Good

2gether NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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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)
RTQ01	Charlton Lane Centre Charlton Lane Cheltenham	Chestnut Ward Mulberry Ward Willow Ward	GL53 9DZ
RTQX1	Stonebow Unit Stonebow Road Hereford	Jenny Lind Ward Cantilupe Ward	HR1 2ER

This report describes our judgement of the quality of care provided within this core service by 2gether NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 2gether NHS Foundation Trust and these are brought together to inform our overall judgement of 2gether NHS Foundation Trust.

Summary of findings

Ratings

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

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

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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Overall summary

We rated older people's inpatient services as good because:

- All the wards were clean and safe.
- Staff were visible on the wards, there were sufficient staff on the wards of the right grades and experience with appropriate skills, training and competencies to care for patients appropriately.
- Patients were protected from the risk of unsafe medication practices.
- Each patient had a comprehensive, individually tailored, risk assessment.
- The service had robust arrangements in place to ensure that staff learn from incidents, or when things go wrong.
- Care plans were person-centred, holistic, recovery orientated with detailed intervention plans.
- Staff applied recommended best practice and guidance to ensuring that patients received care which was high quality and effective, including pharmacological and psychological interventions recommended by the national institute for health and care excellence.
- Patients, family and carers were included in the decisions about their care and were listened to by the professionals involved.
- There were no delays in admission to the older age adult's wards and no out of area placements attributed to a bed not being available.
- Patients had a comprehensive discharge plan in place and there were no delays in discharge that can be attributed to the trust.
- The service had a limited number of complaints in the past year and staff were supported to learn from the complaints received.
- Staff were clear about the organisation's visions and values and worked with a clear philosophy on ensuring each patient received the highest standards of care possible and there were governance arrangements in place.
- The service had accreditation for its inpatient mental health services awarded for their work and commitment to elderly care by the Royal College of Psychiatrists, and electro convulsive therapy, which is a procedure where a brief application of electric stimulus is used to produce a generalized seizure.

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:

- The same sex accommodation requirements were not met on all wards and so not all the bedroom facilities were organised to ensure the patients' privacy and dignity. On the Jenny Lind ward patients had to pass through rooms occupied by the opposite sex to reach their toilet and washing facilities near to their bedrooms.
- Female only lounges were not clearly identifiable.
- The ligature risk assessment actions and outcomes were not detailed on the assessments held at ward level.
- There was not a robust system in place to safeguard children whilst they were visiting the service.
- There was not a thermometer in the clinic rooms so medications in the clinic room may not have been kept within the required temperature.
- Where there were restrictions in place on the wards and for informal patients, the risk was not documented or care planned as appropriate, and there was no appropriate signage to notify the patients of these restrictions.
- The outside area for the patients on the Cantilupe ward had uneven and slippery paving stones and posed a slip, trip and fall hazard for patients and staff. We notified the managers about this and we were told that the trust were going to put a soft rubber surface down in this area.

However:

- The wards were clean and safe. Cleaning schedules were in place, equipment was checked, environmental risk assessments were completed, and systems were in place to reduce the possible risk of infection.
- The service had taken steps to reduce the risk of possible harm to patients. They had ensured that blind spots on the wards were mitigated and that the risk of ligature occurring was minimised.
- Staff were visible on the wards and there were sufficient staff on the wards of the right grades and experience in line with the trust's staffing model.
- Each patient had a comprehensive risk assessment. It was individually tailored, used a range of recognised risk assessments, and was reviewed daily, weekly or monthly depending on the risks associated with the patient.

Requires improvement

Summary of findings

- Patients were protected from the risk of unsafe medication practices because regular audits were carried out and pharmacists attended the multi-disciplinary meetings.
- The service had sufficiently competent, skilled and trained staff on duty to ensure that patients were safe and protected from abuse.
- The service had robust arrangements in place to ensure that staff learn from incidents, or when things went wrong.

Are services effective?

Good

We rated effective as good because:

- Care plans were person-centred, holistic, and recovery orientated with detailed intervention plans. They ensured that a patient's mental and physical health was appropriately assessed.
- The records reviewed demonstrated good use of decision specific capacity assessments and best interest decisions, in line with the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff applied recommended best practice and guidance to ensuring that patients received care which was high quality and effective.
- There were regular and effective handovers, multi-disciplinary meetings and care programme approach meetings.
- Staff received professional development and training to ensure that they were able to effectively meet the needs of individuals.
- Patients receiving covert administration had care plans which showed that their families had been consulted. They also had recorded advice from the pharmacy team regarding which medications could be covertly administered and how.

However:

- Patients were not always aware of any contingency plans put into place for their support when they were on section 17 leave, including what they should do if they think they needed to return to hospital early.
- There was not a consistent approach to the handover discussions on the wards for older people with mental health problems.
- We could not find evidence in all files of the responsible clinician's record of their assessment of the patient's capacity to consent at first administration of treatment for mental disorder in all records.
- Several patients were being given their medication covertly as a matter of course. This was not compliant with the trust policy,

Summary of findings

which states that covert administration should be a 'contingency' rather than 'routine.' The patients' medication charts did not clearly document each time covert administration had been used, or not.

Are services caring?

Good

We rated caring as good because:

- Staff treated people with dignity and respect. They demonstrated kindness and compassion towards patients, and would go that extra mile for patients, family and carers.
- Patients, family and carers were included in the decisions about their care. They were listened to by the professionals involved. Care plans were holistic and took into account the patients' views, and those of the family and carers.
- **However:**
- The service did not actively promote advanced decisions with the patients on the wards.
- Some patients were not always involved in the decisions in relation to their care plan and section 17 leave, and section 17 leave did not always take into account the patient's wishes, and those of carers, friends, and others who may be involved in any planned leave of absence in adherence to 27.10 of the Code of Practice.
- Patients were orientated to the ward. They were provided with a welcome pack, including information about the wards, the Mental Health Act, and advocacy. Family and carers also received an information pack, including information about the wards and where they could access support.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There were no delays in admission to the older age adult's wards. There were no out of area placements attributed to a bed not being available.
- Patients were discharged when clinically appropriate. There were no delays in discharge that can be attributed to the trust. Patients had comprehensive discharge plans in place identifying individually tailored ongoing support. They were discharged at times to suit them, avoiding weekends.
- The trust had responded to the rise in patients on palliative care and offered end of life care to patients on the older age adult wards.

Summary of findings

- Patients could access appropriate spiritual support and had a choice of food to meet the dietary requirements of religious and ethnic groups.
- The service had a low number of complaints in the past year. Patients, family and carers received information on how to make a complaint when they were admitted to the ward. If patients wished to make a complaint, staff would support them in doing so or offer alternative support. All complaints were investigated fully. Patients received a written response to formal complaints. Staff were supported to learn from the complaints received.

However:

- The environment on Cantilupe Ward did not wholly meet the evidence based practice in the assessment and treatment of dementia. The trust had plans to improve the wards for older age adults by the end of 2016.
- The two organic wards for patients with dementia and similar cognitive impairment did not have community meetings. Some of the patients we observed were higher functioning than others on these wards so may have been able to engage in some form of community forum.
- There was not a five day timetable of therapeutic activities, or social and recreational activities at the weekends, on all wards. There were no reporting mechanisms in place for times when activities were cancelled, or contingency plans.

Are services well-led?

Good

We rated well-led as good because:

- Staff were clear about the organisation's visions and values. They worked with a clear philosophy on ensuring each patient received the highest standards of care possible.
- There were good governance arrangements in place. There were systems in place to ensure that staff received mandatory training. Shifts were covered by a sufficient number of staff of the rights grades and experience. Staff were supervised and appraised. Incidents were reported, complaints are welcomed, and the service learned from these through feedback in handover, and team meetings and trust meetings.
- The service used performance indicators to measure the performance of the team, ensuring that they were delivering high quality, effective and compassionate care.

Summary of findings

- Staff morale was high. Staff felt positive about their team, their managers and the work they did to improve the lives of others. They felt able to provide feedback on the service, or raise concerns.

Summary of findings

Information about the service

2gether NHS Foundation Trust had five wards for older people with mental health problems. These wards predominantly provided care for patients who are aged over 65 and require hospital admission for their mental health problems.

Two of these wards were located at the Stonebow Unit in Hereford: Cantilupe Ward and Jenny Lind Ward. Cantilupe Ward was a 10 bed, mixed sex ward, which had two additional emergency beds. It was an assessment and treatment ward for older people with organic mental illness or cognitive impairment, such as dementia. Jenny Lind Ward was an eight bed mixed sex ward. It provided assessment and treatment for older adults with functional mental illness like depression and psychosis.

The three other wards for older people were located at the Charlton Lane Centre in Cheltenham, Gloucester. Chestnut Ward was a 14 bed mixed sex ward and Mulberry Ward was an 18 bed mixed sex ward. Both were assessment and treatment wards for older people with functional mental illness. Willow Ward was a 16 bed mixed sex ward providing assessment and treatment for older people with organic mental illness, like dementia.

Our inspection team

Chair: Vanessa Ford, Director of nursing standards and governace, West London Mental Health NHS Trust

Team Leader: Karen Bennett-Wilson, head of inspection, Care Quality Commission

The team comprised of seven people:

- an expert by experience
- one CQC inspector
- three mental health nurses
- one mental health act reviewer
- an occupational therapist

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?

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 patient and carer groups.

During the inspection visit, the inspection team:

- Visited all five of the wards at the two hospital sites, looked at the quality of the ward environment, and observed how staff were caring for patients.
- Spoke with 11 patients and 18 carers who were using the service, and an advocate.

Summary of findings

- Spoke with the managers, or acting managers, for each of the wards, and the modern matron for each site.
- Spoke with 42 other staff members; including doctors, nurses, occupational therapists, physiotherapists and psychologists.
- Observed two hand-over meetings, a multi-disciplinary meeting, and a care programme approach review meeting.
- Looked at 27 treatment records of patients.
- Looked at 18 supervision and appraisal records, including recruitment information and documentation.
- Carried out a specific check of the medication management on five 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

Patients told us that they were happy with their care. They told us that they felt listened to, and were treated well by staff. They told us that staff were kind, patient, respectful and polite. Family and carers spoke highly of the staff and they echoed the remarks of the patients. They said that they felt confident leaving their relative on the wards. Family and carers told us that nothing was too much trouble for the staff. Patients and carers told us that they were included in the decisions about their care and treatment. Where patients were unable to tell us their experience, we observed how they were cared for. We saw that staff treated patients with kindness and compassion.

Good practice

- In response to the increase in patients with palliative care needs, the trust had made a decision to offer end of life care on the older age adult wards, where the patient has been in the service for a short time (unless they chose to go home). This was consistent with the local strategic priorities. End of life care was delivered in accordance with the shared care pathway. The Stonebow Unit had recruited a doctor who was a specialist in end of life care. Both sites had strong relationships with the palliative care teams, palliative care consultants and the hospices, and were supported by them. GPs, geriatricians and physical health care nurses also supported the end of life care packages in line with the leadership alliance for the care of dying people "one chance to get it right" guidelines. The modern matrons sat on the internal steering group that fed into the local authority end of life care agenda.
- The service uses a wide range of best practice principles with respect to physical and mental healthcare, including Addenbrooke's cognitive examination, 'essence of care,' the 'falls risk assessment tool,' modified early warning signs' scores, the 'malnutrition universal screening tool,' the 'depression test questionnaire,' the 'anxiety test questionnaire' the pressure risk ulcer calculator and an assessment of 'venus thrombosis.'
- The service has accreditation for their inpatient mental health services (AIMS) awarded for their work and commitment to elderly care by the Royal College of Psychiatrists. All three of the functional wards received the grade of excellent accreditation.

Areas for improvement

Action the provider MUST take to improve

The provider must:

Summary of findings

- Ensure that the same sex accommodation requirements are met on all wards and that all the bedroom facilities are organised to ensure the patients' privacy and dignity.
- Ensure that female only lounges are available and clearly identifiable for patients.

Action the provider SHOULD take to improve

The provider should:

- Ensure that there is a system in place to safeguard children whilst they are visiting the service.
- Consider positive risk taking on the wards for older adults with mental health problems and accept that patients could be cared for in a less restrictive environment, and that all risk should be documented and care planned as appropriate.Where restrictions are in place, the provider should consider how to make the staff and patients aware of these restrictions.
- Enable patients to participate in decision-making as far as they are capable of doing so in relation to the care plan and section 17 leave according to the Mental Health Act (MHA) Code of Practice 1.10.
- Ensure that there is evidence in all files of the responsible clinician's record of their assessment of the patient's capacity to consent at first administration of treatment for mental disorder in all records.
- Assure itself that all administration of covert medication adheres to good practice and legislation, and that the practice reflects the trust policy.
- Ensure that there is a consistent approach by the wards for family members and carers travelling long distances to visit patients, including where patients from Hereford have been placed at the Charlton Lane Centre in Cheltenham either at first admission or following a period of leave, and that this is detailed in the bed management policy.
- Ensure that the wards for organic illnesses like dementia meet the requirements of the king's fund dementia friendly environment.
- Ensure there is a range of timetabled therapeutic activities planned for patients on all wards five days per week, with planned social and recreational activities planned on all wards at weekends. Patients' wishes should be considered when planning activities. Systems and reporting mechanisms should be put in place for times when staffing is short or situations where community or volunteer facilitators do not attend.
- Ensure that the patients on the two organic wards for patients with dementia and similar cognitive impairment can engage in some form of community forum if they are able to.

2gether NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Chestnut Ward Mulberry Ward Willow Ward	Charlton Lane Centre
Cantilupe Ward Jenny Lind Ward	Stonebow Unit

Mental Health Act responsibilities

- The data provided by the trust for September 2015 showed that two staff from the Charlton Lane Centre had completed the one day overview training. Prior to our visit, training in the Mental Health Act and the guiding principles was not mandatory. However, this training is now mandatory training. Staff were aware of the new code of practice and there was a copy located in the ward offices. There was no formal training on the code of practice except for the bespoke training provided for the MHA Managers and delivered in 2015. The staff we spoke to were aware of the trust MHA administrator who offered support and legal advice on the MHA and the code of practice.
- Information on the rights of patients who were detained, and information about the independent mental health advocacy (IMHA) services, was displayed in all the wards, provided in the patient handbook, and in the family and carer information. Patients were read their rights weekly when they were admitted under a section 2, and every three weeks where they were admitted under a section three. All MHA records reflected lawful detention. Records showed that attempted discussion of rights under Section 132 were taking place but the records did not all demonstrate that this was happening immediately upon detention or change of status from a Section two to a three, or regularly following an initial attempt. Staff told us that where patients were not in a position to understand their rights, they would document this, and retry. We saw no evidence of patients' rights in an easy to read format. IMHAwere readily available to support patients and we saw evidence of referrals to the advocates in the files we

observed. Advocates visited some of the wards on a weekly basis. Staff told us that where they felt that patients were unable to request advocacy for themselves, they would make a referral on their behalf. All documentation was stored and scanned on to the secure RiO system.

- For people detained under the MHA we found that antipsychotic medicines were prescribed appropriately and reviewed regularly. The required documentation for treatment for mental disorder was in place but nursing staff were not able to demonstrate an understanding of the documentation. All treatments were given under the appropriate legal authority. In the records we reviewed, we could not find evidence of the responsible clinician's record of their assessment of the patient's capacity to consent, at first administration of treatment for mental disorder in all records. The electro convulsive therapy patient consent forms were extremely robust, including two evidenced discussions about consent. Several? patients were being given their medication covertly as a matter of course. These patients all had covert administration care plans which showed that their families had been consulted. They also had recorded advice from the pharmacy team regarding which medications could be covertly administered and how. The covert administration of medication on Willow Ward was not compliant with the trust policy, which states that covert administration should be a 'contingency' rather than 'routine.' The patients' medication charts did not clearly document each time covert administration had been used, or not. This was an area of practice in which the service could improve their standard of record keeping and appreciation of the rights of the individual patient.
- A standardised system was in place for Section 17 leave by which responsible clinicians can record the leave they authorised and specify the conditions attached to it. Current forms were available on the ward and previous forms were available as scanned documents on the electronic patient record system.The forms we observed were not all completed sufficiently and old leave forms were not always removed or scored through.In the patient records we reviewed on Cantilupe Ward, we could not be sure if the patient or relative had signed the authorisation for leave or received a copy. As such, they may not have been aware of the legal conditions of authorised Section 17 leave. There was no evidence of risk assessments prior to Section 17 leave in all records, or evidence to confirm whether the leave had been taken, or the outcome.Staff told us that risk and leave was discussed at the multi-disciplinary meetings and we observed that this was on the standard multi-disciplinary meeting agenda. During our visit, one patient was due to go out on leave to a medical appointment that day. He did not have authorisation to go. This was only discovered about an hour before he was due to go when the MHA reviewer asked to see the authorisation. Staff rectified this situation immediately.
- The MHA was audited quarterly to ensure that it was being applied correctly. The audit was reviewed by the MHA scrutiny committee. An action plan was cascaded and overseen by managers at ward level, for example the actions from the recent capacity and consent audit.We saw evidence of this from the scrutiny committee board meeting minutes.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There were 13 Deprivation of Liberty Safeguards (DoLS) applications across the trust between 1 May 2014 and 30 April 2015. Eight were not granted and two others were repeat applications that were due to expire. All the DoLS applications were made by the wards at the Charlton Lane Centre in Cheltenham, with Chestnut ward being the only ward with successful DoLS applications. There were no applications made on the Hereford wards in this time period. Where applications were not granted, the patient's care and any restrictive practice was reviewed in the multi-disciplinary meeting using the standard meeting agenda we observed.
- Prior to the inspection, training on the Mental Capacity Act (MCA) was not mandatory across the trust. The information we received from the trust for training in the month of September showed that 24 staff had completed the Mental Capacity Act training in that

month. An introduction to MCA and DoLS was covered on the corporate induction.Staff told us that they felt confident in applying the MCA, including DoLS, and demonstrated some understanding in the application of the Act and the five principles. The RiO system supported staff through prompting capacity assessments for patients. The trust had a MCA and DoLS policy that could be found on the intranet. Staff told us that they could access further support from a consultant nurse who was the trust lead on MCA and DoLS. The implementation of Mental Capacity Act and Deprivation of Liberty Safeguards was overseen by the Mental Health Act scrutiny committee, and actions implemented, evidenced through the scrutiny committee Board report.

- We saw evidence of capacity being reviewed in the standard multi-disciplinary team meeting agenda, as well as in the discharge plans. We reviewed one patient's record in detail. The patient was an informal patient and was not detainable under the Mental Health Act. The patient had five capacity assessments since their admission in relation to different issues, for example, eating and self-care and physical support. There was evidence in the record of the capacity assessments, and clinical and best interest assessments for each individual decision. The best interest decisions took into consideration the person's wishes and took account of their history.

Requires improvement

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

- The wards for older people with mental health problems at the 2gether NHS Foundation Trust had several blind spots. These were mitigated. For example, Cantilupe Ward had a single sex lounge on a corridor running adjacent to the main facilities of the ward. This was mitigated through patient observation. The whole of the room could not be observed through the viewing panels on Jenny Lind Ward. Staff told us that they would enter the room if they cannot see the patient. At the Charlton Lane Centre, all the wards had the potential to provide "extra care" areas. This was two rooms opened up and separated so the patient could move between them. It was separated from the main ward by double doors.This produced a blind spot from the main ward. The blind spot was overcome by increasing the numbers of staff in the "extra care" areas.
- Ligature assessments were carried out annually on each of the wards to identify possible risks to patients, and were in place for all services. Actions on the ligature assessment for 2015 included patients not being alone in the garden and considering anti-ligature door accessories. However, responsibilities and timescales required were not present on the ligature assessment that was held at ward level. The actions in the ligature assessments at the Charlton Lane Centrewere not measurable, for example "consider anti ligature door accessories," and were not present in the Stonebow ligature assessments. Anti-ligature hooks and anti-ligature curtain tracks were present on the wards, and ligature cutters were available.
- The service accommodated both males and females. All the wards were mixed sex wards. Staff on all of the wards told us that they tried to ensure patients were given a room in the appropriate male or female bedroom areas. Chestnut, Mulberry and Willow wards had designated male and female bedroom areas comprising of single rooms with en-suite facilities. At the time of our visit there were members of the opposite sex on the designated male and female areas. Same sex accommodation were met on these wards due to all the rooms having en-suite facilities and risk assessments in place in these instances. Cantilupe Ward had two single bedrooms with ensuite facilities, a female dormitory with five beds and a male dormitory with another five beds and designated male and female toilet and bathroom areas. Jenny Lind Ward had eight single bedrooms, three of which had ensuite facilities. At the time of our visit, a male patient was allocated a bedroom in between two female patients on the Jenny Lind ward, as he needed a bedroom with ensuite facilities. There was a separate male and female toilet on this ward, a female assisted bathroom and a shower room for both female and male patients. As such, the same sex accommodation requirements were not met and the bedroom facilities were not organised to ensure the patients' privacy and dignity because patients had to pass through rooms occupied by the opposite sex to reach their toilet and washing facilities near to their bedrooms. Managers informed us that whilst they tried to mitigate the mixed sleeping and bathroom areas for patients on Jenny Lind ward, they were fully aware of the issues. They informed us that planning is underway to scope and agree the works required to make all bedrooms ensuite so that this can be considered within the trust's capital programme planning meetings for possible inclusion in next years 2016/17 capital programme. This will ensure that the Jenny Lind Ward meets the same sex accommodation requirements, regardless of the patient case mix. All wards had quiet areas identified that could be used as a female only day room if required. However, there was no appropriate signage to inform patients of this and they were not clearly identifiable.
- The clinic room on the wards were fully equipped with resuscitation equipment and emergency drugs that were checked regularly. This was evidenced by a daily checklist. The Charlton Lane Centre used a medical emergency response team (MERT) approach with regard to resuscitation. The MERT team comprised of a staff member from each of the three wards. This was supported by a MERT policy and MERT action cards. The

action cards were visible in each ward area. The Stonebow Unit dialled the emergency response team from the general hospital, which was on the same site, for additional support in an emergency.

- Despite the Charlton Lane Centre for patient-led assessment of the care environment (PLACE) data for 2015 being below the national average, all the wards we observed were clean, tidy and well maintained. The site cleaning schedules for the Charlton Lane Centre and the Stonebow Unit were available on the trust system, Sharepoint. They had been reviewed in line with the national cleaning standards. Each ward had a daily cleaning schedule in place overseen by the housekeeping manager in the trust hotel services department. The bathrooms and the gym had individual cleaning schedules and signature confirmation to evidence cleaning had been completed. The Charlton Lane Centre was well furnished and welcoming, with bright colours and signage to help patients move around their environment. The Jenny Lind ward and Cantilupe Ward were blander in colour which made the wards seem darker and less welcoming. There is little signage on these wards to help patients navigate around the wards. The outside area for the patients on the Cantilupe ward had uneven and slippery paving stones and posed a slip, trip and fall hazard for patients and staff. We notified the managers about this and we were told that the trust were currently in the process of putting a soft rubber surface down in this area. The patient-led assessment of the care environment data for 2015 for the condition, appearance and maintenance of the wards was 7% above the national average compared to the other trusts.
- Hand gels and soaps were available in each of the ward areas and toilets, and on the entry to the wards. Hand washing leaflets were displayed in hand washing areas and hand hygiene audits were completed monthly. Mattresses were cleaned monthly. Personal protective equipment like gloves and aprons were observed in full dispensers. Slings used in hoists were not disposable. We were told that they are laundered away from the ward and kept for a single use. Shower curtains in the en-suite rooms were also not disposable. We were told that they were washed and disinfected following a patient's discharge.
- The service had an 'infection prevention and control and decontamination committee'. Infection control audits were carried out annually using the infection prevention society quality improvement tool. We saw evidence of the last annual report where topics such as staff training and responsibilities had all been discussed. A plan was implemented to develop staff training and knowledge in regards to infection control and prevention. Infection prevention and control was mandatory training for the trust. Staff told us they felt supported by the infection control and prevention team who regularly attended the wards. They provided advice, support and education for all staff. We observed one of the infection control and prevention leads on some of the wards we visited. Local issues were reported and were resolved quickly by the estates department. An example of a ripped chair being replaced was given.
- Moving and handling equipment, and safety apparatus, was audited annually by an external provider, for example hoists and lifting equipment, stand aids, profile beds, adapted baths. Staff informed us that any concerns about equipment were immediately reported to the estates management team.
- The wards had environmental risk assessments in place. These were completed by the ward managers and were reviewed quarterly in line with the trust's health and safety policy.
- Nurse call buttons and alarms were in place on the wards. Personal alarms and pagers were in place for staff for incidents or emergencies, like requesting the MERT at the Charlton Lane Centre. A pager system was also in operation, for example to request staff support from on call clinicians. Alarms were charged and serviced on the wards regularly.

Safe staffing

- We asked the service to provide information regarding key staffing indictors. The data they provided regarding staffing establishment, included 42 whole time equivalent qualified nurses and 69 whole time equivalent nursing assistants. There were 11 whole time equivalent vacancies for qualified nurses and nursing assistants. One thousand three hundred and three hours were filled by bank or agency staff to cover sickness, absence or vacancies in the last three months.

Requires improvement

Are services safe?

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

The trust did not provide any data on how many shifts were not filled by bank or agency staff. The wards for older people with mental health problems recorded a cumulative absence rate of 6.7% for the 12 month period ending 31 August 2015. The average turnover rate recorded by the trust for these wards was 9.7% for the 12 month period ending 30 September 2015.

- The Keith Hurst mental health / learning disabilities staffing tool had been used by the trust, alongside the Royal College of Nursing guidance relating to safe staffing, to form the planned staffing levels for all inpatient units. Staffing levels and staff mix was dependent on the ward. The staff rotas for the last three months were reviewed. These confirmed that the wards met the required staffing levels stated. The trust minutes from the most recent governance committee meeting on the 23 October 2015 recorded that the wards for older adults with mental health problems continually met these required staffing levels. The minutes stated that whilst the were the correct numbers of staff on the wards in line with the trust model, there was not always the right complement of qualified and unqualified nurses. However, the number of hours reported for September where the skill mix was not in line with trust model was below 10% of the total staffing hours on all wards, and below 1% at the Charlton Lane Centre. Meeting minutes attributed this to a range of issues including sickness, vacancies and acuity of the patients. Staff told us that there was sufficient staff on the wards and that ward managers were able to increase the levels of staff as required according to the clinical need and risks associated with the patients on the ward. During the inspection, three of the wards had increased the staffing numbers due to the acuity of the patients currently on the ward, including those being nursed in extra care. Patients, carers and staff confirmed that qualified nurses and nursing staff were visible in the communal areas of the ward. We observed lounge areas where patients were engaged and supervised by staff.
- Managers informed us that where additional staffing was required due to sickness or vacancies, they contacted the usual bank staff to cover the shifts required. If bank were not available, they requested that the agency contacted those agency staff that usually worked on the older age adult wards, before contacting any others. All bank and agency staff were orientated to the ward and had to complete an induction checklist. Staff told us that agency staff were rarely used but that it had increased on the organic wards more recently, which were the wards were patients were supported with dementia and similar cognitive impairments.
- Staff, patients and carers all told us that patients could have regular one to one time with their named nurse. This could be planned or when a patient requested it, and Mulberry ward had implemented an hour patient-protected time per week where nursing staff spent some concentrated time with patients. There were adequate staff to carry out physical interventions. Nursing staff and healthcare assistants completed daily modified early warning scoresand physical observations with patients. A physical health nurse attended the Charlton Lane Centre daily and general health nurses were employed at the Stonebow Unit.
- A speciality doctor was employed at both sites on a part time basis, plus GPs responsible for the patients attended all wards as required. Staff told us that there was adequate medical cover day and night, with out of hours cover from a senior house officer.There was daily consultant psychiatrist cover for the Charlton Lane Centre (1.4 whole time equivalent) and part time cover at the Stonebow Unit (0.6 whole time equivalent) from three consultants who worked part time in the community. The wards were also supported by two junior doctors.
- Information from the trust stated that no escorted leave or activities were cancelled. This information was anecdotal because neither the Charlton Lane Centre or the Stonebow unit had mechanisms in place to collect this data. Staff told us that sometimes activities were cancelled due to occupational therapists not being available as there had been issues at both sites with occupational therapist sickness and vacancies. These had been addressed through recruitment and some restructure. There was no documentation to evidence this, or datix (the trust's internal incident reporting system) incident information. Staff stated that they would not complete a datix report for missed escorted leave or activities. We observed missed activities on the wards. Volunteers or external providers did not attend and there was no contingency plan from staff for the activity. Therefore patients had no meaningful activity to engage them or to support their recovery.

Requires improvement

Are services safe?

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

- The average mandatory training rate for staff on the wards for older adults with mental health problems was 88%. This information was recorded on the trust system SharePoint which we observed. This allowed ward managers at a local level to monitor mandatory training compliance. Staff confirmed that managers ensured that they attended mandatory training through email reminders, supervision and appraisal. Occupational therapists, doctors and physiotherapists on the older age adults' wards were also compliant, with an average training compliance rate of 87% for the 12 month period ending 30 September 2015. Mandatory training for all staff included training on risk assessment, positive behaviour management or prevention and management of violence and aggression, infection control, information governance, moving and handling, and safeguarding vulnerable adults.Training on the Mental Health Act and the Code of Practice, and the Mental Capacity Act, was not mandatory. However, during the inspection, the trust took the decision to make this training mandatory for all staff.

Assessing and managing risk to patients and staff

- Between the 1 January 2015 and 30 June 2015, the trust reported that the service had 50 incidents of restraint, one of which was in the prone position. In the same time period, it reported no incidents of seclusion and no incidents of long-term segregation.
- Seclusion and segregation were not used on the wards for older age adults with mental health problems, nor by the trust as a whole. Two patients at the Charlton Lane Centre were being nursed in “extra care” areas: two rooms adjacent to each other opened up at the end of a ward that could be separated by a door. Staff told us that one patient was being nursed in extra care to maintain their dignity whilst providing them with personal care.For the other patient it was due to their level of “unpredictable” potential aggression. Staff told us that these patients were not being segregated from other patients because they did have access to the rest of the ward. We observed both patients out of the extra care areas and in the main ward areas on a number of occasions. However, there was no policy available regarding the use of extra care for managing behaviour in this way. There was no evidence that the ward teams had been supported to review the care being delivered with reference to the MHA Code of Practice chapter 26, or that the definition of long-term segregation had been referred to, in order to differentiate extra care from segregation. The trust was in the process of reviewing their policy on the management of disturbed behaviour, including seclusion, segregation and restrain and so this was not available to review.
- Of the 50 episodes of restraint between 1 January 2015 and 30 June 2015, the incidence of restraint was highest on the wards for older age adults with dementia. Willow Ward had the highest number of recorded restraints with 23, involving seven patients, with none in the prone position. This was followed by Cantilupe Ward recording 13 restraints, involving five patients, with one of those restraints in the prone position. The greatest number of restraints recorded on a functional ward for older age adults was seven restraints on Jenny Lind ward, followed by four on Mulberry ward and three on Chestnut ward. All incidents of restraint involved three patients and there were none in the prone position.
- Twenty-seven care records were reviewed and all had detailed risk assessments present, individually tailored to their needs. All these risk assessments except one were up to date.Each patient had a risk assessment and risk management plan in place identifying risks individually associated with them. A trust wide risk assessment tool was used and they were documented on the RiO system. All risk assessments were completed on admission and reviewed weekly through the multidisciplinary meeting, or more frequently as required. The risk assessment was comprehensive and included physical health assessments like falls risk assessments, venous thromboembolism screening, skin integrity and malnutrition screening, and had to be completed within 24 hours of admission. Mental health, and risks of harm to self or others was also assessed. Scales such as the Hamilton depression scale were used. Additionally, there was a monthly risk assessment review that covered all the domains of the risk summary. Each time a risk assessment was completed or updated, a risk management plan and contingency plan was agreed with the patient where this is possible. We observed risk assessments and risk management plans that had been updated in light of new information or incidents, for example, an increase in aggressive behaviour or increased confusion, and appropriate responses including increased observation or further assessment with an appropriate clinician. We observed

actions to reduce risk that were individual to the patients, for example, one patient did not like noise but if staff talked to them, this would reduce their distress and the likelihood of their behaviour escalating. Staff told us that risk information relevant to each patient was communicated at the handovers on the wards. Of the two handovers we observed, one communicated a detailed risk summary of each patient.

- All the wards we visited were locked. Staff told us that informal patients are informed to ask if they want to leave the ward and they can leave.We did not see this documented in the care plans that we reviewed. All patients had a key or a swipe card to have free access to their own room. On Willow Ward the rooms were all locked. Staff would open the rooms on request. In addition, on some of the wards we accessed, patients did not have free access to outside space, nor were able to access tea and coffee 24 hours a day, without asking for support from staff. Staff informed us that this was due to the risk behaviour by some of the patients on the ward at that time. At other times, access outside, or to tea and coffee, was not restricted. This was not documented in any risk plans or in the handover documents, nor in the handover we observed. There were no appropriate signs to instruct patients about the restriction on the ward at that time or instead to ask a member of staff to help. On one of the functional wards, patients could have mobile phones but could not have their chargers. They had to ask staff for the chargers because of the ligature potential for individual patients, and other patients on the wards.
- Where patients were at risk of harm due to vulnerability and presentation of their mental health they were closely observed. These observations were detailed in patient files and the records we reviewed demonstrated that they were being completed.
- The trust had a search policy which all wards followed if necessary. Staff told us they had never had to search any patients, or rooms, due to increased risks. All wards informed us that as part of a patient's admission to the ward, two members of staff supported the patient to unpack their property, log it and remove any items that are not allowed on the ward. All these items were documented in the patient handbook.
- Staff told us restraint is only ever used as a 'last resort' and is used "infrequently." All staff were confident in using de-escalation techniques to defuse challenging behaviours like removing patients from the situation, changing facial expressions and verbal tones, distraction, validation and reassurance. Staff felt confident in managing aggression or violence. Staff were trained in positive behaviour management at the Charlton Lane Centre as part of the mandatory training schedule. Staff on the Cantilupe ward and Jenny Lind ward had had mandatory training in preventing and managing of violence and aggression (PMVA). We were told that this is because the staff on these wards were required to respond to incidents on the working age adult ward in the Stonebow Unit. Staff told us they used the lower level PMVA techniques with the older age patients as it is more suitable to their behaviour. A trust policy on managing violence and aggression was available to all staff on the intranet and staff know how to access it. Staff completed a datix incident form for all hands-on restraint, a body map to show how the patient was restrained, and an assaultive rating scale. Where a patient's behaviour could not be managed, staff told us that a bed on the psychiatric intensive care unit (PICU) ward was always accessible. However, following an incident in the last quarter where two staff members were injured, a clinical decision was made to move a patient to a facility out of area that was better suited to an older aged adult exhibiting this more extreme behaviour. Rapid tranquilisation was rarely used in the service whilst patients were in restraint.
- Staff on the wards for older adults with mental health problems were aware of the different types of abuse.They demonstrated a clear understanding of how to ensure that patients were protected from the risks of abuse and possible risks of harm, including from staff. Examples were given of patient to patient abuse. We saw evidence of alerts raised and risk management plans for the patients involved. Staff informed us of prompt action taken where there had been allegations of staff abuse towards patients, including skin integrity checks and photographs, and the involvement of the safeguarding team and the police.
- There was mandatory adult safeguarding training every two years for all staff, and child safeguarding training was mandatory for qualified staff. All the mandatory training for older age adults with mental health problems was over 75%. In Hereford, safeguarding training was provided by the clinical commissioning

group, for example, the recent "think family" training. All staff were aware of how to escalate safeguarding concerns to a line manager, to the named contacts for child or adult safeguarding in the trust safeguarding department, or to the local authority. The staff on the wards were aware of the safeguarding polices and guidance on the trust intranet, including the "safeguarding adults: multi-agency policy" and the "safeguarding: recording alerts" guidance. The RiO system is programmed to support staff in safeguarding patients through appropriate prompts following the input of information into the system.

- Staff demonstrated an understanding of how to safeguard children.Examples were given where patients had not been allowed to have contact with their own child, or their grandchildren, in order to protect them physically or emotionally.In the example given on Chestnut ward, which is the functional ward for patients with mental illness like psychosis and depression, the patient was supported to engage in treatment with a goal of working towards supervised contact with their children.
- A trust policy was available to all staff on the intranet regarding children visiting inpatient settings. Some staff were aware of this. None of the wards followed any consistent formal procedure for allowing children on to the ward. Staff told us that visits with children generally take place in the patients' rooms, the designated family rooms or quiet rooms. They said that some visits with children do take place in the main patient lounges. We were given examples where individual risk was managed, for example, where there had been someone on the ward with convictions for sex offences against minors, and where there had been previous child safeguarding concerns with a patient. We were told that these would be documented in the individual risk and care plans. We could not see any documents to confirm this as there were no current risks of that nature on the wards. There was no specific documentation to show that each family visit with children had been risk assessed considering the dynamic nature of the ward environment and the patients on them. There was no document to show decisions about whether the visit should take place at all on the ward, or which room should be used, nor confirming who is responsible for the child at the time of the visit, or if the visit is in the best interest of the child. There was no forum where children's visits would be discussed, for example, the handover.
- Medicines were stored in clean clinic rooms and were transported and stored securely within the hospital. Not all wards were using the fridge temperature recording form specified in the trust medicines policy and there were dates where nothing had been recorded.Some staff did not know how to reset the thermometer to make sure that the maximum and minimum temperatures recorded were current. Controlled drugs were stored securely and recorded in the register.We observed that the clinic rooms at the Charlton Lane Centre were hot and that there was no thermometer to record the room temperature. This was raised with the modern matron.
- Pharmacy services were provided from NHS acute hospitals in Gloucester and Hereford. Nursing staff told us that members of the pharmacy team visited regularly and provided a good service.Records showed that medicines including take home medicines were available when needed, although nursing staff told us they had to plan ahead to allow time for supplies to arrive.
- The hospital used a comprehensive prescription and medication administration record chart which facilitated the safe prescribing and administration of medicines. Reviewing 52 records, we saw that the prescriptions were regularly reviewed, and records of administration were fully completed to confirm that people were receiving their medicines as prescribed. Records showed that patients on certain medicines, like Lithium, had regular blood tests to check that they were safe.

Track record on safety

- There had been eight recorded serious incidents between 1 August 2014 and 31 July 2015. All of these incidents were recorded at the Charlton Lane Centre. There were no serious incidents recorded from Cantilupe ward and Jenny Lind ward. There were four incidents on Mulberry ward, two on Willow ward and

one on Chestnut ward. These incidents included four falls which resulted in a fracture. The other three incidents were grade two and grade three pressure ulcers.

- Reviewing the trust investigations and recommendations documentation, there was clear evidence of good practice by the wards in response to incidents. For example, we observed that the use of hip protectors is now documented on RiO in response to a patient fall, including whether patients had declined to use them, and the slips, trips and falls pathway was reviewed. Physiotherapists assessing the use of equipment and reporting into the multidisciplinary meeting was also reviewed in the physiotherapists' assessments and care plans, like the use of high or low beds for patients that are confused with mobility. The serious investigation recommendations also included audit and training, for example, on physiotherapy and risk assessment training respectively. These documents demonstrated that learning from previous serious incidents relating to slips, trips and falls had been implemented.

Reporting incidents and learning from when things go wrong

- There were systems in place to report any incidents that occur on the wards. The electronic trust wide datix system was used to log and report incidents. We observed datix submissions for incidents that had the potential to cause or harm, or caused actual harm. They were able to provide examples of these, such as medication errors, falls, pressure ulcers, restraint, emergency resuscitation responses and problems with equipment.
- Staff informed us that there had been an issue with staff sickness in the occupational therapy department at both Gloucester and Hereford sites. This resulted in a reduction of the number of activities delivered on the wards by the occupational therapy department. Staff told us that they did not report this as an incident, or the missed activities, but would consider doing so in the future.
- Staff described best practice to us with regard to being open and honest with patients where incidents had occurred, often in a verbal discussion as oppose to a letter where the incident did not meet the threshold for the duty of candour. They also discussed examples where they had debriefed with patients and family members, like following a serious fall. Staff told us how they would involve the independent mental capacity advocate in some of these discussions with patients. All staff had received an information leaflet on the duty of candour by post. All band 6 staff and above received training on the duty of candour.As such, staff understood the key principles of this and the organisation's responsibility. Staff gave us clear examples of where they had apologised to patients where incidents had occurred, including a broken hip occurring from a fall. The duty of candour decisions were evidenced in all the trust serious incident investigations and recommendations documentation.
- The incidents submitted on the datix system were reviewed by the trust's risk management team. The incident cluster trends were circulated as part of the trust's monthly safety thermometer reports to all wards. Ward managers told us that they can also produce their own reports from the datix, for example, if they want to review the number of aggressive incidents or falls for a specific patient, and amend the care for that individual through discussions at the multidisciplinary meeting. The trust pharmacist completed audits on medication errors and fed back to the individual wards. We were told by the pharmacist that missed doses on the wards had been a problem in the past but now there are no longer any significant gaps in missed doses. All staff involved in serious incidents were invited to the review meeting following the investigation and were encouraged to attend. This meeting was an opportunity to debrief and to discuss areas of good practice, as well as to review the feedback about the lessons learned. The minutes from these serious incidents evidenced the attendance of staff across the multidisciplinary staff team, as well as the discussions that had taken place. Staff told us that immediately following incidents, ward managers would offer them an opportunity to debrief on the ward, including the the opportunity to debrief with the psychologist. Staff confirmed that they were also aware they could be referred to the trust staff counselling service following a serious incident if they felt that they needed further support.
- Recommendations from audits and serious incidents were fed back through an action plan from the trust and the ward manager was responsible for cascading this

Requires improvement

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information and ensuring that they are completed. Information about incidents and lessons learned were recorded in the team meeting minutes for the wards, including those that did not have incidents as a standard agenda item. Staff also told us that emails and handovers were used to cascade information about incidents. One of the two handovers we observed included a discussion around the liaison with a carer and offering them support following an incident with a patient. Recent actions were observed following incidents, for example the wound management policy was reviewed and nurses had been offered a three day training course for wound management following a pressure ulcer incidents at the Charlton Lane Centre.

Are services effective?

Good

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 twenty-seven patient records were reviewed. Care plans were person-centred, holistic, with detailed intervention plans.They were recovery orientated, including the patient's strengths and goals. All the records we reviewed evidenced that a physical health screen had been completed by a doctor within 24 hours following admission, as well as detailed ongoing physical health monitoring. Evidence in the records addressed the essence of care domains, using modified early warning signs scores, the malnutrition universal screening toolscores, skin integrity assessments, falls risk assessments using the falls risk assessment tool, body mass index calculations, venous thromboembolism assessments, water-flow assessments, and delirium assessments.
- The care plans reviewed included evidence of 'general anxiety assessments', depression assessments including the patient health questionnaire, the Hamilton depression scale, and the Addenbrooke's cognitive examination. There was evidence of occupational therapist assessments in some of the records. The care plans included referrals to the physiotherapists, psychology, occupational therapy and electro convulsive therapy, as well as involvement with other community services.
- The care plans, including any change in mental or physical health condition, were reviewed in the daily handovers, weekly at the multi-disciplinary meetings, and monthly at the care programme approach meetings. This was evidenced in the care plans, and the handovers and meetings we observed.
- The records we reviewed demonstrated good use of decision specific capacity assessments and best interest decisions, including personal care and hydration and nutrition. There was evidence of referrals to independent mental Health advocates for patients detained under the Mental Health Act.
- Where patients had a 'do not attempt resuscitation' (DNAR) form there had been multidisciplinary involvement which consisted of nursing staff, relative and consultants and the patient. There was evidence that these decisions were reviewed, for example, when a patient was moved from the general hospital with a DNAR in place. There was limited evidence in the records we checked of advance decisions, except in a patient's record that was undergoing electro convulsive therapy. Staff told us that patients do not usually have advanced decisions in place. Advance decisions were on the standard agenda of the multi-disciplinary meeting we observed.
- All treatment and care was documented and stored securely on the RiO system. Staff employed by the trust were allocated a card which enabled approved staff to access the system. All paper documentation was scanned on in a timely manner, for example, some of the Mental Health Act documentation. All information was easily accessible for staff that were familiar with the system. We observed the hydration and nutrition plans in the dining rooms in communal areas on a number of wards to support staff in being responsive to patients' needs. These were accessible to other patients and carers and contained patient information. Ward staff were made aware of this during our visit and removed these files to a locked cabinet or a secure area which was not accessible by patients.

Best practice in treatment and care

- The assessments and care plans on RiO were underpinned by national institute for health and care excellence guidance, as the system was programmed according to NHS England's payment by results and mental health clustering tool (MHCT). The MHCT incorporates items from the health of the nation outcome scales (HoNOS), and the 'summary of assessments of risk and need', in order to provide all the information necessary to allocate individuals to clusters. Staff confirmed that they use the HoNOS outcome measure to measure health and social functioning outcomes in mental health services. When a patient assessment was completed, an appropriate care plan was identified by the system in line with the clustering tool, including appropriate medical and psychological interventions.
- The assessment and clinical prescribing we observed were evidence based intervention and in line with national institute for health and care excellence (NICE) guidance, for example, the use of antispsychotics, anti-

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depressants and electro convulsive therapy. The pharmacist supports the clinicians with decisions around prescribing medications using the British national formulary.

- The service offered psychological therapies recommended by NICE. In the main, this was delivered by the occupational therapy and psychology department. The psychologist at the Charlton Lane Centre used neuro-psychological assessments and brief solution focussed training. There was no psychologist at the Stonebow Unit for older age adults. The care plans showed that nursing staff do use cognitive behavioural therapy and motivational interviewing approaches which are in line with NICE guidance. Building a therapeutic relationship and goal setting were evident.
- The occupational therapy departments used the model of human occupation (MOHO), including the model of human occupation screening tool. The occupational therapists were involved in the patients' discharge plans and resettlement, and their role included a mix of assessments and facilitating group activities. A mindfulness group had recently commenced on the Stonebow Unit.
- We observed speech and language group therapeutic sessions. The activities supported the patients with swallowing and communication. Other activities included cooking, painting, hand massage and gardening. Occupational therapists also supported patients in a sensory garden.
- All the wards had access to reminiscence and sensory equipment, and the occupational therapists used cognitive stimulation with the dementia patients. Nursing staff had access to this equipment but do not use it. Occupational therapists had started 'life story' work with patients on two wards, where they work with the patient over time to make a personal record of important experiences, people and places.This helps the service to deliver a more person-centred care package. They plan to extend this to all wards. A nurse consultant, leading on dementia, Mental Capacity Act and the Deprivation of Liberty Safeguards was involved in the organic wards to improve meaningful activity and encourage non-pharmacological approaches for patients with dementia and other cognitive impairment. They also conduct dementia care mapping twice a year.
- There was good access to physical health care, including specialist when required, for example, the geriatrics registrar and the palliative care consultant. The service use a wide range of best practice principles with respect to physical and mental healthcare, including:
- Addenbrooke's Cognitive Examination
- Essence of Care
- Falls risk assessment tool
- Modified Early Warning Signs scores
- Malnutrition Universal Screening Tool
- Depression Test Questionnaire
- Anxiety Test Questionnaire
- Pressure risk ulcer calculator
- Assessment of Venus thrombosis
- Clinical staff on both sites participated in clinical audit. There was clinical audit training and a department that supported this work. Clinical staff told us that they had been involved in medication audits like Lithium, Clozeril, and Mepicane, as well as a psychosis skills audit, national patient safety thermometer and falls prevention.

Skilled staff to deliver care

- All the wards had access to a full range of mental health disciplines on top of the team of nurses and healthcare assistants, with a few exceptions. There was input provided by consultant psychiatrists, doctors and junior doctors, on a daily basis. GPs also visited the wards and there was access to a specialist geriatrician. Pharmacists supported all five wards, attended multi-disciplinary team meetings, visited the wards, and were available for advice and guidance. Both sites had input from physiotherapists.
- The Charlton Lane Centre and the Stonebow Unit both had occupational therapist vacancies, maternity leave and sickness absence. This impacted on their ability to deliver the activity programme and attend the multi-disciplinary meetings. This had improved since the recent occupational therapist team recruitment,reportedstaff. The occupational therapist team at full complement comprised of a mix of band five and six occupational therapists overseen by a band

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seven occupational therapist, occupational technicians and occupational assistants. The occupational therapists currently work Monday to Friday but there were plans for them to move to a seven day working week.

- The Charlton Lane Centre had a psychologist three days per week. They input into all three wards, see patients on a one to one basis, and support the staff team. Staff told us that it was easy to access psychology through a simple referral and that there was no wait. A few staff told us that they thought there should be an increase in input from psychology at the Charlton Lane Centre to enable them to attend all multi-disciplinary team meetings and have more one to one time with patients. A business case had been submitted for the trust to consider. The Stonebow Unit had a psychologist but they do not see any patients, or have any direct input, on the two older age adult wards. They do provide advice and guidance where required.
- We observed the speech and language therapist on the three wards at the Charlton Lane Centre. The Stonebow Unit accessed speech and language support from the general hospital. Physical health nurses attended the Charlton Lane Centre three days per week, whilst the general hospital provided the physical health support to the Stonebow unit. General medical nurses were also employed to work on the wards in the Hereford, as well as registered mental health nurses.
- Community psychiatric nurses and social care workers attended all the wards, mostly to support a patient's discharge. Where a patient is on end of life care, the wards had input from the palliative care team, palliative care consultant, and the local hospices. The consultant in Hereford was a specialist in end of life care. A nurse consultant had input into the organic wards. They led on the Mental Capacity Act, Deprivation of Liberty Safeguards and dementia.
- The 18 personnel files we reviewed showed that staff were skilled and experienced enough to complete their roles. All the relevant checks had been completed including references, qualifications, disclosure and barring checks, pin membership checks, and fitness to work declarations. Evidence of the interview and recruitment process were available in files, except where they were transfers from other services.
- Specialist physical health training was delivered by the trust and the physical health nurses, including, tissue viability, catheter care, sepsis, wound management, continence care, sub-cutaneous fluids, electrocardiography and phlebotomy. One nurse had been funded for diabetes training at the University of Worcester, and one for catheter care training at the University of Birmingham.
- Training to support carers included 'carer aware', carer assessment, and family assessment. Training on delirium, personality disorder and dementia awareness were delivered, with staff attending dementia care mapping. Motivational interviewing and cognitive behavioural therapy were delivered by the trust. The managers informed us that they were completing a skills analysis on the older age adults' ward with respect to specialist training. This included psychosocial interventions like brief interventions and family approaches, as well as other softer skills, like relaxation techniques and sleep hygiene. They told us the trust will then support the requirements of the wards with regard to training for psychosocial interventions appropriate to their role in an over-arching training schedule.
- The trust evidenced good relationships with specialist services around the county who had been able to provide training and input to ensure that these wards offer person specific care and interventions. Staff told us they had received sessions from palliative care, Parkinson's and Huntington's services.
- Staff demonstrated a good knowledge and understanding of their role and patients told us they felt safe and confident that staff knew what they were doing to support them properly.
- Medical staff appraisal rates for the wards as of the end of June 2015 were 81%. For non medical staff, Mulberry Ward had an 80% appraisal rate as of the 30 September 2015, and the other four wards had appraisal rates of 92% and above. The occupational therapy department for the older people's wards had an appraisal rate of 100%. On the day of our visit, 100% of the 18 staff files we reviewed had current appraisals completed with input of both staff and their managers with detailed objectives. Mulberry Ward had high levels of sickness at this time which could account for the low appraisal rate on that ward.

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- All 18 supervision files demonstrated the completion of supervision. Seventy per cent of the files had supervision completed in line with the six week supervision intervals outlined in the trust policy. Staff told us that they always had supervision but it did not always fall within the six week intervals. They told us that if they needed support in between supervision, managers would always make time for this. The supervision records reviewed recorded discussions about clinical issues and clinical unmet needs, issues with the RiO system, training needs, safeguarding, and linked with the staff member's appraisal. There was evidence of group supervision in the supervision files we observed. Evidence of a ward induction lasting three months, probationary reviews lasting six months, and action plans to address underperformance were present as appropriate in the files we reviewed. Where agency staff were used, an induction checklist was used to orient them with the ward and their responsibilities. Staff employed by the trust also received a corporate induction.

Multi-disciplinary and inter-agency team work

- The shift times on the older people's ward overlapped allowing staff from the previous shift to handover to the staff on the next shift. This inbuilt time allowed information to be exchanged on each of the patients and ensured that risk is effectively managed. Nurses and health care assistants were present on the handover and doctors would attend where they could. Staff told us that handovers were collaborative and everyone was able to contribute. We observed this to be the case. Ward managers informed us that they used the handover to cascade trust information, including new policies and feedback on complaint and incidents.
- We observed two detailed handovers. The handovers were different to each other with regard to the information delivered in them possibly because there was no standard service handover agenda and the handovers were delivered by different staff members. One of the handovers included modified early warning signs scores, doctor's examination notes and risk summary, but did not discuss legal status or observation levels. The other handover discussed the previous night's sleep, diet and fluids, continence, levels of observation, Deprivation of Liberty Safeguards, do not resuscitate information and personal care.It did not include the patient's diagnosis and current mental health, engagement in activities or risk profile.
- All the consultants had weekly multi-disciplinary meeting on the wards. We observed one multidisciplinary meeting during our inspection. Three medical staff were present, a student nurse, a physiotherapist and a pharmacist. The service had access to occupational therapists, social workers, physiotherapists, speech and language therapists, psychology as well as access to other health professionals such as specialist nurses and dieticians. Staff told us that some staff availability was limited due to the time shared between wards and locations of the service but they attempted to get to as many multi-disciplinary team meetings as they can. Health care assistants were also able to attend. Community staff did not attend and staff told us that they did not expected them to attend unless there were concerns, or discharge, that required their input. Patient, family and carers did not attend the multi-disciplinary meetings, but were given the opportunity to feed into the meeting via their named nurse prior to it. The multi-disciplinary meeting had a comprehensive set agenda including goals of admission, mental and physical diagnosis, allergies, do not attempt resuscitation decisions and advanced decisions, Mental Health Act status and expiry date, Deprivation of Liberty Safeguards status, previous plans, reports from patients, families, carers and professionals, care planning and risk management.
- Whilst on our visit, we observed a care programme approach (CPA) meeting. The consultant, a nurse, an occupational therapist, a community psychiatric nurse (CPN), the patient, and a family member attended. The consultant explained the rationale of the meeting to the patient. All the participants were given time to feedback, including the patient and their family member. The psychiatrist explained the medication and discussed the results of the patient's recent memory assessment. The information was discussed in language that the patient and her family member could understand easily. Despite this being the patient's first CPA meeting, discharge outcomes were discussed with the patient. Regular planned CPA meetings were observed on all wards, with a number of these taking place on the wards during our visit.

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- The community mental health teams did not attend multi-disciplinary meetings at the Charlton Lane Centre but would attend the care programme approach meetings prior to discharge, which is when the patient makes contact with them if they have not known them previously. The Charlton Lane Centre had good relationships with the social care team and they would attend CPAmeetings and some multi-disciplinary meetings. They could also facilitate early discharge. In Hereford, staff told us that the community psychiatric nurses usually maintain contact throughout a patient's stay and the crisis team facilitate discharge. Since the loss of the section 75 agreement in April 2015, Hereford social care workers who were embedded in the community mental health recovery teams, were withdrawn back to the local authority. Now all social care referrals are through the single point of contact. This has affected the joined up approach between the community mental health team and social care. This was put on the trust risk register due to the potential, and actual, delays to discharge from Jenny Lind and Cantilupe Wards. Regular input from pharmacists on the ward, and at multi-disciplinary meetings, ensured that there was a joined up approach between the service and the local GPs to ensure that prescribing continues seamlessly when a patient is discharged.

Adherence to the MHA and the MHA Code of Practice

- The data provided by the trust for September 2015 showed that two staff from the Charlton Lane Centre had completed the one day overview training. Prior to our visit, training in the MHA and the guiding principles was not mandatory. However, this training was now mandatory training. Staff were aware of the new code of practice and there was a copy located in the ward offices. There was no formal training on the code of practice except for the bespoke training provided for the MHA Managers and delivered in 2015. The staff we spoke to were aware of the trust MHA administrator who offered support and legal advice on the MHA and the code of practice.
- Information on the rights of patients who were detained, and information about the independent mental health advocacy (IMHA) services, was displayed in all the wards, provided in the patient handbook, and in the family and carer information. Patients were read their rights weekly when they were admitted under a section two, and every three weeks where they were admitted under a section three. All MHA records reflected lawful detention. Records showed that attempted discussion of rights under Section 132 were taking place but the records did not all demonstrate that this was happening immediately upon detention or change of status from a Section 2 to a Section 3, or regularly following an initial attempt. Staff told us that where patients were not in a position to understand their rights, they would document this, and retry. We saw no evidence of patients' rights in an easy to read format. Independent Mental Health Advocates were readily available to support patients and we saw evidence of referrals to the advocates in the files we observed. Advocates visited some of the wards on a weekly basis. Staff told us that where they felt that patients were unable to request advocacy for themselves, they would make a referral on their behalf. All documentation was stored and scanned on to the secure RiO system.
- For people detained under the Mental Health Act we found that antipsychotic medicines were prescribed appropriately and reviewed regularly. The required documentation for treatment for mental disorder was in place but nursing staff were not able to demonstrate an understanding of the documentation. All treatments were given under the appropriate legal authority but in the records we reviewed we could not find evidence of the responsible clinician's record of their assessment of the patient's capacity to consent at first administration of treatment for mental disorder in all records. The electro convulsive therapy patient consent forms were extremely robust, including two evidenced discussions about consent. Several patients were being given their medication covertly as a matter of course. These patients all had covert administration care plans which showed that their families had been consulted. They also had recorded advice from the pharmacy team regarding which medications could be covertly administered and how. The covert administration of medication as it was being done on one of the wards was not compliant with the trust policy, which states that covert administration should be a 'contingency' rather than 'routine.' The patients' medication charts did not clearly document each time covert

Are services effective?

Good

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administration had been used, or not. This was an area of practice in which the service could improve their standard of record keeping and appreciation of the rights of the individual patient.

- A standardised system was in place for Section 17 leave by which responsible clinicians can record the leave they authorised and specify the conditions attached to it. Current forms were available on the ward and previous forms were available as scanned documents on the electronic patient record system. The forms we observed were not all completed sufficiently and old leave forms were not always removed or scored through.In some of the patient records we reviewed, we could not be sure if the patient or relative had signed the authorisation for leave or received a copy. As such, they may not have been aware of the legal conditions of authorised Section 17 leave. There was no evidence of risk assessments prior to Section 17 leave in all records, or evidence to confirm whether the leave had been taken, or the outcome.Staff told us that risk and leave was discussed at the multi-disciplinary meetings and we observed that this was on the standard multi-disciplinary meeting agenda. During our visit, one patient was due to go out on leave to a medical appointment that day. He did not have authorisation to go. This was only discovered about an hour before he was due to go when the Mental Health Act reviewer asked to see the authorisation. Staff rectified this situation immediately.
- The MHA was audited quarterly to ensure that it was being applied correctly. The audit was reviewed by the Mental Health Act scrutiny committee. An action plan was cascaded and overseen by managers at ward level, for example the actions from the recent capacity and consent audit.We saw evidence of this from the scrutiny committee board meeting minutes.

Good practice in applying the MCA

- There were 13 Deprivation of Liberty Safeguards (DoLS) applications across the trust between 1 May 2014 and 30 April 2015. Eight were not granted and two others were repeat applications that were due to expire. All the DoLS applications were made by the wards at the Charlton Lane Centre in Cheltenham, with Chestnut ward being the only ward with successful DoLS applications. There were no applications made on the Hereford wards in this time period. Where applications were not granted, the patient's care and any restrictive practice was reviewed in the multi-disciplinary meeting using the standard meeting agenda we observed.
- Prior to the inspection, training on the Mental Capacity Act (MCA) was not mandatory across the trust. The information we received from the trust for training in the month of September evidenced that 24 staff had completed the MCA training in that month. An introduction to MCA and DoLS was covered on the corporate induction.Staff told us that they felt confident in applying the MCA, including DoLS, and demonstrated some understanding in the application of the Act and the five principles. The RiO system supported staff through prompting capacity assessments for patients. The trust had a MCA and DoLS policy that could be found on the intranet. Staff told us that they could access further support from a consultant nurse who was the trust lead on MCA and DoLS. The implementation of MCA and DoLS was overseen by the Mental Health Act scrutiny committee, and actions implemented, evidenced through the scrutiny committee Board report.
- We saw evidence of capacity being reviewed in the standard multi-disciplinary team meeting agenda, as well as in the discharge plans. We reviewed one patient's record in detail. The patient was an informal patient and was not detainable under the MHA. The patient had five capacity assessments since their admission in relation to different issues, for example, eating and self-care and physical support. There was evidence in the record of the capacity assessments, and clinical and best interest assessments for each individual decision. The best interest decisions took into consideration the person's wishes and took account of their history.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- In all five wards we saw people treated with dignity and respect. We observed staff helping and supporting people and encouraging them to be as independent as possible. Staff spoke calmly and clearly to patients showing compassion and care, with good eye contact and voice tone. The patients who were able to told us that they were happy with their care, were listened to, and treated well by staff. They told us staff were kind, patient, respectful and polite. Family and carers spoke highly of the staff. They echoed patients in their remarks about the staff and said that they felt confident leaving their relative on the wards and that nothing was too much trouble for the staff. The patient-led assessments of the care environment data for 2015 demonstrated that all five wards were well above the national average in comparison to other trusts for scores on privacy, dignity and well-being.We saw gender preferences observed for personal care. The care offered was enhanced by the fact that all the nursing staff knew their patients well and a named nurse was allocated at admission. Staff on the wards could tell us detailed information about the patients, whether they were named nurses or not, including their likes and dislikes. Staff names and photos were displayed on all wards. On some wards there was also some brief information about the staff so that patients could be more familiar with them as people, not just as staff.

The involvement of people in the care they receive

- Staff on all wards told us that on admission, patients were shown around the ward, helped to unpack their belongings, and allocated a named nurse. All patients received a welcome pack appropriate to the ward and site containing details about the ward and advocacy information. Where patients cannot read or understand the welcome pack, we were told by staff, carers and patients that this is discussed verbally in a manageable way, dependent on the individual needs of the patient and carer. Family and carers must be contacted within three days of a patient's admission by the named nurse, as this is a trust target. Carers were also provided with information about advocacy, visiting times and local carers' support groups. There were no carers groups specifically delivered by the wards for older age adults with mental health problems. Family and carers were invited in to speak with the named nurse and some of the wards offered weekly family clinics with the ward manager.Information on the triangle of care, which is a best practice guide for how professionals, service users and carers can better work together, was seen in the bedrooms on some wards, including sheets with the names of the people involved in that patient's care.
- All but three of the plans we reviewed on the functional wards, (for patients with mental health problems like depression and psychosis), demonstrated patients' views had been taken into account in their care plan.
- All patients had their current care plan in their room in a folder. The care plans were completed on the RiO system, usually away from the patients. The care plans we observed had a section for patients and carers to put comments on when a care plan had been completed. There was limited evidence, particularly on the organic wards for patients with dementia and other cognitive impairment that patients had agreed to their care plan as there were few comments and signatures. Family and carers were involved in the care plans we reviewed, particularly where the patients were unable to consent or make their own choices known. Family and carers told us that they felt involved in the patient's care and treatment. They told us that they were always offered support from the staff on the wards. There was a carer's assessment in one of the files that we reviewed. Staff told us that the community teams generally complete the carer's assessments.
- The section 17 leave forms reviewed demonstrated that some patients were not always involved in the decisions in relation to their section 17 leave. Also section 17 leave did not always take into account the patient's wishes, and those of carers, friends, and others who may be involved in any planned leave of absence in adherence to 27.10 of the Code of Practice.
- This folder in the patient room also included information on advocacy for both independent mental health advocacy and independent mental capacity advocacy. Information on advocacy was also given verbally. Staff told us that where a patient is unable to access advocacy themselves, they would involve them on their behalf. We were given examples of where staff had done so. Staff had contact details for advocacy support and on some wards independent mental health

Good

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advocates attended weekly to make contact with the patients. We saw little evidence in the files we reviewed that advance decisions were in place for patients. Apart from being a standard agenda item on the multi-disciplinary team meeting we observed, we saw no evidence of advance decisions being promoted, for example in the leaflets in the patient or carer file, or on the wards.

- We were told that patients could be involved in decisions about the trust through the social inclusion team. This included involvement in recruitment and board meetings. At ward level, previous patients volunteered on the wards supporting activities, like knitting, following the relevant recruitment checks.

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

- Admission criteria was clear for each ward. Admissions were primarily made from older adult community teams, following an admission assessment. Admission decisions were medically led in consultation with wards managers. Patients could be admitted on the functional ward if they had physical health needs which made them suitable for treatment and care there. Similarly, the organic wards would accept patients on the wards who were younger than 65 who had dementia. Ward managers and clinicians told us they are able to refuse admission if they had concerns the patient mix would not work on the wards. Full and complete assessments were done for patient's physical and mental health needs. Carers were involved in sharing information with staff. This was evidenced in the patients' records we reviewed on RiO.
- The average bed occupancy on the older age adults' wards for people with mental health problems between 1st January 2015 and 30th June 2015 was 90%. All the wards had individual average bed occupancies above 85%. Jenny Lind ward had an average bed occupancy of 94% which was the highest of all the wards in the older age adults' services, and in the trust. The Royal College of Psychiatrists state that the optimal bed occupancy is 85% as this allows patients to be admitted in a timely way to a ward that is local to them. It also allows patients to be able to take leave and return to the same ward. However, there were no delays in admission or out of area placements attributed to this core service that was due to no bed being available. The trust had sent two older adults out of county in the last year. This was due to the challenges with the patients' behaviour and them requiring a more specialised placement. Both patients went to a specialist challenging dementia unit in Taunton. The largest pressures on bed availability was in Hereford. Eighteen patients, plus a further seven transferred patients, from Hereford older age adults wards were placed in Gloucester older age adults wards in the last 12 months. Whilst, two older age adults from Gloucester were placed in Hereford. This was in line with the trust bed management policy.
- The Cantilupe Ward in Herefordshire had two additional beds to the 10 beds commissioned by Herefordshire Clinical Commissioning Group. Whilst these extra two beds were not commissioned and staff could not provide a clear reason why this was the case, there were regular transfers and admissions to these beds to accommodate bed pressures particularly at the Hereford site. Whilst we visited the ward, both these additional two beds were in use. Prior to our visit a patient who was a working age adult was transferred onto the organic older age adults ward. The managers told us that the patient's stability was assessed before any transfer or admission onto an alternative ward, and they also considered transferring other more stable patients. All these discussions were discussed with the patient. This was all detailed in the bed management policy. A bed manager was in post in Gloucester who managed the Charlton Lane Centre admissions. The Gloucestershire bed manager is now working across both Gloucestershire and Herefordshire inpatient units to support bed management at the Charlton Lane Centre and Stonebow Units. Herefordshire services were exploring options to enhance the bed management arrangements through the recruitment of a Herefordshire based bed manager to work in conjunction with the bed manager based in Gloucestershire.
- The bed management policy stated that where a patient is on leave for over 48 hours, a bed may not be available in the same locality. Staff, patients and carers confirmed that it was common for patients in Hereford to go on leave and have to return to a bed in Gloucester. Following a complaint about this, all staff had been reminded to ensure that they communicated this information to patients, families and carers. The data we received from the trust confirmed that patients always get a bed following leave at either site and do not get placed out of area. Patients were not moved between wards during an episode of admission unless it was justified on clinical grounds, or in the best interest of the patient, in line with the bed management policy. The policy stated that patients on different wards, including in different localities, for longer than 28 days should remain on that admission ward for continuity. Staff told us that they attempt to get the patient moved to a ward in their own locality as soon as possible following admission as it is better for the patient and carers in terms of support from local services and accessibility. Where family members and carers were travelling long

Are services responsive to people's needs?

Good

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distances to visit patients, including where patients from Hereford had been placed at the Charlton Lane Centre in Gloucester either at first admission or following a period of leave, all the staff we spoke to described how they tried to accommodate this, for example through extended visits and arranging transport. However, there was not a consistent approach and this was not detailed in the bed management policy.

- The managers we spoke to stated that where a patient's behaviour cannot be managed by the older age adults' ward, a bed on the psychiatric intensive care unit (PICU) is always available. However, they often choose not to send patients to the PICU wards but to a service that specialises in managing older age adults' challenging behaviour. PICU not having specialist beds for older people was recorded on the local risk register.
- Staff told us that when patients are moved or discharged they would do it at a time agreed by the patient; usually the middle of the day, avoiding Fridays and weekends. Patients, carers and staff told us that discharge plans are discussed from when the patient enters the service. This was evident at the care programme approach meeting that we observed. Managers told us that discharge is only ever for clinical reasons and this was recorded in the discharge plans we reviewed. The discharge plans evidenced patient and carer involvement, and support from community teams. Between 1 January 2015 and 30 June 2015, there had been four delayed discharges; one on Mulberry Ward and three on Jenny Lind Ward. The reasons for these delays included waiting for complex community support packages to be put in place or support or training required for patients with more complex physical needs. Staff in Hereford told us that there had been delays in discharge since the loss of the section 75 agreement, where social workers who were embedded in the community mental health recovery teams had been withdrawn back to the local authority. This had an impacted on the sharing of information to facilitate discharge. Managers told us that this had been placed on the local risk register. At the time of our visit, this issue was starting to improve. There were 18 readmissions in the 90 days post discharge. Twelve of these were on Mulberry ward. Information provided by the trust included non-compliance or cessation of medications, escalating suicide ideation and self-harm, and behavioural and safeguarding concerns. Recent discharge questionnaires had been introduced, which patients and relatives were requested to complete.
- The trust had responded to the increase in patients with palliative care needs. They had made a decision to offer end of life care on the older age adult wards where the patient has been in the service for a short time (unless they chose to go home). This was consistent with the local strategic priorities. End of life care was delivered in accordance with the shared care pathway. The patients on the wards that had received end of life care had done so for between two and 14 days. In the past 12 months, nine patients had received end of life care on Mulberry ward, seven on Willow, one on Chestnut and two on Cantilupe. Cantilupe ward told us they had always offered end of life care. The Stonebow Unit had recruited a doctor who was a specialist in end of life care. Both sites had strong relationships with the palliative care teams, palliative care consultants and the hospices, and were supported by them. GPs, geriatricians and physical health care nurses also supported the end of life care packages in line with the "one chance to get it right" guidelines. Staff told us that where a patient died on the ward, all the staff are offered a debrief session with the managers or the psychologist, and can access the trust counselling service, 'working well'. The ward manager or the nursing director acts as the last officer. The trust had an end of life steering group including pharmacists and medics from both localities. The policy had been reviewed and circulated for internal consultation. The modern matrons sat on the internal steering groups that fed into the local authority end of life care agenda. The trust told us that they were considering training on syringe drivers from the local hospice. Carers told us about the high level of compassionate and family focussed care offered whilst a patient is on end of life care. Carers and family members told us that staff had supported them to stay on the ward with the patients either in the patient's room or in the assistive technology suite at Charlton Lane which has a bed and cooking facilities. Staff gave details of how this was risk assessed.

The facilities promote recovery, comfort, dignity and confidentiality

Are services responsive to people's needs?

Good

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

- All the wards had a range of fully equipped rooms including clinic rooms, activity rooms and therapy rooms on all sites. There was a gym, kitchen area and laundry facilities where occupational therapists could work with patients. There was a room containing sensory and reminiscence equipment at the Charlton Lane Centre for the patients with organic illnesses like dementia. On our visit, there was sensory and reminiscence equipment on Cantilupe ward but it was in a cupboard in a box. There was an assistive technology room at the Charlton Lane Centre where patients and carers could learn how to use the technology ready for when they returned home. Managers told us that this was used for training staff in the trust in assistive technology. The occupational therapists told us that they could order some of the basic assistive technology but the social workers ordered the more expensive equipment, which could delay a patient's discharge. There were private spaces and quiet rooms available for patients to meet with relatives and for patients who needed low stimuli. We observed that there were no rooms allocated as a female only lounge but we were told that this would be available on request.
- All patients could make a call in private. There were telephones situated in quiet rooms on the wards and we observed patients using these. Staff told us on the Jenny Lind ward that patients could have mobile phones but staff kept the chargers as they had been considered a potential ligature risks to the patients on the ward.
- Patients could access outside areas from all the wards. The outside areas at the Charlton Lane Centre were pleasant with lots of seating and lighting, as well as rubber flooring. Some of the tables and seating were not suitable for older age patients in terms of the height and stability. There was a sensory garden on the Mulberry ward. Patients had worked with the occupational therapists to get the plants. There was a shed with gardening accessories. The garden areas we observed at the Stonebow Unit was a good space but had uneven flagged surfaces. Managers told us that the paving was being replaced by the end of this year with rubber flooring. However, some of the wards we accessed, did not have free access to outside space. We were told that this was dependent on the case mix of patients on the ward. There were no appropriate signs to instruct patients about the restriction to the outside area and to ask a member of staff to help if they wanted to go outside.
- We observed a choice of main meals and snacks offered throughout the day. The majority of patients and carers confirmed that the food was good quality and tasty. The patient-led assessment of the care environment data for 2015 showed that patients were happy with the food overall. The score for food was above the national average in comparison to other trusts, with Charlton Lane Centre outcomes of 100% for ward food. We observed that some menus were written on boards were hard to read and mixed with other information, for example, the staffing compliment on the ward for the day. However, staff on all wards were proactive in discussing meal choices with patients, which we also observed. Willow ward had implemented a picture menu to discuss with patients which we were told was going to be implemented on other wards. Staff supported patients individually with their dietary requirements, and a nutrition and hydration file was accessible on all wards. On some wards this was in the patient area rather than locked away, which we brought to the services attention and they addressed it immediately. Patients could choose where to eat their meal and for those who chose to eat in the dining area, tables were set accordingly. Support from staff was offered where this was planned. Meal times on the wards were protected for the most part but the wards acknowledged that some visitors would have travelled a considerable distance to see their relatives. Family and carers told us that ward staff let them stay and offered them a meal.
- On some wards patients were able to access tea and coffee, and snacks 24 hours a day. On others, patients needed to ask for support from staff. We were informed that this was due to the risk behaviour of some of the patients on the ward at that time. At other times tea, coffee and snacks were not restricted. We saw no evidence of this being risk assessed or documented. There was no clear signage informing patients about the tea, coffee or snacks, or directing them to ask staff for support.
- All patients were able to personalise their own bedrooms, though this was more challenging in the

Are services responsive to people's needs?

Good

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Cantilupe dormitories due to the communal space. All patients on Cantilupe were allocated their own pin boards but we observed that these were underutilised, leaving the dormitory looking sparse and uninviting. All patients had wardrobes to store their possessions and safes for their valuables.

- We observed activity calendars for each wards. Generally, the activities were more social and recreational in nature, rather than therapeutic. On three of the ward there were no weekend activities. There were activities for a full seven days on the Chestnut ward and Mulberry ward. Cantilupe and Jenny Lind ward staff told us that activities were only available Monday to Friday. Staff told us they would try to do more responsive social and recreational activities at weekend like bingo or watching a film and that there were plans for the occupational therapy team to be available at weekends. Staff, patients and carers told us that there were not enough activities on the wards and that they sometimes got cancelled. We observed "you said we did" information displayed where patients had requested more activities. The Charlton Lane Centre had taken an approach where activity was "everybody's business." Some of the nursing staff were championing the delivery of activities. On these wards patients said that staff were good at getting them involved. The staff on the older age adult's ward in Hereford saw the activities as the occupational therapists' responsibility. During our visit, two activities were cancelled including the theatre group on the Cantilupe ward and the pat the dog activity on Willow ward. These activities were delivered by external agencies and volunteers but the wards were not clear about the reasons for the non-attendance. We did observe one activity which was a pumpkin carving session. We observed good interaction, appropriate equipment, and a choice of roles for the patients. There was evidence of craft and painting activities around the wards as the patients' work was on display. There was a plentiful stock of board games and other recreational activities on the wards. Carers told us that they too were involved in the activities if they were on the wards, for example the music group, which they enjoyed.
- All three functional wards for patients with mental health problemshad weekly community meetings or friendship meetings. We saw minutes from these meetings which demonstrated the involvement of the patients on the ward with regard to their environment and the service. The minutes showed discussions around the food, staffing, activities and meaningful discussions, for example around spirituality. The two organic wards for patients with dementia and similar cognitive impairment did not have community meetings and we were told that this was due to their cognitive difficulties. Some of the patients we observed were higher functioning than others on these wards so may have been able to engage in some form of community forum.

Meeting the needs of all people who use the service

- All the wards we observed were adapted to meet the needs of patients with mobility problems or a disability. The organic wards for patients with dementia and similar cognitive impairment had limited dementia signage. Cantilupe ward specifically had no colour and no signage specifically to support patients with dementia to move around the ward. There was no evidence that the organic wards had used evidence from the 'kings fund' document, 'enhancing the healing environment' commissioned by the Department of Health, to create a dementia friendly environment (2015) as the wards did not meet with this guidance. The patient-led assessment of the care environment data for dementia care for 2015 was above the national average compared to other trusts. The national average was 86% and the Stonebow Unit was 92% and the Charlton Lane Centre was just over 99%.
- Staff told us that they knew how to access interpreters. A contact number for the interpreting service through the trust was available on the wards, and on the trust intranet. Staff could access leaflets on the intranet in different languages. An example of a leaflet in Italian was provided. Accessible information like Braille or Moon, as well as access to signers, could be accessed through the intranet, speech and language therapists and the occupational therapists. Staff told us that the occupational therapists had ensured that there was some easy read information for all wards.
- The Charlton Lane Centre had a contemplation room which has various spiritual items including prayer mats and spiritual literature, for example the Bible and the Koran. Patients are supported to maintain their religious individuality. There was also an ablutions room next to the contemplation room for patients to wash

Are services responsive to people's needs?

Good

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themselves as ritual purification prior to prayers. Chaplains visited all the wards to see individual patients. Staff ensured these visits can happen privately on the wards, in the contemplation room, or in a quiet room on the ward. Staff told us that they would request representatives of other religions through the chaplaincy service as required. Staff told us that they would ensure that a patient's religious dietary requirements were met through an appropriate care plan. There were no care plans to review to confirm this at the time of the visit due to the patient case mix being predominantly white British and reflecting the general population. We observed that other dietary requirements were met through nutritional assessments, care planned and accessible on the wards.

Listening to and learning from concerns and complaints

- Out of the eight complaints received by the trust between the 1 April 2014 and 31 March 2015 for the wards for older age people with mental health problems, four had been withdrawn and four had been upheld. None of these complaints were referred to, or upheld by, the ombudsman. Of the four complaints upheld, all related to two of the three functional wards for older people. Three were relating to the Jenny Lind Ward, Herefordshire.The trust respondedappropriately in all cases. For example, there was a review and adaptation of the toilet and shower area on the Jenny Lind Ward by the estates department in response to a compliant. The other three wards did not receive any complaints in that same 12 month period.
- Patients and carers were provided with information on how to complain in the information that they received on admission to the wards. This information included details of advocacy and carers groups for additional support. Patients and carers told us that they felt confident to complain and would either approach the named nurse or the ward manager. Comments? referred to the staff being approachable. One carer informed us that he had complained about the bed availability following a period of leave and he had been supported by staff on the ward, as well as the carers group in Hereford, to complain. We were told that a response was received in writing.
- Staff told us they encouraged patients to complain as it improved the service, and would support patients to complain if they need it. As well as the written information, staff would also discuss the complaints procedure verbally to support patients and carers in their understanding. Staff told us that they would attempt to resolve the issue at a local level and then advise the patients, family or carers about the formal complaints procedure to the trust complaints team if it is necessary. Staff gave a mixed response with regard to the feedback about formal complaints.Some stated that they did not receive feedback from the trust, whereas others told us that complaints were fed back in a positive manner by email, team meetings or handovers. Willow Ward specifically had a standard agenda to include complaints, which evidenced discussions about a complaint by a relative that the patient's care plan was not always available in their room.The agreed action was for staff in the patient's care group to check the care plans are in place. There was no evidence in any of the other ward team meeting minutes that patient or carer complaints had been discussed over the last three months prior to the inspection.
- There was a complaints policy in place. Leaflets were available and posters were seen in the public and wards areas about different ways of complaining including to the trust, Patient Advice and Liaison services and the Care Quality Commission. A suggestion box and "you said, we did" information was observed on some wards. For example, Chestnut Ward had "you said, we did" information visible that patients had stated there were not enough activities and the ward responding through offering additional activities.
- There was evidence of compliments from patients and carers in all the ward areas in "thank you" files. Jenny Lind ward had a complaint and compliment tree in the ward are for all staff and patients to observe.

Are services well-led?

Good

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

- The trust vision and values were displayed in the ward and communal areas. Staff had a good working knowledge and understanding, demonstrating them through their practice. Team meeting agendas in the last three months recorded a commitment to understanding the patient and carer's experience. Staff demonstrated a commitment to learning and improving through their completion of mandatory training and learning from incidents. The effectiveness of the service was ensured through trust targets known as integrated care pathways, like contacting family and carers within three days of admission and contacting the patient within 48 hours after discharge.
- Staff spoke positively about the organisation informing us that the board communicated well with the service. Senior managers were visible on the wards and at events arranged by the wards, like the garden party held at Charlton Lane Centre. Staff told us they took an active interest in the performance of the service, including patient safety walks every six weeks, annual board visits and "team talk" bulletins.

Good governance

- Good governance was demonstrated on the wards for older age adults with mental health problems. The modern matrons, ward managers and deputy ward managers ensured that that systems were effective in ensuring that staff had received mandatory training, staff were supervised and appraised,. Incidents and complaints procedures were robust. Iand complaints were welcomed. Staff were encouraged to
- The ward used key performance indicators known as integrated care pathways to gauge the performance of the team. These were submitted to the trust quarterly but ward managers and deputy ward managers took monthly responsibility for ensuring these were completed. These integrated care pathways included targets like contacting the patients 48 hours after discharge, contacting a patient's family and carers within three days of admission, and reviewing care plans and risk assessments on a monthly basis. Staff told us that underperformance is addressed through supervision, which we observed in staff supervision files. Where there was a team issue, this was addressed through team meetings, which we observed in the team meeting minutes, for example, the allocation of discharge appointments and follow up within 48 hours. The ward managers told us that they felt they had sufficient authority to make decisions autonomously to benefit their ward environment but at the same time sufficient support from the trust. All the wards had administrative support. The quality of care was overseen by two clinical matrons who were responsible for the function and standards of the wards. We saw examples of where the matrons had taken responsibility in ward improvements by attending, and representing, the service at divisional meetings and governance meetings. We saw evidence that staff were able to submit items to a local, and trust, risk register.Examples we saw were, recruitment and bed occupancy, which were both issues on the older age adults wards.

Leadership, morale and staff engagement

- Staff we spoke with talked positively about their team. They told us that they enjoyed coming to work because all the team were positive, friendly and really cared for the patients. Staff told us that they felt positive about the work they did to improve the lives of others and the service was a positive environment in which to work. They told us morale is high and staff engagement is good. We observed a good atmosphere amongst the staff on the wards we visited.
- Staff sickness and turnover rates reported in July 2015 for the service were 12% and 13% respectively. We saw evidence that staffing was being addressed through active recruitment. Staff sickness rates were significantly higher on Mulberry ward which raised the sickness rate well above the 4% benchmark for staff sickness, proposed for productive wards. The ward manager informed us of the action she had taken in response to the levels of sickness on the ward. These including home visits, ongoing supportive contact, support from the psychologist, referrals to the trust counselling service, and re-deployment.As such the sickness levels had reduced significantly at the time of our visit and staff are back at work on the ward. The ward manager was supported by the trust's human resources department, which was the same for all wards where there was issues with staff sickness.

Are services well-led?

Good

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.

- Staff told us that they would know how to use the whistleblowing process. They felt able to raise concerns without fear of victimisation. Staff spoke positively about their managers. Staff had confidence in them and felt able to approach them, and that appropriate action would be taken. Staff told us that managers were always visible on the ward, which we observed during our visit. The deputy ward managers did not have protected time for management duties like auditing or to ensure that the integrated care pathway targets were completed. They told us that they were counted in the main staffing numbers, whereas ward managers were not, which meant that as their priorities were with the patients, sometimes it was difficult for them to find the time to complete the managerial tasks allocated.
- Staff had the opportunity to have more leading roles on the ward for specific things including becoming champions for dementia, activity, smoking cessation, triangle of care , and physical health. Staff told us that they were well supported in their roles and they had access to areas of development such as attending university courses, for example a tissue viability course. They told us that registered nurses, who are newly qualified, or have not completed this before, as part of their professional development will complete facilitating learning and assessment in practice training, which is a qualification to be able to mentor student nurses. The trust had a budget for any other training that staff are interested in. Where training is beneficial to the staff member and related to their role and the ward, staff are encouraged to apply for the course.Ward managers and deputy ward managers were also encouraged to attend leadership and management training such as the leadership foundation programme and national courses, like the Mary Seacole leadership course.
- Staff told us they felt valued by their managers and the trust. They spoke about the 'recognising outstanding service and contribution awards,' which volunteers, staff and teams are nominated for by their colleagues. Staff gave a mixed response with regard to being involved in future development of the service. Some felt that recent developments with regard to shift changes for example had already been decided. For the most part, staff told us that they felt able to feedback through managers about any development in the service through team meetings and handovers. They gave examples of making changes such as the presentation of the patient menu choices, and the integrated care pathway targets required by the trust. Regarding the shift changes, we were told by other staff that there had been consultation and that people could feed back through "staff side" union representatives. Staff and mangers told us they were regularly updated on what was happening within the organisation through the intranet, emails, handovers and team and management meetings. We observed trust information provided through the team meeting minutes that we observed.

Commitment to quality improvement and innovation

- The service was committed to improvement and innovation. Where the service fell short of standards this was identified through the governance systems in place. Action plans were implemented to ensure improvements were made as observed in the minutes from the governance committee meeting.
- The service had accreditation for inpatient mental health services awarded for the work and commitment to elderly care by the Royal College of Psychiatrists. All the wards were due for reassessment in 2016.All three functional wards received excellent accreditation. The two organic wards received accreditation.
- We observed an electro convulsive therapy clinic for older age adults with mental health problems at the Stonebow Unit. This service had received electro convulsive therapy accreditation for this by the Royal College of Psychiatrists. They were due for reassessment in 2018. We reviewed the care records of a patient on Mulberry ward at the Charlton Lane Centre who was accessing electro convulsive therapy in Gloucester. The Gloucestershire electro convulsive therapy service also has accreditation by the Royal College of Psychiatrists.
- The service is working with Lancaster University in a study to understand the nature of restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia.
- It was evident throughout our inspection that staff on the wards for older age adults were committed to providing high quality care that meets the needs of people who used the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The same sex accommodation requirements were not met on all wards and so not all the bedroom facilities were organised to ensure the patients' privacy and dignity. Female only lounges were not clearly identifiable. There was a breach of regulation 10 (2a) (2c)