Newholme Hospital

Quality Report

Newholme Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

Summary of findings

Contents

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Overall summary

Newholme Hospital is situated in Bakewell, North Derbyshire it is run by Derbyshire Community Health Services NHS Trust. Newholme Hospital is also the headquarters of the Trust.

Newholme Hospital provides two inpatient wards: Riverside ward has 18 beds and provides care for elderly patients with mental health difficulties. This can include patients detained under the Mental Health Act 1983.

Rowsley ward has 18 beds and provides rehabilitation for elderly patients. Additionally, there are some day patient services at Newholme Hospital.

Patients and families were largely positive about inpatient care. They felt staff treated them with respect and dignity. Staff were sensitive to patients needs and used good communication skills to get to know them. Patients were routinely offered choices and were involved in their care. However, mental health care plans were standardised and did not contain sufficient detail about the person as an individual, their views, wishes and preferences.

There were systems in place to identify, investigate and learn from patient safety incidents. However in the past some significant delays in processing incident reports have reduced the effectiveness of learning lessons. Staff were trained in safeguarding adults and there were suitable systems in place to handle any allegations of abuse. Patients' records were filed separately by different professionals which could lead to lack of consistency of care and treatment.

Services were effective in meeting patient's needs. There was good collaborative and multi- agency working in place to ensure patient's needs were met. There were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act.

Patients were involved in discharge planning and there were systems in place to ensure they would receive suitable care and support at home if it was needed. However discharge arrangements were not always well documented.

Hospital Managers had rudimentary understanding of many of their duties in respect of the Mental Health Act. Legal updates, support in risk assessment and role specific training were not provided. Senior managers were aware of the challenges they faced. They had been responsive to problems when they arose and had strategies in place to improve services.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

There were systems in place to identify, investigate and learn from patient safety incidents. However in the past some significant delays in processing incident reports have reduced the effectiveness of learning lessons. Staff were trained in safeguarding adults and there were suitable systems in place to handle any allegations of abuse. Patients' records were filed separately by different professionals which could lead to lack of consistency of care and treatment. There were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act

Are services effective?

Services were effective in meeting patient's needs. There was good collaborative and multi- agency working in place to ensure patient's needs were met.

Are services caring?

Patients received good care and regarded them with respect and dignity. Staff were sensitive to patients needs and engaged with them to get to know them. Patients were routinely offered choices and were involved in their care. Mental health care plans were standardised and did not contain sufficient detail about the person as an individual, their views, wishes and preferences.

Are services responsive to people's needs?

Patients were involved in discharge planning and there were systems in place to ensure they would receive suitable care and support at home if it was needed. However discharge arrangements were not always well documented.

Are services well-led?

Services are well led. The Trust board are visible to staff and were approachable. Senior managers were aware of the challenges they faced. They had been responsive to problems when they arose and had strategies in place to improve services. Hospital Managers had rudimentary understanding of many of their duties in respect of the Mental Health Act. Legal updates, support in risk assessment and role specific training were not provided.

Summary of findings

What we found about each of the core services provided from this location

Community inpatient services

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Other services

Mental Health Act responsibilities

We found that there were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act. The detention documents were available and contained all the required information including the views of the patients and the nearest relative as appropriate. For one individual where no nearest relative had been identified by the Approved Mental Health Professional (AMHP) at the point of admission there was no evidence of any further attempts to rectify the situation. This is an important safeguard in ensuring the least restrictive option was considered and the views of people and their nearest relatives were considered. All detentions appeared to be lawful.

We found evidence that the Hospital Managers discharged their duties to review individuals' detentions holding full panel meetings when individuals appealed against their detention and also when the Responsible Clinician renewed the detention whether or not the individual contested the renewal.

We found that the lead pharmacist and technicians visited the wards to monitor stock levels, undertake general medication audits and provide specialist advice on the use of covert medication. They referred to the Derbyshire Healthcare NHS Foundation Trust pharmacist for specialist advice relating to mental health. However the monitoring and audit against the National Institute for Clinical Excellence (NICE) guidelines relating to anti-psychotic medication prescribed by the Responsible Clinician was undertaken by Derbyshire Healthcare NHS Foundation Trust.

In respect of the operation of Part IV of the Mental Health Act we found inconsistency in the recording of discussions between the patients and Responsible Clinicians regarding their capacity to consent to medication at initial administration or prior to the end of the first three months.

Responsible Clinicians were employed by Derbyshire Healthcare NHS Foundation Trust and operated in Derbyshire Community Health Services NHS Trust under a Service Level Agreement. We found a lack of clarity over which organisation's policies and procedure medical staff were working to when on the wards, and duplication of information as a result of case notes from two organisations being used.

We found that detained people were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in adherence with the Mental Health Act Code of Practice.

Summary of findings

Individuals' capacity to understand their rights was assessed and recorded by nursing staff. However we found that the format in which the written information on those rights was provided had not been adapted to meet the patients' needs in adherence with the Mental Health Act Code of Practice.

We found that the mental health care plans were rudimentary, formulaic, and focused on process rather than being person centred. There was insufficient recording of the patient's own views of their care being taken into consideration.

Information on the role of the Independent Mental Health Advocacy service was provided. We found automatic referrals to the Independent Mental Health Advocacy (IMHA) service in place for all new patients, though staff will also made referrals for individuals who lacked capacity when necessary. IMHA and Independent Mental Capacity Advocate (IMCA) attended ward rounds, multi-disciplinary team and discharge planning meetings to support people in hospital

We also found evidence of the consideration to less restrictive treatment options including documented discussion by professionals of the use of the Deprivation of Liberty safeguards (DoLS).

Summary of findings

What people who use the community health services say

The Friends and Family Test seeks to find out whether patients would recommend their care to friends and family. Derbyshire Community Health Services NHS Trust completed the test in April 2013. The most recent figures (October 2013) placed the trust in the top 25% of the whole of England for inpatient scores.

We received verbal and written feedback from patients and relatives during our visit, who told us the staff worked hard and provided good quality care.

Areas for improvement

Action the community health service SHOULD take to improve

- Review the documentation used for recording and updating care plans, to ensure that up to date information about each patient is easily accessible to staff.
- Ensure that medicines are disposed of safely and in line with Trust policy.
- Care plans should specify mental health treatments and demonstrate patients' views are taken into account.
- NICE guidance should be followed in respect of mental health treatment with audits to monitor outcomes.

Action the community health service COULD take to improve

- Provide suitable space for therapy sessions, and adequate storage facilities for wheelchairs and other bulky pieces of equipment.
- Ensure all staff are clear about their roles and responsibilities in reporting safeguarding concerns.
- Have suitable arrangements in place for staff to access Trust policies and procedures, in electronic or paper format.
- Ensure staff access clinical supervision regularly, by monitoring and reviewing uptake.

Newholme Hospital

Detailed findings

Services we looked at:
Community inpatient services; Mental Health Act responsibilities

Our inspection team

Our inspection team was led by:

Chair: Helen McKenzie, Director of Nursing and Governance Berkshire Healthcare Foundation Trust.

Head of Inspection: Ros Johnson, Care Quality Commission

The team included CQC inspectors, two community nurses, a learning disability/mental health nurse and an expert by experience. Experts by experience are people who have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to Newholme Hospital

Newholme Hospital is situated in Bakewell, North Derbyshire and registered with the CQC in May 2011. It hosts the headquarters of Derbyshire Community Health Services NHS Trust which delivers a variety of community services across Derbyshire and in parts of Leicester. Newholme Hospital is registered to provide the regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures, and Treatment of disease, disorder or injury.

The hospital has two inpatient wards. Riverside ward provides care for up to 18 elderly patients with mental health difficulties, including those detained under the Mental Health Act 1983. Rowsley ward provides rehabilitation for up to 18 older people.

The inpatient services at Newholme Hospital have not previously been inspected by the CQC although there has been monitoring of one ward where people were liable to be detained under the Mental health Act 1983.

Why we carried out this inspection

This location was inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

The inspection team looked at the following service:

- community inpatient services

Before visiting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the provider.

We carried out announced visits to Riverside and Rowsley Wards on 25 February 2014 and an unannounced visit to Rowsley Ward on 27 February 2014. During our visits we held focus groups with a range of staff; we observed how people were being cared for, talked with carers and/or family members and reviewed personal care or treatment records of patients.

Community inpatient services

Information about the service

The hospital has two inpatient wards. Riverside ward provides care for up to 18 elderly patients with metal health difficulties, including those detained under the Mental Health Act 1983. Rowsley ward provides rehabilitation for up to 18 older people. The hospital also provides some daycare for patients after discharge. At this inspection we visited both inpatient wards but there were no patients at the day care service.

During our inspection we spoke with patients and relatives. We spoke with the modern matron, ward managers, an advanced nurse practitioner, staff nurses, physiotherapists and domestic staff. We reviewed patient records, observed care being delivered and reviewed information we had received from the Trust.

Summary of findings

Patients and families were largely positive about inpatient care. They felt staff treated them with respect and dignity. Staff were sensitive to patients needs and used good communication skills to get to know them. Patients were routinely offered choices and were involved in their care. However, mental health care plans were standardised and did not contain sufficient detail about the person as an individual, their views, wishes and preferences.

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Community inpatient services

Are community inpatient services safe?

Safety in the past

We found in one ward that over previous months incidents were reported but records were not completed or finalised. The backlog of incidents was being addressed but meant that incidents had not been escalated or analysed. Staff were working hard to reduce the backlog but 35 incidents remained open at the time of our visit, some dating back to May 2013. This delay had adversely affected the team's ability to learn lessons from safety incidents and amend practice where necessary

Learning and improvement

Insulin administration had been an area of significant concern in the Trust across inpatient areas following seven incidents in community hospitals since April 2013. In one patient's records we saw that a medication administration record for prescribed insulin had not been correctly written with the route of administration. Staff identified the recording error before the patient received their insulin, so no harm resulted. We asked if this had been recorded as a 'near miss' event as the identification of the error was dependent on the knowledge and expertise of the nurse who was on duty. We were told that this had not been reported but were given assurances that it would.

Systems, processes and practices

Staff told us it was usual practice to use the same care planning booklets when patients were readmitted within three months. We saw an example of this. The limited space available in the care plan booklets meant that three booklets, all with relevant care plans were in use. Some of the person's needs had changed and a specific care plan had been updated in a different booklet but the previous plan was not scored through. The number of booklets with similar care plans in place was confusing and meant staff could not access current and relevant information quickly and easily.

Wards were supported by visits from pharmacists to ensure there were sufficient stocks of medicines. We saw on one ward that medicines prescribed for individual patients had not been disposed of in a timely manner as they were on the ward many months after their discharge. The Trust's policy for the disposal of out of date medication stated these should be disposed of in a yellow topped bin to ensure medicines would be suitably incinerated. We saw that staff were not using the correct type of bin as a yellow and red topped bin was used. This meant that medicines were not disposed of in accordance with the Trust's own policy. There was insufficient security for the disposed of medicines as the bins were stored in the treatment room on worktops so were accessible to non- clinical staff.

Staff confirmed they had received training in safeguarding adults. They told us that if they had any safeguarding concerns they would report these on the incident reporting system. Staff told us that some decisions regarding the escalation of safeguarding allegations would be made by the quality and safety team on the basis of the incident reports. We were given an example of one on-going safeguarding allegation. The actions taken to the safeguarding allegation were considered suitable and a conclusion has yet to be reached. However, we were concerned to hear that after the safeguarding referral had been made some staff came forward with additional related concerns that they had not raised earlier.

Monitoring safety and responding to risk

Patients told us the wards were clean and they felt safe. The Trust monitored the environment and standards of hygiene through regular audits, including hand washing audits and checks of the environment.

On Rowsley ward we saw wheelchairs and other equipment stored in the treatment room/dining room. Staff told us these were moved during therapy sessions but during our visit we saw them remain in place during patients' therapy sessions. They limited the space available for therapeutic activities and posed a risk to patients should they use them for support or fell against them. The lack of storage space and the combined use of the day room as an activity room was highlighted as a concern by the Clinical Commissioning Group in November 2013.

Staff carried out patient assessments on admission, which included the risk of venous thromboembolism (VTE), pressure ulcers, poor nutrition and falls. Staff told us that where patients had pressure ulcers a root cause analysis was routinely undertaken to establish if lessons could be learned. There had been three incidents of these in the past year but staff told us that all the three pressure ulcers were considered to be unavoidable.

In one patient's care record we saw a referral had been made to the tissue viability nurse but there was no record that the nurse had visited or provided advice about a

pressure ulcer. We asked staff about this and they discovered that the referral had not been sent so the patient was not assessed and professional advice for the patient was not received.

Staff told us that where patients were admitted with pressure ulcers these were reported as safeguarding concerns through the Trust's incident reporting system. Staff told us that the decision to escalate the concerns to formal safeguarding procedures was made by staff from the quality and safety team. Staff could not tell if any of these incidents had progressed to formal procedures. This did not support the purpose of safeguarding procedures which are to make sure people are protected from present or future harm.

Are community inpatient services effective?
(for example, treatment is effective)

Evidence-based guidance
Staff used a range of evidence based risk assessment tools and approved national guidance to assess each patient's risk relating to falls, malnutrition, blood clots and pressures sores. For example, staff were using the Malnutrition Universal Screening Tool (MUST) to determine patients' nutritional needs,This enabled staff to plan care according to assessed needs. We saw that most risk assessments were updated on a regular basis.

Policies were available electronically via the intranet. We asked to see some policies during our visits to wards but on a number of occasions links to the policies were not working. Paper copies were not available which meant staff may not have access to policies and procedures when they were required.

The décor on the dementia care ward had been designed using evidence based research from Sterling University. This approach aims to improve orientation and stimulation for patients who have dementia. An example of this was a door which was not meant for patients to use had been painted yellow to match the colour of the walls. This had decreased patients' attempts to access the area.

Sufficient capacity
Staff used a range of evidence based risk assessment tools and approved national guidance to assess each patient's risk relating to falls, malnutrition, blood clots and pressures sores. For example, staff were using the Malnutrition Universal Screening Tool (MUST) to determine patients' nutritional needs,This enabled staff to plan care according to assessed needs. We saw that most risk assessments were updated on a regular basis.

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Multidisciplinary working and support
Most rehabilitation patients were admitted from acute hospitals. We did not have any reports of difficulties with transfers or delays. All staff reported good working relationships with community based staff which enabled smooth discharges to take place. Social services staff attended ward meetings regularly to ensure multi agency approaches to meeting patients' needs.

Rowsley ward was nurse led and staffed by physiotherapists and occupational therapists during weekdays. Medical support was provided by local GPs and visiting psychiatrists. Different GPs visited the wards each day to provide day to day general medical support to patients. There was also out of hours GP cover provided by a different provider.

When people are detained under the Mental Health Act 1983 there is a requirement to appoint a responsible clinician (RC). The provider contracted the services of RCs from another NHS Trust. Staff reported the RC was accessible and worked flexibility to provide clinical care to patients.

Staff told us that they had access to a range of specialist and community nurses as part of providing care to people. This included a Parkinson's nurse, tissue viability nurses, and diabetic nurses. We were told that there was good

relationships with other professionals. One patient was currently requiring a specific bandaging technique and community nurses visited the ward to provide support and ensure the right technique was used.

Are community inpatient services caring?

Compassion, kindness, dignity and respect

We observed patients being supported in a sensitive and respectful manner. Staff used curtains and closed doors to ensure patients' privacy and dignity were protected. We observed that a patient who asked for additional pain relief was given this immediately. However another patient waited for some time to receive the pain relief they requested.

Staff used curtains and closed doors to protect patient's dignity and privacy. Patients were supported with sensitivity when they needed personal care. Patients appeared well cared for. Ladies were supported by staff to put on make-up.

Involvement in care

There were ward information packs which informed patients about what they could expect during their stay. This included information about protected mealtimes, visiting and discharge arrangements. There were systems in place to support patients to manage their own medicines if they had capacity to do so safely.

On Riverside ward there was a weekly carers meeting to provide support and information to relatives. Staff told us they tried to make time to speak with relatives and answer any questions available during visiting times.

Some end of life care was given to patients. Staff told us how relatives could stay with patients who were near end of life. Beds could be placed in rooms for relatives and food and drinks were provided.

Trust and respect

All patients we spoke with were complimentary about the staff, describing them as kind and hard working. Patients were offered a choice of meals each day by the housekeeper and patients could choose to eat meals by their beds or in the dining room. We observed staff talking with patients to get to know them and routinely offered them choices. Patients and relatives told us they were given information and explanations about medical care needs and were offered choices.

Emotional support

We observed respectful interactions with patients. On both wards we saw patients engaged in rehabilitation treatments or activities. Rowsley ward was a calm environment where staff spoke in a quiet and kindly manner to patients.

Staff told us there was flexibility around patients being able to go out on leave. This enabled people to visit home for a day, attend social events or spend time with relatives and friends.

Are community inpatient services responsive to people's needs?
(for example, to feedback?)

Meeting people's needs

Each patient had a care plan which described their assessed needs and the support they needed. We found some gaps in the care records where they were not fully completed and not all changes in needs were documented. We saw one a person's current wound management plan, but staff told us the person no longer needed treatment for their wound. Some medication administration records had gaps so it was not known if patients had received their medicines.

The same patient care plans were used throughout the Trust. On Riverside ward, for people with mental health problems, people's care plans were focused on physical healthcare needs and did not include sufficient on their mental health needs.

In general patients' needs were met. We received overwhelmingly positive comments from patients regarding the care they received. Staff were described as wonderful, kind, and caring and patients told us they were well looked after. Rehabilitation patients described the good progress they had made. Patients requiring a soft diet told us there were plenty of options to choose from. On one ward where patients could experience a longer stay a weekly Church service was held to meet patients' spiritual needs. Ministers of other denominations were available on request.

Protected mealtimes meant limited visiting from relatives and healthcare professionals to ensure patients' nutritional

needs were met. A flexible approach had been adopted, so that visitors could support relatives at meal times if considered beneficial. Relatives had mixed experiences of flexibility with visiting times.

One patient told us the ward was "Wonderful" with staff being very "Attentive". Most patients had been admitted from other hospitals and told us their experience at Newholme was good in comparison to others.

Vulnerable patients and capacity

Most people on Rowsley ward had capacity and the care plan confirmed that patients had been consulted about their care. On Riverside ward there were people with dementia who did not always have the capacity to consent to their care. The nurse began the process of assessing a patient's capacity. If required additional assessments were completed by GPs or the consultation psychiatrist (responsible clinician). There were also two nurses on Riverside ward who had a specific role to support other staff with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Occupational therapy and physiotherapy records consistently recorded that patients' consent had been sought.

In one patient's file we saw a 'do not attempt resuscitation' order (DNACPR). This had been discussed with a relative but not the patient. There was no assessment of the patient's capacity to consent or be involved in this significant decision and there were no records to evidence that the decision was made in the patient's best interests.

On Riverside ward, where people were detained under the Mental Health Act 1983, there was an automatic referral process in place for both independent advocates who were both involved in discharge planning for the patient.

Access to services

People were able to go to Newholme Hospital for rehabilitation following illness or injury, and were referred from an acute hospital or by their GP for assessment. This meant that people did not have prolonged stays at an acute hospital and were able to stay closer to home. Rowsley ward was full and staff told us there were occasional waits for beds to become available.

Both wards at were on ground level so easily accessible to patients and visitors with mobility problems. Free car parking was available on site. Staff told us they could access to interpreting services if needed.

Leaving hospital

Ward staff used the 'Jonah system' and held multi-disciplinary meetings to discuss discharge planning. The Jonah system concentrates on the patient pathway with a view to planning discharges from the point of admission. It can also highlight barriers to that discharge so they can be prioritised and tackled by the ward team. Staff told us this was effective.

The care records contained a section dedicated to planning discharges. Some discharges were imminent but the records about planning the discharge were not being completed. One patient told us that their discharge was planned but they did not feel ready to go home. Staff listened to the patients' views and the discharge was delayed.

People told us they were aware of the discharge arrangements in place. They spoke highly of the involvement of a range of staff including the occupational therapist who undertook home visits and the physiotherapists who worked with patients on rehabilitation. We were given examples where aids and adaptations had been put in place at patients' homes to facilitate discharges. Occupational therapists had good links and working relationships with community mental health teams.

On Riverside ward, there was an average stay of between 42 -56 days. Discharges for five patients were considered as delayed discharges. The delays in discharges were attributed to a lack of suitable placements being available. On Rowsley ward the average stay was 24 days and there were no reports of delayed discharges.

Some patients visited Newholme Hospital as day patients after their discharge as Stanton Day Unit provided day care for patients requiring further rehabilitation or for patients who had received care for mental health treatment on Riverside ward.

Learning from experiences, concerns and complaints

We spoke with the matron about how complaints and concerns were handled. It was openly acknowledged that over the past year there had been two complaints on one ward which had not been handled effectively or resolved in a timely manner. This was being addressed. Responses had now been given to complainants and an offer extended to meet with them to answer any further queries. An

improvement plan had been developed to address these issues. Staff meeting minutes indicated that the content of the complaints and the action plan had been openly shared with staff.

Patients told us they knew how to complain but no one we spoke with had raised any concerns. We saw comment cards and boxes in reception areas where patients and visitors could give feedback to the trust on their experiences. Staff told us patients were given information packs which included details of the complaints process.

Are community inpatient services well-led?

Vision and strategy

On Rowsley ward there were plans to extend the working hours of the advanced nurse practitioners to cover weekends. This was at a stage where adverts had been placed to recruit staff. Additionally we were told a longer term plan was in place to extend the hours of occupational therapists and physiotherapists so that patients had access to rehabilitation programmes every day.

Each ward had notice boards to give information to staff and patients about how the ward was operating, for example recording how long it was since there had been accidents with injuries or how many complaints had been received.

Quality, performance and problems

On one ward we spoke to the modern matron. There was a culture of openness and transparency and matron was aware of the areas where improvements were required. There were systems in place to meet with staff and share with them any action plans and introduce innovations or changes which were planned.

Leadership and culture

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Patient experiences and staff involvement and engagement

Each month the Trust Board heard a patient's story and their experiences of receiving care. Staff gave us positive accounts of how these had been received by Board members. The Trust is aspiring to become a foundation trust and has a shadow board of governors established in readiness for this. This included staff and patient representatives.

Learning, innovation, and sustainability

Staff told us that regular 'essential' training included a range of annual updates. We saw that most staff were up to date with required training. Staff who were nurse prescribers told us they received supervision for their prescribing role. All qualified nurses were in the process of completing e-learning training in insulin administration following insulin errors in parts of the organisation. Many staff were yet to complete this, and were required to do so by the end of March 2014.

There was no consistent approach to making sure staff received regular clinical supervision. On one ward staff told us they were regularly supervised. On a second ward staff told us supervisions were held on an ad hoc basis.

The Board had recently made a decision to close one ward at Cavendish Hospital temporarily and transfer patients to Riverside ward. The decision was a proactive one to ensure all patients received the care they needed, but was taken rapidly within a few days without consultation and had caused inconvenience to relatives, patients and staff. The Trust was recruiting staff so that the ward could re-open. One relative told us this had been handled very well and there was continuity of care for patients as staff had transferred to the new ward as well.

Mental health act responsibilities

Information about the service

The Mental Health Act (1983) allows a person to be admitted to hospital for assessment and treatment of their mental health. This imposes restrictions upon their liberty; for example they may not be able to leave hospital without permission, and they may be given treatment against their consent. This means important "safe guards" must be in place to make sure they know their rights to appeal against detention and systems are in place to ensure correct procedures are followed in detaining and treating the person. The Mental Health Code of Practice gives guidance to hospitals on how to do this. We monitor the Mental Health Act and Code of Practice to ensure it is being adhered to.

Riverside Ward is an Older Adults psychiatric assessment ward, based within Newholme Hospital. It has 18 beds. The ward cares for people suffering from either functional or organic illnesses and respite care is provided. When we visited, four of the 15 patients were detained under the Mental Health Act 1983, and one patient on a Community Treatment Order was placed in a residential home. Some of the patients had been transferred from Cavendish Hospital when Spencer ward was temporarily closed.

The ward appeared clean, and the patients were neatly dressed and looked well cared for. Whilst the ward does not have fully single accommodation, male and female areas are well signposted. There were clear attempts to support privacy and dignity.

We last undertook an unannounced visit to the ward in October 2013 and found a number of concerns to which the Trust responded with an action plan.

Stanton day hospital is staffed by nurses, Occupational Therapists, and Care Assistants. People are seen following referral within three weeks. When we visited people were leaving at the end of a busy day and were complimentary about the service.

Summary of findings

We found that there were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act. The detention documents were available and contained all the required information including the views of the patients and the nearest relative as appropriate. For one individual where no nearest relative had been identified by the Approved Mental Health Professional (AMHP) at the point of admission there was no evidence of any further attempts to rectify the situation. This is an important safeguard in ensuring the least restrictive option was considered and the views of people and their nearest relatives were considered. All detentions appeared to be lawful.

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over which organisation's policies and procedure medical staff were working to when on the wards, and duplication of information as a result of case notes from two organisations being used.

We found that detained people were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in adherence with the Mental Health Act Code of Practice.

Individuals' capacity to understand their rights was assessed and recorded by nursing staff. However we found that the format in which the written information on those rights was provided had not been adapted to meet the patients' needs in adherence with the Mental Health Act Code of Practice.

We found that the mental health care plans were rudimentary, formulaic, and focused on process rather than being person centred. There was insufficient recording of the patient's own views of their care being taken into consideration.

Information on the role of the Independent Mental Health Advocacy service was provided. We found automatic referrals to the Independent Mental Health Advocacy (IMHA) service in place for all new patients, though staff will also made referrals for individuals who lacked capacity when necessary. IMHA and Independent Mental Capacity Advocate (IMCA) attended ward rounds, multi-disciplinary team and discharge planning meetings to support people in hospital

We also found evidence of the consideration to less restrictive treatment options including documented discussion by professionals of the use of the Deprivation of Liberty safeguards (DoLS).

Are other services safe?

Governance

There was a service level agreement in place with Derbyshire Healthcare NHS Foundation Trust, which provides the three Responsible Clinicians for Old Age Mental Health Psychiatry services. There had been discussion over the past year to develop a detailed new service level agreement to cover governance arrangements, audits, policies and procedures. The absence of finalised service level agreements meant there were clinical risks that were not being addressed. For example, we found that there were separate patient medical notes and separate files for nursing and other professions. We found that some but not all information from the nursing and professions allied to medicine were copied to medical files. This lack of integration of notes meant there was a danger of a patient's history and plans not being seen in sequence and therefore subject to misunderstanding leading to errors. Staff informed us that they did not agree with the separate patient files. However, they had been told that because the medical staff were employed by another trust, the files had to be kept for clinical governance purposes. Staff were not clear what audits or governance processes the patient's medical files were subject to.

Whilst the responsible clinicians were employed by another trust, staff told us they worked very flexibly and were easily accessible and responded to emails quickly. Access to local GP services was provided on-site. The GPs visited regularly and were readily available. An out of hours service was provided by Derbyshire Health United. We were told that patients did not always come with their notes if admitted from another trust. This was a risk as it potentially caused delays in treatment.

Hospital Managers discharged their duties to review individuals' detention and held full panel meetings when needed. Other than in relation to their powers to review an individual's detention and hear appeals, the Hospital Managers had rudimentary understanding of their duties in relation to admission, transfer, assignment of Responsible Clinicians, referral to the Mental Health Tribunal, provision of information and the victims of crime requirements.

Mental health act responsibilities

There was no explicit training programme for Hospital Managers or those with delegated responsibility. We were informed legal updates, risk assessment and role specific training was not provided.

We were informed there were 10 to 14 Hospital Managers panels a year, but only one resulted in the patient being discharged from detention. The Hospital Managers said they had never used their discretionary power to discharge at any point.

Staffing

We found good staffing levels on the day of the visit, with a ratio of just under two staff to each patient during the day. There was a low staff sickness rate on the unit and it was carrying one vacancy. The use of agency staff was reported to be low. Staff reported that staffing numbers had been low, but senior staff had listened and increased staffing. They were also reviewing the skill mix to increase the numbers of qualified nurses in the future.

Detention

We looked at the files of four detained patients and found that all detention papers appeared to be lawful. We found that there were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act. The detention documents were available and contained all the required information including the views of the patients and the nearest relative as appropriate. We found that Approved Mental Health Professional reports were available in each file.

We found evidence that the Hospital Managers discharged their duties to review individuals detention holding full panel meetings when needed.

Capacity and Consent

A Second Opinion Appointed Doctor (SOAD) provides an essential safeguard for detained patients who do not consent to their treatment. SOADs were requested as appropriate to review the medication treatment plans. The Approved Mental Health Professionals from the Local Authority acted as the second consultee during this process. Occasionally whilst waiting for a SOAD, treatment was given as an emergency under section 62 of the Mental Health Act.

Mental Capacity Assessments were used by nurses to assess if people using the services were able to consent. We found that it was difficult to find recorded capacity assessments by the medical staff particularly on the administration of medication for the first time.

Community Treatment Orders

There was a Community Treatment Order in place for one person currently living in a nursing home, who would not be recalled to Riverside if mental health treatment was required. This shows responsiveness to individual needs.

Section 17 Leave of Absence

Section 17 leave under the Mental Health Act means that people cannot leave the hospital without authorisation from the responsible clinician and with clearly defined conditions relating to frequency , amount, and location and whether the leave is escorted or not. We found section 17 leave was authorised appropriately and had conditions specified. The section 17 leave forms and other relevant documents were not routinely copied to people using the services or their carers; only when they actually went on leave. There was no section 17 leave authorised for emergency medical treatment. Staff said this would be done in retrospect. Most patients on the wards had physical healthcare needs in addition to their mental health needs and so were quite likely to require admission to an acute hospital.

Are other services effective?
(for example, treatment is effective)

Are Mental Health Act Responsibilities safe?

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Mental health act responsibilities

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Are other services caring?

Compassion, dignity and empathy

Staff delivered compassionate and safe care and we observed positive staff interactions with patients. Staff gave examples of making exceptions to protected meal times to give carers the opportunity to feed their relative when they knew this would be more successful. Staff gave an example of providing food and visiting flexibility to a 90 year old carer who travelled on three buses to reach their 91 year old relative. We received positive comments from patients and carers on the day unit and on Riverside ward.

Involvement in care

Care plans did not record information about the person's views on their care or the family and carers involved in supporting them. The ward did not hold community meetings for patients to comment on the ward, this was due to some patient having dementia. Carers were able to drop in and ask for advice. A weekly carers group was run to help educate carers about the care pathway. The Stirling Dementia Centre initiatives were being implemented on the ward. The ward was well decorated with impressive examples of patient artwork for which it had received a Kings Fund Award.

Trust and respect

On the Riverside ward we observed people being escorted outside, church services and one to one time with staff. Occupational Therapists were developing a spirituality pack to be rolled out across the Trust. The ward had also forged links with the local community, in particular education providers. This meant they could provide a wider range of activities including singing and tai chi.

Emotional support

We heard from staff and observed that the ward has a good timetable of therapeutic activities on Stanton Day Hospital On the day of our visit people had built a coat of arms as part of their self-awareness exploration.

Are other services responsive to people's needs?

(for example, to feedback?)

Governance

We were informed that the Associate Hospital Mangers on the Mental Health Act Committee were not consulted over the recent closure of a ward at Cavendish hospital and the move of detained patients to Riverside.

There were systems in place to organise Hospital Managers hearings and Independent Mental Health Review Tribunals. However we found no systems in place for referral of individuals on section 2 who lack capacity to appeal. Section 2 allows a person to be admitted to hospital for an assessment of their mental health and receive any necessary treatment; they do not have the right to refuse treatment. Ward staff told us there was no automatic manager's review on renewal which was inconsistent with the documented records.

Rights

Detained people were given their rights under section 132 of the Mental Health Act by the nurses, so that they knew how to appeal against their detention. Patients' rights were being represented where patients did not understand. Copies of rights were given to carers as required. The Code of Practice requires that rights are given in a format that can be understood. We did not see evidence of formats such as pictorial, audio or visual being used to enable people to understand.

Advocacy

The ward contained information about detained people's rights to an Independent Mental Health Advocate (IMHA) or Independent Mental Capacity Advocate (IMHCA) to support them. Staff stated there was an automatic referral process in place for both IMHA and IMCA who were both involved in the multi-disciplinary team (MDT) ward rounds. IMHAs were involved in section 117 aftercare planning for detained patients and tribunal hearings.

Are other services well-led?

Leadership

Staff told us they felt supported and well led. They felt there was good Board level visibility on the ward giving examples of directors working on wards. They said there was a clear vision of organisational objectives especially in relation to the NHS safety thermometer. One staff group said that

Mental health act responsibilities

changes in the management structure has provided greater access to resources and they now feel listened to when they voiced concerns. Regular updates from the Chief Executive were received and staff felt consulted about change. Staff said they were proud to work for the Trust, many choosing to work and stay there for a long time. They said they were proud of the compassionate individualised care they gave to people and their relatives.

Training, supervision and appraisal

Staff told us they had access to clinical and managerial supervision and there were senior staff who had been trained as clinical supervisors. They reported they had regular individual and group supervision. However we found that the uptake of supervision was mainly ad hoc and informal. There was a good appraisal system in place and the ward achieved 100% completion of staff appraisals. Staff continuous professional development plans were based on appraisal.

Staff said they had Mental Health Act and DoLS training last year which had been accessed via the local Mental Health Trust. The Trust also had a dedicated Mental Health specialist trainer. We observed that staff had access to the Mental Health Act and the Code of Practice. All staff had completed their mandatory training programme, apart from those on leave. A Leadership development programme for was in place.

Partnership Working

Staff reported good partnership working with the local authority, the local acute trust and the mental health trust. Members of the Mental Health Act Committee were unsure if they were part of the Mental Health Act Partnership Working Group that monitors the Implementation of the Mental Health Act across the local health economy.