

Manchester Mental Health and Social Care Trust

Wards for older people with mental health problems

Quality Report

Trust Headquarters

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Date of inspection visit: 23 - 27 March 2015
Date of publication: 05/10/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
TAE03	Park House	Cedar Ward Maple Ward	M8 5RB
TAE02	Laureate House	Cavendish Ward	M23 9LT

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care 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 Manchester Mental Health and Social Care Trust and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care 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?

Inadequate



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 gave an overall rating for wards for older people with mental health problems of requires improvement because:

- We identified regulatory breaches around the suitability of fridges on Cedar and Maple wards and testing of their operational temperatures to ensure they were safe.
- Progress had not been made in the use of the Mental Health Act and Mental Capacity Act. Mental Health Act documentation was not completed correctly for patients on Cedar, Cavendish and Maple wards so they were not always supported to understand their rights, their medication was authorized, their leave was approved and their detention was legally supported by the appropriate documentation being in place.
- Where applications to deprive patients of liberty had been made to the local authority by means of an urgent or standard application. The local authority had agreed with the trust that where it had been unable to process and authorise applications, the trust could deprive patients of their liberty without time limits until the authorisation was agreed. This agreement was subject to the trust making urgent and standard authorisation applications together for individual patients and the local authority had confirmed this agreements with senior managers within the trust. The agreement had not been communicated to the relevant service or ward managers so urgent applications to deprive patients of their liberty were not consistently made with standard ones and patients were deprived of their liberty without local authority approval.
- Patients were not always involved in their care planning across the wards nor did they have a copy of their care plans where appropriate.

The ward environments should reflect a recovery focused approach and aid patients living with dementia to be more independent through appropriate signage and low stimulus areas for patients to relax.

The trust had recognised there were performance issues around the management of Cedar and Maple wards and had made remedial changes to the management of the wards as a result. There were also issues about

recruitment of staff to later life services effecting Cedar ward. As a result the trust decided to close Cedar ward because of concerns about risk arising from patient case mix and difficulties in recruitment of nursing staff. This also aligned with the trust later life strategy to increase community services and care close to home. It was also good to see that Cedar ward was maintaining safe standards of care during the closure period.

The staff we spoke to across all wards felt connected to the later life service and the trust. Staff were not aware of the trust vision and values. They were well led by their immediate line managers.

Wards were operating the trust wide audit schedule which was used to quality assure services.

The commitment and care displayed by many of the staff was observed throughout the inspection. Wards were well led and on Maple and Cedar wards alternative management arrangements had been implemented. Risks were being well managed.

Relatives and carers were positive about being informed and involved in care decisions, which we observed during multi-disciplinary meeting which they were involved in.

We observed a number of caring and respectful interactions between staff and patients. Staff members were very respectful, for example knocking on doors before entering bedrooms. We observed staff laughing and joking appropriately with patients in a manner which suggested familiarity and mutual respect. Patients we spoke to were positive about their ward and the care they received.

There were many examples of good multi-disciplinary working and work between agencies to facilitate people being discharged.

We saw patients, relatives and carers were involved in MDT meetings and discharge planning. We saw examples of good relationships between community mental health teams and inpatients services, which meant patients, were referred at the appropriate time to community mental health teams.

Patient's cultural and religious needs were met. Information was available in different languages/formats

Summary of findings

and a varied choice of meals meeting peoples differing dietary needs was available. Patients were well informed on how to complain and concerns were addressed as needed.

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:

- On Cedar and Maple wards the fridges in the ward kitchens were not safety tested for over two years. The seals on the fridge doors were split and missing in place as well as operating temperatures of the fridges being too high, not cleaned or not suitably monitored. These were not the medical fridges used to store medicines but domestic fridges used to store food. Food without a used by date was left in an occupational therapy room fridge on Maple ward.
- Staff working on wards for older people needed to clearly identify in individual patients' care plans and risk assessment how they were supporting patients to remain safe when environmental risk assessments identified ligature risks in areas of the ward they were accommodated in or used for their personal or social care needs.

However:

- There were sufficient staff to meet the needs of people using the service and where bank or agency staff were used they generally knew the ward. Risk assessments were in place and were being updated regularly.

Requires improvement



Are services effective?

We rated effective as **inadequate** because:

- Patients across the three wards did not have regular access to and input from clinical psychologists as part of their assessment, treatment and recovery as recommended by the national institute for clinical and health excellence (NICE).
- Mental Health Act documentation was not completed correctly for patients on Cedar, Cavendish and Maple wards: to ensure people are being supported to understand their rights, their medication is authorized, their leave is approved and their detention is legally supported by the appropriate documentation being in place.
- Where applications to deprive patients of liberty had been made to the local authority by means of an urgent or standard application. The local authority had agreed with the trust that where it had been unable to process and authorise applications, the trust could deprive patients of their liberty without time limits until the authorisation was agreed. This

Inadequate



Summary of findings

agreement was subject to the trust making urgent and standard authorisation applications together for individual patients and the local authority had confirmed this agreements with senior managers within the trust. The agreement had not been communicated to the relevant service or ward managers so urgent applications to deprive patients of their liberty were not consistently made with standard ones and patients were deprived of their liberty without local authority approval.

However:

- On Cedar and Maple ward diagnostic and screening checks were routinely conducted to confirm the diagnosis and ensure that medication prescribed was suitable.
- Good multi-disciplinary team working was taking place with the exception of the lack of psychological input. Staff had a working knowledge of the Mental Health Act and Mental Capacity Act although further work is needed to ensure all the correct documentation is maintained to ensure peoples' rights are protected at all times.

Are services caring?

We rated caring as good because:

- We received good feedback from the relatives and carers about the care provided and their level of involvement in care and decision making.

However:

- Patients were not always involved in their care planning across the wards nor did they consistently have a copy of their care plans where appropriate.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

- Patients, relatives and carers were involved in MDT meetings and discharge planning. We saw examples of good relationships between community mental health teams and inpatients services, which supported patients being referred at the appropriate time to community mental health teams.
- Patients' cultural and religious needs were met. Information was available in different languages/formats and a varied choice of meals meeting peoples differing dietary needs was available. Patients were well informed on how to complain and concerns were addressed as needed.

Good



Summary of findings

However:

- The ward environments were not recovery focused and did not able people living with dementia to be more independent.
- Patients' bedroom or dormitory areas were not homelike to support patients' recovery.
- Cavendish ward had dormitory, which contained four beds, and despite curtains partitioning the beds; the dormitory did not offer privacy. The dormitory had an adjoining bathroom.

Are services well-led?

We rated well-led as **requires improvement** because:

The ward leadership had not recognised:.

- The actions identified from past Mental Health Act reviewer visits had not been completed.
- There were concerns with incomplete Mental Health Act paperwork which did not assure that patients detained under sections of the Act were safeguarded.

However:

- The staff felt connected to the later life service and the trust. Staff were not fully aware of the trust vision and values. They felt well led by their immediate line managers.
- Wards were operating the trust wide audit schedule which was used to quality assure services.

Requires improvement



Summary of findings

Background to the service

Cavendish ward provides inpatient treatment for older age adults with functional and organic disorders. It is a mixed sex ward located in Laureate House in the grounds of Wythenshawe Hospital. The service had 20 beds located in three corridors composed of one dormitory with four beds, two double bedrooms and 12 single bedrooms.

Cedar Ward was a 20 bed ward for older men with either functional or organic mental health difficulties. The ward was based on the ground floor of the Park House unit on the North Manchester General Hospital site and offering accommodation in dormitories and single bedrooms. At the time of our inspection Cedar ward was only accommodating seven patients as the ward was in the

process of closure. Discussions regarding changes to the inpatient capacity for later life had been underway for some time. However, the decision to reduce from three wards to two had to be made at short notice due to a severe staffing shortages, made worse by the challenges presented by Cedar Ward operating as a ward for adult and later life men with both organic and functional illnesses. Patients remaining on the ward were due to be discharged within the near future.

Maple ward was a 20 bed, for older women with either functional or organic mental health difficulties. The ward offers accommodation in dormitories and single bedrooms. The ward was based at the Park House unit on the North Manchester General Hospital site.

Our inspection team

Our inspection team was led by:

Chair: Steve Shrubbs, Chief Executive Officer, West London Mental Health NHS Trust.

Team Leader: Brian Burke, Care Quality Commission.

Head of Inspection: Nicholas Smith, Care Quality Commission.

The team that inspected the wards for older people with mental health problems consisted of: one expert by experience, one inspector, one Mental Health Act reviewer, one nurse, one psychiatrist, one psychologist and one occupational therapist.

Why we carried out this inspection

We inspected this trust as part of our on going comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of 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, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited all three of the wards at the two hospital sites and looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with 21 patients who were using the service

Summary of findings

- spoke with the managers or acting managers for each of the wards
- spoke with 29 other staff members; including doctors, nurses and social workers
- attended and observed three hand-over meetings and two multi-disciplinary meetings.
- collected feedback from six family members when speaking with them.
- looked at 21 treatment records of patients.
- carried out a specific check of the medication management on three wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 21 patients and six relatives. Most were positive about their experience of care on the wards. They told us that they found staff to be very caring and supportive, and most people were involved in decisions about their care.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **MUST** take to improve the wards for older people with mental health problems

- Cedar and Maple wards must have the kitchen fridges safety tested and door seals replaced to ensure the fridges are operating at safe temperatures, operating temperatures monitored, recorded and kept in a clean state.
- The trust must ensure that Mental Health Act documentation is completed correctly for patients on Cedar, Cavendish and Maple wards to ensure people are being supported to understand their rights, their medication is authorized, their leave is approved and their detention is legally supported by the appropriate documentation being in place.

Action the provider **SHOULD** take to improve the wards for older people with mental health problems

- The trust should ensure fridges used for storing medicines are maintained and cleaned regularly.
- The trust should ensure food left in fridges is correctly labelled to show a date opened and a use by date.

- The trust should ensure prescribed medicines of the same type but with different batch numbers and expiry date are not stored in one box, when a new supply had been received from the pharmacy.
- The trust should ensure staff working on wards for older people can clearly articulate through patient centred care planning how they are supporting patients to keep safe in terms of the ligature risks on the ward.
- The trust should ensure patients in later life services have regular access to and input from clinical psychologists as part of their assessment, treatment and recovery as recommended by the national institute for health and care excellence(NICE).
- The trust should ensure that where patients are subject to a deprivation of liberty safeguards that the authorisations pending agreement from the local authority are kept under review, updated as needed and decisions about time limitations is communicated to the relevant managers.
- The trust should follow guidance on dementia friendly environments and use research to promote dementia friendly environments.

Manchester Mental Health and Social Care 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
Cedar Ward Maple Ward	Park House
Cavendish Ward	Laureate House

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.

Our last Mental Health Act visits to the trust were to Cedar ward on 5 September 2014, Cavendish ward on 9 March 2015, and Maple ward on 1 September 2014. Common themes had been identified during these visits:

- Explanation to patients of their rights whilst detained was very inconsistent.
- Administration of medication without proper authorisation and T3 forms authorising the administration of specific medication were not held with the related medication card. .

- Section 17 leave forms were left on file or were not completed correctly. This means staff would not have clear or up to date information about the leave arrangements agreed with the responsible clinician and patients may not receive their full leave arrangements.
- There was evidence patients were not involved in or aware of the content of their care plans and were not given copies of these. Care plans were not person centred.
- Recording of capacity assessments under the MCA was very inconsistent. There was also inconsistent evidence of assessment of capacity to consent to treatment.
- Recording of IMHA referrals for detained patients- what about it? Not recorded?

At this inspection across the three wards, we saw continued examples of how the Mental Health Act and code of

Detailed findings

practice were not being adhered to. It was reported that regular audits of the MHA documentation were happening across all sites. However the issues found would indicate that these audits were not effective in highlighting errors.

Staff received training on the mental health act but only 64% of staff had received training this training. Staff working on the wards had a good understanding of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff training on the Mental Capacity Act (MCA) was mandatory and records showed the staff figures for complete on of training on the Mental Capacity Act as 44%. This falls below the trust requirements.

There were several issues around the use of deprivation of liberty safeguards (DOLS) authorisations. The local authority had in agreement with the trust identified a work around for when the local authority was not able to process and approve standard applications. This arrangement was that if both urgent and standard applications were

submitted at the same time, the trust were allowed to deprive individuals without limit of time until the local authority had approved the application. This is not in line with the Mental Capacity Act.

Across the three wards we observed that staff supported patients to make decisions where appropriate when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history, which were recorded in care plans.

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

Summary of findings

Our findings

Safe and clean ward environment

On Cedar and Maple wards there were not clear lines of sight for observing patients. There were many blind spots on these wards. We did not see consistent use of convex mirrors in areas on the wards where you couldn't clearly see. However, staff said they regularly checked corridors and would discretely follow a patient if they moved out of view.

We saw all the wards had copies of the most recent ligature audit which was reviewed in August 2014, which had been completed by the acute services manager. However, we saw from the ligature assessments for each ward a range of ligature points had been identified and the control measures were "to manage these individually". The risk assessment and risk register had been reviewed because all wards were accommodating adults of working age (AOWA) and additional risks had to be considered. The service manager and associate director for later life services told us that this decision to provide places for AOWA had been reviewed and was in process of change during our inspection. Therefore the risk registers and ligature assessment needed to be updated to reflect this decision. There was active assessment of risk of self harm observed.

For example we looked at risk assessment information regarding patients' historic risk to suicide or ligature. On the three wards no patients who fitted this profile were identified. We looked at risk assessment of patients with elevated risks to suicide where this had been identified. Examples we saw were when patients had made comments about self harm and staff had discussed this with them to ascertain if there was a risk. We saw good examples of staff recording the patients' explanation of their comments to clarify there were not a current risk of self harm or suicide.

One of the three wards visited did not comply with the guidance on same sex accommodation. On Cavendish ward we found there was no separate female quiet lounge in the female accommodation. We also saw a male patient being escorted by staff from the female accommodation. We raised this as a concern with the trust.

Cavendish ward had one dormitory which contained four beds, separated by curtains between the beds. The dormitories did not offer privacy. Each dormitory had adjoining bathroom. We visited Cavendish on the day that it was receiving additional temporary patients from Cedar ward.

Cavendish ward was originally built to accommodate 28 patients but only operated at that level for a short time after it was commissioned in 2001. For some years its capacity has been held at 20 beds. The ward includes an annex providing an OT room including a kitchen, a physiotherapy gym, and offices. At the time of the visit there were 26 patients accommodated on the ward using the original designed space. This was a temporary measure following the closure of Cedar ward.

The main lounge had 28 seats in it but the seats were in lines and very close together, not allowing any personal space.

This was further complicated by patients with mixed functional and organic mental illness and differing levels of acuity all socialising in the same area.

The size of the dining room could not safely or comfortably accommodate all of the patients on the ward taking into account the specific needs of the patients, such as the numbers of patients with limited mobility or using wheelchairs. Patients were observed eating their meals in the lounge due to patient choice.

We raised the concerns about Cavendish ward at the time of our inspection with the trust. We received assurance from the trust that the patient numbers on Cavendish ward would be reduced from 1st April 2015 to 20 patients and this would be complete by 7th April 2015. The trust assured us they would monitor the ward and get feedback from patients and carers. Clinical feedback on risk assessment and care would be sought and recorded. Each patient would be reassessed and if required, single room

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accommodation provided. The trust had undertaken an environmental audit of Cavendish ward and would review the arrangement for chairs in the lounge and any other environmental issues that arose. In addition the executive team would be monitoring the ward on a daily basis and the chief executive would provide the board with daily situation reports. In terms of mixed sex accommodation the trust were reviewing the patient flows around the ward and monitor that no accidental breaches happened and were to provide staff with training on the same sex accommodation guidance.

Clinic rooms were found to be clean and tidy with accessible equipment. Medications which had been regularly monitored and checked by a pharmacist or pharmacy technician. However on Cedar ward we found there was a prescribed sedative medication supplied by two different Manufacturers with different expiry dates and batch numbers stored in one box. We asked the pharmacist present at the time about this arrangement. They said this was not good practice but did not pose a risk to patients because they did not manage their own medicines. The pharmacist clarified this was not in keeping with the trust medicines policy. We noted end of the month medication expiry checks were being carried out by the pharmacist who was visiting at the time. The pharmacist told us they checked dates of expiry on all medicines. For example on Cedar ward we found insulin stored in the fridge which was out of date, the pharmacist immediately removed this as part of their checks. In all of the clinic rooms, we saw guidance for the management of controlled and recorded drugs was clearly displayed on the wall. The medicine fridge temperatures were being checked daily on all three wards. However on Cedar ward we found the drugs fridge had a damaged seal and in the bottom of the fridge there was fluff and hair present. This fridge had been taken out of use because of the damaged seal.

In the ward kitchens on Cedar and Maple wards, the kitchen fridges for food storage had broken door seals. On Maple ward the fridge temperature was recorded as operating above the maximum safe operating temperature since October 2014. We were told this was reported to the estates department but had not been responded to. On Cedar ward the fridge door seal was also damaged. The minimum maximum temperature was working and recording the operating temperature as safe. However this was stuck to the fridge shelf with a brown sticky substance, which meant the fridge, was not being cleaned regularly.

Minimum/maximum thermometers do not provide an accurate temperature measurement. We noted these fridges had not been safety tested since 2013. In the occupational therapy room on Cavendish ward there was a fridge used to store food patients would prepare as part of their therapy. We found an open pack of sausages without a date of opening or to be used by on it.

All the wards had accessible resuscitation equipment which was checked daily and emergency medication was in place and in date.

On Cedar ward we noted there were unoccupied bedrooms and corridor areas which were not cleaned. Staff had visible cleaning schedules which were being regularly completed, which included all the ward area. The domestic staff said they were not routinely cleaning unoccupied ward areas.

The bedrooms on Cedar ward were not personalised and looked sterile and institutional. On Cedar and Cavendish wards some bedrooms were personalised and more homelike. The furnishings we saw were clean and in good order.

We found that the trust had completed environmental risk assessments and these were reviewed in August 2014.

We saw the infection control audits displayed on all wards which were completed monthly. The audits identified where the ward was not meeting the trust standards. For example we saw an audit which identified bank and agency staff had been observed not washing their hands. The action plans identified these staff needed to be reminded and monitored to observe they followed the hand hygiene guidance. However information provided to us by the trust confirmed the wards achieved compliance with the trust infection control audits despite the shortfalls noted as a result of the local audits.

We saw all staff had personal safety alarms which were linked into the main alarm system. We saw when the alarms were activated staff could identify which area of the ward the alarm had been activated in and responded promptly.

Safe staffing

The trust regularly reviewed the staffing levels on all the wards we visited. We looked at staff rotas and saw the amount of nursing staff on duty usually reflected the required staffing establishment. Each ward had an individual staffing board at the entrance to the ward

Are services safe?

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

indicating the expected and actual staff on duty. All three wards were exceeding the required nursing staff levels. The ward manager and allied health professional were in addition to the nursing requirement.

The staffing levels were maintained using bank and agency staff. The same agency staff were used where possible to promote continuity of care.

The trust had a workforce strategy in place looking at recruitment. The ward managers we spoke with worked with the trust bank staff to ensure bank staff members had the appropriate training to work on the ward.

The acute service manager and associate director told us the workforce strategy had been used to support the decision to close Cedar ward. As the trust could not recruit sufficient registered nurses to meet safe staffing levels.

Some of the existing staff from Cedar ward was supporting patients transferring from Cedar ward to Cavendish ward and some were working in Maple ward as Cedar only had seven patients at the time of our visit.

Cedar and Maple wards had significantly higher number of shifts that had been filled by bank or agency staff to cover sickness, absence or vacancies.

The numbers of shifts covered by bank or agency staff between October and November 2014 were Cedar ward 265; Cavendish ward 82 and Maple ward 226.

We were told by the associate director, acute service manager and ward managers that ward managers had autonomy to be flexible with the staffing numbers when required and this helped to maintain the safety of the ward.

There was always at least one registered nurse on duty on the wards at all times. However, health support staff told us the registered nurses were very busy and only out on the ward when dispensing medication or when specifically requested for a nursing task.

We saw no examples of escorted leave or ward activities being cancelled due to insufficient staffing.

Junior doctors were on site during the day and on call at night. A consultant psychiatrist was present for weekly ward rounds. The later life services were located on acute hospital sites and if urgent medical cover was needed, arrangements were in place to transfer patients to A&E if required.

All staff had to complete training on physical interventions which was refreshed on an annual basis, 79% of staff had completed the training and the rest were booked in to attend. Staff described how they would try and manage patients' care without the use of physical interventions. On Cavendish ward we witnessed one occasion when a male patient became distressed and threatening and this was dealt with quickly and efficiently with the minimum of distress to the patient and others. On Maple ward there was evidence of a caring response by nursing staff towards distressed patients. We observed staff leading the patients gently away from each other. In addition, staff maintained a calm atmosphere in terms of their voice and general behaviour. The junior doctors, the pharmacist and the locum Consultant had in depth knowledge of the 7 patients on Cedar ward and were able to explain how patients' distressed behaviour was managed.

Staff received some specialist training. For example staff received specialist physical healthcare training. We looked at mandatory training records and saw staff complete training in infection control, safeguarding children and adults, mental health act legislation and Mental capacity act deprivation of liberty safeguards, management of falls, fire safety, equality and diversity, customer care, physical health monitoring, medication management, physical intervention and resuscitation.

Assessing and managing risks to patients and staff

Patients had up-to-date risk assessments in place which were regularly reviewed and updated reflecting any change in risk level or after incidents.

The numbers of restraint in the later life service reported through incident reporting between October and December 2014 was Cedar ward 6, Cavendish 14 and Maple 25 incidents. There was no use of prone restraint recorded for the three later life wards for this period.

There were few blanket rules being used and when they were applied it was used proportionately to maintain patient safety. We saw signs up next to ward exits indicating that informal patients were able to leave when they wished. All the ward front doors had a keypad and informal patients were not given the code so they could not leave without asking staff. Staff across the wards told us they were responsible for monitoring patients who were either detained under the mental health act or subject to a deprivation of liberty safeguard. Information boards

Are services safe?

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

recorded the patients who were to be monitored so staff were not depriving patients of their liberty. Staff were able to demonstrate the arrangements for monitoring patients through information boards, risk assessment and observation arrangements.

Staff across all wards received mandatory safeguarding training and all were able to tell us how to identify and report a safeguarding incident. Safeguarding training was a two face to face course covering both vulnerable adults and children. Team performance for training was 78% of staff had completed this across the service.

On Cavendish ward a patient raised concern about an agency staff member's behaviour toward them and alleged the staff member had taken property belonging to them. We assured the patient we would act upon their concerns and spoke with the ward manager who said they would immediately raise a safeguarding concern and assured the patient of their actions before we left.

Staff were aware of the risk of falls and pressure ulcers within the patient group and managed risks accordingly. All patients had a falls screen on admission and then a care plan completed if a risk of falls was identified. This plan could include physiotherapy or medical assessment, provision of aids and other measures in addition to implementing one to one care when required. Following a fall there is a review of the risk and management plan.

There was evidence in the care plans of assessing for physical health needs on admission and regular reviews

taking place. There was evidence of discussion in the multi-disciplinary team about both physical and mental health needs for all the patients. Visiting arrangements for families, relatives, carers and friends were flexible and the only time that visitors were discouraged from visiting was during meal times. This was because the trust observed protected meals times which allowed patients to have their meals in a calm environment supported by staff. This arrangement was not aimed at excluding visitors.

Reporting incidents and learning from when things go wrong

Most of the staff we spoke with were aware of what to do when reporting incidents through the electronic reporting system datix. We were shown examples of incident reports made using the datix system. There was a clear description of the incidents, actions taken, debriefs of patients and staff and lessons learnt. In addition the serious incident reporting investigation was completed where necessary through the governance process to ensure appropriate actions had been taken and trust policy and guidance had been followed. We discussed examples of recent incidents with staff. They told us how they had debriefings following incidents and how risk assessments and management plans were amended. We saw examples of how observations were adjusted in response to incidents in risk assessments and on ward rosters.

Staff we spoke with showed a good awareness of patient's individual risks and how these were managed.

Are services effective?

Inadequate 

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.

Summary of findings

Our findings

Assessment of needs and planning of care

We looked at samples of care plans on all the wards. Mostly records were regularly reviewed and orientated towards recovery or management of conditions. There was evidence that the multi-disciplinary team (MDT) knew the patients well and considered all their needs, including social care needs before and after discharge.

Most care records we looked at showed that physical health checks were completed upon admission. Patient records at the three wards showed that there was on going monitoring of physical health issues. Information around diet and nutrition, pressure ulcers and falls was thorough and up-to-date.

During the multidisciplinary meeting and review of medicine administration records on Cedar ward, there was evidence of psychotropic poly pharmacy in 4 of the 7 patients with complex needs who were still accommodated. Thirteen patients had already moved from the ward as it was in the process of closing. Two of the remaining patients were prescribed four psychotropic medications and a patient living with dementia was prescribed two anti-dementia medicines. This latter prescription was good practice in patients with complex needs.

The national prescribing observatory for mental health (POMH-UK) supports specialist mental health trusts improve their prescribing practice through the identification of specific topics within mental health prescribing and develops audit-based quality improvement programmes (QIPs).

We saw examples of daily temperature, pulse and respiration charts (TPR) being completed for periods as required where necessary. Patient information was stored electronically and was password protected.

Best practice in treatment and care

There was no dedicated psychology service for the later life services. The acute services manager told us psychology

service were offered a half day a week to each of the wards in the three later life services but the resources was provide by the community mental health services, so was dependent upon availability of psychologists. Psychology was offered on individual patient referral only. There was no regular psychology input into therapy or recovery groups on the wards, or to support staff in the formulation of risk assessments or recovery plans for patients. We saw an example where a patient has been assessed as having post-traumatic stress disorder and had to ask for themselves to be referred for a psychology assessment. We saw this had taken over two months to do and the patients had an initial assessment only. There was no indication when the patient was to be offered psychology sessions. The patient said they had expressed their dissatisfaction with the arrangements to staff. The National Institute for Health and Care Excellence (NICE) recommendations were that a range of psychological therapies should be made available. Evidence of the effectiveness in improving outcomes for people experiencing a range of common and severe mental health problems. The guidelines state that for depression and anxiety disorders, psychological therapies were preferable to drug treatments on first contact with services and psychological therapies were as effective for older people as working age adults. Consultants told us there were insufficient psychological services available for the later life inpatient service and would welcome an increase in service.

We spoke with a ward manager for Cavendish ward and acting ward manager for Cedar Ward about quality initiatives used in the service such as the royal college of psychiatrist accreditation for inpatient mental health services (AIMS). Neither of them were aware of the quality initiative or peer review process.

A wide range of clinical audits involving clinical staff took place including care plans and risk assessments, medication, safeguarding reporting, infection control, ligature risk and staffing audits including training and supervision.

Skilled staff to deliver care

Staff received supervision, mandatory training and appraisals. Supervision usually occurred every 6-8 weeks as detailed in the trust policy. On Cedar and Maple wards staff said due to managerial changes on the wards supervision timescales had slipped. However staff said the interim managers were available to offer support and advice. The

Are services effective?

Inadequate 

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.

interim managers for Cedar and Maple wards were described as 'brilliant' and 'supportive'. On Cavendish ward we saw records of staff having had supervision in March 2015. We were provided with information that appraisals on Cavendish were up to date. However on Cedar and Maple wards appraisal dates had slipped due to changes in management.

All the services we visited had a range of skilled specialists working either on the ward or in the community linking in to the ward, including OT's, clinical psychologist on referral, pharmacists and activity coordinator. Though none of the wards had a social worker on site although there were links to a named social worker in the local authority social work teams or through care coordinators.

There was access to dietician, speech and language therapist and a physiotherapist across both locations. At Park House these services were available from the acute trust, via referral and at Laureate House services were based on site.

Multi-disciplinary and inter-agency team work

All the wards held regular multi-disciplinary team (MDT) ward rounds weekly. We observed two ward rounds on Cedar and Maple wards led by the consultant psychiatrist and attended by members of the MDT and community mental health team care coordinators. Patients and their families were included in the meetings and discharge arrangements were discussed and agreed with them. There was clear demonstration of thorough decision making and recording. Staff present were respectful of all contributions and the meetings had a holistic patient centred focus.

Regular handovers took place between shifts enabling the sharing of essential information. We observed three handovers from the morning to afternoon shifts and wards had good structures in place to ensure information was passed over. We noted a particularly effective recorded handover system being used on all three wards incorporating staff allocation of individual roles and responsibilities ensuring staff were aware of their duties during the course of the shift.

There was evidence from the MDT ward rounds we observed of strong working relationships with a range of outside professionals and agencies. They were invited and welcomed to join the MDT ward rounds and needs were discussed holistically. We received good feedback from the South CMHT. They were very complimentary about the

relationship between the team and Cavendish ward, especially the MDT process and communication between the ward and community staff. They were complimentary about the use of trust electronic patient record system called Amigos by both teams. They described the detail of records keeping in terms of risk assessment and daily records they could access to monitor patients they were involved with were detailed and up to date. They gave examples of staff making referrals post admission so patients were introduced to the CMHT as early in their recovery as possible. On Cavendish ward the consultant described good relations with the large geriatric medicine service which provided geriatric liaison to the ward on a regular basis.

Adherence to the MHA and MHA Code of Practice

Our last mental health act visits to the trust were to Cedar ward on 5th September 2014, Cavendish ward on 9th March 2015, and Maple ward on 1st September 2014. Common themes identified during these visits related to providing patients with an explanation of their rights, administration of medication without using appropriate forms or authorisation, completion of section 17 leave forms, patients involvement in the care planning process, recording of capacity assessments for treatment and recording referrals to independent mental health act advocates.

- At this inspection across the three wards we saw continued examples of how the Mental Health Act and code of practice were not being adhered to. We saw examples that form T2's did not specify the number of medications from the British National Formulary (BNF) groupings. For example 'medication by mouth from BNF classes 4.2.1 antipsychotic medication within BNF dosage guidance' this did not state whether one, two or three medications from this class could be prescribed. We alerted the responsible clinician (RC) to this and they rewrote the T2 forms.
- One patient had a one month gap between section 58 authorisation being required (three month rule) and a form T2 being completed. This meant that the patient had been treated without authorisation for one month.
- Form H3's were incorrectly completed on numerous occasions. These forms had been scrutinised by medical records and remained unchanged.
- One patient was admitted to the ward and the detention papers were misplaced. This became

Are services effective?

Inadequate 

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apparent when the patient was reviewed for electro convulsive therapy (ECT), which was not administered. The notes indicated that during this time staff were unclear whether the patient was detained. The patient was re detained on a section 3 as the original papers had been lost. The new application papers were available. The matter was raised with mental health act administrator to ensure section expiry dates and three month rule dates were correct.

- No section 17 leave forms indicated who had been given a copy of the leave authorisation form.
- Some form T3's were not stored with the medicine cards.
- Care plans were not individualised and interventions were often the same for different patients. The paper notes were disorganised and the electronic notes were difficult to navigate.
- One patient who was recalled and revoked from a CTO did not have the original paperwork available.
- Section 2 lapsed for one patient who continued to require hospital admission. The patient record stated that section 5(2) could not be used as it would not be legal. The patient's record suggested that covert (disguised) medication was being administered at the time and the patient was being actively stopped[BB1] from leaving the ward.

Good practice in applying the MCA

- Staff training on the Mental Capacity Act (MCA) was mandatory and records we looked at showed the staff figures for completion of training on the Mental Health Act as 64% and Mental Capacity Act as 44%.

- There were several issues around the use of deprivation of liberty safeguards (DOLS) authorisations. Urgent DOLS were requested without a standard authorisation meaning that the urgent DOLS could not be extended.
- Manchester City Council had made the decision that urgent DOLS authorisations were not time limited. This information had not been passed to clinical staff.
- It was unclear how the outcomes of DOLS authorisation requests were communicated to staff. For example the local authority shared information with us regarding their decision on the process of DOLS authorisation which had been sent to the trust. The local acute services manager and ward managers were unaware of this decision and guidance on DOLS applications.
- A further example we saw in the records of one patient was a one month gap between the rescinding of a section 3 and a DOLS authorisation. There was no documented evidence of a change in capacity during this time or why a DOLS application was made when the section 3 was rescinded.

Across the three wards we observed that staff supported patients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests and this was recorded, recognising the importance of the person's wishes, feelings, culture and history.

During our observation of two MDT ward rounds we received good feedback from families and carers they felt they were appropriately involved in decisions about care and mental capacity.

Are services caring?

Good 

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

Summary of findings

Our findings

Kindness, dignity, respect and support

Across the three wards we observed a number of caring and respectful interactions between staff and patients. Staff members were very respectful, for example knocking on doors before entering bedrooms.

Staff demonstrated an understanding of the individual needs of patients. We observed staff laughing and joking appropriately with patients in a manner which suggested familiarity and mutual respect.

Patients we spoke to were positive about their ward and the care they received. However two patients on Maple ward raised concerns that at night they were woken due to patients living with dementia being accommodated in the same dormitory area as them. They said these patients were walking around and calling out during the night, which meant they had a disturbed sleep.

We observed mealtimes on all three wards. We saw patients were supported to eat when assistance was necessary and appropriate aids such as cutlery, plates with guards and non slip mats were available for them. Patients could choose to eat their meals in the main lounge as well as the dining room.

The involvement of people in the care they receive

Staff described how new patients were carefully introduced to the different ward environments. This often had to take place gradually as people may be very unwell on their arrival. This included showing patients around and introducing them to staff and other patients.

Patients were not always involved in their care planning across the wards. Where patients told us they did not have a copy of their care plan it was evident in their records why

this was the case or if a care plan had been given but the patient could not retain the information. Only two patients gave us examples of when they had been involved in their care plan. For example one patient on Cedar ward showed us a printed copy of their care plan and another told us staff had asked them about how they wanted to be supported with their care and treatment.

We saw care plans were mainly written in clear and accessible language. However they were not written from the patient's perspective of their care. For example 'You have a diagnosis of schizophrenia'. We also saw care plans contained inaccurate information about patients because they had been cut and pasted from another patient's care plan. For example referring to a female patient as the male gender. This meant patients care plans were not person centred or confidential.

There was evidence of family involvement in care. We were told that relatives and carers were routinely invited to review meetings and saw evidence of this at the MDT meetings we observed.

We received good feedback from the relatives and carers we spoke with about the care provided and their level of involvement in care and decision, making.

Patients had access to advocacy services. We saw most wards had information freely available to support patients and relatives and carers to access advocacy services and information about drop in or other local support groups for them to be able to discuss their concerns with the ward managers. We were told by patients that advocates regularly attended the community meetings. In the community meeting we observed on Maple ward was well led and staff responded to patients with respect. We saw patients were happy to communicate and discuss the things that mattered to them. Activities were discussed and a new idea of having a 'Thoughtful Tree' on the wall which patients could contribute to was discussed. This opened up a discussion about "wishes" for patients to identify as part of their recovery and treatment.

Are services responsive to people's needs?

Good 

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

Summary of findings

Our findings

Access, discharge and bed management

There were pressures on beds and the average bed occupancy rate for the service was between December 2014 and January 2015 was 97-99%. The average safe occupancy rate for England is 85%. We were told that usually the wards did not operate a waiting list and there were always beds available for people in their catchment areas. We saw that patients always received a Manchester bed and that time and distances within the Trust are relatively small. For example patients from North Manchester could be admitted to South Manchester and vice versa. With the impending closure of Cedar ward, male patients who could not be discharged were transferred to Cavendish ward. The trust had made arrangements to assist relatives to travel from North Manchester to visit their family members and attend meetings. On Maple ward there had been an arrangement to admit patients of working age, usually aged over 60 years of age and with a low risk of their mental health. The associate director and acute service manager said this arrangement had stopped and any remaining patients of working age would be treated at Park House or Laureate House acute wards for adults of working age then discharged as their recovery progressed.

We were provided with figures about delayed discharges and readmissions to later life services. We were told by the acute services manager about delayed discharges were related to a lack of and availability of suitable accommodation in the community.

At Cavendish and Cedar wards the links with the local community mental health team (CMHT) were strong and conducive to ensuring patients were discharged into suitable accommodation as soon as clinically appropriate. From information provided by the trust we saw Cedar ward had 3 delayed discharges in the last six months and 2 readmissions in the last 90 days. Cavendish ward had no delayed discharges and 5 readmissions in the last 90 days and Maple ward 4 delayed discharges in the last six months and 8 readmissions in the last 90 days. This meant responsive bed management arrangements were in place.

An example we saw of this was on Maple ward, which was in the process of closing. A patient was due to be transferred from Maple to Cavendish ward but relapsed. Staffing levels on Maple ward were increased to support the patient to remain on Maple ward. A patient in A&E was referred to the later life services at the same time of the imminent transfer of the patient from Maple ward. A clinical decision was made to keep the patient on maple ward and allowed the patient in A&E to be admitted to the bed on Cavendish ward. This meant the patient in A&E was responded to quickly and was able to receive care and treatment.

The ward optimises recovery, comfort and dignity

The three wards were not conducive to patients' individual well-being, dignity and comfort. At the time of our visit Cavendish ward was cramped and cluttered in the main lounge. We found the ward environments were not recovery focused and did not follow best practice on offering a low stimulus or dementia friendly environment. Signage was not specifically dementia friendly on any of the three wards. On Cavendish ward the signage about which areas were single sex accommodation was insufficient to help people who were cognitively impaired recognise the difference in male/female accommodation. Best practice guidance on dementia friendly environments was not seen in use.

Cavendish ward had a dormitory, which contained four beds, and despite curtains partitioning the beds; the dormitory did not offer privacy. The dormitory had an adjoining bathroom.

On Cavendish males had access to female ward areas. There was no separate female lounge the level of noise and emotion on the ward seemed heightened by the level of how unwell the patients were.

Patients had access to private telephone facilities on and off the ward as well as being able to keep their mobile telephones dependent upon individual risk.

The wards had open access to an outdoor space with garden areas located by the wards.

Patient's bedrooms or dormitory areas were not all personalised for their individual comfort. However the wards were intended to provide short term treatment so may not afford patients the opportunity to personalise their living space. Patients on Cedar ward who had been

Are services responsive to people's needs?

Good 

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

accommodated on the ward for several months expressed they would have liked to have personalised their living space. We saw that attention had been paid to ensure patients had their personal belongings with them. Patients had access to a lockable facility in their bedroom or dormitory area. Patients were able to lock their own bedroom doors if occupying a single room and there was no risk to them having a key. In dormitory areas patients had privacy curtains around the beds so they could have privacy when needed.

Weekly activity programmes for patients were advertised on all wards. Patients had access to occupational therapy and on Cedar ward an activity worker in addition to an occupational therapist. There was mixed views across the wards about the programme of activities. At Maple ward the feedback was overall positive and people were accessing culturally and age appropriate activity both during the day and in the evening. However a patient raised concern about their individual access to more therapeutic activities. We saw the patient had been referred to a psychologist and an initial assessment had been completed. However no follow up appointment had been confirmed. The patient said they believed this was delaying their access to therapy. At the weekends we were told that the majority of the wards had activities carried out by the ward staff. The feedback received was that this was dependent on who was on duty as to whether it happened. Staff told us that planned activities were sometimes cancelled at busy times or if there weren't staff available to run them. We saw a variety of activities were planned for the week including quizzes and table top activities.

The food available across the three wards was cooked from chilled. This was an arrangement across the trust where food was prepared and then cooked on site in portable heated trolleys. We received mixed feedback on whether there was enough food and if the choices were acceptable. Food was regularly identified in community meetings as an on going issue with varying positive and negative comments. Hot drinks and snacks were available twenty four hours a day outside of meal times across the three wards but patients were not able to freely make themselves a hot drink or snack and had to request staff prepare it for them.

Meeting the needs of all people who use the service

Across the wards we saw that attempts were made to meet patient's cultural and religious needs and information on

the main ward areas was available in English but could be made available in a number of different languages. We saw the pharmacy had access to a patient drug information system which produced drug information sheets in a variety of languages for patients. This meant patients could access information to assist them in understanding the medicines prescribed to treat their physical and mental health and report any adverse effects.

All wards had access to local interpreting services. Wards had a culturally diverse staffing team so staff could help provide interpreting on a day to day non clinical basis. We witnessed this on Cedar ward during mealtime and when inspecting one patient's care records. We saw staff using the patient's first language. The patient's care plans contained information that an interpreter had been used during their assessment and ward round meeting.

A varied choice of meals meeting peoples differing dietary needs was available. This meant patients with requirements associated with their religion or beliefs were able to access appropriate meals. However on Cavendish ward the ward clerk ordered the food and decided what patients who were living with dementia were going to have without regularly consulting them. This meant some patients' dietary choices on Cavendish ward may not have met their expectations. On Cedar ward two patients told us they could order their meals and they were satisfied with the choice available. We saw in another patient's records on cedar ward the patient was provided with a Halal diet and heard the patient saying the food was 'good'. Another patient's family had provided a patient's meals due to their mental health, but had chosen to then have the food provided on the ward when their mental health improved.

Ward facilities included disable access via the main doors to the corridors in Park and Laureate House. Cavendish House was located on the ground floor and Cedar and Maple wards were accessed by main corridor which was graduated to allow easy access. Wards contained assisted bathing and shower facilities, which included disability support aids for toilets and showers.

Listening to and learning from concerns and complaints

Patients we spoke to on the three wards told us they would complain to staff if they were unhappy with any aspect of the service they were receiving. There were complaint leaflets and posters displayed in all wards and were also

Are services responsive to people's needs?

Good 

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

available in different languages and styles that were easy to understand. Patients told us they would be able to raise complaints in the community meetings or with the advocates if they felt they were not being listened to.

Staff and managers told us they would always attempt to resolve the complaint at a local level in the first instance by dealing with the issue straight away. Staff said they would inform their manager of any patient complaints.

Information provided by the trust about complaints was that Cavendish ward had the most upheld complaints in this service area. We saw evidence that complaints were responded to and patients and their families were given an explanation as to whether their complaint was partially fully or not upheld and an apology was offered. During our visit to Maple ward patient raised concerns about the

competency and attitude of agency staff toward them and other patients. We were told some agency staff on night duty were abrupt and told patients to sit down, would not assist patients with personal care and complained if day staff had left them tasks to complete. The patient told us on one occasion an agency registered nurse was 'flustered' and tried to give them another patient's medication, but was helped out by a full time member of staff. We advised the patient to raise their concern with the ward manager and use the trust complaints process so they could have their concerns looked into.

Patients were actively involved in the contributing to their care through a weekly community meeting which was minuted and the minutes were produced as a document for patients to have access to via the noticeboard.

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.

Summary of findings

Our findings

Vision and values

Staff across the three wards felt connected to the later life services and trust. Staff were not aware of the trust visions and values when we showed them the information the trust had given us. Staff were provided with information on the trust's vision and values through a daily intranet message and from blogs from the chief executive, yet still remained unaware of the trust visions and values. For example paper copies of the trust values were attached to their most recent payslips. We also saw a guiding principle of the trust visions and values poster displayed in the reception area of both Park and Laureate House.

Generally, the staff were familiar with the senior leadership team from the trust and were able to identify who the directors of the trust and the senior manager for the later life services were. They felt informed about the recent decision to close Cedar ward and were aware this was due to the trust not being able to recruit suitable registered nurses for later life services.

Staff on Maple and Cedar wards said they had been informed about the recent management changes on the wards due to performance issues. They were aware of the reasons they needed to know about as to why the managers were removed from the service. Staff told us there had been regular visits to Cedar and Maple ward by their senior managers and the executive team. They said this included shadowed shifts and weekend visits, which staff said they found supportive.

Both wards had acting managers. Cedar ward was due to close so plans for the future of the ward had not been finalised. There was a plan to advertise the ward manager post for Cedar ward. The acting manager on Maple ward did not have a mental health background but was a very experienced registered general nurse who said they had ensured they understood the areas they needed to improve on. The acting manager on Cedar was a long standing member of staff who was a registered nurse in mental health. Both were supported by a service manager from another team as well as the acute service manager and

associate director who visited the service regularly. Staff described the acting manager as having the right values. The manager for Cavendish ward had been in post for many years and had delayed their retirement while the transition of patients from Maple ward and increase in beds on Cavendish ward was managed. Staff told us they had wanted to work on Cavendish ward when they were student nurses because the ward manager was 'inspirational'. Three of the registered nurses we spoke to had been student nurses on the ward and applied for posts on Cavendish post registration.

Good Governance

Local systems were in place which ensured staff were well supported and received adequate training to do their job. Staff did learn from incidents, complaints and audits. The wards all had access to information to monitor and audit quality through data extracted from the electronic record system. However staff described the AMIGOS system as being difficult to use and extract information from. All three wards in the later life services used an 'at a glance' white board to monitor key performance indicators for nursing and medical staff, as well as indicating patient information about care and treatment. This included information about seven day follow up on discharge and completion of assessments of nutrition, physical health, memory and capacity assessment and assessment of risk and completion of care plans. Statistics were also gathered about average length of stay, bed occupancy and discharges. Seven day follow up for the service was 100%. The average length of stay for 2014 was Cavendish ward was 95 days, Cedar ward 75 days and Maple ward 49 days. The later life service average length of stay was 41 days.

The wards were operating the trust wide audit schedule and we observed input from the lead for the prevention and control of infection nurse who completed the infection control audits for the wards. However audits regarding the safety of equipment and monitoring of the Mental Health Act and code of practice were lacking. Domestic staff told us monitoring of the cleanliness of the ward environments were carried out by the contractor's supervisors and the outcome of the audit process shared with local managers. However we found examples of areas of wards which had not been cleaned and fridges used to store food not cleaned and containing food without a use by date on.

The manager on Cavendish wards had sufficient time and autonomy to manage their ward. However the manager for

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.

Maple ward had only been in post for two weeks, while the acting manager for Cedar ward was a long standing member of staff. Both reported that their local management structures supported them to be able to raise concerns and escalate them to the trust risk register when appropriate.

Leadership, morale and staff engagement

We saw that the service was well led with the associate director taking necessary action to address the recent concerns the trust had identified about the management of Cedar and Maple wards. The managers on the three wards were visible and accessible. Staff appeared enthusiastic and informed us they were well supported by the local managers and enjoyed their jobs.

Staff were aware of the whistleblowing process and said they would not hesitate about escalating concerns higher in the trust. Staff told us that at service level their wellbeing was cared, they felt respected and were encouraged to develop. Managers had an open door culture and the teams said they could suggest ideas to improve the quality of care.

Staff on Cedar ward told us they were aware of and understood the need for the change in management due to performance in their roles and to protect patients. On Cedar ward staff told us they were of the reasons for the closure of the ward and they would be re deployed within the mental health service. On Cedar and Maple wards there were clear outliers in terms of performance therefore acting managers had recently been put into post to address this.

Sickness and absence rates were reported to be running at above the trust average across later life services. Cedar ward has the highest levels of sickness and turnover in this service area from October to December 2014 at 10%. Cavendish ward was 5% and Maple ward 6%.

All the staff said they felt passionate about the patients and their teams. They told us they felt well supported and enjoyed their jobs. Some staff told us they struggled with the high use of agency staff and the management issues surrounding the mix of functional and organic patients across all inpatient wards.

Commitment to quality improvement and innovation

The staff and senior manager were aware of the trust introducing 'safe ward' across the trust but this had been delayed in later life services due to the closure of Cedar ward and management changes to Cedar and Maple wards. We were told this would be implemented in the near future once the closure of Cedar ward and transfer of patients and staff was completed.

At the trust presentation we were told about the trust being a University teaching hospital with a major research and development function. However we did not see this in evidence in the later life service, for example reflected in the identified good practice on environments.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>The provider had not ensured that patients were protected from the risk of unsafe equipment by ensuring equipment was properly maintained and suitable for its purpose.</p> <p>How the regulation was not being met: Cedar and Maple wards had kitchen fridges with broken door seals and thermometers which did not record an accurate temperature. Temperatures were seen to be operating above the maximum safe storage for food and dairy products.</p> <p>Regulation 15(1)(a)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider had not ensured that patients were not protected against the risk of inappropriate or unsafe care and treatment by means of the operation of safe systems designed to assess and manage risks relating to the health, welfare and safety of patients.</p> <p>How the regulation was not being met: The Mental Health Act and Code of Practice and Mental Capacity Act Deprivation of Liberty Safeguards were not being adhered to.</p> <p>Regulation 17(2)(a)</p>