Good

Navigo Health and Social Care CIC

Wards for older people with mental health problems

Quality Report

NAViGO House
3-7 Brighowgate
Grimsby
North East Lincolnshire
DN32 0QE
Tel: 01472 583000
Website: www.navigocare.co.uk

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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)
1-243099827	The Gardens	Konar Suite	DN33 1NU
1-243099827	The Gardens	Older People's Home Treatment Team	DN33 1NU

This report describes our judgement of the quality of care provided within this core service by NAViGO. 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 NAViGO and these are brought together to inform our overall judgement of NAViGO.

Summary of findings

Ratings

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

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

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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Overall summary

We rated the integrated services for older people with mental health problems as good because:

- Staff did a comprehensive risk assessment for each patient, highlighting risks and setting out the individualised care and treatment required. They reviewed and updated risk assessments regularly. Each patient's records could be seen by staff in the community and on the ward, which helped provide continuity of care.
- Staff did a physical healthcare assessment of each patient admitted to the ward and patients had good access to physical healthcare. Care plans were person-centred and holistic; they were updated for patients as they moved in and out of hospital.
- The integrated team included a wide range of mental health trained professionals. Staff applied recommended best practice and guidance to ensure patients received a high quality of care. They received professional development and ongoing managerial supervision to ensure they could meet the needs of patients in their care effectively.
- We found staff well informed about issues of capacity and the application of the Mental Capacity Act, including Deprivation of Liberty Safeguards. The Mental Health Act code of practice was understood by staff and had become part of practice both on the ward and in the community.
- Patients and relatives told us the staff treated them with dignity and were respectful at all times. Where patients were unable to tell us, we saw staff treat patients with kindness and compassion. Staff supported carers and kept them involved in the care of their loved ones. Staff across the service promoted support groups for patients and carers.
- Patients were admitted to Konar ward if a full assessment showed it was where their needs would best be met. Staff planned patients' discharge with care given to prepare patients and their relatives. Ongoing support from the older people's home treatment team gave continuity of care before and after discharge.
- The ward environment and associated outside areas, optimised patients' recovery by meeting their needs and offering stimulation. The ward had achieved accreditation for inpatient mental health service wards for older people (AIMS-OP) with excellence.
- Staff spoke about being part of an excellent team. Work across the multidisciplinary team was respectful in the way it shared practice and morale was high.
- The whole team had a strong commitment to positive practice that would improve the quality of care for older people with mental health needs. Staff felt involved in service development and believed that if they had an idea it would be listened to.

However:

- The separation of patients with organic illness (caused by disease affecting the brain) and functional illness (a diagnosed mental health problem) was not always possible. This could mean that at times patients, particularly those with functional illness found the ward noisy and distressing. The inpatient unit was originally two five bedded units; one that cared for functional patients and the other for organic patients. Due to a reduction in funding from the clinical commissioning group, this was amalgamated into one unit.
- Half the ward's patients prescribed 'as required' medication had their prescription recorded across two medication cards. This could lead to dispensing errors. The prescribing doctor assured us that this would be changed.
- On Konar ward 82% of staff had completed all mandatory training and 60% of the older people's home treatment team, making a joint figure of 71%. Each team's figures fell below the provider target of 85%. The senior operational leader and team leaders had a specific action plan to address this, with actions identified for both the service areas and the training team. Managers expected all staff to have met the provider target by April 2016.

Summary of findings

- On Konar ward, 67% of staff had completed intermediate life support training. Staff that had not yet accessed this training were expected to receive it within the next three months.
- Staff used Restraint Elimination System Practical Effective Control Technique (RESPECT) training to de-escalate difficult situations. Staff were required to update their RESPECT training every six months. All staff had completed their initial training however, the proportion of staff who had completed refresher training was low at 42% compared with the provider's target of 85%. Managers had an action plan to address this, which included a RESPECT instructor on site helping staff if required.
- Following the decommissioning of fifteen care beds, which had provided step-up, step-down support, the range of care options had reduced.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The ward had been refurbished to a high standard, with all fixtures and fittings anti-ligature (designed to prevent someone intent on self-harm from tying something to them to strangle themselves).
- Each patient had an individual folder containing both their medicines chart and well-being information, which included ongoing physical health results. Staff followed robust processes including checks to dispense medication safely.
- Each patient had a comprehensive risk assessment, which identified individual risks and could be accessed by all staff. Staff reviewed and updated risk assessments regularly.
- The ward was clean and well maintained, with handwashing facilities available to staff and visitors to ensure effective infection control. The clinic room used by both teams was clean and tidy, and staff carried out and recorded all required checks regularly.
- Team leaders could access additional staff when needed; they were able to use staff known to the service from within the teams or NAViGO bank. Patients and carers told us they felt safe and confident that staff knew what they were doing.
- The service had systems for staff to report and review incidents and accidents. Lessons learned were cascaded to individual staff by email and discussed in team meetings. Staff understood their responsibility to be open with patients and their carers if something had gone wrong.

However:

- The separation of patients with organic illness (caused by disease affecting the brain) and functional illness (a diagnosed mental health problem) was not always possible.
- The ligature cutters on the ward were stored securely but this could delay staff access to them in an emergency.
- The separation of genders was achieved by using adjacent bedrooms off the large main corridor for patients of the same gender. Although there was no physical barrier between these rooms and the main corridor, staff were vigilant in their observation of this corridor night and day.
- The proportion of ward staff who had completed intermediate life support training was 67%. Staff who had not yet had the training were expected to receive it in the next three months.
- Staff used Restraint Elimination System Practical Effective Control Technique (RESPECT) training to de-escalate difficult

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situations. Staff were required to update their RESPECT training every six months. All staff had completed their initial training however, the proportion of staff who had completed refresher training was low at 42% compared with the provider's target of 85%. Managers had an action plan to address this, which included a RESPECT instructor on site helping staff if required.
- The proportion of staff who had completed all mandatory training was 71%. Each team's figures fell below the provider target of 85%, there was an agreed action plan in place with the expectation to have met the provider target by April 2016.

Are services effective?

Good

We rated effective as good because:

- Patients' needs were assessed before they were admitted, with additional information updated and shared with patients and relatives throughout their stay. The older people's home treatment team had access to six beds in an enhanced care home setting for respite care or to avoid an unnecessary hospital admission.
- Across the service, accreditation had been awarded for the provision of assessment and diagnosis of dementia and the provision of psychological interventions for dementia.
- Patients admitted to the ward had a physical health care assessment and good access to physical healthcare. Care plans were person-centred and holistic. They were updated for patients as they moved in and out of hospital.
- The integrated team included a wide range of mental health trained professionals. Staff applied recommended best practice and guidance, ensuring that patients received a high quality of care. Staff received professional development and ongoing supervision to ensure that they were able to meet patients' needs effectively.
- We found staff well informed about issues of capacity and the application of the Mental Capacity Act including deprivation of liberty safeguards. The new code of practice had been embedded into practice both on the ward and in the community.

However:

- Half of the ward patients prescribed 'as required' medication had their prescription recorded across two medication cards. This could lead to dispensing errors. We were assured by the prescribing doctor this would be amended
- The separation of patients with organic illness (caused by disease affecting the brain) and functional illness (a diagnosed

Summary of findings

mental health problem) was not always possible. This could mean that at times patients, particularly those with functional illness found the ward noisy and distressing. The inpatient unit was originally two five bedded units; one that cared for functional patients and the other for organic patients. Due to a reduction in funding from the clinical commissioning group, this was amalgamated into one unit.

Are services caring?

Good

We rated caring as good because:

- Patients and relatives told us the staff treated them with dignity and were respectful at all times. Where patients were unable to tell us, we saw staff treat patients with kindness and compassion.
- There was a strong person-centred culture; staff clearly knew patients well, chatting easily with them about topics of interest to them as individuals. Where possible patients made their own choices about care and treatment, staff knew and responded to patient's likes and dislikes from information gathered from patients and their relatives.
- Patients and carers were encouraged and supported to maintain links with their own social networks recognising that people in the community with whom they had existing relationships may best support them.
- Patients and carers could approach staff with any questions and felt they were given full information, even if it meant finding and asking a different member of the team.
- Staff supported carers and kept them involved in the care of their loved ones. Staff across the service promoted support groups for patients and carers.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Admission followed a full assessment of patient needs and consideration was given to where these needs would best be met.
- Staff planned patients' discharge with care given to prepare patients and their relatives. Ongoing support from the older people's home treatment team gave continuity of care before and after discharge.
- Staff knew and responded to patient's preferences and choices.

Summary of findings

- The service optimised patients recovery by ensuring the layout and facilities were suitable to the needs of patients with dementia. The ward had achieved accreditation for inpatient mental health service wards for older people (AIMS-OP) with excellence.
- There was a range of therapeutic and recreational activities on offer to ensure the needs of the patient group were adequately met.
- Information about how to suggest service improvements or complain verbally or in writing was readily available.

However:

- Following the decommissioning of fifteen care beds, which provided step-up, step-down support the range of options within the care pathway had diminished.

Are services well-led?

Outstanding ☆

We rated well led as outstanding because:

- Staff spoke about being part of an excellent team and morale was high.
- Staff felt involved in service development and believed if they had an idea it would be listened to. Older peoples services had clearly been recognised within NAViGO giving staff confidence in their ability to improve the service further.
- Work across the multi-disciplinary team was effective and respectful in the way it shared practice.
- Team leaders were clear that if they required additional staff for clinical reasons they would be supported in this.
- Managers were open and responsive to staff. Staff received regular supervision and appraisal ensuring their learning and development needs were met.
- There was a strong commitment throughout the team to positive practice that would improve the quality of care for older people with mental health needs.

Summary of findings

Information about the service

The older people's services provided by NAViGO offer integrated care and are at The Gardens, a site within the grounds of the Diana Princess of Wales Hospital in Grimsby.

- The Konar Inpatient Suite provides 24-hour inpatient care for up to 10 people. It is a purpose-built unit designed to meet the needs of older people suffering acute mental health problems. It accommodates patients who would benefit from a period of intensive assessment and treatment in a safe environment.
- The older people's home treatment team provide support to older people in crisis between 7am and 10pm each day. They work with individuals and their carers, visiting up to four times a day to facilitate early discharge and avoid unnecessary admissions.

The last inspection of these services was on 24 January 2014. The service met all the standards and there were no compliance actions.

This is the first inspection of these services using the Care Quality Commission's new methodology.

Our inspection team

Our Inspection Team was led by Patti Boden, Inspection Manager, Care Quality Commission.

The team that inspected the integrated services for older people with mental health problems consisted of one inspector, a mental health act reviewer, a nurse specialist, a psychiatrist and an expert by experience (someone who has developed expertise in relation to health services by using them or through contact with those using them).

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:

- 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 group meetings.

During the inspection visit, the inspection team:

- visited one ward and the older people's home treatment team at the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients, three carers of those who were using the service and a carers' group co-ordinator
- captured the experiences of patients who may have cognitive or communication impairments using the short observational framework tool for inspection (SOFI) on Konar ward
- spoke with the managers for each of the teams
- spoke with 18 staff members; including administrators, cleaners, doctors, nurses, occupational therapists, psychologists, support workers and social workers

Summary of findings

- interviewed the senior operational lead with responsibility for these services
- observed a handover meeting, a morning ward round and a multidisciplinary review
- collected feedback from 16 patients and carers using comment cards
- looked at five treatment records of patients and case tracked the care of two patients
- reviewed eight prescription charts
- carried out a specific check of the medication management on the ward
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients who were able to talk to us about their experience told us they were happy with the care they received. They believed the service supported them to get better and included them in their care planning. Where patients were unable to tell us, we observed how staff cared for them. We saw staff treat patients with kindness and compassion and respond in an appropriate and comforting manner when they were distressed.

Carers told us staff had supported them and kept them involved in the care of their loved one, whether they were in the hospital or at home. They were invited and listened to at meetings. At times, in a room with lots of people this could feel intimidating although staff did their best to make sure they were at ease.

Relatives spoke highly of the ward environment and liked being able to join activities with patients including staying for a meal. They appreciated being able to stay in hospital with their loved one before discharge to a care home. They saw this as sensitive to their needs and very caring.

There was a range of information available to patients and their carers. Staff signposting relatives to information relevant to the difficulties their relative was experiencing. There was a high awareness of support groups from within NAViGO and the local community. Patients were encouraged to maintain links with social networks and recreational groups outside the hospital.

Konar Suite family and friends test had remained at 100% for over a year. CQC comment cards spoke about caring staff that pay attention to detail, doing a great job at difficult times.

Good practice

LaingBuisson present annual awards to organisations dedicated to innovation, effective practice and high quality delivery of healthcare in the United Kingdom. In March 2015, LaingBuisson awarded the specialist care award for Excellence in Dementia Care to the Konar team.

NAViGO is committed to providing high quality care to the older people in the local area. Accreditation had been awarded through the memory services national accreditation programme (MSNAP) for the provision of assessment and diagnosis of dementia and the provision of psychological interventions for dementia.

The unit achieved accreditation for inpatient mental health service wards for older people (AIMS-OP) with excellence for the inpatient areas.

Areas for improvement

Action the provider SHOULD take to improve
Action NAViGO Community Interest Company SHOULD take to improve

- The provider should ensure that the practice of having two medication cards is addressed to reduce the possibility of dispensing errors.
- The provider should ensure compliance of mandatory training to agreed level.

Navigo Health and Social Care CIC

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
Konar Suite	The Gardens
Older People's Home Treatment Team	The Gardens

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 NAViGO Community Interest Company.

We reviewed the Mental Health Act documentation on the ward and found this met the required standards. The new code of practice had been embedded into practice both on the ward and in the community.

Information on the rights of patients who were detained was displayed in wards and advocacy services were readily available to support patients. We saw that staff regularly informed patients of their rights, using easy read information if required.

Compliance with mandatory training for MHA awareness for staff on Konar ward and the older people's home treatment team was 100%.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found staff well informed about issues of capacity and the application of the Mental Capacity Act (MCA) including deprivation of liberty safeguards (DOLS).

Best interest decisions showed involvement from a range people concerned with the care of individual patients, including family and professionals.

The older people's home treatment team completed capacity assessments. If staff admitted an informal patient to the ward they considered capacity again.

We saw staff involved carers in discussion about how best to meet patient needs. Care plans showed that staff had considered relevant legislation and adhered to the MCA and DoLS.

Detailed findings

Compliance with mandatory training for MCA awareness for staff on Konar ward and the older people's home treatment team was 100%.

Good

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

In 2014, the Konar suite was redesigned to meet the needs of older people suffering acute mental health problems, particularly dementia. Dementia friendly signage enabled patients to identify different areas of the ward for themselves.

The ward had large airy walkways with three separate corridors, two of which led to locked doors. The two smaller corridors had blind spots that were not mitigated by mirrors; staff managed this risk by being aware of patients' whereabouts. We saw that staff noticed and responded quickly and appropriately to patients throughout the ward, including on these corridors. The larger corridor had both space and areas of interest where patients could move about, explore items and sit in line of sight of staff.

Staff told us that they aim to separate patients with organic and functional illness. There were three bedrooms on one corridor for patients with functional illness, plus a separate lounge area. However, if there were patients of both gender with functional illness on the ward this separation would not be possible and functionally ill patients would need to sleep off the main corridor in gender specific sections.

Patients with organic illness had bedrooms off the main large corridor. There were short sub-corridors with two rooms at the end of each; women were given adjacent bedrooms, as were men. Whilst this created gender separation of sorts there were no additional doors on these sub-corridors. Staff on the main corridor made sure patients did not go into each other's rooms. All bedrooms had en suite facilities. All patients had access to lockable storage.

The outside space was extensive, accessible and well maintained providing patients with a safe space and fresh air. A summerhouse, converted in to a relaxed, recreation and social area known as The Konar Arms, provided patients with additional indoor space for recreation. We saw individually assessed equipment to aid both activities of daily living and patient's mobility. This equipment met safety regulation standards.

The ward environment appeared clean and well maintained throughout. The domestic staff followed daily cleaning schedules, which their manager monitored. This included spot checks two or three times a week. A deep clean took place following patient discharge. Resources required for cleaning were readily available and safely stored in locked cupboards when not in use. We saw signed rotas clearly identifying areas cleaned each day.

Hand washing facilities were available to staff and visitors to promote effective infection control. Community clinicians carried alcohol gel, and both soap and hand gels were available on the ward. We saw signs showing hand-washing techniques near clinical hand-washing sinks. Annual training for infection control for all staff was 76% compliant.

Staff used the clinic room on Konar ward to store medication for the older people's home treatment team. Community staff had a system in place to book any medication in and out. The clinic room was air conditioned, clean and tidy. Physical examinations of inpatients took place in their bedrooms, so staff had removed the examination couch previously in place. The shift leader maintained a check of emergency equipment once a week. Staff monitored fridge temperatures to ensure medications remained safe to use.

We observed a medicines round and saw that nurses dispensed medication in a methodical manner to minimise errors. Each patient had an individual folder containing both their medicines chart and well-being information covering ongoing physical health results, which was good practice.

Nurses followed a separate medicines policy for patients who were self-medicating, including those in the community. Following prescription, individual boxes of medication for a named individual were dispensed by the pharmacy. A local pharmacy technician did a stock take of medication each week and night staff completed a weekly audit of medicines. Emergency drugs were present, checked and in date.

The ward had anti-ligature fixtures and fittings installed when it was refurbished. Whilst risk of suicide was considered relatively low for patients with dementia, this

Good

Are services safe?

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

was not the case for patients with functional illness. Individual risk assessments and care plans reflected this, with staff observation significantly increased to mitigate any identified risk. There were two ligature cutters on the ward. However, they were not immediately accessible to staff. One ligature cutter was in a locked cabinet in the locked clinic room, and the other in the ward manager's office through an additional door. We discussed this with the ward manager who said they would re-locate these to ensure accessibility.

There was an alarm system within the ward. Whilst on inspection we saw a range of staff respond immediately to a raised alarm.

Community staff followed the provider's lone working policy. They used a signing in and out book to record their visiting schedule and expected time of return. The team had a code word, which they could use if telephoning in from a difficult situation. The team leader, or staff member on office cover, would respond to this type of call, or to someone not returning as expected to the office.

Safe staffing

On Konar ward, there were 11 qualified nurses, whole time equivalent (WTE) and 13 support workers (WTE). The ward was not carrying any vacancies at the time of the inspection. Bank staff who knew the ward and inpatient group filled any shifts that permanent staff could not cover. In the last year, eight shifts were not fully covered. The ward did not use any agency staff. Staff sickness was 3.6% during this period, which compares favourably with NHS figures. Staff turnover was 13%.

The ward operated with a minimum of two qualified nurses and two support workers on both the morning and afternoon shifts. The evening shift comprised of a minimum of one qualified nurse and two support workers. An occupational therapist and occupational therapy assistant worked across the service, with an identified support worker on each daytime shift to support activities on the ward.

The older people's home treatment team comprised of nine qualified nurses, two social workers and seven support workers (WTE). They were carrying one support worker vacancy at the time of the inspection. The team occasionally used bank staff if caseloads required this. Staff provided an in reach and outreach service from 0700 to 2200, seven days a week. A minimum of two qualified staff and two support workers worked each shift. Ward staff provided cover during the night. At the time of the inspection, staff were carrying individual caseloads of 40. The team leader could increase staffing if required. This team did not use agency staff; any additional staff needed came from the ward team or NAViGO bank staff. Staff sickness for the last year was 2% and staff turnover 14%.

Whilst there was no specific staffing tool in place, the teams identified safe staffing numbers required to meet the needs of the patients. This included one to one time with named nurses. We checked staff rotas from the beginning of December, which showed full cover and low sickness.

Staff and carers supported patients to take leave from the ward, particularly if this allowed them to reconnect with previous interests. An accessible vehicle provided by NAViGO was available to support patients to access the local community. We were told by staff that if required, Section 17 leave would be facilitated. Patients, carers and staff told us that activities happened regularly and were rarely cancelled.

Staff training figures for intermediate life support, which includes using the defibrillator, were low, with 67% of staff on Konar ward and 20% of staff from the older people's home treatment team compliant at the time of our inspection. Management assured us that all staff requiring this training were booked to receive it. The older people's home treatment team had all received basic life support training.

Across the two teams, 92% of staff had completed moving and handling of inanimate objects. For staff on Konar ward compliance for moving and handling people sitting, standing, walking, hoisting, bed transfers and mobility was 87%. Staff in the home treatment team had a compliance of 11%. Accessing update training for these modules had been an issue for the organisation as the provider was unable to meet demand. NAViGO had commissioned moving and handling training and train the trainers and were confident of be able to meet the 85% compliance target for all by the end of April 2016.

The overall compliance for all mandatory training on Konar ward was 82% and for the older people's home treatment team was 60%. For each team this figure fell below the

provider target of 85%. The senior operational leader and team leaders had a specific action plan in place to address this with actions identified for both the service areas and the training team.

Assessing and managing risk to patients and staff

Staff working in the older people's home treatment team checked the information available to them for indication of risk before going out to see a patient.

All assessments and care plans were stored electronically and were readily available to the community and ward teams. When the older people's home treatment team received an urgent referral for a patient known to them, they completed a crisis assessment. This identified the current situation and any new issues arising. Staff shared this information within the integrated team and with the patient's general practitioner. For patients not previously known to the service a complete assessment, which included risk, was undertaken. This could take over two days. Practitioners ensured they updated the electronic system with updated information when they returned to the office.

Ward and community staff used the risk assessment tool Decision, Inform, Choice, Explanation, and Support (DICES). Each patient had an individual risk assessment and risk management plan in place. When a patient transferred from the community to hospital their risk assessment accompanied them.

The ward staff completed an older person's DICES, assessing specific areas of risk in more detail if appropriate. For example, risk of falls or risk of choking. Staff completed a nutritional risk-screening tool, for all patients on admission. Team leaders reviewed these at least weekly and referred patients to a speech and language therapist or dietician if necessary.

Once completed, the patient's named nurse and associate nurse reviewed the assessments.

There were reminders on the white board in the office when reviews and updates must take place. If one of the patient's key nurses was not on duty, another qualified nurse completed the review. All the records that we looked at contained care plans that related to the specific risks identified for individual patients.

Each day the ward held a morning meeting and two staff handovers. During a handover, we saw staff discuss treatment and care for each patient and share detailed information that highlighted individual patients' risks covering the previous 24 hours. This ensured staff provided appropriate care and treatment consistently across both teams. In addition to patient needs, staff identified those of their primary carer. Discussion showed good linked practice across an integrated and multi-disciplinary team.

Admissions to the ward were either planned or emergency admissions. Patients came from either their own homes or residential and nursing services within the demographic area following an assessment by the older people's home treatment team. All patient records we reviewed detailed a comprehensive admission assessment highlighting risk, the patient's reason for admission and the care and treatment they required.

The entrance door to the ward was locked, requiring an electronic key both to enter and exit the ward. The reception staff supported patients and visitors to enter the ward and there were notices asking people to find a staff member when they wished to leave the ward. If staff had concerns about the safety of an informal patient wanting to leave the ward they would review their status, otherwise staff would facilitate them leaving. Inside the ward, there were no restrictions on patients' access to the different areas of the ward, other than those needed to ensure the dignity and privacy of others.

Staff were aware of ensuring patients were protected from the risks of abuse and possible risks of harm. Training in safeguarding adults was mandatory and staff compliance rates were 88%. Staff knew how to identify abuse and how to report safeguarding incidents internally and externally to the local safeguarding authority. Children were able to visit patients on the ward using the separate café off the reception area on site. Staff understood the need for children to stay connected to a loved relative in a way that was positive for everyone concerned. Staff compliance with mandatory training in safeguarding children was 76%.

Staff used Restraint Elimination System Practical Effective Control Technique (RESPECT) training to de-escalate difficult situations. This training was person-centered and designed to help staff support patients using the least restrictive options. Physical interventions used to restrain patients should be least invasive, promote breathing and maintain dignity and respect. All staff had completed initial RESPECT training.

Good

Are services safe?

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

The provider required staff to update this training every six months. We found that only 42% of staff had received a training update. We were told this was due to a lack of availability. The community and ward managers had both requested this training for their staff. In the meantime, a RESPECT instructor was on site to provide assistance to staff if required.

Konar ward had recorded 15 incidents of restraint, relating to nine different patients in the six months from April 2015. Staff had not used rapid tranquilisation or prone position restraint during this period. The techniques used ensured staff remain with the patients at all times. Staff did not prevent the patient leaving any area, instead they went with them. A debrief of both patients and staff took place following these incidents.

The ward did not have a seclusion facility. If the team were unable to manage a situation and there was a need for more enhanced care, they would transfer the patient to Brockelsby ward where staff known to the patient from the Konar suite would support them.

Track record on safety

The service had had no serious incidents in the past two years. Staff understood they would be debriefed individually and as a team if a serious incident took place.

Reporting incidents and learning from when things go wrong

There were systems in place to report and review incidents and accidents that occurred. The staff we spoke to all knew how to report an incident using the datix system, which they found easy to complete.

We reviewed the incidents reported over three and a half months from October 2015. Of the fifty incidents reported, ten were deprivation of liberty safeguards (DoLS) applications. The highest numbers of incidents were 'falls, not witnessed'. The clinical lead reviewed, assessed the severity and investigated incidents.

Feedback following incidents took place through individual debriefs, one to one supervision and monthly team meetings. An informal process was in place to support staff who found an incident or a near miss upsetting. The organisation sent staff learning from incidents using the NAViGO email system. Individual staff of all grades signed to say they had read this.

Learning from incidents linked to the planning of future care. For example, following an incident of verbal abuse directed towards a staff member in the community, an alert was added on the system with de-escalation within the care planning. On Konar ward, the service had implemented a falls reduction programme to ensure the risk of falls was minimised.

Staff understood the need to be open with patients and their carers if something had gone wrong. Whilst there were internal systems to investigate complaints or concerns, if a patient or carer wished to make a formal complaint staff referred them to the patient advice and liaison service (PALS).

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Patients' care plans were person-centred, holistic and ongoing. They accompanied patients in and out of hospital. Patients who were able to told us they were involved in their care, and that staff had sat with them to agree what would happen. Where patients were unable to communicate their needs, we saw evidence in care records that relatives/carers had been involved in the formulation of plans.

The care plans showed consideration to the needs of families, whether a patient was in hospital, going to respite or at home. Crisis plans were in place for all patients open to the service. In an emergency, the rapid response team would respond. Electronic systems in place allowed community and ward staff access to individual patient information wherever the patient was.

On admission to the ward, all patients had a physical health care assessment carried out by the doctor. This included height and weight, blood pressure, routine blood screening and urine analysis, an electrocardiogram (ECG) to check the heart's rhythm and activity, and a swab to test for meticillin-resistant staphylococcus aureus (MRSA). MRSA is a type of bacteria resistant to a number of widely used antibiotics. Additional assessments of a patient's physical health needs considered risk of falls; a nutritional assessment, difficulties swallowing, walking, pressure risk, hygiene, self-care and continence, skin integrity, moving and handling.

Assessments commenced pre-admission, with additional information updated on admission. Staff used information from assessments to formulate individual care plans. Relatives were involved in a care planning meeting to give background information to staff. We saw comprehensive care plans detailing the care and treatment provided to older people with both functional and organic illness. The patients named nurse or nurse associate reviewed the care plans weekly, or following any change. For patients with an organic illness a 'my life care plan' which included extensive background information was agreed and shared both with patients and their carers.

Where patients had a 'do not attempt resuscitation' (DNAR) form, the patient, relatives or an independent advocate and the multi-disciplinary team had been involved in the decision.

Best practice in treatment and care

NAViGO had ensured that the refurbishment of the ward provided a dementia friendly themed environment. Whilst staff ensured that patients with functional illness had both the space and specific interventions they required, the ward could be noisy and disturbed at times. There was provision on the acute ward at Harrison House to admit older people with a functional illness but this would have different challenges, particularly if the older person was frail.

Treatment provided included good access to physical healthcare, including a speech and language therapist and positive links with the patient's general practitioner. The Gardens site was within the grounds of the district general hospital, this allowed referral to many departments nearby. In the case of a medical emergency, if access to the accident and emergency department was required, transport would be facilitated by the ambulance service.

There were strong links with the local community with the development of support roles to compliment professionals for example, a dementia and engagement worker who supports and organises volunteers. Professional services with strong links to the older people's home treatment team included home care liaison, admiral nurses, hospital liaison and local authority social workers. There were six beds in an enhanced care home setting, which the team managed; staff could use these beds to admit patients who needed respite care or to avoid an unnecessary hospital admission.

When a patients' nutritional assessment scores were over 15, indicating more specialist knowledge was required referral to a dietician was made. This team were based at the general hospital and their response times to support the ward staff to meet the nutritional needs of individual patients were within 24 hours. We saw food and fluid charts completed for patients requiring this level of monitoring.

Psychology offered behavioural management input into care planning and specific screening of cognition, fluency and neurology. For some patients a full neurological assessment was undertaken. Occupational therapy assessed all patients to gain an overview of the client's

Are services effective?

Good

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

occupational functioning using the model of human occupation screening tool (MOHOST); sometimes in relation to the activities of daily living, a specific assessment of motor and process skills (AMPS) was used. The outcomes of all such specific tests were fed back to the patient, their carers and the team at the MDT. All patients on the ward had individual activity plans geared to maintaining and improving their abilities. The occupational therapist also undertook home assessments when required.

We reviewed all the inpatient medicine charts and found prescribing in line with NICE Guidance. However, we found that half the patients had their 'as required' pro re nata (PRN) medication spread over two cards. This increased the possibility of a drug error. Our pharmacist raised this concern with the prescribing doctor who assured us that this would be changed.

We saw examples of staff following NICE guidance and staff told us they had referred to NICE guidelines to clarify the way forward in treatment where there had been a difference of opinion between clinicians. Staff discussed new NICE guidance and legislation in team meetings. This informal learning increased staff awareness and helped identify any formal learning required. This had been particularly effective in embedding the new code of practice. Although the service aspires to following NICE Guidance, we saw no specific dementia or functional care pathway.

Skilled staff to deliver care

This integrated team had a wide range of mental health trained professionals: nurses, social workers, support workers, occupational therapists and an activities co-ordinator, a speech and language therapist, a psychologist and psychology assistant, a consultant psychiatrist, trust grade and a staff grade doctor. In addition, a pharmacist visited weekly and was available to patients, carers and staff for support and advice about medicines. The experienced and qualified workers we met all expressed a commitment to delivering excellent care to older people. Staff had a good knowledge and understanding of their role. Patients and carers told us they felt safe and confident that staff knew what they were doing.

We carried out a short observational framework tool for inspection (SOFI) on Konar ward to observe how staff provided care and treatment. We found staff engaged well with patients, care was not task orientated and staff responded to patient distress and needs.

In addition to mandatory requirements, all staff had received training in dementia awareness.

Staff described the training accessed through the workforce development team as very good. Staff we spoke to felt NAViGO would support them to undertake additional study when it would develop further skills within the team. Examples included, a support worker being seconded to undertake nurse training, and a qualified staff member considering the degree in non-medical prescribing.

Staff we spoke with said that they received regular clinical and managerial supervision. The provider's requirement for supervision was monthly which we saw being adhered to. Two support workers told us that formal supervision was monthly, but ad hoc supervision can be requested any time from senior staff if needed. Compliance with annual appraisal for staff across both teams was 100%.

Multi-disciplinary and inter-agency team work

The integrated team worked with the same patient group across the ward and the community. This ensured care and treatments were delivered consistently across both teams. Care included supporting both the patient and their carer. We saw a breadth of understanding of individual cases and excellent verbal communication between team members. We attended a handover and a morning meeting, at both staff from the ward and the older people's home treatment team shared detailed information about patients who were clearly well known to them.

We attended a multi-disciplinary review (MDR) meeting for three patients, this comprised of a wide range of health care professionals. The MDR reviewed current care needs and formulated a plan following discussion. Patients and their carers did not attend the MDR as for the individuals concerned it was believed they might find the size of this forum intimidating. Instead, the patients named nurses discussed the outcomes of the MDR directly with patients and relatives following the meeting. When the MDR identified patients approaching discharge a smaller meeting was arranged to discuss plans directly with patients and their carers.

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All team members could access the electronic systems where assessments and care plans were. The team saw assessment of risk and care planning with patients and carers as predominantly a nursing role. Interventions by other team members were referred to in care planning, rather than being fully integrated. We were concerned that although the software within the electronic system exists, recording of medication for in patients was only available on the drugs charts.

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

We reviewed the Mental Health Act documentation on the ward and found this was meeting the required standards. The new code of practice had been embedded into practice both on the ward and in the community.

The ward displayed information about detained patients' rights and advocacy services were readily available to support patients. In the documentation we reviewed patients were regularly informed of their rights and leaflets given. When patients did not understand their rights staff repeated these daily.

An approved mental health professional (AMHP) employed by NAViGO, appointed through North East Lincolnshire local authority, visited the unit daily. This meant there was good co-ordination and planning for any admissions or likely changes in the legal status of patients who may need to be assessed by the AMHP or second opinion appointed doctor (SOAD). Whilst the AMHP's role was, separate from the team, their presence at the morning meeting and at multi-disciplinary reviews added positively to communication about the application of the MHA.

We saw a timely and robust discussion by informed staff about the needs of patients currently detained in hospital on section 2 of the Mental Health Act (MHA) who due to their presentation and possible risks, were being assessed in a hospital setting. The team explored a range of options including section 3 of the MHA, deprivation of liberty safeguards (DOLS) and discharge.

The manager of the older people's home treatment team was also an AMHP, which provided staff with additional support in their application of the Act and the new code of practice. Compliance with mandatory training for MHA awareness for staff on Konar ward and the older people's home treatment team was 100%, with 100% of qualified staff on Konar ward trained in accepting and scrutinising section papers.

Good practice in applying the Mental Capacity Act

From discussion with staff, observation at meetings and case tracking notes we found staff well informed about issues of capacity and the application of the Mental Capacity Act (MCA) including deprivation of liberty safeguards (DOLS). Staff made referrals to an independent mental capacity assessor (IMCA) if required.

Best interest decisions showed involvement from a range of people concerned with the care of individual patients, including both family and professionals. The home treatment team completed an initial capacity assessment prior to any admission. If a patient agreed voluntarily to admittance to the ward, staff considered capacity again following admission. We saw staff involve carers in discussion about how best to meet patient needs when this was relevant and possible.

Care plans showed staff had considered the relevant legislation. When staff used passive holds to carrying out personal care tasks there were best interest assessments in place. Konar ward rarely used covert medication although staff were aware of a specific policy should administration of covert medication be required. The family, the multi-disciplinary team including the pharmacist would ensure a best interest decision was in place before the administration of covert medication.

Compliance with mandatory training for MCA awareness for staff on Konar ward and the older people's home treatment team was 100%.

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

During our time on the ward, staff approached patients in an open manner and spoke with them in a way that met their needs. For example, speaking calmly or if the patient was hard of hearing used a louder voice and making sure the patient could see their lips. Staff clearly knew patients well, chatting easily with them about topics of interest to the individual patient concerned. When needed, staff discretely assisted patients to the bathroom and protected their dignity and privacy. Patients being aided to walk were encouraged and supported throughout. Patients who wished to walk about the ward were able to. There were different areas available to them and whilst staff knew where people were they allowed them the freedom to explore easily accessible areas without restriction. The dementia friendly environment on Konar ward offered interesting areas and items for patients to explore.

We conducted a SOFI over 30 minutes in a busy ward area. We saw that in spite of a great deal happening during this time the staff were all very positive and respectful to patients. Where they were in distress, staff responded to patients appropriately. Whether involved in the activity or not, staff continued to support patients with dignity and respect maintaining a calm environment.

Some of our inspection team joined patients and staff for lunch. Patients made their own choice of meal from three options, including a vegetarian choice. Staff knew the specific nutritional needs and the likes and dislikes of individual patients. There were a number of patients who needed both support and encouragement to eat and drink; staff alongside them during their meal did this subtly. The night shift on Konar ward were trialling wearing nightclothes and slippers. Not only was their footwear quieter, if patients woke at night this helped orientate them to time.

Patients and relatives told us the staff treated them with dignity and were respectful at all times. Where patients were unable to tell us, we saw staff treat patients with kindness and compassion. A number of staff, including the cleaners, mentioned that a part of their motivation at work was to deliver a service they would be happy for their relatives to receive.

The involvement of people in the care that they receive

On Konar ward, there was a comprehensive information pack and welcome booklet for patients and their families. Patients and carers knew who their key staff member was. Patients who were able to talk to us about their experience told us they were happy with the care they received. They believed the service supported them to get better and included them in their care planning. The strong links between the ward and the home treatment team led to shared knowledge so patients and carers did not have to repeat information and care was continuous.

Staff read care plans to patients and carers following admission and any review point. Although not all patients and carers could identify what a care plan was, all were clear they had been involved in decisions about care. For example, what was currently happening and what the plans for the future were. Each patient had a linked nurse and an associate worker, who was involved in reviewing care and ensuring updated information, was communicated effectively to patients', their carers and the wider staff team. In both hospital and the community, we saw good practice in involving people in their care. Staff offered copies of care plans to patients and to carers if consent had been given.

Carers told us staff had supported them and kept them involved in the care of their loved one. Staff were open to relatives remaining involved in direct care giving when this was seen as less distressing for the patient. For example, one carer assisted their loved one to shower, as they had at home. This not only maintained the patient's dignity but also gave the carer a purpose. The pharmacist visited the ward weekly and was available to patients and carers, as well as staff, if they had any medication queries.

Patients were also encouraged to maintain links with social networks and recreational groups outside the hospital. There was an accessible vehicle provided by NAViGO, available if required. There was a separate multi-faith room on the ward and staff worked towards ensuring patients' spiritual needs were met.

The multi-disciplinary team invited carers into some meetings. One carer told us the large group of people in the room could feel intimidating however; staff did their best to make sure they were at ease. Relatives spoke highly of the

Good

Are services caring?

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ward environment and liked being able to join patients for a meal. Carers saw being able to stay in hospital with their loved one before discharge to a care home as sensitive to their needs and very caring.

The patients and carers we spoke to all said they would approach staff with any questions they had large or small. They always felt they received full information in a response to a query, even if it meant asking a different member of the team. The feedback system within Konar allowed carers and some patients to pass on comments or suggestions. People were aware of this system and some relatives had used it.

There was a range of information available. We saw staff signposting relatives to support groups and information relevant to specific difficulties their relative was experiencing. We saw information about carers support in the reception area of The Gardens.

Carers we spoke with told us they had accessed Nelles where support is offered to people with dementia and their carers within a friendly environment. The carers support service was described as offering a range of advice and support. The role of dementia and engagement worker had been developed to organise volunteers who in turn supported patients and carers.

Konar Suite family and friends test had remained at 100% for over a year. CQC comment cards spoke about caring staff that pay attention to detail, doing a great job at difficult times.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Konar ward had clear admission criteria. Admissions followed an assessment by the older people's home treatment team . This team had access to beds in two care homes if a hospital admission was not required. Following the recent decommissioning of 15 care beds, which provided step-up, step-down support the range of options within this care pathway had diminished.

The integrated team, which included community practitioners, ward staff, doctors and managers, made the decision to admit a patient to hospital. If there were concerns the patient mix would not work staff could refuse admission. For example, if a patient presented with needs that would compromise the recovery of others already on the ward. In these cases, NAViGO would find the patient a different placement. There had been out of area placements used for four patients in the last year.

Patients admitted to the ward have their own en suite room, which they came back to following leave. Patients were not moved without clear clinical grounds to do so. Discharge was about meeting the needs of the patient; it did not focus on length of stay. Families were involved in planning discharge whether the patients was returning home or elsewhere. If a patient was moving on to residential care, staff offered overnight accommodation to relatives to stay a last night with their loved one. Staff gave patients a written aftercare plan on discharge. Patients received ongoing support from the older people's home treatment team following discharge. This gave continuity of care to both patients and carers. This team could visit patients up to four times a day.

On Konar, ward over a six-month period from to April to October 2015 the average bed occupancy of 88%. There had been three delayed discharges due whilst patients waited for a nursing home placement.

The facilities promote recovery, comfort, dignity and confidentiality

Dementia friendly signage was present in the reception area and throughout the ward. This enabled patients to identify different areas of the ward for themselves. The refurbishment was to a high standard with 'places to visit' including a post office, bakery and sweet store all situated off the large corridor with areas for patients to stop, sit and to try the goods. The re-furbished rooms had décor, furniture including wardrobes and drawers all of which were dementia friendly. All rooms had en suite facilities, with three rooms having an additional lounge area with a sofa bed for family use. Patients had access to their own room, which had safe lockable storage areas. Whilst the environment for patients with dementia was exceptional, the mixed patient group included 30% patients with functional illness. Along one of the smaller corridors were three bedrooms used for these patients. Whilst well-appointed, these rooms had less appealing decor. There was a separate lounge for this patient group which led onto an attractive outside space.

The large dining area made it possible for patients, carers and staff to eat together across staggered times to lessen the noise. This was adjacent to a large lounge area where activities took place. In addition, there was a sensory bathroom area with the option to use a jacuzzi, lights and music. The space outside was large and safely fenced with wide level paths to walk on, shaded seating, grassy areas and raised beds to garden. A large summerhouse within the garden had been converted into the Konar Arms, with a bar and informal seating patients could use for activities such as card playing or watching a film. A member of staff had suggested this development and following a team discussion, a proposal was made by the team which resulted in the award of a grant from NAViGO. Staff were clearly proud they could bring forward ideas around innovative practice.

Food was cooked within the Gardens; meals for individual patients reflected both their nutritional requirements and personal preferences. Staff were knowledgeable about patients' food likes and dislikes. The menu worked on a two-week rota with a main meal choice of three options, one of which was vegetarian. Choices were made by the patient the day before, however we saw flexibility if patients had changed their mind or forgotten what they had ordered. There was a menu board in the dining room with information about that day's food choices. If patients did not like any of the choices, they could request different food. Each Wednesday was 'fry up night'; this was particularly popular with patients. The small kitchen off the dining room meant patients had access to drinks and snacks at any time.

Information from patients and relatives was put together to describe 'my life'. This informed many aspects of care

Are services responsive to people's needs?

Good

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

including individualised activity plans. Staff encouraged patients to maintain interests where possible. There were a range of therapeutic and recreational activities on offer, in addition to the occupational therapy team, support workers facilitated activities daily. Staff displayed a daily activities program on a white board on the ward. We observed patients engaged in an activity in the ward lounge. The patients were encouraged to join in by a staff member with an engaging and easy manner. Patients chose the activities they wanted to join in. The ward also had areas available for patients who did not want to take part or who needed a quieter or calmer environment.

Meeting the needs of all people who use the service

Patients received an individual welcome pack on admission containing information about the ward. Staff awareness of the need to treat patients as individuals and with respect was high. We observed staff taking time to listen and understand a patient before going on to explain what was happening and offering them choices. The physical layout of the environment meant areas were accessible to patients. If equipment and aids were required, for example, to improve mobility, the service was responsive to this. The kitchen was able to respond to specific diets to meet individual patients' nutritional and/or cultural needs.

There was a multi faith room on the ward; staff supported patients to access this as needed to maintain their religious practice. Chaplains visited the ward to see individual patients and staff ensured these visits could take place in private. If patients needed a quiet place to be on their own or with carers, this was also possible.

Staff knew how to access interpreters and signers if the need arose. Staff sought advice from the patient's carer about the best way to communicate with the patient if they were experiencing difficulties.

We saw a range of leaflets and information on display in the reception area and the ward, some of which were easy read. Information included details of carers support groups; mental health act legislation; explanation of specific mental health problems, and how to complain. We observed a member of staff signposting a carer to something specific they had requested.

Listening to and learning from concerns and complaints

There was a complaints policy in place. Leaflets were available and posters seen in the reception and ward area about different ways of complaining including to NAViGO, PALS and CQC. There had been no formal complaint relating to this service in the last year.

Information about how to suggest service improvements, complain verbally or in writing was readily available. Some of the patients and all the carers we spoke to knew how to make a complaint. All told us they would approach the staff first to get a response to any concern. Where this had happened people said staff had listened to them and given the information they had requested. Feedback forms were available, and one person told us they had used this system on two occasions to make suggestions.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and values

The NAViGO code of conduct identified what patients could expect from the service; what was expected of staff and how staff could expect to be treated. The code was displayed on Konar ward and in the offices of the older people's home treatment team. Staff awareness of the values within this code was high. Staff spoke positively about the organisation; they knew who senior managers were, including the chief executive officer. Senior managers had visited the service and demonstrated an active interest in what was happening. Staff who attended NAViGO's annual general meeting spoke of it being a positive experience.

Staff felt they were an important part of the organisation and were proud to work within the older people's team. We found carer's with an awareness of NAViGO's vision and values, which formed the basis of what they expected for their loved one.

Good governance

All staff had regular monthly supervision and 100% of staff had completed their annual appraisal. The service measured staff performance using key performance indicators (KPI).

Staff reported incidents reported using the DATIX system. Team leaders reviewed this information on a daily basis. They then dealt with issues arising from these reports in a timely way. Learning from incidents took place through individual debriefs, one to one supervision and at monthly team meetings.

Managers used team meetings to cascade information. We saw minutes of past meetings indicating active participation across the disciplines. The whole team discussed any incident they thought was relevant to clinical practice, taking away action points from these discussions. This included identifying new training needs for staff. To ensure staff awareness of updated practice, sharing new learning and informal training took place within team meetings.

Team leaders monitored mandatory training and highlighted areas where training was overdue with both the individuals concerned and the training team. When mandatory training could not be immediately accessed, action plans were in place whilst staff waited for training to become available.

The operational lead supported both team leaders if they required additional staff. The priority for both teams if cover was required was to use staff known to their patients. This was achieved by asking suitably trained staff to cover shifts from within the integrated team, or from specifically identified NAViGO bank staff.

The refurbishment and redesign of the ward areas had given the team managers confidence that their teams were valued by NAViGO and that they could influence change.

Leadership, morale and staff engagement

Staff spoke of an open door policy all the way to the top of the organisation and talked positively about their line managers. They felt well supported in their roles and liked the access they had to areas of development beyond required mandatory training.

The focus of both teams was to deliver high quality care. Staff felt positive about the work they did to improve the lives of others. One staff member commented that although the job could be very stressful, the level of support available made anything possible. Moral was high and staff engagement was good.

Staff spoke about being part of an excellent team. Work across the multi-disciplinary team was respectful in the way it shared practice and morale was high. At team meetings, staff were asked to consider together 'how might we improve'. Staff were clearly proud they could bring forward new ideas, innovative practice and be listened to.

No one reported any bullying or harassment within the team. Staff said they felt able to approach their team leader with any concerns they might have. The staff we spoke to understood how the whistle blowing process worked and would be confident that if the process was used this would not affect their future within the organisation.

When asked staff could describe their responsibilities in relation to duty of candour. One of the team told us that NAViGO positively encourage duty of candour in all the teams, staff saw it as their duty to make people aware.

Konar suite family and friends test had remained at 100% for over a year.

Are services well-led?

Outstanding ☆

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Commitment to quality improvement and innovation

There was a strong commitment from the senior operational leader through the whole team to positive practice and improving the quality of care for older people with mental health needs. It was evident throughout our inspection that all grades of staff were committed to providing high quality care that met the needs of people who used the service.

Staff told us they were encouraged to consider doing things differently if it would improve care.

Within the teams, we heard of positive attitudes to ideas, welcomed by managers who listened. Thoughtful consideration and exploration of how a suggestion could work in practice, and how its success measured was normal practice.

Ideas could be brought to team meetings for discussion, and if supported may be implemented. We saw examples of a team unafraid to try new and innovative practice: the Konar Arms, a pub/ cinema space within the summerhouse in the ward garden, and the introduction of night staff in pyjamas and slippers to help orientate patients to time of day and maintain quiet through the night on the ward.

The service had received an accreditation award through the memory services national accreditation programme (MSNAP) for the provision of assessment and diagnosis of dementia and the provision of psychological interventions for dementia. The ward had also achieved accreditation for inpatient mental health service wards for older people (AIMS-OP) with excellence.