

Requires improvement 

Solent NHS Trust

Wards for older people with mental health problems

Quality Report

Solent NHS Trust
Highpoint Venue
Bursledon road
Southampton
Hampshire
SO19 8BR
Tel:02380608900
Website:www.solent.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
R1CF2	St James Hospital	Brooker Unit	PO4 8LD

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated wards for older peoples mental health as requires improvement because:

- Safeguarding procedures were not always being adhered to with regards to patient on patient assaults. Staff did not consider any patient on patient assaults as a safeguarding events.
- Staff did not know where the ligature cutters were or what they were used for. Some ligature risk and control measures were missing from the annual audit tool.
- Staff were not adhering to best practice with regards to mixed sex environments or following local safety procedures. There was no separate female lounge in the smaller eight bedded area.
- Confidential information was not stored securely.
- Statutory and mandatory training was limited and did not include medication management and the management of violent and aggressive patients. Staff were not trained in the management of violence and aggression.

- There was a lack of oversight by senior staff on the ward with regards to resuscitation procedures, safeguard reporting and managing mixed sex environments. Staff were not trained in restraint procedures and staff did not know how to respond to an incident involving the use of ligature cutters.

However:

- Staff were caring and committed to delivering a positive patient experience. Patients told us that they felt safe on the ward.
- Physical health monitoring was completed on admission and routinely thereafter. Care plans were up to date, comprehensive and patient focused.
- Best practice with regards to prescribing was being adhered to. Covert medication was being managed well.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Safeguarding procedures were not always being adhered to with regards to patient on patient assaults. Staff did not consider any patient on patient assaults as safeguarding events.
- Doors that should have been kept locked in the interest of patient safety were found open. Staff did not know where the ligature cutters were or what they were used for. There were ligature risks and control measures missing from the ward audit.
- Staff did not know the resuscitation status of one patient.
- Staff were not adhering to best practice with regards to mixed sex environments or following local safety procedures. There was no separate female lounge in the smaller eight bedded area.
- Statutory and mandatory training was limited and did not include medication management and the management of violent and aggressive patients. Staff were not trained in the management of violence and aggression.

However:

- Retention of staff was good, with ongoing recruitment of vacancies.
- Risk assessments were completed on admission and reviewed regularly thereafter. Care plans relating to identified risk were present and up to date.
- The ward was clean. Furnishings were in good order and the ward was well maintained.
- Infection control practices were adhered to. Staff were using the relevant colour coded aprons to help feed patients.

Requires improvement



Are services effective?

We rated effective as Requires Improvement because:

- The nursing office door had been left unlocked and unsupervised, allowing access to confidential information, including copies of Mental Health Act detention papers.

Requires improvement



Summary of findings

- Appraisal rates were low and data relating to staff that had been trained in dementia awareness was unclear which meant there was an unclear picture of staff skills and development needs.
- Ward rounds were not attended by qualified staff due to vacancies amongst registered nurses.

However:

- Physical health monitoring was completed on admission and routinely thereafter. Care plans were up to date, comprehensive and patient focused.
- Best practice with regards to prescribing was being adhered to. Covert medication was being managed well.
- Staff were receiving regular supervision.

Are services caring?

We rated caring as good because:

- Staff were caring and committed to delivering a positive patient experience. Patients told us that they felt safe on the ward.
- Relatives and carers were involved in patients care. Fortnightly carers meetings were being held.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- There were disabled facilities within the ward. Corridors were wide. Bedrooms were spacious and could accommodate wheelchair users. Equipment such as hoists were available.
- There were few complaints and those that had been made had been addressed.
- Bed occupancy levels were good at 91%. There were no delayed discharges.

However:

- The environment did not make best use of dementia friendly initiatives to promote independence and orientation.

Good



Are services well-led?

We rated well-led as requires improvement because:

Requires improvement



Summary of findings

- There was a lack of oversight by senior staff on the ward with regards to resuscitation procedures, safeguard reporting and managing mixed sex environments. Staff were not trained in restraint procedures and staff did not know how to respond to an incident involving the use of ligature cutters.
- Staff were receiving mandatory training. However, statutory and mandatory was lacking some subjects such as medicines management and the management of violence and aggression. Training data was not available about the number of staff that had been trained in the Mental Health Act and the Mental Capacity Act. Safeguard training figures were high at 83%. However; staff did not recognise that some patient on patient assaults may require consideration in line with formal safeguard procedures.
- Staff meetings were irregular.

However:

- Morale amongst staff was high.
- Staff were receiving supervision regularly.
- Staff had a good understanding of duty of candour regulation and could give examples of when they had used it.

Summary of findings

Information about the service

Brooker unit is a 22-bedded older people's ward for both men and women. The ward is split into two areas. One area cared for 14 patients with an organic illness. An organic illness is usually caused by disease affecting the brain, such as Alzheimer's. The other area with eight beds cared for patients with a functional illness. A functional illness has predominantly a psychological cause, such as depression.

Brooker unit is located at St James Hospital.

On the day of our visit, there were 10 patients detained under the Mental Health Act and four patients subject to Deprivation of Liberty Safeguard (DoLs) procedures.

Brooker unit had previously been known as the Limes (Appleby and Kitwood ward) and was split into two ward areas as described above.

Appleby and Kitwood ward were previously inspected in March 2014.

Our inspection team

The inspection was led by: Joyce Fredrick, Head of Hospital Inspection.

The team that inspected wards for older people comprised: two CQC Inspectors and two specialist

advisors, with specialist knowledge and experience of older people's mental health services and one expert by experience, who had experience of caring for someone with dementia.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- Visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with five patients who were using the service and one relative.

- Spoke with the manager and matron for the ward.
- Spoke with 15 staff members; including doctors, nurses, physiotherapists, pharmacy and occupational therapy staff.
- Attended and observed one hand-over meeting and one ward round.
- Collected feedback from three patients using comment cards.
- Looked at 18 medication records of patients.
- Carried out a specific check of the medication management on the ward.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

Patients we spoke with told us that they felt safe on the ward.

Patients we spoke with told us that they were well cared for and that staff treated them with dignity and respect.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that staff are aware of how to use ligature cutters and where to find them. It also must ensure that all information relating to the management of ligature risks is documented clearly.
- The trust must ensure that incidents of patient on patient assaults are reviewed and that safeguarding referrals are made appropriately.
- The trust must ensure that procedures are in place to maintain the safety of individual patients within a mixed sex environment, in line with national guidance.
- The trust must ensure that all confidential information is stored securely.

- The trust must ensure that there are systems and processes in place to monitor, assess and evaluate procedures and practices, including staff competence and training, resuscitation procedures, safeguarding procedures and managing mixed sex environments.

Action the provider **SHOULD** take to improve

- The provider should consider regular and consistent attendance of a registered nurse at ward rounds.
- The trust should consider requirements relating to statutory and mandatory training, including medicines management and the management of violence and aggression.
- The trust should consider improving the ward environment to ensure it is more dementia friendly, in line with nationally recognised best practice.

Solent NHS 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
Brooker Unit	St James 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.

- Mental Health Act (MHA) training figures showed that 52% of staff had undertaken this training.
- Staff we spoke with had an understanding of the MHA, the code of practice and its guiding principles.
- We reviewed six care records relating to consent to treatment and capacity and assessments. All were completed correctly, present and up to date.
- We spoke with the Mental Health Act administrator who showed us the process in place for recording patient rights under section 132. Rights were explained regularly by nursing staff.
- Legal advice could be sought from a centralised MHA team.
- Detention paperwork was filled in correctly and up to date. Original copies of detention paperwork were stored in a secure place. However, the nursing office door had been left unlocked and unsupervised, allowing access to confidential information, including copies of detention papers.
- The ward manager undertook a weekly audit of section 17 leave and a weekly audit on the explanation of the rights for detained patients.
- Where patients lacked capacity, automatic referrals were made to the independent mental health act advocate (IMHA).

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Health Act (MCA) training figures showed that 91% of staff had undertaken this training.
- At the time of our inspection, four of the patients on the ward were subject to Deprivation of Liberty (DoLs) safeguard applications.
- There was a policy on MCA including DoLs, which staff were aware of and could refer to. This was located on the trusts intranet page.
- We reviewed eight care records and all showed evidence of a medical assessment of patient's capacity to agree to admission. Assessments were decision specific.
- The ward manager considered that the ethos of the ward was to support patients to make decisions as far as possible. We reviewed eight care records and there was evidence of best interest's meetings with advocates involved.
- Staff we spoke with were able to explain their understanding of restraint in line with the MCA definition.
- Staff were able to seek support from a centralised MCA and MHA office.
- We saw evidence of DoLs applications being made appropriately. All patients were screened by the doctors regarding their capacity to consent to admission and we saw this documented on the trust's form.

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

- Brooker ward was split into two areas. There was an eight bedded mixed sex unit for patients with a functional mental illness. There was a 14 bedded mixed sex unit for patients with an organic illness. The wards were light and airy. There was a central communal space on both wards with male and female corridors leading away. There were clear lines of sight in both areas. There were small recesses at bedroom doors but these were not deep enough for patients to hide behind so staff could observe them fully when in bedrooms.
- Both ward areas had multiple ligature points including ensuite taps, bed frames and curtain rails. There was an up to date audit which had detailed each ligature point. However, there were some items missing from this audit including hinges on the maintenance access doors. One room had been described as having 'numerous hazards', whereas all other rooms listed each ligature point and item. Information surrounding control measures was limited. Areas that should have been locked in order to minimise risk to patients were open on the day of our visit. These areas were the cleaning cupboard, the staff only kitchen and the ward office. We raised these concerns on the day of our visit with the matron and who assured the issues would be addressed.
- Both ward areas had divided the bedroom areas into male and female corridors. All rooms were ensuite. On the fourteen bedded unit there was a quiet lounge which could be used by females only, if needed. However, the eight bedded unit was smaller and did not have additional space to allow for a female only lounge. On the day of our visit, there was one female patient occupying a room in a male corridor in the eight-bedded area. Under these conditions the matron and the ward manager described that a risk discussion surrounding the patients involved would take place. In addition, patient observations would be increased particularly during the night and staff would apply the bed beams to alert them to when patients were moving in and out of bed. Bed beams are virtual bed rails in the form of lasers which does not restrict movement but does alert staff to movement. We reviewed the care records relating to the female patient and found no evidence to show that any of these safety measures had been discussed and applied.
- The ward had a clinic room, but did not have a couch for examining patients. Examinations occurred in patients bedrooms. Resuscitation equipment was checked daily and we saw records to show that this was the case.
- There was no seclusion room on Brooker unit and we found no evidence in any care records to show that patients were being secluded in their bedrooms or other areas of the ward.
- The ward was clean and well maintained. There were no odours relating to incontinence care and furnishings were in good condition.
- The overall PLACE score for cleanliness for St James hospital where Brooker ward was located was 98%; this is the same as the national average score.
- Staff were adhering to infection control procedures and practices. For example, staff wore personal protective, colour coded clothing at meal times. Most of the seating was wipe clean and free of debris and dirt. There was signage around the ward areas directing staff and patients and visitors as to how to wash their hands correctly. Mop heads were colour coded, washed after use and tumble dried. We reviewed three weeks records relating to the management of legionella and all were completed. There were three members of staff who were infection prevention and control link advisors. The key role of the link staff was to develop best practice within their clinical area.
- Equipment was well maintained and subject to electrical testing. We observed that one nebuliser and two of the sphygmomanometers had not been checked; the check should have been completed in April 2016.
- Staff wore personal attack alarms that were serviced regularly. In addition, there were wall mounted alarm systems that alerted staff to incidents. We observed on two occasions these alarms being activated and both were responded to without delay.

Safe staffing

Are services safe?

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

- Staff sickness rates for February and March 2016 were 6%.
- Data provided by the trust with regards to agency usage was done so over the past 12 months (May 2016 to April 2016). These figures were reported when Brooker unit was split into two wards (Appleby and Kitwood). Combined figures showed that there were 208 shifts filled by agency staff. Only 18 shifts in the same time period had not been filled.
- The ward ran a three shift system, with nine staff on an early shift, nine staff on a late shift and seven staff on a night shift. On each shift there would be three registered nurses working across both areas with the remaining staff being health care assistants.
- There were no vacancies amongst the band seven (ward manager), band six (deputy ward managers) and band two (health care assistants) posts. Band five staff (registered nurses) had five vacancies. Two registered nurses had been recruited and were waiting to start once all necessary checks and clearances had been approved. Recruitment was ongoing to vacancies for registered nurses.
- The ward manager told us that bank and agency was used on occasion throughout the week. Where additional staff were required, generally this was covered by the wards own substantive staff who were bank members. This created consistent care and familiar faces for the patients.
- The ward manager told us that they are able to adjust staffing levels to take into account clinical demand, for example increased observations and one to one nursing.
- Escorted leave or ward activities were rarely cancelled because there were not enough staff. If this did occur activities and leave would generally be postponed as opposed to cancelled.
- There were enough staff on duty on the day of our visit to carry out physical interventions if required. From reviewing staff rosters we saw that there were enough staff on duty each day to carry out physical interventions, the ward manager told us that most staff were out of date with regards to managing situations that may require restraint.
- Out of hours medical cover was through the trusts on call system. There is a registrar doctor also on call at night. The majority (all except one Foundation Year One doctor) of junior doctors participated in the on call rota for the wider trust. On call staff are not resident but there is an on call room at St James hospital if their own home base is more than 30 minutes away.
- The trust had eleven subjects on their statutory and mandatory training agenda. This included diversity training: 86% of staff had completed this, fire safety (90%), health and safety (83%), infection Control (91%), manual handling (97%), resuscitation (100%), safeguarding children (93%) and safeguarding adults (83%). Information governance (93%) and staff appraisals (57%). We found that there was no medicine management, including rapid tranquilisation on the statutory and mandatory training agenda. We were also concerned to learn that there was no information available with regards to the management for violence and aggression. We were told by the ward manager that the delay in training was due to the previous course provider no longer being used by the trust and as a result staffs training in relation to the management of violence and aggression had expired. The trust was currently adjusting the prevention and management of violence and aggression (PMVA) course content to suit the older people's services. We were told seven people had completed this however we did not see any records on the ward to support this was the case. Post inspection the trust provided information surrounding PMVA training. The trusts consultation papers surrounding PMVA training stated that 'currently none of the old people's mental health inpatient staff have sufficiently or consistently been trained in any one restraint technique'. However, the trust had identified this as a risk and this was on the local risk register.

Assessing and managing risk to patients and staff

- There were no reported incidents of seclusion or long term segregation over the past six months prior to inspection.
- The trust reported four incidents of restraint over the six months prior to the inspection, involving four different patients. Of these none were reported as being in the prone position.
- On the day of our inspection we found that one patient's resuscitation status was not clearly known to staff. Staff had handed over on the day of our inspection that one patient was not for resuscitation. We were unable to

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locate the relevant documentation relating to this. We were later informed that the patient concerned was in fact for resuscitation. We checked the handover notes for the previous three days and found the error to have occurred only on the day of our inspection but this identified a potential risk. We brought this to the attention of the ward management. Following the inspection the trust submitted an action plan outlining what action had been taken.

- We reviewed eight care records and all patients had an up to date, completed risk assessment. A falls risk assessment and risk screen was completed within six hours of admission. All assessments were comprehensive and any identified risks had a plan of care. We found one care record where a risk of aggression was not matched with a plan of care. Risk screening was updated every week or after incidents.
- Staff used the risk assessment documents held on system one (the trusts electronic recording system) to formulate patients risk information.
- We were told that patients were not able to make hot drinks and snacks independently for safety reasons. However, there was a water fountain and we were told that drinks would be made on request.
- Brooker unit was locked. The locked door policy was displayed on the notice board. However, this was written in language aimed at professionals and not easily understood by patients and their visitors. There was no notice by the exit door to remind informal patients that they could leave the ward and what they needed to do if they wished to. Informal patients who wanted to leave remained subject to a risk assessment first. An identification record, including what clothes they are wearing when they left was taken. A contingency plan was discussed with patients in case there were any problems whilst patients were away from the ward.
- Patients were observed hourly, as a minimum. This was to check on patient's whereabouts, safety and general wellbeing. We saw observation records to show that this was the case and staff were carrying out observations consistently and properly.
- We saw examples during our inspection of how de-escalation techniques were applied in order to avoid restraint. Staff could explain this clearly and would intervene quickly using distraction techniques to avoid situations escalating.
- Staff were administering intra muscular rapid tranquilisation (RT) in line with trust policy. Physical health monitoring was being completed and patients monitored for side effects post a RT event. We saw records to show that this was the case. However, when the same RT medications were administered orally, staff were not recognising this as a RT event and as a consequence; physical health monitoring was not taking place in line with local policy. We asked three registered nurses if Flumazenil, a medicine used to reverse the effects of benzodiazepine overdoses was available on the ward, where it was and what is what used for? All but one were able to answer all questions.
- Eighty three per cent of staff were trained in safeguarding adult procedures. Staff we spoke to were able to give examples of what type of incidents they would raise a safeguard alert about. For example, financial exploitation and if a patient were to be found with bruising that could not be accounted for. However, staff we spoke to did not consider that any patient on patient assaults should be subject to a formal safeguard process.
- There were good medicines management practices on the ward. Scheduled and controlled medicines were stored appropriately. Fridge temperatures were taken on a daily basis and recorded. We reviewed these records and all were complete and up to date. Records indicated that fridge temperature were in range of two to eight degrees. The records looked at were within the temperature range of two to eight degrees. We reviewed the controlled drug (CD) stock register and this was up date and complete. The CD stock and stock register was checked by two registered nurses weekly. We checked the stock and expiry dates of three controlled drugs and found these to be in date. We checked three scheduled drugs and found these to be in date. Medicines reconciliation was undertaken by the ward pharmacist on admission. Reconciliation checks were easily identifiable on the medication cards as they were written in green. We reviewed covert medication practices on the ward. Covert medication is the

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administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. All relevant documentation was present and up to date. Covert practices were being well managed on the ward. However, we did raise with the ward manager that there was no indication as to the route covert medications should be administered under, for example, in food or drinks.

- All patients were subject to a pressure ulcer assessment and we saw records to show this was the case. There had been one incident in the past twelve months involving a pressure ulcer. However, this had developed following a general hospital stay and was addressed and cared for by Brooker unit upon the patients return to the ward.
- There was a visiting room in the reception area that was child friendly. We were told by the ward manager that children were allowed onto the unit following a risk assessment of the ward at that time.

Track record on safety

- In the past 12 months, there were three serious incident related to Brooker unit, although two of the incidents occurred during a period of leave form the ward. Prior to these incidents in the past 12 months, Brooker unit had one serious incident which resulted in death and was related to a physical health complication. As a result, the ward had implemented a bowel management care plan for every patient. We reviewed eight care records

and found this care plan to be present in all cases. In addition, bowel movement charts are kept on each patient and we saw records to show that this was the case.

Reporting incidents and learning from when things go wrong

- All incidents that should be reported were being reported. Staff we spoke with knew what to report and how to report incidents. The trust used an electronic incident reporting system called 'safeguard'. We saw evidence to show that incidents involving medication errors and patient on patient and patient on staff assaults were being entered on to this system.
- Staff we spoke with were familiar with the term duty of candour regulation. Staff were able to provide examples of when they had been open, honest and transparent with patients when things had gone wrong.
- We were told that following any incidents and investigations staff would meet as a group to discuss the outcomes. Emails were also used to cascade information.
- We saw evidence to show that learning had occurred as a result of incidents. For example, all patients were subject to a choking assessment on admission regardless of their need. This would be subject to review once staff were more aware of the risks related to patients when eating.
- We were told by staff that following any serious incidents, staff are offered support and debrief sessions which were held on the ward.

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 eight care records and found that on admission all patients received a physical examination and mental state examination including mini mental state examinations. Bloods and electrocardiograms were done routinely. The electronic records system that the trust used called System one could allow access to some of the general practitioner records, including blood tests and medication history. In addition, a capacity assessment and a deep vein thrombosis assessment was completed. Within six hours of admission, nursing staff completed a range of assessments including a manual handling, waterlow scoring (an assessment for identifying risk of pressure ulcers) a new early warning score (which monitors vital signs,) malnutrition universal screening tool (which assess patients dietary needs) and a falls risk assessment.
- We found evidence in all care records to show that ongoing physical health monitoring happened, routinely and regularly.
- All care plans were personalised, holistic, and recovery-oriented.
- We were concerned to find during our visit that the nursing office had been left unlocked and unsupervised creating a potential information governance breach.

Best practice in treatment and care

- We reviewed 18 medication charts and found that prescribing was in line with the National Institute for Health and Care Excellence (NICE) guidelines. We found that NICE guidance on prescribing for behavioural problems and non-cognitive symptoms in dementia was being taken into consideration and a number of patients were receiving anti dementia medications.
- There were plans for staff who were based at a nearby general hospital that specialised in health care of the elderly to come to Brooker unit and advise staff on best care and treatment approaches on specific elderly patients; this was by referral only. Medical staff on the

ward managed all other physical health care needs. Dental care was sourced locally and podiatry and dieticians were employed by the trust would see patients referred to them.

- The ward manager told us that all patients had a choking risk assessment and we saw records to show that this was the case. All patients that had an organic illness had a food and fluid chart and care plan put in place on admission. If following admission there were no risks relating eating and choking these would be discontinued. The ward manager completed audits of food and fluid charts. We saw evidence of these being completed in records. Patients also had access to specialist assessments from the speech and language therapist (SALT).
- Patients were assessed on admission using the health of the nation outcome scales (HONOS). HONOS was used to measure the health and social functioning of people with severe mental illness.
- The ward participates in the national prescribing observatory for mental health (POMHS) audit of antipsychotics prescribed in dementia.

Skilled staff to deliver care

- There was a range of professionals who were involved in patients care, including medical staff, occupational therapists, nursing staff and pharmacists. Psychologists were available by referral.
- Staff were experienced and qualified. However, we were concerned to learn that some staff did not know where ligature cutters were or what they were used for.
- New staff would attend a trust induction. We spoke with the ward manager and the matron about access to the care certificate. Neither were aware of what this was.
- Staff were receiving supervision on a monthly basis. All staff had received supervision for the months May and April 2016. We saw records to show this was the case. Fifty seven per cent of staff had completed their annual appraisal.
- Team meetings were not happening on the ward consistently. The ward manager told us that they tried to

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hold monthly meetings but they were not always able to, preferring to send emails with information instead. We did not see any records to confirm frequency or content of these meetings.

- We were told by ward management that staff had access to dementia awareness training. We asked for data relating to this post inspection. However, it was not clear from the information provided whether staff had received dementia training or not.
- On the day of our visit there were no staff subject to staff performance issues. The ward manager was able to articulate what course of action they would take if they had concerns about staff performance.

Multi-disciplinary and inter-agency team work

- There are two consultant led multi-disciplinary team (MDT) ward rounds per week per ward area (functional & organic). We observed a ward round during our visit. Staff who attended, including medical and pharmacy staff, were professional and knowledgeable about patient needs. Medical staff did raise concern about the lack of nursing staff attending ward rounds. We were told by ward management this was due to vacancies with registered nurses. Although a handover is provided by the nursing staff in preparation for the ward round, there is a risk that information will be missed, impacting on care and treatment.
- Handovers happened at the change of each shift. We observed one handover. Although initially we had observed a handover that provided information in detail about patients care, we were concerned to later learn that the wrong information surrounding a patients do not resuscitate status had been incorrect. When we raised this with the ward it was addressed immediately.
- We were told by ward staff that care-coordinators attended care programme approach meetings on the ward. The consultant psychiatrists who worked on the ward were also linked to the community mental health teams which supported good communication.
- The electronic patient records 'system one' allowed access to selected GP records. An independent charity provided post diagnostic support to patients with dementia and monitoring was done by the memory clinic nurse based within the community; the ward had access to all of these services.

Adherence to the MHA and the MHA Code of Practice

- MHA training figures showed that only 52% of staff had completed training.
- However, staff we spoke with had an understanding of the MHA, the code of practice and its guiding principles. Trust devised paperwork assisted staff to consider the Mental Health Act when determining the legal framework for detention. There was a copy of the revised Code of Practice in one of the nursing offices on the ward.
- We reviewed six care records relating to consent to treatment and capacity and assessments. All were completed correctly, present and up to date. We found evidence of second opinion approved doctors (SOAD) being requested in a timely manner and evidence of the SOAD discussion with the statutory consultees within care records.
- We spoke with the Mental Health Act administrator who showed us the process in place for recording patient rights under section 132. Rights were explained regularly by nursing staff and the patient's level of understanding clearly documented. We reviewed six care records relating to section 132 rights and saw that this was the case.
- Legal advice could be sought from a centralised MHA team.
- Detention paperwork was filled in correctly and up to date. Original copies of detention paperwork were stored in a secure place. However, the nursing office door had been left unlocked and unsupervised, allowing access to confidential information, including copies of detention papers.
- The ward manager did a weekly audit of section 17 leave and a weekly audit on the explanation of the rights for detained patients.
- Where patients lacked capacity, automatic referrals were made to the independent mental health act advocate (IMHA). At other times, staff would contact the IMHA office on behalf of patients and an IMHA would attend the ward.

Good practice in applying the MCA

- Staff training figures showed that 91% of staff had completed training on MCA and Dols.

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.

- Between 1 September 2015 and 1 March 2016 there had been 10 Deprivation of Liberty safeguard (DoLS) applications made by Brooker ward. At the time of our inspection, four of the patients on the ward were subject to DoLS applications.
- There was a policy on MCA including DoLS which staff are aware of and could refer to. This was located on the trusts intranet page.
- We reviewed eight care records and all showed evidence of a medical assessment of patient's capacity to agree to admission. Assessments were decision specific. For example, other capacity assessments related to finances were evident and more day to day decisions, such as what to wear were held in care records.
- The ward manager considered that the ethos of the ward was to support patients to make decisions as far as possible. We reviewed eight care records and there was evidence of best interest's meetings. Staff would seek to involve an advocate or social worker and we saw records to show that this was the case.
- Staff we spoke with were able to explain their understanding of restraint in line with the MCA definition. We found proactive recognition and recording of restraint in the care records we reviewed.
- Staff were able to seek support from a centralised MCA and MHA office.
- We saw evidence of DoLS applications being made appropriately. All patients were screened by the doctors regarding their capacity to consent to admission and we saw this documented on the trust's form. This assessment would trigger DoLS applications where required. We saw evidence of this being kept under review if capacity changed.
- The ward manager acknowledged that chasing the progress of DoLS applications could be improved. At present staff would write a reminder in the diary to chase an urgent authorisation for DoLS however we did not see a systematic overview of this.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff caring for patients in a discreet, good humoured and respectful way. Staff were chatting quietly with patients and comforting patients when they were distressed. Where help was needed to navigate their way around the ward, patients were helped by staff in doing this, by gently holding hands and offering words of encouragement.
- Patients we spoke to told us that they were happy and that staff looked after them well.
- Overall staff we spoke with had a good understanding of dementia patient needs and the needs of the individual patients. However we were concerned to learn that one patient's resuscitation status was unknown to the staff.
- PLACE data for St James reported 91% compliance with regards to patient's privacy, dignity and wellbeing. The national average is 87%.

The involvement of people in the care they receive

- The admission process included information about the ward and orientated patients to the ward environment.
- Where possible, patients were involved in care planning and we saw evidence to show that this was the case. Where the nature of the patients' illness limited input to care planning and treatment choices, family members would be consulted.
- Advocacy information was displayed around the ward. Advocacy representatives visited the ward weekly and upon request.
- Carer focus groups were held fortnightly on the ward.
- We found no evidence to show that patients were involved in decisions about the service including being able to recruit staff.
- We found no evidence to show that advance decisions had been made by any patients.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- Bed occupancy figures for the month of May were 91%.
- We were told that there were no out of area placements at the time of our visit. We found no evidence to suggest that this was not the case during our visit.
- We were told that beds were available to patients living within the catchment. We found no evidence to suggest otherwise during our visit.
- Staff was access to a bed for patients returning from leave. Extended periods of leave may result in beds being used for other patients. However, staff told us that they would consider how many patients were due for discharge before they made the decision to admit patients into leave beds.
- We were told that patients were not moved between wards during an admission episode. Brooker unit was the only older people's mental health ward in the trust and therefore did not have access to similar provision within the trust.
- We were told by the ward manager that discharge always happened at an appropriate time of the day. We were told that every effort was made to support discharge at a time when families and carers were able to help facilitate discharge.
- The ward manager told us that discharge was never delayed for reasons other than clinical need. We found no evidence to suggest this was not the case.
- As of May 2016 there were no delayed discharges. The ward manager told us when delayed discharges have occurred this had been due to finding and agreeing funding for appropriate placements.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward lacked appropriate decoration and items used to make old peoples wards more dementia friendly. There was no use of colour around bedroom door frames to help patients orientate themselves to their own rooms. There were no memory boxes or photographs or other identifying features to help patients locate their own bedrooms or appropriate signage to help navigate their way around the ward.

- There was a visiting area for families in the main reception area. However, families were allowed on to the ward to visit patients.
- Patients were able to use mobile phones. At other times, patients were able to use the ward phone and where necessary were supported to do this.
- There was a pleasant outside space that was central to the ward which patients had access to.
- We looked at four weeks menus. Overall, there was always a vegetarian option and a choice of sandwiches and soup, as well as the main menu choices. Specific dietary needs were catered for such as soft foods and diabetic foods. Religious needs such as Halal meat would be ordered specially if needed.
- Patients were supported by staff in the dining room at mealtimes.
- Drinks and snacks were available but patients required assistance and supervision due to the nature of their illness.
- Staff told us patients were encouraged to personalise their rooms but this was dependent on relatives bringing in personal effects.
- Patients had locked cabinets within their own bedrooms for personal belongings.
- Group activity programmes were displayed in the ward areas. Group activities ranged from chapel services, exercises and domestic activities. These were mostly led by the OT staff, Monday to Friday, 9am until 5pm. Other activities such as board and card games would be led by nursing staff, including at weekends, although these types of activities were more spontaneous and we were told by staff, that they would only be initiated when staff had time. We asked the ward manager and the OT staff about activities that involved reminiscing. We were told that cooking and music sessions would be used to provoke reminiscence. On the hospital site there was a dementia cinema where old-time movies would be shown.

Meeting the needs of all people who use the service

- Both ward areas had disabled facilities including adjusted bathrooms and bedrooms. Corridors were wide and wheelchairs were available.

Are services responsive to people's needs?

Good 

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

- There were no information leaflets in other languages on display on the ward. However, staff told us that they were able to source these from the trust intranet system.
- We saw lots of information surrounding old people's physical and mental health displayed in reception. However, these were not immediately available to patients on the ward due to their location.
- Access to the interpreters was by referral and sourced locally.
- The trust had a spiritual support department and a vicar would visit as required. This arranged through local churches. Other religious representatives would also be sourced locally.
- The trust reported seven complaints over the past 12 months, prior to our inspection. Of these two were concerns about discharge arrangements, one about nursing care, two about clinical treatment, one about communication and one about the outcome of a previous complaint. Of these two were fully upheld, three were partially upheld with the remainder no case to answer. None were referred to the ombudsman.
- Patients we spoke to and those that were able to, told us that they knew how to make a complaint and if necessary would seek help from staff in doing so.
- Staff we spoke to were able to verbalise their understanding of the complaints process. All said that they would try and deal with the complaint if they were able to. If not, complaints would be escalated to the ward manager and support from patients advocacy liaison staff would be sought. There was information on how to make a complaint displayed on the ward.

Listening to and learning from concerns and complaints

Are services well-led?

Requires improvement 

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

Our findings

Vision and values

- Staff knew about and some were able to recite the trust's values and vision. Staff told us that they felt the trusts values and vision reflected their own ward philosophy for which they had a positive attitude about.
- Staff we spoke with knew who the most senior managers were in the organisation although they had not seen them visit the ward.

Good governance

- Staff were receiving mandatory training and attendance and completion rates were good, however, medicines management and the management of violence and aggression was missing. Although practices around MHA and MCA were good, training data showed that only 52% of staff had been trained in the Mental Health Act. Staff were receiving supervision regularly but the amount of staff that had completed an annual appraisal was low at 57%. Safeguard training figures were high at 83%. However; staff did not recognise that some patient on patient assaults may require consideration in line with formal safeguard procedures.
- Key performance indicators (KPI) relating to older peoples services looked at suggested length of stay and was subject to regular review by the trust and commissioners.
- The ward manager told us that they felt they had sufficient authority on the ward. Administration support was provided by the reception staff.
- When asked, the ward manager was not clear about how to contribute to or what information was held on

the risk register. The matron had access to the local risk register. We were able to see that items such as PMVA training had been added. These risks would be reviewed at monthly governance meetings.

Leadership, morale and staff engagement

- Staff sickness rates for February and March 2016 were 6%.
- At the time of our visit there were no bullying and harassment cases and neither were we informed of any by the ward management or staff.
- Staff we spoke with told us that they knew how to use the whistleblowing process and that they would use it if they had concerns, without fear of victimisation.
- Staff we spoke with told us that they were proud of the care that they delivered and that they had a real sense of purpose and achievement. Staff described good team working between their immediate team members and wider professional groups. Staff were particularly complimentary about the ward manager and the matron for the ward, observing that they both had a good working relationship that was supportive of the wider staff team.
- Overall, staff we spoke with were familiar with the term duty of candour. Those that were not, once explained, were able to offer examples of when they have been open and transparent with patients and explained when things have gone wrong.

Commitment to quality improvement and innovation

- The ward was not involved in any national quality improvement programmes.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment

Providers must make sure that staff have the qualifications, competence, skills and experience to keep people safe.

Staff did not know where the ligature cutters were or what ligature cutters were used for.

This is a breach of Regulation 12 (1) and (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment

Providers must prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment.

This section is primarily information for the provider

Requirement notices

The ward had not adequately assessed the risk to patients within a mixed sex environment.

This a breach of Regulation 12 (1) and (2a) and (2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13: Safeguarding service users from abuse and improper treatment

The provider must safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment.

We found that no patient on patient assaults were being considered or reported as safeguarding events.

This is a breach of Regulation 13 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Safeguarding service users from abuse and improper treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance

This section is primarily information for the provider

Requirement notices

The provider must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others.

There was a lack of oversight by ward management with regards to resuscitation procedures, safeguard reporting, managing mixed sex environments, knowledge of trained staff in restraint procedures and staffs knowledge of how to respond to an incident involving the use of ligature cutters.

This is a breach of Regulation 17 (1) and (2a) and (2b) and (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance

The provider must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice.

This section is primarily information for the provider

Requirement notices

Information relating to ligature risks was missing from the annual audit tool.

This is a breach of Regulation 17 This is a breach of Regulation 17 (1) and (2a) and (2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance

Providers must securely maintain records in respect of each person using the service.

We found that confidential patient records had not been secured properly due to open office doors, allowing easy access to unauthorized persons.

This is a breach of Regulation 17 (1) and (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance.