Care Quality Commission

Nottinghamshire Healthcare NHS Foundation Trust

Wards for older people with mental health problems

Inspection report

Duncan Macmillan House
Porchester Road
Nottingham
NG3 6AA
Tel: 01159691300
www.nottinghamshirehealthcare.nhs.uk

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Wards for older people with mental health problems

Inadequate 

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services.

We have rated safe, effective and well led following this inspection. The rating at the previous inspection of March 2022 was requires improvement, this inspection shows that the rating has gone down.

We inspected the Wards for older people with mental health problems as part of this inspection. The trust has 5 wards across 2 locations, Highbury Hospital in Nottingham and Millbrook Hospital in Mansfield. We visited the following wards:

- Highbury Hospital - Silverbirch ward for older people with mental health problems. This ward was for patients living with dementia. 18 beds (male and female)
- Highbury Hospital - Cherry ward for older people with mental health problems. 16 beds (male and female)
- Millbrook Hospital – Kingsley ward for older people with mental health problems. 20 beds (male and female)
- Millbrook Hospital – Orchid ward for older people with mental health problems. 11 beds (female)

Our rating of services went down. We rated them as inadequate because:

- We found missing signatures on the administration of patient's medicines.
- We found examples where a patient's sedative medication had been administered against the prescribed dose and against medical advice.
- We observed examples of moving and handling that put patients at risk of harm.
- The ward for patients living with dementia did not follow national guidance in its environment.
- We were not assured that falls risks were routinely identified effectively, and mitigation or plans how to manage the risk.
- There was an inconsistent approach on which documentation to use when recording patients risks.
- There was an inconsistent approach in the completion of charts that were being completed by staff.
- We found inconsistencies on the provisions of informing informal patients of their rights under the Mental Health Act.
- There were still wards in the service that did not have single ensuite rooms and dormitories were still in place on 3 out of the 4 wards visited.
- There were documents for staff to complete on each ward we visited. We were not assured that data collection was used for specific reasons, such as stool charts or self-care charts when patients did not present risks in these areas.
- We were not assured that dietary intake of patients was being effectively completed by staff.
- We were not assured that management had timely oversight over data collected by staff regarding patient risk.

Our findings

However:

- We found activities taking place on 2 out of 4 wards visited.
- Staff were receiving supervisions from there managers and felt supported
- Clinic rooms were stocked, organised and clean.

How we carried out the inspection

During the inspection we:

- spoke with 12 patients
- interviewed 11 staff members
- reviewed 18 patient care plans
- Looked at 4 clinic rooms
- Reviewed 48 patient medical cards
- visited 4 wards
- reviewed handover documents
- Reviewed patient records on food and fluid and self-care
- Observed staff interacting with patients
- reviewed section 17 leave documentation on all wards
- looked at environmental risk assessments.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

A patient told us that they don't like sharing a room.

People told us that the ward is noisy with the building work, and they didn't know what was being built.

People told us they were confused which room they could sit in.

People told us that sometimes they don't have their own clothes and have someone else's.

People told us that staff were kind and caring.

People told us that there are some activities.

Our findings

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained. However not all wards were fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We reviewed environmental risks assessments of all wards we visited, and all potential ligature risks had been mitigated. However, whilst on Orchid ward we found an open communal bathroom which should be locked when not in use which meant it could have been easily accessed by patients unsupervised. At the time of our inspection there was a patient identified as at risk of using a ligature. We alerted managers of this, and the door was promptly locked.

Staff could observe patients in all parts of the wards. There were curved mirrors in place to allow staff to be able to observe all areas. The wards had closed circuit television (CCTV) apart from within patient's bedrooms and bathrooms. On Kinglsey ward there was no CCTV, but we saw mirrors to allow for staff to be able to fully observe the ward.

We found no clear signage on the wards to support people living with dementia. On Silverbirch ward we found patients were confused about the location of some rooms. We found no signage directing or informing them how to access rooms. The signs we did see did not comply with best practice in dementia friendly environments. We observed a patient supporting another patient into a toilet as they were confused where the toilet was. No staff were present to intervene to support the situation. We observed a male patient supporting a female patient into their room as the female patient was confused where their bedroom was. Staff were able to intervene and support the female patient before they fully entered their bedroom.

During our visit on Silverbirch ward we observed that due to a change of rooms between the activity room and the lounge (where the lounge became a dining room) staff had placed chairs at the end of a corridor where we found patients congregated instead of using the lounge. During our inspection, we observed a patient, sat on these chairs, who became distressed and agitated, verbally assaulted staff and other patients but staff did not intervene or redirect the patient to another environment. We were not assured that staff kept this area as safe as possible, and it posed a risk to patient who were confused about the environment and the new location of the lounge.

Three wards did not comply with guidance on shared sleeping arrangements. All wards were mixed sex accommodation except Orchid ward which was female only. During the inspection we found that Cherry, Kingsley and Orchid did not comply with national guidance regarding shared sleeping arrangements and these wards had dormitories for between four and six patients. The dormitories were male and female only. The dormitories contained lockable storage facilities for patients to store personal possessions. Staff and patients used privacy curtains to ensure patients' privacy and dignity when using the bathrooms located on corridors. All wards except had female only lounges and designated bathrooms for males and females. There were plans in place to eradicate dormitories. The Trust had informed The Care Quality Commission (CQC) that improvements to the Millbrook Hospital site will be made to accommodate three older adults' wards in single room accommodation. This is planned for completion 2025.

Our findings

Staff had easy access to alarms and patients had easy access to nurse call systems. We heard patients using their alarms on all wards visited and saw that staff wore alarms including agency staff.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished. However, some of the wards were not fit for purpose.

The **National Institute for Health Research (NIHR)** recommends that wards that have dormitory accommodation should make specific plans for the management of infection control in these areas. We saw that these dormitories had beds that were two metres apart which met NIHR recommendations. Dormitories were clean, however, whilst on Cherry ward we found curtains that provided privacy for patients were dirty and stained. Managers did not know when they were last changed and there was no record of it. These curtains were reported to managers during the inspection and were changed. Whilst on Orchid ward in one of the dormitories we found a cup of toothbrushes for the patients, they were not labelled and posed a risk of cross contamination on the patients using them.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records on each ward we visited and found them to be completed. However, on Cherry ward staff were not able to locate the cleaning records. We found ward paperwork on this ward to be disorganised and staff found it difficult to locate current and completed records.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We reviewed all clinic rooms on each ward we visited. Staff kept these areas clean and organised. Temperatures of each room was recorded, and all medicines were locked and stored correctly. However, when we reviewed the clinic room on Orchid ward, we found that a cupboard which stored needles was left unlocked when it should be locked at all times. Patients had access to this room but only when supervised, this room held the examination table for physical examinations.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. We reviewed staffing data across all wards within the service. No shifts were short staffed. The wards had enough qualified and unqualified staff as planned.

We found that the service overall had a challenge in recruiting nurse associates and had vacancies for 21.92 full time equivalent staff. The trust had identified this challenge and had placed staffing issues on their risk register and rated it as high. Managers had placed staffing on their risk register and rated it as a high risk which acknowledged the risk to overall quality of patient care if shifts were filled with agency staff. Managers conducted daily comprehensive reviews in workforce planning meetings which reviewed staffing needs for each ward. This meant staff could be moved between wards if needed to meet patient need. Work was ongoing with recruitment and the trust had over recruited to band 6 nurse posts to fill the vacant posts as an interim measure. Whilst there were enough staff to cover duties, staff told us that it was “just manageable.”

During our visit on Cherry ward there was a significant impact on staffing due to a serious incident that had occurred on 5 November 2023 where staff had been suspended pending investigation into the concerns raised by the incident. Shifts

on Cherry ward had been filled by a mix of bank staff and staff from other wards in the service. Ward managers told us they had created flash cards that contained key information about each patient which staff who were unfamiliar to the ward used. Staff who had come from other wards told us that they understood the needs of the service and enjoyed the change of work and saw it as good experience.

The ward manager could adjust staffing levels according to the needs of the patients. Managers of the service conducted regular comprehensive reviews through the trust's workforce planning team. Daily demand meetings were held for each ward within the service. Ward managers and service managers attended to discuss any risks for the previous 24 hours and any issues arising including staffing issues and could move staff between wards to meet patient need. On Cherry ward, no one attended the daily demand meeting on the morning we visited the ward. Staff told us that this was “ok” and that the service manager would know about any issues. We were not assured that information would be passed to the service manager as the ward staff who would attend were not on shift at the point of the meeting. Staff we spoke with at the time, did not know how information got to that meeting. However, we did see examples where there was a need to adjust staffing levels and ward managers could contact service managers for support.

Staff shared key information to keep patients safe when handing over their care to others. We observed one handover on Silverbirch ward and one on Orchid ward and reviewed paper copies of handovers on the other wards we visited. The handovers we observed gave the staff coming onto shift enough information about the previous shift to understand the current risks and areas of concern to the next shift. The handover documents we reviewed had enough information on them to support staff to run the shift.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency.

The trust had put in place medical cover 24/7 for all wards in this service.

Mandatory training

Staff had not always completed and kept up to date with their mandatory training. We reviewed the training data for the service. However, given we found issues with how staff recorded enhanced observation we found that training on observing patients was 67% on Kingsley ward, and Cherry ward. This meant not all staff knew how to carry out observations of patients effectively to keep patients safe.

The mandatory training programme was not always comprehensive and met the needs of patients and staff. We reviewed the services’ training matrix and found no evidence that training in dementia was offered by the trust. Management told us that within their block training which is for the service included 2 days on dementia. We did not see this recorded on the training matrix we were given. Silverbirch ward was a ward for people with dementia. This could mean that staff would not have the necessary skills to be able to support and understand patients with this condition on this ward.

Assessing and managing risk to patients and staff

Staff assessed risks to patients and themselves. However, staff did not effectively include mitigations in the risk assessments to prevent future occurrence.

Assessment of patient risk

Staff completed risk assessments for each patient, using a recognised tool, but did not always ensure that effective mitigations were in place to prevent risks reoccurring in the future. We found charts that recorded food and fluid, bath/

shower use and stool charts. In the kitchen areas we found information about dietary needs. However, although a range of charts were in place, we found that not all charts were completed effectively and consistently over all wards. For example, we found bath and shower charts on Orchid ward that were completed for all patients including patients who were there on an informal basis and were independent with their self-care. Staff we spoke with told us that it was standard practice to complete these although staff didn't know exactly why they were needed.

On Orchid ward we reviewed stool charts for 11 patients between 23 October 2023 and 10 December 2023. This meant that every patient was being recorded when they when they had a bowel movement. We did not find any correlating information that justified the need for all patients to have this recorded. For instance, if a patient was as risk of constipation that could cause adverse physical effects, then the risk would require close monitoring. We did not find this reasoning. We tracked one patient record and found that this patient had not had a bowel movement for 4 days. Within the document it was clearly highlighted that if a patient had not had a bowel movement in more than 3 days to report this to the medical team and nurse in charge. We found that no one had followed this up for this patient, it was not written in their daily notes or in handover documents. We were not assured that the assessed risk was being managed effectively even though monitoring charts were in place.

Staff understood the needs of the patient group. For example, the service monitored falls well. We saw that service managers collated fall data each month from each ward, analysed factors which included, the time, location, frequency and causes of falls. We saw that patients at risk of falls had crash mats near their beds, pressure mat alarms were in place and observation levels were heightened. We saw that patients who were at risk of a fall, wore a coloured band on their wrist to alert staff to the risk. However, due to the incidents we identified during our inspection, we were not confident the data collected was used in the best way for the teams to prevent future falls in an individualised way. This meant there was not a robust plan in place of how falls could be reduced across the service.

Management of patient risk

Staff knew about risks to each patient but did not always act to prevent or reduce risks and prevent reoccurrence.

Whilst on Orchid ward we observed a patient who required a walking aid to help mobilise. We saw them carry it at the side of them not utilising it effectively, the patient walked past registered staff and they did not intervene. We observed this to happen again after informing the staff it was happening and they did not intervene at that point either.

We were not assured that falls risks were routinely identified effectively, and mitigation or plans how to manage the risk. We were informed of one serious injury to a patient on Cherry ward that occurred on 30 November 2023. A patient on 5-minute observations had fallen in the bathroom and had broken their hip. Staff told us this incident had not been investigated.

We reviewed the patient's daily notes and found the doctor’s entry who attended the incident 20 minutes following the fall and recorded the patient was experiencing slight tenderness to the hip. The entry had been recorded on a nurse's login due the doctor not having access to the system. This went against the trusts policy. The patient was seen by a physiotherapist at 2.30pm, 10 hours after the fall, which followed policy on post fall check-up. The patient was found to be experiencing severe pain and sent to hospital where it was found they had broken their hip. We were not assured that the patient's risk of falls had been identified and mitigated effectively. The risk assessment stated they were at risk of falls, highlighted when incidents had occurred, but had not recorded how staff would mitigate future occurrence or manage incidents related to future falls. This meant the 5-minute observations required to prevent a fall, had not been effective.

Our findings

We found an incident on Silverbirch where a patient had been found following an unwitnessed fall with a bloody wound on their head and a dent in the wall where they had fallen. Staff told us the patient was at risk of falls and knew the reason for the type of incident that could occur. We found in the patient's daily notes that staff were unaware of when this incident had happened and approximated that it was 4 am and had recorded this entry at 6.52am. We found that the doctor had seen the patient at 10.33am and stated staff were required to closely monitor vital signs. There was no record of follow up vital signs or what action staff should take to prevent future occurrence. This meant, staff were not proactive in preventing falls despite the knowledge there was a high risk of this happening.

We reviewed food and fluid charts on each ward we visited. We found them all to be inconsistent in their recording. On Cherry ward we found a food and fluid chart that was completed on a scrap piece of paper, where staff had not used the correct document, and this had not been challenged. In addition, on all wards, staff placed completed charts in a tray for the ward administrator to upload into the electronic patient record. This meant it was not reviewed by senior staff in a timely manner to identify issues with food or fluid intake of patients.

We reviewed 11 food and fluid charts whilst on Kingsley ward. We found an example of a patient who had received 1700mls of fluid over 3 days. The document did not state how much fluid the patient required in a 24-hour period. We found this had occurred on 3 other fluid intake charts. Therefore, we were not assured that staff had escalated the intake to the relevant professional.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. All care records were uploaded onto the trusts electronic systems. Staff had access to handheld devices which recorded daily notes. Each staff member had personal login to access patient information. Staff on each ward had access to computers on the ward. We found that each ward had administration support to upload documents onto patient's clinical records.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. However, these systems were not effective to always administer medicines safely. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe and administer medicines safely. We reviewed patient's medicines charts on all the wards we visited. All had regular pharmacy audits. On Cherry ward we found 4 patient medicine cards where signatures were missing. On Orchid we found 2 patient medicine cards where signatures were missing also. This meant that people would not be able to tell if the medicine had been taken. One example of a missed signature was against a critical epilepsy medication. We found that this had been highlighted like all the other missing signatures by the pharmacist, but no action had been taken by ward managers or other qualified staff members.

Staff did not always complete medicines records accurately and kept them up to date. The service did not always ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. On Silverbirch ward we found one example where a patient was given medication which did not follow the prescribed dose. We were told by a qualified member of staff that when patients displayed behaviour that challenged, they would "top them up with lorazepam." We reviewed medicines cards and found no examples of this occurring in the weeks prior to our inspection. However, we did find some evidence to indicate medication had been used in this way. One member of staff told us in one example, (the patient who had been given Lorazepam) would not have had adverse effects from the medicine taken

Our findings

but would have been more ‘sedated’. The patient had been prescribed Clonazepam and had been prescribed Lorazepam when required. Both prescriptions had clear instructions not to have a mixture of both within two hours of each other. We found 4 occasions where this had been done in August 2023 and 3 occasions that had been done in October 2023. This showed that qualified staff were not administering according to the patient's prescription.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers investigated incidents but did not always give feedback to staff and share feedback from incidents outside the service. During our inspection we were informed that there had been a serious incident on Cherry ward in November 2023. Managers had started an investigation. During the investigation managers found that members of staff had not been conducting or recording observations prescribed to the patient involved. The investigation found that staff members had falsified records to show that observations had been done but on reviewing of close circuit television (CCTV) the observations had not happened. Staff had been suspended due to this serious incident and at the time of our inspection remained in progress.

The trust had other serious incidents, which caused severe harm where observations were falsified within other services at the same location as Silverbirch and Cherry ward. Staff in this service were aware that an incident had happened on Cherry ward and managers checked the completion of observation records but did not know why.

Managers debriefed and supported staff after any serious incident. Staff we spoke to told us that management were supportive and that debriefs did occur after incidents.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Care needs were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients’ assessed needs, but were not always personalised, holistic and reflected the likes and dislikes of the individual.

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

Staff regularly reviewed and updated care plans when patients' needs changed. We found that reviews happened on a multidisciplinary basis, patients had ward rounds regarding their care. We saw notes in patients care records where changes have been made. We saw this then to be referred to in handovers of staff.

Our findings

Care plans were not always personalised, holistic and reflected the likes and dislikes of individuals. We reviewed care plans on the wards we visited. We found the plans to have information about needs of the patients and risks posed to them. However, there was no holistic viewpoint of the patient as a whole. We did not find examples where a patient's history and personal preferences were reflected. The service had “About me” documents contained within the patient's files, but they were stored separately from care plans and not linked to each other. We were unable to find examples of completed “About me” plans. This information would be important when supporting the patients on all wards and in particular Silverbirch as they were living with dementia. This meant staff would not know how to personalise care for each individual.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. They did not always ensure that patients had good access to physical healthcare and supported them to live healthier lives.

Staff provided a range of care and treatment suitable for the patients in the service. All wards had activity co-ordinators who devised activities to occupy patients during the day (such as quizzes, drawing, card making). The activities offered were varied and patients were offered the opportunity to attend. Some wards had activity rooms where patients could engage in activities with staff, or on their own, and some activities used the lounge areas. We observed activity staff engaging positively and in a caring way with patients. However, staff told us the activities delivered were not based on the preferences of patients and did not link to the therapeutic needs or care plans of individuals. There was a lack of activity on Silverbirch and Cherry ward.

Staff met patients’ dietary needs and assessed those needing specialist care for nutrition and hydration. On Silverbirch ward we were not assured that patient's dietary intake was being completed effectively. We observed a lunchtime and although extra support staff were brought in to assist patients due to their needs. However, staff did not effectively redirect patients to be seated for as long as possible to finish their food. We were not assured there was sufficient flexibility in the timing of the lunch hour to accommodate the needs of patients who had difficulty remaining seated. Staff told us that they tried to complete food charts but his was not consistent or accurate due to the increased wandering seen by the patients during the meal. Ward managers told us that they were trying to improve this.

Staff used recognised rating scales to assess and record the severity of patients’ conditions and care and treatment outcomes. We found examples of completed NEWS2 (national early warning score) within patients care plans who had shown deterioration of physical health.

Managers used results from audits to make improvements. When reviewing audits made by pharmacy on Silverbirch and Orchid we found that managers had not acted on what was identified.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers did not always make sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the patients on the ward. We found there was a full MDT for all wards in the service which included dietitians, physiotherapists, occupational therapists and activity co-ordinators.

Our findings

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. We were not assured staff knew how to support people living with dementia as this was not included in the mandatory training for the service.

We observed on Cherry ward, a staff member drag lift a patient who was unsteady on their feet. The patient had tried numerous times to get off the chair and each time the staff member drag lifted under their armpit to re position and stop the patient from getting up. The same staff member was observed to place their foot in front of the patient's feet to stop them from moving. We alerted the ward manager, and they removed the staff member from working with that individual.

Managers supported staff through regular, constructive appraisals of their work. We reviewed the service appraisal figures. We reviewed data for all wards for the month of September 2023 as we did not receive the data for November 2023. Silverbirch had a low compliance at 66% of staff that had received an appraisal compared to the other wards who were achieving higher results.

We reviewed staff supervision data for the month of September 2023, and we found that each ward achieved less than the previous month. Silverbirch ward had a low compliance at 57.5% achieved for clinical supervision and 47.6% achieved for managerial supervision. The ward had a new ward manager in place, and we saw their plan to tackle appraisals and supervisions for staff.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Informal patients knew that they could leave the ward freely. However, we found that all wards we visited apart from Kingsley ward had posters displaying this to patients. Due to the nature of patient's illness, we found whilst on Silverbirch ward that patients didn't understand that they couldn't leave, and we observed people going towards the entrance door to leave the ward and became distressed when they couldn't leave. We observed staff re-direct patients when this occurred, but we are not assured that due to the lack of dementia friendly environment this would have had a negative impact on patients.

Is the service well-led?

Inadequate ↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed but were not always visible in the service.

Our findings

Although the ward managers were present on the wards, we did not always see them being visible to patients. However, the ward managers were able to give us detailed information about the patients who they were caring for. Senior leadership had become more visible to patients and staff following the serious incident on Cherry ward. However, staff told us that sometimes this wasn't the case and that they had seen 'some' a few times.

Managers did not have the experience to demonstrate they had full and effective oversight of safe care delivery. We found that managers were not aware that observation records had been falsified and that records across all wards in the service were inconsistent. We were not assured that service leaders used data to prevent incidents occurring in the service, such as falls. We were not assured that data collection was used for specific reasons, such as stool charts or self-care charts when patients did not present risks in these areas.

Culture

Staff felt respected, supported and valued. Staff on Kingsley ward told us how supported they felt by managers. Staff on Silverbirch ward told us they found the new manager supportive.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

We have reported on how data collection took place but analysis of this did not always help to ensure safe and effective care delivery. We found examples where oversight of data was not used to prevent incidents or where data was used routinely, instead of in an individualised way.

We found each ward had their own systems and processes for managing the day-to-day operations of the ward. This meant that when staff moved between wards, they were not always familiar with how these systems and processes operated.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

We have reported on areas where risk was not always identified in a timely way and action taken to prevent future occurrence.

Learning, continuous improvement and innovation

The trust informed us of improvement groups that have been put in place to address the issues that had been identified from previous inspections in other services. Senior leaders from the trust had decided to apply these improvement groups to this service to ensure similar themes and issues could be addressed. However, we were not assured that senior leaders always had a proactive approach to service improvement, as the improvement groups were implemented after a serious incident that had occurred in this service.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Wards for older people with mental health problems

- The trust must ensure that staff are competent to complete observation duties as per trust policy. (Regulation 12).
- The Trust must ensure medicines are administered in accordance with any prescriber instructions. (Regulation 12)
- The Trust must ensure comply with guidance from the department of health about the prevention and control of infections. (Regulation 12)
- The trust must ensure that the environment on Silverbirch ward is reviewed to ensure that the health safety and well fare needs of patients is met. (Regulation 12)
- The trust must ensure that leaders of the service have the rights skills, knowledge and experience to have oversight of care delivery. (Regulation 17).

Action the trust Should take to improve:

Wards for older people with mental health problems

- The trust should ensure that is managed across the service in line with the Department of Health Code of Practice.
- The trust should ensure staff follow treatment plans when caring for those patients at risk of falls.
- The Trust should ensure that information for informal patients to know how to leave is clearly displayed on the entrance doors on each ward.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 4 other CQC inspectors. The inspection team was overseen by an Operations Manager and a Deputy Director.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance