Inadequate

Gateshead Health NHS Foundation Trust

# Wards for older people with mental health problems

## Quality Report

Trust Headquarters
Queen Elizabeth Hospital
Queen Elizabeth Avenue
Sheriff Hill
Gateshead
NE9 6SX
Tel: 0191 482 0000
Website: http://www.qegateshead.nhs.uk/

Date of inspection visit: 07-09 December 2016
Date of publication: 28/06/2017

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RR7EN | Queen Elizabeth Hospital | Cragside Court | NE9 6SX |
| RR7EN | Queen Elizabeth Hospital | Sunniside Unit | NE9 6SX |

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

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

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

# Summary of findings

## Ratings

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

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

**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

## Contents

# Summary of findings

## Overall summary

We rated wards for older people with mental health problems as inadequate because:

- Cragside Court and Sunniside Unit were not safely identifying, assessing and mitigating risks to patients or staff. Staff did not review and update individual patient risk assessments regularly. Staff on neither ward had identified and assessed all ligature risks or identified how to mitigate the risks posed by potential ligature anchor points. Neither ward had undertaken an environmental risk assessment. Sunniside Unit was not regularly monitoring the temperature of fridges used to store medication. Cragside Court did not have enough personal alarms for all nursing staff to have one each.
- Craigside Court and Sunniside Unit did not deploy a sufficient number of staff who were adequately trained, supervised and appraised. Staff sickness rates and turnover rates were high. Appraisal and supervision rates were low. Mandatory training compliance was low. Not enough staff were up to date with refresher training in cardiopulmonary resuscitation. Qualified staffing levels were consistently lower than planned on Cragside Court.
- Care was not planned effectively on Cragside Court and Sunniside Unit. Care plans were not holistic, personalised or reflective of the patient's voice or preferences. Patients and carers were not partners in their care. Care records were disorganised and documentation had gaps which meant staff could not rely on records as a defensible account of the care being provided.
- The care and treatment at Cragside Court and Sunniside Unit did not seek to maximise the independence of patients. The wards had a number of blanket restrictions that applied to all patients regardless of their individual needs. Staff did not provide activities at evenings and weekends. Patients could not access facilities at all times to make their own hot drinks and snacks. The ward environments were 'clinical' and were not adapted to support older people and people with dementia.
- Cragside Court and Sunniside Unit did not have an internal process of assurance which regularly identified and addressed areas of concern in the service. Managers had no oversight of staff supervision. There was no audit process for care records, care plans and risk assessments to identify gaps or improve quality. There was no audit of incidents to identify inconsistencies between reports and care records. Morale was mixed on both wards and several staff told us that there was a culture on the wards which needed to improve.

# Summary of findings

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

**Are services safe?**

Inadequate

We rated safe as inadequate because:

- Staff on Cragside Court and Sunniside Unit did not recognise concerns regarding environmental risks. Staff had not identified and assessed all ligature risks. Neither ward had clear lines of sight. This put patients at risk because it made it difficult for staff to observe patients in some parts of the ward. This included places where there were potential ligature anchor points that had not been mitigated, or in some cases identified, by an appropriate risk assessment and action plan. Neither ward had an environmental risk assessment to identify environmental hazards and the actions required to mitigate these.. Cragside Court did not have enough personal alarms for all nursing staff to have one each.
- Staff on Craigside Court and Sunniside Unit did not review or update risk assessments regularly. Staff documented incidents of restraint on the incident reporting system but not in risk assessments or care plans. There was little evidence that staff reviewed incidents and learnt lessons from these reviews.
- Staff did not report and record incidents of the use of rapid tranquilisation and did not follow trust policy following its administration to ensure patients were safe.
- There was a substantial use of bank staff and a high sickness rate on both Cragside Court and Sunniside Unit. The safe staffing shift fill rate on Cragside Court between July – October 2016 was 76% for qualified staff, and was 142% for nursing assistants. The ward had a high turnover of staff. Both wards had low compliance with mandatory training including cardiopulmonary resuscitation refresher training. This placed patients at risk because it meant that staff would not be able to respond to patients in a medical emergency. On Cragside Court only 44% of staff had received refresher training in safeguarding adults and safeguarding children.
- Cragside Court and Sunniside Unit did not have lounges designated for females only as required in Department of Health guidance on eliminating mixed sex accommodation. This meant that patient dignity was not upheld.
- Cragside Court and Sunniside Unit had a number of blanket restrictions, such as locked doors and restrictions to food and drink, with no evidence that these were regularly reviewed.

# Summary of findings

- Sunniside Unit was not regularly monitoring the temperature of fridges used to store medication. In both units the temperature of fridges used to store patients' food was not monitored. This meant that patients were at risk of being served food which was unsafe.
- Not all staff on Cragside Court and Sunniside Unit knew or understood the duty of candour.

**Are services effective?**

**Requires improvement**

We rated effective as requires improvement because:

- Care plans used on Cragside Court and Sunniside Unit were not holistic, personalised or reflective of the patient's voice or preferences.
- Neither unit had multidisciplinary meetings which included all professionals where they could discuss the needs of patients as a team and discuss approaches from different disciplines to give a holistic approach to patient care
- Physical health monitoring on Cragside Court and Sunniside Unit was inconsistent. Staff on the two wards did not always monitor the physical health of patients adequately. This meant that they might miss physical health problems that could be treated if picked up early.
- Care records were disorganised. Records had papers which fell out when the file was opened. When staff could not locate specific documents in files, we were told that it was likely the papers had been lost.
- There was no evidence of psychological interventions or interventions which followed national best practice on Sunniside Unit. The care delivered in both units was one in which staff supported patients with personal care, and administered and monitored the effects of medication in an inpatient setting.
- Cragside Court and Sunniside Unit had low appraisal rates. Neither ward monitored or maintained a record of attendance for supervision sessions. Both units offered supervision sessions once a week during the day. This meant night staff would always miss supervision sessions.
- There was no evidence that staff on Cragside Court and Sunniside Unit regularly considered or assessed patients' mental capacity for decisions other than those related to the deprivation of liberty. Staff could not locate mental capacity assessments for two out of three patients subject to deprivation of liberty safeguards.
- On Cragside Court only 44% of staff were trained in the Mental Capacity Act.

# Summary of findings

## Are services caring?

Good

We rated caring as good because:

- We observed kind, caring and respectful interactions between staff, patients and their carers on both Cragside Court and Sunniside Unit.
- The regular staff on Cragside Court and Sunniside Unit had a good knowledge and understanding of individual patients and their needs. On Sunniside Unit we saw there was an open-door policy which encouraged interaction between staff and patients. We observed handovers on both units which were comprehensive and respectful of the individual needs of patients.
- Patients and carers gave us mostly positive feedback about both staff and the service on Sunniside Unit.
- Carers gave us mostly positive feedback about staff and the service on Cragside Court.
- Cragside Court and Sunniside Unit had an 'opt-out' system for referral to the independent mental health advocacy service which meant that all detained patients were referred to the service unless patients specifically stated they did not want this to happen.
- Sunniside Unit held a patient forum chaired by the psychiatrists and there was evidence of good patient participation, although the meeting was not regular.

However:

- There was limited evidence of patient and carer involvement in care planning on both Cragside Court and Sunniside Unit. Patients on both units and their carers did not receive a copy of their care plans.
- Two carers gave us feedback about the service which they had felt they could not raise with staff. The service was not always encouraging a culture where carers could give honest and frank feedback.

## Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Cragside Court and Sunniside Unit were plain, clinical environments which were not adapted to meet the needs of older people. Cragside Court which was a unit for people with organic mental health problems did not meet national guidance on dementia friendly wards. The wards did not have a

# Summary of findings

beverage bay. This meant that patients could not make their own hot drinks or snacks. Neither ward had a portable telephone available for patients to make a call in private. There was limited personalisation of bedrooms on both wards.
- Cragside Court and Sunniside Unit did not provide activities in the evenings and at weekends.
- Cragside Court and Sunniside Unit had limited information displayed to advise patients and carers on how to make a complaint.
- Cragside Court and Sunniside Unit were not actively monitoring the number of delayed discharges although staff were aware that these were happening.

However:

- Bed occupancy rates on Cragside Court and Sunniside Unit were within the Royal College of Psychiatrists' recommended level for adult inpatient mental health wards.
- The average length of stay on Cragside Court and Sunniside Unit was low and was less than the last publically available national average for wards for older people with mental health problems.
- Cragside Court and Sunniside Unit had a range of rooms available to support treatment and care. Both units were accessible to people using wheelchairs.
- Cragside Court and Sunniside Unit both had an activities coordinator who provided activities throughout the week.

**Are services well-led?**

**Inadequate**

We rated well-led as inadequate because:

- Cragside Court and Sunniside Unit did not follow a model of care or service delivery that would be expected of an old age mental health service.
- Cragside Court and Sunniside Unit did not have an internal audit or assurance process to identify inconsistencies between incident reports made by different staff members or inconsistencies between incident reports and care records.
- Staff on Cragside Court and Sunniside Unit did not have a clear and consistent understanding of what constituted an incident of rapid tranquilisation.
- Cragside Court and Sunniside Unit did not have an internal audit or assurance process to identify issues in care records including unexplained gaps in documentation, gaps in reviews and updates of assessments, and missing documents.

# Summary of findings

- Cragside Court and Sunniside Unit did not have a process which reviewed the quality of care planning and risk assessments.
- Cragside Court and Sunniside Unit had low mandatory training compliance and low appraisal rates. Neither ward actively monitored staff supervision rates or ensured that all staff who were regularly employed received regular supervision.
- Cragside Court and Sunniside Unit were not able to provide detailed information related to incidents on the unit.
- Cragside Court and Sunniside Unit had high sickness rates, and a high use of bank staff which did not correspond to the low vacancy rates.
- Cragside Court had consistently low safe staffing shift fill rates for qualified staff over a four month period.
- Staff morale on Cragside Court and Sunniside Unit was mixed with several staff citing that the wards had a culture which needed to improve.

# Summary of findings

## Information about the service

Cragside Court and Sunniside Unit were two wards for older people with mental health problems provided by Gateshead Health NHS Foundation Trust.

- Cragside Court was a 16 bedded ward for older people with an organic mental illness such as Alzheimer's and dementia. The ward provided inpatient services for both men and women.
- Sunniside Unit was a 16 bedded ward for older people with a functional mental illness such depression, mood disorders and schizophrenia. The ward provided inpatient services for both men and women.

## Our inspection team

**Team Leaders:** Chris Storton, Inspector (Mental Health) Care Quality Commission

The team inspecting the wards for older people with mental health problems comprised one inspector, one assistant inspector, one registered mental health nurse, and one occupational therapist.

## Why we carried out this inspection

We last undertook a comprehensive inspection of Gateshead Health NHS Foundation Trust in September 2015. Cragside Court and Sunniside Unit were not included as part of this inspection. This is the first focussed inspection of Cragside Court and Sunniside Unit This was an unannounced inspection.

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited Cragside Court, a ward for older people with mental health problems
- visited Sunniside Unit, a ward for older people with mental health problems
- toured both wards to look at the quality and safety of the environment
- spoke with the ward managers of Cragside Court and Sunniside Unit
- interviewed 14 staff including doctors, nurses, nursing assistants and other staff
- spoke with four patients who were using the service
- spoke with 12 carers of patients who were using the service
- reviewed 12 care records of patients who were using the service
- reviewed 15 prescription charts from Cragside Court and 15 prescription charts from Sunniside Unit
- attended and observed one handover at Cragside Court and one handover at Sunniside Unit
- observed two ward activities at Cragside Court and one ward activity at Sunniside Unit

# Summary of findings

- looked at policies, procedures and other documents relating to the running of the service

## What people who use the provider's services say

We received feedback from people using the service during the inspection. We spoke with four patients and 11 carers of service users either in person or by phone. Generally staff were praised as caring, kind and compassionate. However three carers told us that whilst this was the case, staff often seemed 'rushed' and 'busy'. One carer told us that they felt like 'there weren't enough staff'.

The trust participated in the patient led Assessment of the Care Environment audit in 2016, which found that Sunniside unit scored slightly above the national average in all indicators. Cragside unit was not selected for the 2016 patient led assessment of the care environment audit.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure that Cragside Court and Sunniside Unit have an environmental risk assessment and ligature risk assessment which identifies room by room each potential ligature point and the action or mitigation in place.
- The trust must review blanket restrictions on Cragside Court and Sunniside Unit to ensure that care is provided in a way that demonstrates that risks had been assessed on an individual basis.
- The trust must ensure that care plans on Cragside Court and Sunniside Unit are personalised, holistic and reflective of patient preferences.
- The trust must ensure that patients on Cragside Court and Sunniside Unit have access to psychological therapies.
- The trust must ensure that Cragside Court and Sunniside Unit have lounges which are designated for female patients only.
- The trust must ensure that patients' risk assessments are regularly reviewed and updated on Cragside Court and Sunniside Unit and that identified risks are reflected in care plans.
- The trust must ensure that Cragside Court has enough personal alarms for all members of staff on shift.
- The trust must ensure that staff on Sunniside Unit regularly monitor the temperature of fridges used to store medication and that staff take action if the temperature exceeds the safe levels as per the manufacturer's instructions.
- The trust must improve the state and quality of care records and ensure that care records are regularly audited to identify and address gaps in documentation.
- The trust must ensure that staff on Cragside Court and Sunniside Unit fully complete incident reports for the use of restraint and/or rapid tranquilisation. The use of restraint or rapid tranquilisation must be clearly documented in patients' care records.
- The trust must collate data related to delayed transfers of care on Cragside Court and Sunniside Unit.
- The trust ensure that effective assurance processes are put in place to ensure that all staff receive regular supervision, annual appraisal and mandatory training.
- The trust must ensure that staff understand the duty of candour.
- The trust must ensure that effective governance systems are in place to share information in a timely manner.
- The trust must ensure that staff are trained in techniques to ensure patients can be supported in an emergency.
- The trust must ensure that staff are trained in the Mental Health Act and Mental Capacity Act.

### Action the provider SHOULD take to improve

- The trust should ensure that patients on Cragside Court and Sunniside Unit have access to activities at evenings and weekends.

# Summary of findings

- The trust should ensure that patient bathrooms on Cragside Court and Sunniside Unit are appropriately designated by gender.
- The trust should review its use of prone restraint with older people
- The trust should ensure that patients on Cragside Court and Sunniside Unit have access to hot drinks and snacks.

Gateshead Health NHS Foundation Trust

# Wards for older people with mental health problems

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Cragside Court | Queen Elizabeth Hospital |
| Sunniside Unit | Queen Elizabeth Hospital |

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Training in the Mental Health Act was mandatory for qualified nurses and nursing assistants working both at Cragside Court and Sunniside Unit. The trust was not able to provide training data related to the Mental Health Act. Unqualified staff had limited knowledge of the Mental Health Act, the Code of Practice and the guiding principles.

Mental Health documentation was kept securely on each ward, and with copies kept by the trust's Mental Health Act office. Staff knew that patients should regularly have their rights under the Mental Health Act explained to them and care records evidenced that this was done.

Patients had access to an independent mental health advocacy service.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was mandatory for qualified nurses and nursing assistants working both at Cragside Court and Sunniside Unit. Training in the Mental Capacity Act was included as part of the trust's mandatory training. Cragside Court's compliance with Mental Capacity Act training was 44%. Sunniside Unit's compliance with Mental Capacity Act training was 81%. Not all staff were aware that the trust had a policy on the Mental Capacity Act. Not all staff were aware of the Mental Capacity Act, the Code of Practice or the guiding principles.

We found no evidence from our interviews with staff or our review of care records that staff considered or assessed

capacity for specific decisions other than those related to Deprivations of Liberty. Staff knew how to initiate an assessment for Deprivation of Liberty Safeguards when they felt that patient care was depriving someone of their liberty. However, they did not undertake capacity assessments for less complex day to day decisions

We reviewed three care records for patients subject to Deprivation of Liberty Safeguards. In two of the three records staff could not locate the initial assessment of capacity which had initiated the deprivation of liberty safeguards application.

Inadequate

# 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

Cragside Court and Sunniside Unit were inpatient units for older people with mental health problems based in Gateshead. Both units were clean and well-maintained with up to date cleaning records. Both units had a cleaning rota and we saw that domestic staff were aware of what cleaning tasks were required on each day. Equipment on both units was clean and well-maintained apart from one hoist in a female bathroom on Cragside Court which was overdue a service. Both units used electrical equipment which had undergone portable appliance tests to ensure they were safe for use. The furniture on both units was in good condition.

Cragside Court was designed as a square of four corridors surrounding a central courtyard. Sunniside Unit was designed as an 'L' shape. Neither unit allowed staff to observe all parts of the ward environment. Both units had several areas where staff could not see patients. We did not see mitigation such as mirrors which would allow staff to observe all parts of the ward environment. Bedrooms and other rooms on both Cragside Court and Sunniside Unit contained a number of potential ligature points. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We reviewed the ligature risk assessment for both units. Staff on Sunniside Unit had not conducted a ligature risk assessment of the whole unit. The assessment was a general assessment which was not fit for purpose. It did not identify room by room each potential ligature point and what action or mitigation was in place. This meant that not all staff could be aware of the risks because not all of them had been identified and shared with staff via the assessment. On Cragside Court the staff had conducted a ligature risk assessment for each room on the unit. However, it did not identify all potential ligature points. The ligature risk assessments for both units identified that there were ligature risks because of the door handles on the unit. However, neither assessment included what action staff should take or what mitigation was in place to address the ligature risk. We asked the service manager and the ward managers of both units to address this as an urgent action during the inspection. Following the inspection the trust submitted updated ligature audits for patients who may be intent on self-harm, and any necessary mitigating actions.

Neither unit had regularly checked the environment for environmental hazards such as falls risks or maintenance issues. During the inspection we are able to interview the health and safety officer for the trust who told us that both units had a yearly inspection from a patient environment assessment team which included trust staff and patient representatives. This inspection included an assessment of patient environment including bathroom areas, lighting, floors and patient areas. The health and safety officer told us that the unit did not have any environmental risks. In between the annual patient environment assessments, the unit staff were required to regularly flag maintenance issues to the trust estates department.

Both units admitted both men and women. Although both units had a number of lounges and other rooms for patients, neither had a day-room designated for women only. Guidance issued by the Chief Nursing Officer and Deputy NHS Chief Executive in 2010 on eliminating mixed sex accommodation in hospitals states that on mental health wards, women must have access to a women-only day room. Both units grouped male and female bedrooms into designated areas with each area having a bathroom. Bathrooms were not designated male or female and during the inspection we observed a male patient walk into a bathroom on the female corridor.

There was a clinic room on both units. Drugs were kept in a locked cupboard and were stored appropriately. On Cragside Court medicines fridge temperatures were checked daily and were within the required temperature. On Sunniside Unit whilst the fridge was at the right temperature on the day of inspection, the unit was not regularly monitoring and recording the medicines fridge temperature. This is a risk to patients because medicines may not be fit for purpose if not kept at the correct temperature. Emergency drugs were available and were checked and within their use-by date. Emergency resuscitation equipment was available and was checked

regularly. Neither clinic room had a couch for examinations. Staff conducted physical examinations in patients' bedrooms. This does not promote the use of patient bedrooms as a therapeutic space.

The trust had a food safety and hygiene policy that was introduced in July 2015. This allowed patients to bring only very select foods and drinks onto the ward, and otherwise all food was to be prepared on trust premises. This policy appeared very restrictive: both ward managers told us that the units were storing patient foods in fridges on the unit and that this included items which were contrary to the trust policy. However, neither unit monitored the fridge temperature in line with trust policy. This meant that staff could not ensure that the food being served was safe

We saw staff using personal protective equipment to reduce the risk of infection. On Cragside Court there were hand gels available at the unit entrance for staff and visitors to the unit. Sunniside Unit did not have hand gels available at the unit entrance, although staff carried individual sanitizers.

Both Cragside Court and Sunniside Unit had a nurse call system in place. Staff on both units had access to personal alarms. However, on Cragside Court we were told that there were not enough personal alarms for all staff members. On the day of inspection we saw that there were eight members of staff working on the ward, but only six personal alarms available for staff. The ward manager told us that replacements were in process of being ordered. This increased risk to staff and patients of being unable to call for help in an emergency.

### Safe staffing

The trust stated that the number of nurses required to staff both units was estimated using a 'nurse per occupied bed' methodology. The minimum number of nurses was calculated as 90% of the number of beds with an additional 21% to account for annual leave (13%); study leave (4%); and sickness (4%).

We requested staffing establishment levels for both units. As a whole, wards for older people with mental health problems had 22.6 whole time equivalent qualified nurses. The average vacancy rate for qualified nurses was 6%. There were 21 whole time equivalent nursing assistants. Cragside Court had a vacancy rate of 15% for nursing assistants. Sunniside Unit had no vacancies for nursing assistants and was over establishment levels with one additional whole time equivalent nursing assistant above planned levels.

Safe staffing data was reported to the board in the monthly 'nurse staffing exception report'. This report highlights wards in which safe planned staffing drops below 75% or rises above 125%. Fill rates for qualified staff on Sunniside Unit were consistently above 75% from July 2016 to October 2016. Cragside Court filled an average of 76% of shifts for qualified nursing staff for the four months of July to October 2016. In October 2016, Cragside Court was highlighted in the board report as having achieved a 71% fill rate for shifts for qualified nursing staff. The service had mitigated the impact of this by overfilling shifts for nursing assistants, with a 142% fill rate for nursing assistants. The low fill rate for qualified nursing staff was due to staff vacancies.

Both Cragside Court and Sunniside Unit had a sickness rate which was above the nationwide average for NHS services. In the period November 2015 to October 2016 the average staff sickness rate was 14% for Cragside Court and 9% for Sunniside Unit. The NHS nationwide average is 4%. Cragside Court had seven substantive staff leave the service in the same period which equated to a turnover of 27%. Sunniside Unit had no substantive staff leavers in the last twelve months.

The managers of both Cragside Court and Sunniside Unit told us that they were able to adjust staffing levels to take account of the case mix, patient acuity and activities on the ward. Both units had a high use of bank staff. In the three months between September 2016 to November 2016 Cragside Court made 417 requests and Sunniside Unit made 135 requests for shifts to be covered with bank or agency staff. Of the 552 total requests,

- 462 were filled with bank staff
- none were filled with agency staff
- 33 were not filled with bank or agency staff
- 57 requests were cancelled

Whilst we were told that the service used bank staff who were familiar to the units, we found that bank staff had little knowledge of patients' care plans. Bank staff told us that if they needed to know specifics about care plans then they would be informed by the permanent staff.

Inadequate

# Are services safe?

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

We saw a more visible qualified nursing presence in communal areas on Sunniside Unit than on Cragside Court. Staff on both units told us it was rare for patients to have regular one to one with their named nurse although they would try to ensure that patients received some one to one time with staff. Most staff told us it was rare that leave and ward activities were cancelled because of too few staff although on Cragside Court we were told it was more common. Neither ward had a system to monitor how often leave or ward activities were cancelled.

Cragside Court had one consultant psychiatrist who worked on the wards for eight hours a week and another who worked on the ward for three hours a week. The consultants were able to provide cross cover during periods of absence. Sunniside Unit had four consultants who worked both on the ward and with the trust's community mental health teams for older people. Both units were had senior medical cover provided by an on-call consultant rota which operated at all times. The trust had an on-call rota for junior doctors which was shared with Monkwearmouth Hospital which was within thirty minutes of both units. Both units were based within the grounds of the Queen Elizabeth acute hospital and in an emergency staff would either phone the junior doctors or contact emergency services for an ambulance.

Both unit managers told us that the units had issues with mandatory training compliance. The trust had 13 modules of mandatory training, of which 11 were completed as e-learning sessions. Only two modules of mandatory training were completed as classroom sessions; cardiopulmonary resuscitation refresher training and fire safety training. The trust judged mandatory training compliance based on the number of staff who had completed all 13 modules of mandatory training as a percentage of the total number of staff. On Cragside Court the mandatory training compliance rate as calculated by the trust was 0%. This was because none of the staff had completed the classroom based cardiopulmonary resuscitation refresher training. On Sunniside Unit the mandatory training compliance rate as calculated by the trust was 54%. Seven of the 13 eligible staff had completed all 13 modules of mandatory training including the two classroom based sessions.

The low compliance with cardiopulmonary resuscitation refresher training put patients at risk of unsafe care. It meant that the service was not assured that staff had the required skills, competence and experience to respond to patients in an emergency. The low compliance with cardiopulmonary resuscitation refresher training was a breach of the trust's rapid tranquilisation policy which stated 'all staff involved in administering or prescribing rapid tranquilisation… must receive ongoing competency training to a trust recognised standard which includes maintenance of airway, cardiopulmonary resuscitation, the use of defibrillators, and the use of pulse oximeters'. The low compliance was a breach of the trust's restrictive interventions policy which stated that 'staff taking part in any physical intervention must be trained in basic life support'.

Staff told us that the trust's security staff could be called to help the units with physical interventions. The trust provided data related to the number of incidents on both units. We requested a detailed breakdown of incidents for both units as reported by security staff and by ward staff, however the trust did not provide this. We requested the compliance rates for mandatory training in the prevention and management of violence and aggression. The compliance rate for training in the prevention and management of violence and aggression was 29%. This meant that we could not be assured that staff were trained to keep patients and staff safe when incidents occurred. The trust had implemented an action plan to increase the number of staff who had completed the refresher training in the prevention and management of violence and aggression.

### Assessing and managing risk to patients and staff

We looked at twelve care records. Both Sunniside Unit and Cragside Court used the functional analysis of the care environment risk assessment which is a nationally recognised risk assessment tool. Both services also used an 'adult pre-operative and inpatient' risk assessment which assessed potential risks related to patients' physical health.

Not all care records included a risk assessment which was regularly updated. In one record, a patient's risk assessment had not been updated for several months after admission. Care plans were not linked to risk assessments.

Both units had a number of blanket restrictions in place.

- The trust food hygiene and safety policy stated that all food served to patients must be prepared on trust premises. Carers and relatives were not allowed to bring food in for patients and patients were not able to order takeaway meals at any time.

Inadequate

# Are services safe?

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

- Neither unit had a facility available for patients to make their own hot drinks or snacks. We saw that the units had set times where drinks were brought out. Staff told us that they routinely offered drinks to patients.
- The front door to both units was locked which required a key card to unlock them. The sign on the front door of Cragside Court did not fully explain to patients about their right to leave.
- No patient on either unit had the option to have a key to their bedroom. Staff told us that bedrooms were left unlocked unless patients specifically asked staff to lock them. Patients would then have to ask staff to unlock their bedrooms when they wanted to go into them.

There was no evidence that these blanket restrictions were regularly reviewed or applied on the basis of the individual risks of current patients on the units.

Both units had informal patients admitted on the day of inspection. Although both units had signs near the front door, the sign on Cragside Court did not specifically advise informal patients of their right to leave the unit at will and stated 'under no circumstances should anybody be let out of this ward without the permission of the nurses'. This does not meet the standards of the Mental Health Act Code of Practice which states 'Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward'.

Staff told us that they rarely had to search patients. On Sunniside Unit staff were able to describe an incident where they had searched a patient and used the trust's search policy as guidance. Children were allowed to visit both units and we were told that this would be individually risk assessed.

The trust submitted data on the use of restrictive interventions. In the period November 2015 to November 2016 Cragside Court had 22 uses of restraint affecting 12 patients and Sunniside Unit had one. Cragside Court had four uses of prone restraint and Sunniside Unit had none. Cragside Court had two incidents of the use of rapid tranquilisation. The trust did not have a separate restraint policy for frail older people. The trust was not able to provide assurance that all staff had received training in appropriate restraint techniques.

We reviewed four incidents which included the use of restraint or rapid tranquilisation. The trust data suggested that the use of restrictive interventions was low on both units. In the incidents we reviewed, we found issues with the recording and monitoring of incidents of restraint and rapid tranquilisation. We found issues with the recording of physical health observations after restrictive interventions.

In one incident, a patient was recorded as receiving lorazepam via intramuscular route in response to increasing agitation after the patient had refused to take their routine oral medication earlier in the day. This was not recorded as an incident of rapid tranquilisation in line with trust policy which defines rapid tranquilisation as 'administration of medication to calm or sedate an agitated, violent or aggressive patient as quickly as is safely possible'.

We reviewed an incident which was separately recorded by nursing staff and by security staff. The electronic incident recording system and paper care records were not completed correctly and fully which meant that the incident of restraint was not identified clearly and there was no record of the staff members involved in the restraint, the type of restraint used or whether there were any injuries to the patient or to staff.

In a third incident we saw that staff had recorded on the electronic system that a patient had been restrained by security. Neither the patient's care records nor the nursing progress notes contained reference to use of restraint on the day of the incident. The records also indicated that the patient had received rapid tranquilisation but we could not find evidence to confirm that staff had undertaken physical health observations after the administration of medication.

Neither service had a process in which the use of restraint or rapid tranquilisation was monitored or reviewed at ward level. We saw no evidence of staff using incidents of restraint or rapid tranquilisation to inform risk assessments or care planning.

Safeguarding refresher training was delivered as a mandatory training module via e-learning. All staff were required to undertake safeguarding adults refresher training as one module of training and safeguarding children level one and level two as another module of refresher training. Cragside Court had 27 staff eligible for the training. Only 12 staff had completed both modules of training which meant that compliance with

Inadequate

# Are services safe?

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

safeguarding training was 44%. Sunniside Unit had 21 staff eligible for the training and 17 staff had completed it which meant that compliance with safeguarding training on Sunniside Unit was 81%. Both qualified nurses and healthcare assistants told us that they knew what constituted a safeguarding concern and would pass their concerns to the safeguarding lead on site. Two nurses told us that they had made a safeguarding referral in the past.

### Track record on safety

Between May 2016 and November 2016, there were 187 incidents reported across both sites, with 131 incidents on Cragside Court and 56 on Sunniside Unit.At Cragside Court, 49% of those incidents were categorised as violence, abuse and harassment, and 35% of the incidents were recorded as patient falls. On Sunniside Unit, 83% of incidents were categorised as patient falls and only 10% were recorded as incidents of violence, abuse and harassment.

Incident data for the period November 2015 to December 2016 for Cragside Court showed that there were 244 incidents on the unit. Of these incidents 62.7% were classed as 'no harm', 34.8% were classed as 'low or minor', less than 1% were classed as 'moderate' and 2.2% were classed as safeguarding incidents. For the same period Sunniside had a total of 88 incidents reported of which 64.8% were classes as 'no harm', 31.8% were classed as 'low or minor', 2.3% were classed as 'moderate' and 1.1% were classed as safeguarding incidents.

In the twelve months prior to inspection the service had one serious incident requiring investigation on Sunniside Unit and none on Cragside Court. The incident related to a patient sustaining a fracture caused by a fall during admission. Remedial works had been carried out to the unit's garden space to prevent the future incidents.

### Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system. Whilst all staff felt encouraged to report incidents we were told by nursing assistants on both Cragside Court and Sunniside Unit that they would ask the nursing staff to complete the incident report on the electronic system. Staff told us they were sometimes offered informal debriefs following incidents.

Staff were not able to describe any incidents that had led to an improvement or a change in practice. Team meeting minutes for Sunniside did not include any reference to incidents on the unit. Team meeting minutes for Cragside Court were not available. However, we did see that Cragside Court had posters in staff areas advising staff of a medication risk following an incident on a ward in the acute hospital.

The duty of candour is the requirement that staff are open and honest to patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Whilst both ward managers had a good understanding of the duty of candour we found that this was not shared by the rest of the team. One incident had met the threshold for duty of candour on Sunniside and the ward manager had followed the duty of candour process. Most qualified and unqualified staff did not know about the duty of candour.

# Are services effective?

**Requires improvement**

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

## Our findings

### Assessment of needs and planning of care

We reviewed six care records from Sunniside Unit and six care records from Cragside Court. In all twelve records we identified areas that did not demonstrate good practice.

We saw that three care records did not include a comprehensive assessment. One care record was for a patient who had entered the service in 2015 and we found no evidence that the patient's care plan or risk assessment had been reviewed until fifteen months after the admission date.

Care plans were not holistic. We found that care plans were a list of prompts for nursing staff for how to care for the immediate mental health needs of patients. We found no evidence in any of the 12 care records of a care plan which addressed the entirety of a patient's mental, physical, emotional, social, spiritual or environmental needs. None of the records had any evidence of a coordinated approach to planning care which included multiple professionals. Care plans were not goal orientated and did not have clear and measurable objectives. We saw that progress notes in care plans did not link to the care plan objective.

Care plans were not personalised. Some care plans did not include the patient's name and referred only to 'the patient'. Nursing care plans were written as prompts for nursing staff using language for actions such as 'the nurse will'. We found that some care plans were standard templates. All patients who were detained under the Mental Health Act had an additional "Mental Health Act Care Plan" which was a printed template in each patient's care record and one generic activities care plan was used, which not personalised to each patient.

Care plans did not consistently have evidence of the patient's voice. We saw in some care plans that carers had been encouraged to complete a 'this is me' form which described the patient's personal history from the carer's perspective. In three records we saw that carer's had completed these forms. However, we did not find evidence that this information was used to inform care plans.

All records showed that staff had undertaken a physical examination with patients and there was evidence in some records of monitoring of physical health problems but this was not consistent. We found that the service identified in medical notes if a patient had an established physical health condition. However, we did not find care plans which addressed this need. Seven care records showed that staff had undertaken physical checks using a 'pre-operative and inpatient risk assessment tool' which included weekly weight measurements and a nutritional monitoring tool. One care record had no evidence of physical health monitoring. One record had four weekly bodyweight measurements for the patient between October and November which had stopped in the first week of November with no indication for why these had been discontinued. One record had a weight chart which had two entries however the entries were not dated.

Care records were kept in a locked office on both units. All were paper files and we found that no one care record was organised in a similar way to another. Records had papers which fell out when the file was opened. When staff could not locate specific documents in files we were told that it was likely the papers had been lost.

### Best practice in treatment and care

In 2011 the National Institute for Health and Care Excellence published 'service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services'. This guidance stated that patients admitted to hospitals should have access to pharmacological, psychological and psychosocial treatments. Both units had a psychologist who visited once a week. We did not see evidence in care records of direct psychological input in patient care. The service had a medical model and the main disciplines involved in patient care were psychiatrists and nurses. The service could access other specialities but this required individual referrals for patients. We saw in one record that a patient had been noted as requiring an assessment from the occupational therapy department. The referral took several months and we could not find an outcome of the referral following the assessment. Neither unit had the wider input of a range of professionals such as occupational therapists, physiotherapists, social workers or pharmacists.

Sunniside Unit provided assessment and treatment for older people with functional mental health conditions such as depression, anxiety, delirium or psychosis. The 2011 guidance 'common mental health problems: identification and pathways to care' from the National Institute for Health and Care Excellence states that patients should have access to a range of treatment options including psychosocial interventions such as cognitive behavioural

# Are services effective?

**Requires improvement**

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

therapy, interpersonal therapy and group based peer support. Whilst the unit's service profile stated that the unit had psychology staff who offered one to one sessions with patients as well supporting the patient's forum and staff clinical supervision, we found that care records did not provide evidence that patients received individual psychological interventions.

Two out of the 12 records we reviewed had a completed depression scale or mini-mental state as evidence of the use of rating scales. No other rating scales were being used to track patient progress.

The trust's clinical audit annual programme for 2016-2017 planned six audits which were due for completion by the time of inspection. Only one audit had been completed.

### Skilled staff to deliver care

The service employed consultant psychiatrists, nurses, nursing assistants, psychologists and one activity coordinator per unit. Whilst the service could access other specialities on an individual referral basis, neither unit had professionals such as occupational therapists, speech and language therapists, dieticians, pharmacists or social workers embedded within the multidisciplinary team. Neither unit had multidisciplinary meetings which included all professionals where they could the needs of patients as a team and discuss approaches from different disciplines to give a holistic approach to patient care

On both units, managers did not ensure that staff received supervision regularly or undertook an appraisal of their work performance. The appraisal rate for Cragside Court was 0% and for Sunniside Unit was 41%. Neither unit provided compliance figures for supervision. The trust's supervision policy stated that 'managers will ensure that protected time is given for formal clinical supervision for a minimum of 1 hour every 3 months'. We were told that weekly group clinical supervision was provided on both units. Both services had staff who did not attend these sessions either because they or they were designated night staff and the session ran during the day or they did not work on the day it was provided. Neither unit maintained a record of attendance for supervision which meant that the service had no way of monitoring whether staff received supervision in line with the trust's policy. The lack of supervision and appraisal on the units meant that staff could not regularly discuss practice issues, good practice or training opportunities.

Two members of staff told us they had accessed additional training in cognitive behavioural therapy and a further two members of staff told us they had received training in dementia awareness.

### Multi-disciplinary and inter-agency team work

Neither unit had multidisciplinary meetings which included all professionals. Cragside Court had a 'board round' which was a meeting with the psychiatrist and the nursing staff. Sunniside Unit had four ward rounds in which each of the four consultant psychiatrists could meet with the nursing staff.

We observed a handover on both units. On Sunniside Unit, the handover involved all the nursing staff including the qualified nurses, nursing assistants and the activity coordinator. The handover covered all of the patients on the unit in detail including their behaviours, mood, involvement in activities, and diary plans for the day. On Cragside Court, the handover included a nursing assistant and two staff nurses, one finishing their shift and another who was just starting their shift. During the handover each patient was covered in detail including their Mental Health Act or Mental Capacity Act status, mood and behaviours and any important information related to the patients current physical health.

The four consultant psychiatrists working on Sunniside Unit were shared with the trust's community mental health teams for older people. Cragside Court had one consultant psychiatrist who worked on the unit for eight hours a week and another who worked on the ward for three hours a week. Planned admissions to the service were coordinated by the consultant via GPs, the community mental health teams, accident and emergency departments and other medical wards in the acute hospital. Staff told us that there was a good working relationship with the local authority social services.

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

Training in the Mental Health Act was mandatory for qualified nurses and nursing assistants working both at Cragside Court and Sunniside Unit. Mental Health Act training was provided to all qualified nurses. At the time of inspection all eligible staff had undertaken the training except for staff members who were on long term sick leave. Most staff had last undertaken training in the Mental Health Act in 2015. Unqualified staff were not eligible for training in the Mental Health Act. The unqualified staff in particular

# Are services effective?

**Requires improvement**

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

had limited knowledge of the Mental Health Act, the Code of Practice and the guiding principles. The trust had a policy on the Mental Health Act which had been updated to reflect the changes in the Mental Health Act Code of Practice in 2015.

Mental Health documentation was kept in patients' medical notes. Staff on Cragside Court told us that patients' Mental Health Act statutory consent to treatment forms also were kept in a folder in the clinic room but, when asked, staff could not find these. This meant that patients' treatment status could not be determined by nursing staff when giving medication. Mental Health Act statutory consent to treatment forms should be kept with medication cards as good practice. Staff told us that all patients had their rights under the Mental Health Act regularly explained to them. Care records included the dates that patients' rights had been explained.

Cragside Court and Sunniside Unit shared administrative support from the trust's Mental Health Act office. Copies of detention paperwork was also kept in the Mental Health Act office. All detained patients were automatically referred to an independent mental health advocacy service unless they specifically stated that they did not wish to be referred.

### Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act was mandatory for qualified nurses and nursing assistants working both at Cragside Court and Sunniside Unit. Training in the Mental Capacity Act was included as part of the trust's mandatory training in safeguarding adults. Cragside Court had 27 staff eligible for the training. Only 12 staff had completed both modules of training which meant that compliance with Mental Capacity Act training was 44%. Sunniside Unit had 21 staff eligible for the training and 17 staff had completed it which meant that compliance with Mental Capacity Act training on Sunniside Unit was 81%. Staff told us it had been some time since they had last received training in the Mental Capacity Act. Not all staff were aware that the trust had a policy on the Mental Capacity Act.

On Sunniside Unit we could find no evidence in care records that staff had undertaken assessments of patients' capacity. We reviewed a care record for a patient who was subject to Deprivation of Liberty Safeguards. We asked staff to locate paperwork which documented the capacity assessment and decision made in the patient's best interest prior to applying for the Deprivation of Liberty safeguards but these could not be found. On Cragside Court we reviewed care records for two patients subject to Deprivation of Liberty Safeguards and could find a capacity assessment for one of these patients.

We found no evidence from our interviews with staff or our review of care records that staff considered or assessed capacity for specific decisions other than those more complex decisions related to Deprivation of Liberty Safeguards.

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

On both units we observed kind, caring and respectful interactions between patients and staff. The regular staff were knowledgeable about the patients admitted to the ward. On Sunniside Unit we observed an open door policy whereby patients could interact with staff in the staff room without being turned away. We saw that staff spoke with patients in a friendly and courteous manner. We observed activities taking place which were appropriate and enjoyed by patients. However, on the Cragside Court unit, whilst the interactions we observed between staff and patients were kind, caring and respectful, we saw that there were not enough staff to attend to each. This was reflected in comments made by carers which referred to staff attention being diverted to patients with the most acute and aggressive presentations.

On Sunniside Unit, patients and carers were mostly positive about the way staff treated them, and knew members of staff by name. We were told that staff at all levels were polite and treated each other as equals. On Cragside Court, patients could not generally tell us how staff treated them however carers told us that staff were friendly, patient, respectful and kind.

The regular staff had a good understanding of the patients' individual needs. We observed a handover on both units, and at each handover we saw staff refer to patients by their preferred names and discuss aspects of their lives such as former careers, and individual likes and dislikes.

### The involvement of people in the care that they receive

All of the patients we spoke to said that they were informed about the service on or just after admission, and given a tour of the ward. Staff told us that this process might be delayed for patients who entered the service confused or aggressive; but that when patients were able they were given a guided tour of the unit.

Patients could access an advocate if needed, and staff were knowledgeable about the independent mental health advocacy service. We saw that there were clearly accessible independent mental health advocacy service leaflets on both units. In one care record we saw documentation from the independent mental health advocacy service. Both units had an opt-out system for referral to the independent mental health advocacy service which meant that all detained patients were referred to the service unless patients specifically stated they did not want this to happen.

Sunniside Unit held bi-monthly patient forum meetings led by the psychiatrists, and the records we observed showed good patient participation and engagement. However, we observed significant gaps in the records. This was explained to us as either an absence of psychiatrists to lead the meetings, or that the records were held elsewhere electronically. We did not see evidence of the electronic records, or an explanation in the paper records as to why meetings had not taken place.

We saw limited evidence that care plans and risk assessments had patient or carer input. Patients and carers did not have copies of or access to their care plans. It was not clear how patients were encouraged to maintain independence. Patients or carers were not able to get involved in decisions about the service such as in staff recruitment. We did not see evidence that people who used the service were engaged and involved in service development or in the trust's ongoing plan to improve mental health services.

Carers were kept informed by telephone or when they visited the ward if there were concerns. Carers told us they felt they were informed about the care being provided but were not routinely involved in the care or care planning. Carers were not sure about the progress of treatment, and expressed uncertainty about discharge. Expectations of mental health treatment and outcomes were not routinely explained to carers. We heard feedback from two carers which they had not felt they could raise with the service. This meant that the service was not always actively encouraging a culture where carers were able to give open and honest feedback to the service.

# Are services responsive to people's needs?

Requires improvement

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

## Our findings

### Access and discharge

Both wards received referrals from the trust's community mental health teams for older people. In the period November 2015 to November 2016, the service had an average bed occupancy of 84%. At no point in the twelve months prior to inspection had the service reached 100% occupancy which meant that a bed was always available when needed for people living in Gateshead. Staff told us that it was rare to release a patient's bed to another admission whilst they were on leave and that this had not happened in the twelve months prior to inspection.

In the twelve months prior to inspection the average length of stay for patients was 52 days for Cragside Court and 49 days for Sunniside Unit. In the same period the number of patients who were readmitted within 90 days of discharge was low. Cragside Court readmitted four patients and Sunniside Unit readmitted eight patients. The average length of stay on both units was less than the national average of 68 days stated in the NHS Benchmarking Network's 'Mental Health Benchmarking Report 2013'.

The trust reported that neither Cragside Court nor Sunniside Unit had any delayed discharges in the same period. During the inspection we were told by staff both that the service did not monitor the number of delayed discharges and that delayed discharges had occurred within the twelve months prior to inspection. The reason for a delayed discharge was normally related to issues with confirming suitable packages of care in the community. This meant that the trust data did not reflect accurately the number of delayed discharges on the unit.

### The facilities promote recovery, comfort, dignity and confidentiality

Both Cragside Court and Sunniside Unit had a range of rooms to support treatment and care including a clinic room, a main communal lounge, an activity room and a number of smaller lounges. Both units had a number of smaller rooms where patients could meet visitors. Neither unit had a wireless phone or dedicated patient phone, although there were no restrictions on patients having mobile phones if they wanted them. Patients on both units usually had access to outside space although we were told that Sunniside Unit was due to have the outside space refurbished. The enclosed courtyard on Cragside Court was opened in 2014 and included a lawn and a bandstand to imitate the features of Saltwell Park, an historic park in Gateshead.

We saw limited personalisation of bedrooms on both units. All bedrooms had a lockable chest of drawers which allowed patients to securely store their possessions. Bedrooms on both units were kept unlocked unless patients requested that staff locked them. Patients were not given keys to their own bedrooms. On Cragside we were told that patients with dementia sometimes struggled with the automatic light used in their bathrooms as it was not clear to them that the light would come on only once they had entered the bathroom. This was identified as an issue in September 2016 by the trust's Dementia Environment sub-group meeting. The trust stated that solutions to this issue were still being explored at the time of inspection.

Food was provided from a separate central kitchen and regenerated on the units. Both units could access foods to cater for specific diets or cultural needs and all meals served included a specific vegetarian option. Patients on Sunniside had raised concerns about the food quality and that the service had responded to this by inviting the local catering lead to the patient forum so that patients could give feedback. On Cragside patients told us they were happy with the food served.

Both units had an activity assistant but this was not a full-time position on Cragside Court. Activities were available to patients through the week but not at weekends or during the evening. The 2011 guidance 'service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services' from the National Institute for Health and Care Excellence states that that patients should have access 'to a wide range of meaningful and culturally appropriate occupations and activities seven days per week, and not restricted to 9am to 5pm'. One carer for a patient on Cragside Court told us that activities were more appropriate to female patients and that the unit did not offer activities focussed towards male patients. Neither unit had a dedicated occupational therapist.

### Meeting the needs of all people who use the service

Both Cragside Court and Sunniside Unit were located on the ground floor. Whilst all areas were accessible to people

# Are services responsive to people's needs?

Requires improvement

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

who use wheelchairs, we saw that the doors on both units were quite heavy and could potentially be difficult for older people. Both units had a bathroom which was accessible for patients with a physical disability.

In 2015 the Department of Health published 'Dementia Friendly Health and Social Care Environments'. Neither Cragside Court nor Sunniside Unit had in place many of the environmental adaptations suggested in this guidance to support older people and people with dementia. Whilst the guidance states that 'colour design is a fundamental element in dementia-friendly environments' we saw that both units were plain and clinical. Neither unit had a permanent beverage station for patients and visitors to make their own hot drinks or a designated space where patients and visitors could make their own snacks.

On admission, patients were given leaflets which explained what to expect from their time on the unit, as well as information about the ward routine, medications. Both units had information boards for activities and leaflets for the advocacy service. We did not see information on boards or in leaflets in any language other than in English.

However, at the time of inspection there were no patients whose first language was not English. Both services had access to a pastoral service through the trust which included having a chaplain visit regularly.

### Listening to and learning from concerns and complaints

The trust had a complaints and concerns policy which was introduced in July 2015. The service had one complaint in the period November 2015 to November 2016 which was a complaint about Cragside Court. We did not see that the service was actively encouraging patients and carers to complain. We saw limited information available to patients on the ward for how to make a complaint. Patients told us they would speak to the nurses. None of the carers for patients on both Cragside Court and Sunniside Unit told us that they knew how to make a complaint or were aware of the patient advice and liaison service.

Staff told us that the service rarely had formal complaints and that most concerns were dealt with a local level. None of the staff interviewed were able to tell us about a complaint that had led to improvements in the service.

# Are services well-led?

**Inadequate**

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

Cragside Court and Sunniside Unit were wards for older people with mental health problems provided by Gateshead Health NHS Foundation Trust. The trust had adopted a vision and values as follows:

- Creativity and innovation
- Honesty
- Equality
- Respect
- Trust
- Partnership
- Reform
- Dignity
- Engagement
- Transparency
- Openness

The trust also had a five supporting statements

- We believe in the patient being at the heart of everything we do.
- We also want to work well with our partners to give you the best experience possible
- We want to be the best employer, creating the right conditions for our staff to excel
- We want to spend our money wisely, that means being held accountable to you by a board of non-executive directors and governors
- Living our values every day including honesty, equality, respect, trust, openness, dignity and reform

During the inspection, we asked four members of staff to identify one or more of the trust's values. Staff could give examples of themes but could not recall the exact words used. All four were able to either recall the supporting statement 'We believe in the patient being at the heart of everything we do' or describe something similar to statement.

Staff knew who the most senior managers in the trust were.. On Cragside Court we were told that senior managers had visited when the unit had opened a newly designed courtyard. However, we were also told that this was an exception and on both units it was not routine for senior managers to visit.

### Good governance

We found several deficiencies with governance systems and processes:

The trust provided data which showed that there was limited use of restrictive interventions including restraint and rapid tranquilisation on both units. In our interviews with staff and our review of incident reports, we found evidence which showed the trust data may not accurately reflect the correct position as well as wider concerns about consistent record keeping. We found incidents where patients had been administered medication in circumstances which matched national and trust descriptions of rapid tranquilisation but were not recorded as such. We found incidents of rapid tranquilisation where there was no evidence that staff had undertaken physical health observations in line with the trust policy. The trust governance system did not ensure that incidents of restraint or rapid tranquilisation were reviewed to examine themes and trends, or to update risk assessments and inform care planning.

During the inspection, we made several requests for additional written evidence from the trust to inform the report. Information requests included details of incidents on the units. The trust did not submit the required information in relation to this request.

By the trust's framework compliance with mandatory training at Cragside Court was 0%. Compliance with mandatory training at Sunniside Unit was 54%. None of the staff at Cragside Court had completed refresher training in cardiopulmonary resuscitation. Seven out of thirteen eligible staff had completed the same training on Sunniside Unit. The compliance rate for the prevention of violence and aggression level three training was 29%. The trust had a plan to increase average compliance with mandatory training to above 90% by March 2017.

Both units had low vacancy rates for qualified nurses but high numbers of shifts covered by bank staff. Sickness rates on both units were above the NHS average. Whilst we were told the wards always had at least one qualified member of staff, the service was overfilling shifts for nursing assistants both to mitigate where additional shifts could not be filled with qualified staff and to reflect the patient needs and skill mix required on the ward. In October 2016 Cragside Court

# Are services well-led?

Inadequate

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.

was highlighted in the trust's board report for having managed to cover only 71% of qualified nursing staff shifts. Staff on both units told us they felt there were not enough staff to offer one to one sessions with all patients.

The care records were deficient in a number of respects on both units. The service relied on paper records which were disorganised and disjointed. There were deficiencies in all 12 records that we reviewed. The care plans were neither holistic nor personalised and progress notes did not link to the objectives of care plans. Care records were unwieldy and staff sometimes struggled to locate specific documents and sometimes could not locate documents at all. Neither service had a regular audit of care records which identified issues and gaps in care records.

Managers on both units failed to ensure that staff received regular appraisal and supervision. The appraisal rate for Cragside Court was 0% and for Sunniside Unit was 41%. Neither unit provided compliance figures for supervision. Neither unit had an adequate system for monitoring supervision. This meant that managers could not be assured that all staff received regular supervision in line with the trust policy.

The trust's clinical audit annual programme for 2016-2017 planned six audits which were due for completion by the time of inspection. Only one audit had been completed. The trust submitted a further 'annual suicide prevention audit'. This noted in October 2016 that 'completion of the annual ligature audit has been delayed due to there being a need for training in the completion of this'. We found during the inspection in December 2016 that ligature audits had not been completed we requested that ligature audits be updated as an urgent action after noting that the current audits were not fit for purpose.

Not all staff on both units had received refresher training in safeguarding. Both qualified nurses and healthcare assistants told us that they knew what constituted a safeguarding concern and would pass their concerns to the safeguarding lead on site. The significant issues in care records meant that staff could not consistently produce evidence that they were following all procedures for the Mental Health Act and Mental Capacity Act.

The service used key performance indicators for mandatory training, appraisals, sickness rates and safe staffing fill rates. Both units had significant issues in all four key performance indicators. The managers of both Cragside Court and Sunniside Unit told us that they felt that both units had areas for improvement, that they had sufficient authority to lead improvements and that this process had started.

Both ward managers told us that they had sufficient authority and enough support to perform in their roles. Neither ward had a ward-level risk register. However, there was a risk register at trust level. Four risks on the trust risk register were specifically related to the inpatient provision at Cragside Court and Sunniside Unit.

### Leadership, morale and staff engagement

Staff morale was mixed on the units. The ward managers of both units told us that morale was mixed with some staff happier than others. On Cragside Court staff told us that the unit had suffered from a lack of leadership which had left staff feeling ignored. Staff told us that there was a culture which needed to change on the unit. On Sunniside Unit staff were more positive about their work although they told that the unit had gone through a significant period of change and this was still causing some to feel unsettled. On both units staff told us that individually they happy in their roles but that working on the units was stressful.

There were no reported cases of bullying or harassment raised during the inspection. Sickness rates on both units were significantly higher than the NHS national average. Whilst Sunniside Unit had no substantive staff leave during the twelve months prior to inspection, on Cragside Court 27% of substantive staff had left in the same period.

Staff on both units told us that they felt they could raise concerns without fear of victimisation. Most staff knew and understood the concept of whistleblowing and the trust's whistleblowing procedure. Whilst both ward managers had a good understanding of the duty of candour we found that this was not shared by the rest of the team. Most qualified and unqualified staff did not know about the duty of candour.

### Commitment to quality improvement and innovation

The Faculty of Psychology of Older People is a national group for psychologists working with older people. The faculty is part of the Division of Clinical Psychology within the British Psychological Society. The psychologist and ward manager of Sunniside Unit were involved in original

# Are services well-led?

**Inadequate**

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.

research entitled 'The therapeutic interactions model: working towards cultural change on a 'functional' psychiatric unit' which was published in the faculty's July 2016 academic journal.

The wards did not participate in the accreditation scheme for older adults' mental health wards provided by the Royal College of Psychiatrists. On Cragside Court the trust had completed a refurbishment of the outdoor garden space. The enclosed courtyard on Cragside Court was opened in 2014 and included a lawn and a bandstand to imitate the features of Saltwell Park, an historic park in Gateshead.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**How the regulation was not being met:**<br>The trust did not ensure that people using the service have care or treatment that is personalised specifically for them because:<br>Both Cragside Court and Sunniside Unit had a number of blanket restrictions without evidence of review.<br>Care plans on Cragside Court and Sunniside Unit were not personalised, holistic or reflective of patient preferences.<br>Patients on Cragside Court and Sunniside Unit had limited access to psychological therapies and therapeutic activities.<br>This was a breach of Regulation 9(1)(a)(b)(c) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>**How the regulation was not being met:**<br>Neither Cragside Court nor Sunniside Unit had a lounge designated for females only.<br>This was a breach of Regulation 10(1)(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:** |

This section is primarily information for the provider

# Requirement notices

Risk assessments were not consistently reviewed or updated on Cragside Court or Sunniside Unit. Care plans did not reflect risk assessments.

Neither Cragside Court nor Sunniside Unit had a ligature risk assessment identified room by room each potential ligature point and what action or mitigation was in place.

Neither Cragside Court nor Sunniside Unit had an environmental risk assessment

Cragside Court did not have sufficient personal alarms for all members of staff on shift.

Sunniside Unit was not regularly monitoring the temperature of fridges used to store medication or food.

This was a breach of Regulation 12(1)(2)(a)(b)(d)(g)

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>Care records were disorganised, disjointed and had gaps in documentation.<br>Data on the use of restraint and rapid tranquilisation did not correspond to incident reports.<br>Neither Cragside Court nor Sunniside Unit collated data on the number of delayed discharges.<br>Neither Cragside Court nor Sunniside Unit had effective assurance processes to ensure that all staff received regular supervision, annual appraisal and mandatory training.<br>Both Cragside Court and Sunniside Unit had high use of bank staff to cover shifts, high sickness rates and a high number of shifts below safe staffing levels.<br>This was a breach of Regulation 17(1)(2)(a)(b)(c)(d)(i)(ii) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

This section is primarily information for the provider

# Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

**How the regulation was not being met:**

Mandatory training compliance was low on both Cragside Court and Sunniside Unit.

Not all staff on Cragside Court and Sunniside received regular supervision.

Not all staff on Cragside Court and Sunniside received an annual appraisal.

Staff did not have an understanding of the duty of candour.

This was a breach of Regulation 18(2)(a)