not effectively managed.
- Langworth and Brant wards, and Manthorpe ward were covered by CCTV in communal areas, but patients, carers and their relatives were not informed of this.
- There was a heavy reliance on agency staff on Langworth, Brant and Manthorpe wards.
- Medication was not managed effectively on Manthorpe ward and Rochford unit. We found errors when we looked at medication records and a wound swab was found in the drugs fridge. Staff did not know how to obtain medicines if they did not stock them.
- Staff were unable to access safeguarding training. Staff told us this was booked up until 31 March 2016.
- Some wards had what were described as comfort rooms. Patients were cared for away from others and could not leave the room. These rooms appeared to be used for the purposes of seclusion.
- When patients used the comfort rooms for de-escalation these incidents were recorded on an electronic recording system. We sampled these records on Langworth ward and found staff had difficulty locating and tracking these incidents. There were gaps in recording. This meant risks for individual patients with challenging behaviour using the comfort room was not well managed.
- Access to nurse call systems was limited in the dormitories on the Brant ward. One nurse call bell was shared between four patients and was not easy to locate. These meant patients would not find them accessible in an emergency.

However:

- The service employed sufficient numbers of staff. There was a good ratio of qualified staff to unqualified staff.
- Staff sickness and absence rates were low on the Rochford unit. We saw a positive working culture within this team.
- Clinical areas and ward environments were clean and hygienic.

Summary of findings

Are services effective?

Requires improvement

We rated effective as 'requires improvement' because:

- Two patients from Langworth ward and Rochford unit did not receive required follow up for eye care.
- The multidisciplinary team meetings on Rochford unit were often short and did not allow sufficient time for full discussions of patients' needs.
- Shift working patterns impacted on staff capacity to undertake training.
- Staff were unable to access dementia training. This core service provides care, treatment and support for older people with dementia and other health difficulties. The trust had not identified this training need.

However:

- We reviewed 13 care records and found comprehensive assessments.
- Care plans were holistic with evidence of patient involvement.
- There were effective physical health care assessments with good access to health screening and follow ups.

Are services caring?

Good

We rated caring as 'good' because:

- Staff responded to patient needs, showing discretion and respect.
- Staff treated patients with care and compassion, and communicated effectively.
- Carers and family members were regularly invited in for special events with patients.

However:

- Staff did not respond with meaningful feedback from community meetings on Brant ward.

Are services responsive to people's needs?

Requires improvement

We rated responsive as 'requires improvement' because:

- Rochford ward had limited outdoor space and was located on the first floor.
- Brant ward and Rochford unit dormitories lacked privacy and dignity, with some beds separated by curtains. This did not provide the privacy required.
- Patient discharges were delayed because of limited places to move patients on to.

Summary of findings

- Patients at the Manthorpe centre were unable to make phone calls in private. There was no payphone at the Manthorpe centre and patients would ask staff to use the office phone.

However:

- A range of therapists, occupational therapists and activity coordinators provided a weekly timetable of on-site occupational activities.
- Effective and appropriate signage on wards provided information to patients in a way they could understand.

Are services well-led?

Requires improvement 

We rated well-led as 'requires improvement' because:

- Staff felt a disconnect with the senior management team. Staff told us that senior managers within the trust had not visited the wards.
- We were concerned about the governance systems relating particularly to the assessment and management of ligature risks, mixed sex accommodation, safeguarding training and use of the de-escalation rooms.
- Shift working patterns impacted on staff capacity to attend team meetings and undertake training.
- Staff told us that working a 12 hour shift impacted on their wellbeing.

However:

- Staff felt supported to raise concerns without fear of victimisation and told us that morale and job satisfaction was good. Staff were provided with opportunities for leadership training at ward management level.
- Ward managers had sufficient authority to run the ward and administration support to help them.

Summary of findings

Information about the service

The four older inpatient wards are based in three hospital sites across Lincolnshire. Two wards are in North Hykeham, one in Grantham and one in Boston. The wards are all mixed sex accommodation, providing care for people aged over 65 years who have complex needs related to acute mental health problems and/or dementia patients of any age.

Langworth and Brant wards are based in the Witham Court site in North Hykeham hospital, Lincoln. Langworth ward provides 17 beds for older adults with dementia. Brant ward is a 20 bed specialist assessment and treatment ward for older adults experiencing functional illness, such as depression, anxiety or psychosis. The Manthorpe centre in Grantham hospital provides assessment and treatment for 18 patients with dementia and functional mental illness. The Rochford unit is based in Pilgrim hospital in Boston and is a 17 bedded assessment and treatment unit for older people with dementia who are experiencing complex problems.

The Manthorpe centre was inspected by the CQC in 2011 and was judged compliant in all outcomes. A Mental Health Act review of the Manthorpe centre in May 2015 made two recommendations in relation to privacy and dignity, and admissions. A Mental Health Act review of the Langworth and Brant wards in 2014 required improvements to be made in areas such as leave of absence, admission to the ward, and consent to treatment. These actions were all met by the provider.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, chief executive of Oxford Health NHS foundation trust.

Team Leader: Julie Meikle, head of hospital inspection, mental health hospitals, CQC

Inspection Manager: Lyn Critchley, inspection manager, mental health hospitals, CQC

The team consisted of two CQC inspectors, a psychiatrist, a nurse, a Mental Health Act reviewer and an expert by experience. Experts by experience are people who have direct experience of care services we regulate, or are caring for someone who has experience of using those services.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the location.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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 all four wards at the three hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 31 patients who were using the service and collected feedback from seven patients, using comment cards..
- Spoke with the managers or acting managers for each of the wards.
- Spoke with 27 other staff members; including doctors, nurses and social workers.
- Attended and observed two handover meetings and one multidisciplinary meeting. Looked at 13 treatment records of patients.
- Carried out a specific check of the medication management on four wards.
- 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 twelve patients and five carers. All the patients we spoke with were positive about the staff and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care.

There was information about the trust available for people who used the service. People could access the advocacy, and the patient advocacy and liaison service, to get information and give feedback about the trust's services.

Good practice

On the Rochford unit an ex-patient volunteer was working on the ward, positively engaging with, and supporting patients. The volunteer told us they had taken part in staff recruitment panels for employing nursing assistants and nurses for the Rochford unit.

Areas for improvement

Action the provider MUST take to improve

- The trust must take action to remove ligature risks and to mitigate where there are poor lines of sight.
- The trust must comply with Department of Health guidance in relation to mixed sex accommodation on Langworth ward.
- The trust must ensure patients have access to nurse call systems in the dormitories on the Brant ward.
- The trust must manage medication appropriately on Manthorpe ward and Rochford unit. Ensure staff follow dispensing instructions for medicine patches and accurately record medicines charts for patients being discharged. Stock must be managed effectively and the drugs fridge used appropriately.
- The trust must review the use of the de-escalation rooms, described as comfort rooms and used like seclusion rooms.
- The trust must ensure robust systems for reporting incidents when patients use the comfort rooms for de-escalation.
- The trust must ensure staff receive mandatory safeguarding training.

- The trust must review the arrangements for the patients in the Manthorpe centre to make and receive phone calls in private.

Action the provider SHOULD take to improve

- The trust should ensure patients at the Rochford unit have access to outdoor space.
- The trust should ensure that written information relating to the CCTVs in the communal areas of Langworth, Brant and Manthorpe wards is made available to patients, carers and relatives.
- The trust should ensure staff have access to dementia training at an appropriate level.
- The trust should ensure the duration of the multidisciplinary team meetings on Rochford unit allow sufficient time for full discussions of patients' needs.
- The trust should ensure patients' privacy and dignity are met on the dormitories on Brant ward and the Rochford unit.
- The trust should review governance systems relating to staff engagement with the senior management team.

Lincolnshire Partnership NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Langworth ward	Witham Court
Brant ward	Witham Court
Manthorpe Centre	Manthorpe Centre
Rochford Unit	Pilgrim 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.

Patients had received their rights (under section 132 of the Mental Health Act) and these were repeated at regular intervals. Mental Health Act paperwork had been completed correctly was up to date and held appropriately. Record keeping and scrutiny relating to the Mental Health Act was satisfactory.

Posters were displayed informing patients of how to contact the independent mental health advocate (IMHA).

The staff we spoke with had a good working knowledge of the Mental Health Act and 77% of staff working within this service had received training in the Act via e-learning.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust offered mandatory training in the Mental Capacity Act. Staff had a working knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Thirty six patients were receiving care and treatments subject to DoLS. This was highest in the Manthorpe centre with 17 patients subject to DoLS.

Detailed findings

The care records viewed showed that patient's mental capacity to consent to their care and treatment was not always assessed on their admission or on an ongoing basis.

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

- Each ward had undertaken, and updated when necessary, ligature risk assessments. There were control measures in place to minimise the risk to patients, including patient risk assessments and use of observation. However, a number of ligature risks remained on two wards. On Brant ward the ligature risk assessment did not identify that specialist wardrobes not attached to walls could be a ligature risk. Door hinges were not assessed as a ligature risk and plastic bags, although identified as banned items, and were in use to line rubbish bins. The layout of Rochford unit did not allow staff to observe an area outside the manager's office. We drew this to the attention of the ward manager and an observation mirror was purchased to mitigate this.
- All the wards we inspected consisted of mixed sex accommodation. Langworth ward did not meet the Department of Health's guidance on eliminating mixed sex accommodation. Patients' privacy and dignity was compromised. Two female bedrooms were set off a male corridor, without ensuite facilities. As a result, female patients had to cross the area used by male patients to access the bathrooms. Staff told us additional staffing levels were provided on this corridor to mitigate against any risk, but staff were unclear about the arrangements. Langworth ward did not comply with guidance on same sex accommodation.
- All ward areas were clean and hygienic, had good furnishings and were well maintained. Rochford unit needed redecoration and patient-led assessments of the care environment data showed a score of 88% for condition, appearance and maintenance. The ward manager told us about plans for redecoration and building works for an additional bathroom. The Rochford unit had scored 100% for ward cleanliness. The lowest rating was Manthorpe ward with 97%.
- Ward equipment was well maintained and clean. Equipment displayed stickers with dates when items were cleaned. Cleaning records were up to date and showed that the environment was regularly cleaned. Staff followed infection control principles, including hand washing. Signs were displayed near sinks to remind people to wash their hands. Hand decontamination training was provided annually, with 92 % compliance. Good practice ensured infection control and staff had access to protective personal equipment, such as gloves and aprons. On Rochford unit we saw staff supporting patients to wash their hands before meals.
- All the wards had resuscitation trolleys that were clean and checked on a regular basis. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.
- Patients had access to appropriate nurse call systems on most wards. There was limited access to nurse call systems in the dormitories on Brant ward. One nurse call bell was shared between four patients and was not easy to locate. These meant patients would not find them accessible in an emergency.

Safe staffing

- Staff numbers were sufficient in the four wards we visited. The trust's information showed a total of 180 staff in the service, with 13 (8%) average staff turnover in the last twelve months. Rochford unit had the lowest staff sickness levels with 3% and the highest levels were Brant ward with 11%. Bank and agency staff covered 687 shifts to cover sickness absence or vacancies. We noted that 210 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies. This meant that wards were short staffed, with shifts covered by permanent staff or the ward manager who would undertake the shift.
- Staff and ward managers told us that the staffing difficulties arose from a combination of staff sickness, staff recruitment issues and retention. Information from the trust showed that the average staff vacancy rate per ward for the past twelve months was 5%.
- Ward managers were able to adjust staffing levels on a daily basis to take into account increased clinical needs. This included, for example, increased levels of observation or patient escort. Some requested hours were due to staff sickness and vacancies.

Requires improvement

Are services safe?

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

- The staff from Langworth, Brant and Manthorpe wards told us that there was a reliance on the use of bank agency staff. Shifts filled by agency staff were highest on Langworth ward with 208 in the last three months. There were 3% staff vacancies on this ward. On Brant ward 110 shifts were filled by agency staff in the last three months, with 3% staff vacancies. At the Manthorpe ward 183 shifts were filled by bank and agency staff to cover sickness, absence or vacancies, with 4% staff vacancies. Staff told us, and the duty rotas we saw confirmed that there was always an experienced member of staff on duty on the ward. A combination of permanent, bank and agency staff were covering the shifts to ensure that the correct number of staff were on duty.
- Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments. Recruitment to vacant positions was ongoing. On Rochford unit, during our inspection visit, a nurse and the ward volunteer participated in recruitment panels, and interviewed potential nurses and nursing assistants for the ward.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Where particular risks were identified, such as a risk to self or to others,measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. Overall, the individualised risk assessments we reviewed were detailed and had taken into account the patient's previous history as well as their current mental state. Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, care programme approach meetings or after an incident.
- There was a variety of mandatory training available for staff. The majority of staff (88%) had completed mandatory training.This included courses in medicine management, immediate life support, clinical risk assessment and management, mental capacity act, and safe use of insulin. Ward managers told us staff training was sometimes difficult to access. We found 52% of staff had received food hygiene training, which was available tri-annually. Ward managers said all staff were involved in food handling and needed this training. The Rochford manager and another staff member had trained as fire evacuation trainers and planned to train staff on the ward. We found 86% of staff had completed safeguarding vulnerable adults training and 82% safeguarding vulnerable children training. Staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns. However, ward managers told us they were unable to access current safeguarding training for staff as this was booked up until 31 March 2016.
- The four sites did not have seclusion facilities. Langworth Manthorpe and Rochford wards had de-escalation rooms, described as comfort rooms. Staff told us patients would be taken to this room if they were distressed, and supported with de-escalation techniques until they calmed down. The comfort room furnishings consisted of different sized soft mats and soft chairs. Patients were being cared for away from others and were unable to leave of their own free will. This same aspect was identified during the Mental Health Act reviewers visit at Manthorpe ward in May 2015. Staff told us this room was currently under review and that advice had been sought from the prevention and management of violence and aggression lead. The trust should avoid unnecessary restrictions on a person's rights and freedom of action.
- Staff told us that when patients used the comfort rooms for de-escalation these incidents were recorded on datix - an electronic recording system. We sampled these records on Langworth ward and found staff had difficulty locating and tracking these incidences. There were gaps in recording. This meant risks for individual patients with challenging behaviour using the comfort room was not well managed.
- Seventy three per cent of the staff working within this service had received annual training in control and restraint, which included basic life support (resuscitation) and inpatient observation.
- We looked at medicine management on two wards. On Manthorpe ward there was no record of where medicine patches had been applied on the patient and whether the appropriate rotation of sites was adhered to. Nurses had not always signed the treatment chart when medicines were issued to a patient at discharge. On Rochford unit a wound swab was found in the drugs fridge. Staff confirmed urine specimens were also kept in that fridge. The fridge contained food supplements.

Requires improvement

Are services safe?

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

Staff on Rochford unit were unclear how to source medicines if they did not stock them. We drew this to the attention of both ward managers during our inspection.

- On Rochford unit we found medicine fridge temperature records were missing. The ward manager told us the records were sent weekly to the trust pharmacist for monitoring purposes. The ward manager said they would review this arrangement to ensure they retained copies of the fridge temperatures on the ward.

Track record on safety

- The trust provided information that showed that there had been 61 incidents of use of restraint in the six months prior to our inspection. Of these incidents, five patients were restrained in the prone position which also resulted in the use of rapid tranquillisation. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states that if such a restraint is unintentionally used staff should either release their holds or reposition into a safer alternative as soon as possible. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help calm them quickly. Each incident of restraint was recorded using the trust's incident reporting system. Safety concerns are identified and addressed.
- There had been seven serious incidents related to older people wards between September 2014 to August 2015. These were reported to CQC and recorded on the incident system. One of the incidences was an unexpected death and had occurred within the service in the past 12 months. The death occurred after the patient had been discharged.

Reporting incidents and learning from when things go wrong

- Staff used an electronic system to report incidents. Staff were clear about their role in the reporting process. Each ward had access to an online electronic system to report and record incidents and near misses.
- Staff gave us examples of serious incidents which had occurred within the services. The trust told us that there was a local governance process in place to review incidents.
- Staff received support and debriefing from within their team following any serious incidents.
- Staff discussed trust wide incidents at monthly team meetings. There were weekly multidisciplinary meetings, which included a discussion of potential risks relating to patients and how these risks should be managed.
- Ward managers told us how they provided feedback in relation to learning from incidents to their teams. One manager told us about learning from a significant incident and changing their patient leave procedures to ensure there was robust follow up with the patient. The manager at Langworth ward had difficulty finding outcomes on the electronic systems for patient incidents.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- We reviewed 13 care records for patients receiving care and treatment in the older person inpatient wards. Patients' needs were assessed. Care plans we saw were personalised and holistic and recovery orientated, and included the patients' views.
- Patients' physical health needs were identified. The doctor completed a physical healthcare check on admission and the patients' physical healthcare needs were met. Ongoing monitoring of physical health problems took place. Care plans showed staff how to meet patients' physical needs. However, one patient on Langworth ward told us their eyes hurt from the glare of ward lights and had been provided with pain relief. There was no reference to eye care needs in the patient's records. On Rochford unit a patient's eye care needs had not been followed up, despite the patient's requests. We drew this to the attention of ward managers.
- We saw personalised emergency evacuations plans for each patient on wards. Fire boards on display provided staff with details of equipment available for fire evacuation.
- Staff told us they used the trust electronic systems. However, some paper records still existed, such as current paper care plans provided to patients. We found these matched the patient's electronic records. We saw records were stored securely and were available to staff when they needed them.

Best practice in treatment and care

- Staff followed the relevant national guidance when providing care and treatment. This included guidance from the National Institute for Health and Care Excellence (NICE) and prescribing guidance. Psychiatrists followed the Royal College of Psychiatrists guidance. (This is the professional body responsible for education and training, and setting and raising standards in psychiatry).
- Nurses carried out physical health checks on admission, with ongoing regular physical health monitoring. Staff used the tool NEWS (national early warning score). The tool alerted staff to any medical deterioration and triggered a timely clinical response. Staff used the Malnutrition Universal Screening Tool (MUST) a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obesity.
- Outcomes for patients using the services were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of control and restraint, and rapid tranquilisation. We received positive feedback from the patients and carers we spoke with about the quality of the care and treatment they had received.

Skilled staff to deliver care

- Ward managers told us that the online dementia training took a day to complete and was difficult for staff to access. This service provides care, treatment and support for older people with dementia and other health difficulties. The trust did not provide staff with up to date dementia training at an appropriate level.
- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the ward and trust policies, and a period of shadowing existing staff before working alone.
- Managers told us the national care certificate standards were used as a benchmark for training nurse assistants. The care certificate aims to equip staff with the knowledge and skills they need to provide safe, compassionate care.
- Bank and agency staff underwent a basic induction, including orientation to the ward, emergency procedures, and a handover about patients and current risks.
- Staff had access to supervision on a regular basis. Informal supervision took place regularly. Information from the trust showed that 165 (91%) of permanent staff had received appraisals in the previous twelve months.

Multi-disciplinary and inter-agency team work

- We observed two effective shift handovers within the team. Each shift change discussed each patient in depth about any changes in care plans, patient's presentation including physical health, community leave, activities and incidents.
- We observed in one multidisciplinary team meeting that staff used an electronic wipe board so the patient's notes were effectively displayed and reviewed. However, we saw at the Manthorpe ward the multi disciplinary team sheet for a patient was short and included a

Are services effective?

Requires improvement

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

record of clinical prompts, but patient's details were not captured. This approach to assessing and managing day-to-day risks to patients was focused on clinical risk and did not take a holistic view of the patient's needs.

- Multidisciplinary input to the wards was good and included psychiatry, specialist nurses (including diabetic nurses), an occupational therapist, physiotherapists, a dietician, pharmacist, and activity coordinators.
- Multidisciplinary team meetings and ward rounds provided opportunities to assess whether the care plans were achieving the desired outcomes for patients. On Rochford unit the ward manager told us multidisciplinary team meetings were held two days a week with two different consultants attending different days. However, the duration of these meetings was often short and did not allow sufficient time for full discussions of a patient's needs. This was because of the limited availability of the consultants.
- There were regular team meetings and staff felt well supported by their immediate managers and colleagues on the wards. Staff enjoyed good team working as a positive aspect of their work on the wards.

Adherence to the MHA and the MHA Code of Practice

- Staff were trained in the Mental Health Act (1983). Both Langworth and Manthorpe wards had 100% of staff trained. Brant ward had 58% and Rochford had 70% of staff trained. However, the staff we spoke with had a good working knowledge of the Mental Health Act.
- We checked whether systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the Mental Health Act 1983 code of practice 2015.
- On each ward, we found that Mental Health Act paperwork had been completed correctly. There was administrative support to ensure paperwork was up to date and held appropriately. There was a clear process for scrutinising and checking the receipt of Mental Health Act paperwork. Overall, the Mental Health Act record keeping and scrutiny was satisfactory.
- Patients had received their rights under section 132 of the Mental Health Act and these were repeated at regular intervals.
- Posters were displayed informing patients how to contact the independent mental health advocate, the independent mental capacity advocate and the Care Quality Commission (CQC).

Good practice in applying the Mental Capacity Act

- Thirteen sets of care records viewed showed that patient's mental capacity to consent to their care and treatment was not always assessed on their admission and on an ongoing basis.
- For one patient we found interface issues between Deprivation of Liberty Safeguards (DoLS) and Mental Health Act 1983 (MHA). The patient had been subject to DoLS and treated with frequent medical interventions, but their care records indicated that the use of the MHA might be more appropriate. We drew this to the attention of clinicians during our inspection.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with 31 patients receiving care and treatment on the older person's inpatient wards, and five relatives and carers. We received many positive comments from patients who told us staff were kind, caring and compassionate. We received mostly positive feedback from patient's comments cards about the care they received. From seven comment cards, we received six positive and one negative comment. For example, one patient on Manthorpe ward commented that the food was excellent and patients were given lots of assistance if needed.
- We saw many examples of staff treating patients with care and respect, and communicating effectively. We saw a range of therapeutic activities taking place on each ward, one to one and in small groups, with good interaction between staff and patients. We saw at ward meetings that staff understood individual needs and concerns, and spoke respectfully about patients.
- Each ward had regular community meetings and we saw meeting notes. Patients talked about menus, the ward environment, activities and planned events. Patients were asked for feedback. On Brant ward the staff were not able to provide us with community meeting notes from August 2015 as they had been removed from the ward.
- The patient-led assessments of the care environment data showed that privacy, dignity and wellbeing was low on the Rochford unit, scoring 79%. Brant and Langworth wards scored 89%. The trust average was 88%..
- We saw an agency staff member with a patient on one to one observation on Langworth ward. The member of staff did not engage in conversation with the patient. We drew this to the attention of the ward manager.

The involvement of people in the care they receive

- Patients' views were sought wherever possible and families were actively involved from an early stage after admission. Patient participation was encouraged through the use of the "Knowing You" and "This is Me" documents. The occupational therapist completed this with the patient and families upon admission. These documents identified a patient's individual needs and we found these in care plans we looked at.
- Carers and family members were regularly invited in for special events with patients. We saw ward newsletters and posters displaying current events, and how to contact the local advocacy services and the patient advice and liaison service.
- Patients were invited to the multidisciplinary reviews, along with their family, where appropriate.
- All patients told us they had opportunities to keep in contact with their family, where appropriate. Visiting hours were in operation. There were dedicated areas for patients to see their visitors.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Average bed occupancy over the six month period from February to July 2015 for this service was 84%. The average of length of stay with patients discharged in the last 12 months was 60 days.
- When patients were moved or discharged this happened at an appropriate time of day. Patients had access to a bed on return from leave. Staff from all wards told us there were delays in discharge planning because of inappropriate and lack of placements.
- There had been 15 readmissions within 90 days and seven delayed discharges over the six month period from February to July 2015. The highest readmission had been seven on Manthorpe ward within 90 days. Staff told us this was due to people becoming unwell when moved to an inappropriate placement.
- At the time of our inspection, three patients were in out of area beds (that is, beds which are not within the trust's catchment area).

The facilities promote recovery, comfort, dignity and confidentiality

- Wards had a range of rooms and equipment to support treatment and care. There were clinic rooms to examine patients, and activity and therapy rooms. There were quiet areas on the ward and a room where patients could meet visitors. On Rochford unit we saw a moving screen with local historical sites, past and present. The activity coordinator had photographed local sites and regional events, and uploaded these onto the screen for patients to view. We saw patients watching the screens.
- Each ward had an activity coordinator and activity programme, including at weekends. The programme included activities such as creative crafts, music and movement, relaxation, community meetings, baking, gardening and managing emotions. We saw a group of patients take part in music and movement on Langworth ward. On Manthorpe ward we saw patients in a community meeting discuss the day's activities and the Christmas party menu. On Manthorpe ward the lounge for women patients had been decorated in line with the 1950's era with furniture and fittings, with attention to detail. Patients told us how much they enjoyed sitting in this lounge.
- Wards had locks on the main entrances, with entry and exit controlled by staff. Staff carried personal alarms. During our inspection, we were offered personal alarms on all wards.
- Payphones were provided on most wards, where patients could make a phone call. Following a risk assessment, patients could also use their own mobile phones. There was no payphone at the Manthorpe centre and patients would ask staff to use the office phone. Patients on Manthorpe were not able to make calls in private and the type of phone was not appropriate for this patient group. We drew this to the attention of the ward manager.
- Brant, Langworth and Manthorpe wards had access to outdoor space, in which patients could smoke. We saw garden areas leading off wards. They provided a spacious area for patients to be able to access fresh air.
- The Rochford unit was situated on the first floor and accessed via a staircase or lift. The ward manager told us they previously had access to a garden area but this had been identified for building work. There was designated smoking area on the ground floor. The manager had raised concerns about this on the ward risk register.
- Patients were able to personalise their bedrooms, however on Rochford unit we observed patients' bedrooms were mainly bare. On Rochford unit and Brant ward there was a mix of dormitory style, with up to four patients sleeping in one dormitory. Curtains were provided between the beds but this did not provide the privacy required. Patients had access to lockable storage space but they did not have keys for such storage. Patients had to approach a member of staff for a key and receipt of a key was based on assessed risk.

Meeting the needs of all people who use the service

- Adjustments were made for people requiring disabled access. We saw signs around the wards to assist patients. There were colour coded doors for toilets and bathrooms, with braille text. Some patients' bedroom doors had a front door style, and a picture prompt outside that reflected their interests/lifestyle. One patient had a picture of a steam train as they liked vintage trains.
- Langworth ward and Rochford unit had a mixed patient group. Patients with organic difficulties most commonly have a diagnosis of dementia. Patients with functional

Are services responsive to people's needs?

Requires improvement

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

needs have mainly mental health difficulties. Staff told us the mixed patient group was challenging but that they were meeting patients' needs. We observed staff managing the mix of patients when visiting these wards.

- A patient on Rochford unit commented about limited wheelchair access, a lack of a patient garden area and rated the food as poor.
- Spiritual care and chaplaincy was provided when requested.
- A range of choices in the menu catered for patients' dietary, religious and cultural needs. Staff told us patients food choices were ordered. Sometimes cultural food took a short period to become available. In the meantime staff would purchase food items from the local shops if needed. Patients told us the food on the wards was good. Patients had access to drinks and snacks at any time.
- Interpreters were available using a local interpreting service or language line. However, these services were not often needed.

Listening to and learning from concerns and complaints

- All the wards accessed the trust's complaints system. Information about the complaints process was available on notice boards. Patients knew how to make a complaint.
- Complaints were recorded using the trust's computerised incident reporting system. It showed how the issues were investigated, the outcomes and any learning. Ward managers shared learning amongst their staff via staff meetings. We saw the manager on Langworth ward had difficulty accessing feedback from complaints on the electronic systems.
- There were 262 complaints in total across the trust, 15 of which were for older people's wards. The main themes of complaints were: concerns about care, including physical health concerns of patients; issues about patients being transferred between wards; and the wish for a change in consultant / community psychiatric nurse.
- In the last 12 months, between September 2014 and July 2015, 107 compliments were received for this service. Langworth ward received 55 compliments and Brant ward 49 compliments. Manthorpe ward received three compliments and Rochford unit received none. Both ward managers told us they received regular compliments from patients and carers and recorded this information through trust electronic systems, but felt the data had been lost.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Staff were aware of the trust's vision and values. We saw a vision and values statement poster, specific to each service, displayed on wards.
- Staff were mostly unable to tell us who the most senior managers in the trust were. Staff told us that senior managers within the trust had not visited the wards. However ward staff felt supported by managers and ward manager were supported by their line managers. The teams worked in isolation and did not engage with senior managers.

Good governance

- Governance committees and mechanisms were in place that supported the delivery of the service. Lines of communication, from the board and senior managers to the frontline services, were not clear at a local level.
- Incidents were reported through datix (the trust's electronic incident reporting system). We saw examples of records to show that this recording system was generally good and reviewed individual specific events and incidents. Trust-wide learning from incidents and complaints was shared with staff in order to change to practice. However we did not see a review of care when patients used the de-escalation room on Langworth ward. Staff had difficulty locating and tracking these incidents. There were gaps in recording. The governance arrangements did not always operate effectively.
- Ward managers confirmed that they had sufficient authority to manage their ward and also received administrative support. They told us that they received a good level of support from their immediate manager.
- We had some concerns about the robustness of the governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and a number of ligature risks remained on the wards.
- We had some concerns about staff unable to access safeguarding and dementia training, essential training for this service.
- We had concerns about the use of the de-escalation rooms, described as comfort rooms. Patients were cared for away from other patients and could not leave the room. These rooms appeared to be used for the purposes of seclusion.
- A robust governance system was in place relating to the Mental Health Act. Paperwork had been completed correctly, was up to date and held appropriately. Record keeping and scrutiny, relating the Act, was satisfactory.

Leadership, morale and staff engagement

- On a day to day basis, the wards appeared to be well managed. Staff told us that ward managers were visible on the wards, approachable and supportive. We found that the local teams were cohesive and enthusiastic.
- Staff told us that they felt part of a team and received support from each other. All staff we spoke with said they felt well supported by their immediate manager. They felt they could raise concerns about their work, and felt valued by them.
- Staff spoke positively about the management team on Rochford unit. We saw a positive working culturewithin this team.
- Some staff on the wards told us they worked 12 hour shifts and felt this impacted on their health and wellbeing. They said shift working patterns did not allow them to attend team meetings and supervision meetings. The trust was still in the process of consulting with staff about the proposed shift arrangements.
- The ward managers on all wards confirmed that there were no current cases of bullying and harassment involving the staff. Staff sickness and absence rates were being managed by ward managers, with staff recruitment ongoing.
- Ward managers and nurses told us there were opportunities for leadership development. One ward manager told us they were attending the inspirational leadership programme.
- One of the trust priorities taken from the trust board assurance framework March 2015 related to this service. Proposals included developing separate ward environments for different illnesses, and a project on delayed discharges with the local authority. Trust information did not include any timescales for these actions.

Commitment to quality improvement and innovation

Are services well-led?

Requires improvement

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

- The ward manager and senior managers provided us with an up to date picture of how the wards were performing. They had a good understanding of where improvements were required and were making improvements in the quality of the service.
- We were impressed with the efforts of the volunteer on Rochford unit who was an ex-patient. The volunteer told us they wanted to give back the ward they had stayed on and help patients. The volunteer came in three times a week, talked to patients, served meals and assisted patients with activities. The volunteer sat in on interview panels and helped recruit both qualified and unqualified staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The systems and processes for reporting and recording serious incidents were not robust. When patients used the comfort rooms for de-escalation these incidents were recorded on datix - an electronic recording system. We sampled these records on Langworth ward and found staff had difficulty locating and tracking these incidents. There were gaps in recording. This meant risks for individual patients with challenging behaviour using the comfort room was not well managed. The trust did not comply with Department of Health guidance in relation to mixed sex accommodation on Langworth ward. The trust did not adequately identify and manage risks. We found some ligature risks on Brant ward, which were not effectively managed or mitigated. Brant ward did not have enough nurse call bells for patients to be safe. Patients at the Manthorpe centre were unable to make or receive phone calls in private. Medication was not managed effectively on Mathorpe ward and Rochford Unit. We found errors for dispensing medicine patches. Staff had not always signed the treatment chart when medicines were issued to a patient at discharge. A wound swab was found in the drugs fridge. The drugs fridge was not used appropriately Staff did not know how to obtain medicines that were important if they did not stock them.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff were unable to access safeguarding training. Langworth Manthorpe and Rochford wards had de-escalation rooms, described as comfort rooms and used like seclusion rooms. This is where patients were taken with staff to calm down. These rooms were under review and that advice had been sought from the prevention and management of violence and aggression lead.