Gloucestershire Health & Care NHS Foundation Trust

Wards for older people with mental health problems

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Wards for older people with mental health problems

Requires Improvement 

Gloucestershire Health and Care NHS Foundation Trust provide specialist assessment, treatment and care for older people with functional mental health problems and people with dementia. The service has three wards within Charlton Lane Centre; Chestnut, Mulberry and Willow.

We carried out this unannounced inspection of the wards for older people with mental health problems as we had received information that raised some concerns about the safety and quality of the service.

The hospital is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury

The last comprehensive inspection was in 2018 when the service was delivered by 2gether NHS Foundation Trust prior to the merger with Gloucester Care Services NHS Trust. Following that inspection we rated the service good overall and good for the key questions, 'are services safe, effective, responsive and well-led and outstanding for the key question, 'are services caring'.

Following this inspection our rating of this service went down. We rated them as requires improvement because:

- Staff could not always observe patients as there were blind spots on all the wards. Environmental risk assessments did not include reference to these, or the actions taken to mitigate these risks.
- While there were systems and processes in place to prescribe, administer and store medicines these were not always managed safely. The wards did not have processes for the management of transdermal patches. A transdermal patch is a patch that attaches to your skin and contains medication.
- The service did not always have enough staff to care for patients and keep them safe. All wards had vacancies and could not always find bank and agency staff to cover shifts. Agency staff did not have access to the trust's electronic system to enable them to review clinical information.
- While the wards had dedicated female lounges, these were often used by male patients, visiting family members and used as low stimuli/de-escalation rooms. This did not meet the requirements of the Mental Health Act Code of Practice.
- Most staff had completed Mental Capacity Act (MCA) training. However, staff we spoke with were unclear about their understanding, application and recording of the Act and how this affected their work with patients.

However:

- Staff assessed the risks and needs of patients and acted on them. Staff had training in key skills and understood how to protect patients from abuse. The service managed safety incidents well and learned lessons from them.

Our findings

- Staff participated in the provider's restrictive interventions reduction programme and followed national guidance for the physical monitoring of patients after the administration of rapid tranquilisation.
- Staff gave patients enough to eat and drink and pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients.
- Staff generally treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service followed the John's campaign initiative which advocates for the right of people with dementia to be supported by their carers in hospital.
- Patients had access to the Reminiscence Interactive Therapy Activity (RITA) tool which is a touch screen solution to help patients to recall and share events from their past.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for patients to give feedback. Patients could access the service when they needed it and did not have to wait too long for treatment.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their role.

How we carried out the inspection

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

During the inspection visit the inspection team:

- Visited three wards. We looked at the quality of the ward environment and observed how staff were caring for patients.
- Visited three clinic rooms and reviewed seven medicine charts.
- Interviewed three ward managers, the matron and the deputy director for mental health and learning disabilities.
- Spoke with four patients and nine carers or relatives of patients.
- Spoke with 19 staff including five doctors, social worker, clinical dementia lead, nurses, health care assistants and therapists which included; physiotherapists, occupational therapists and the speech and language therapist.
- Reviewed 12 care and treatment records.
- Observed two staff handover meetings, a music therapy group and a patient feedback meeting.
- Attended three focus groups with a variety of staff including therapists, nurses and health care assistants.

What people who use the service say

Our findings

Some patients said staff treated them well and listened and treated them with respect. They said nurses were nice and there were enough people to help if they needed anything. However, other patients said they got the help they needed but sometimes staff gave the impression that they did not really care. All said there was no continuity in staffing, and that some staff were very noisy.

Carers and family members we spoke with said they were “very happy with the care” and “couldn’t have hoped for a nicer place”. However, most said that communication with the hospital could be improved.

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

The wards had environmental risks, including ligature points and blind spots, but most staff were unaware of the actions to mitigate the identified risks.

Safety of the ward layout

While the matron told us they completed environmental risk assessments, they were unable to direct us to copies during the inspection. Staff we spoke with were not aware of the actions to mitigate any identified environmental risks such as blind spots.

The wards looked welcoming, but the layout was not practical with staff not being able to see patients in all parts of the wards. We observed blind spots on all wards. Following the inspection, the trust’s senior executive team informed us the estates team would work with the ward managers to discuss how these risks could be better managed.

We observed that most patients were accommodated in mixed-sex wards. All the sleeping accommodation was provided in single rooms with en-suite toilet and washing facilities. There were other bathrooms close by which were clearly designated either male or female. The trust informed us they managed their accommodation in line with NHS England guidance. The trust provided us with a copy of the agreement with the Clinical Commissioning Group (CCG) to allow mixed sex wards. Senior staff attended a daily bed management meeting to review their beds to mitigate any risks.

During the inspection, we saw two male patients wandering along the female corridor, calling out patient names, looking through the bedroom viewing panels and trying door handles. Staff did not actively observe the corridors so could not respond when this happened. We raised this with the deputy director for mental health and learning disabilities who assured us that they would take action to address this.

All the wards had a designated female lounge. However, we saw the female lounges on all wards were being used by male patients and visiting family members and relatives which doesn’t meet the requirements of the Department of Health's guidelines. Staff told us these lounges were also being used as low stimuli/de-escalation rooms.

There were identified ligature anchor points on the three wards visited. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. There were ligature anchor points

Our findings

within bedroom, bathroom and communal areas. The trust told us they were in the process of reducing ligature risks by installing new bedroom and bathroom doors which have an alarm system fitted to them. Staff told us patients on the wards had organic or functional conditions and required supervision in these areas due to physical frailty. Patients had been individually risk assessed to mitigate any risks to their safety.

Staff received training on managing ligature risks but were unclear how these risks were reduced and managed. The service had an observation and engagement policy which outlined the practice staff should undertake to prevent harm to patients. However, during the inspection, across all three wards, we found staff carried out limited observations of the female corridors to ensure patient safety.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms were available throughout the wards in bedrooms, bathrooms and toilets. However, in the bedrooms on Willow ward alarms were not always visible and could be difficult to access for those with limited mobility. Staff carried individual alarms, which they could activate if they required assistance.

Maintenance, cleanliness and infection control

Ward areas were clean, mostly well maintained, fit for purpose and mostly well furnished. We found several dining room chairs on Willow ward had damage to the outer fabric exposing the core of the padding. This posed an infection control risk.

The sluice room on Willow ward was cluttered with linen bags on the floor and untidy work surfaces. We observed the linen bags had red infected disposable bags within them. On re-checking in the afternoon, we found the bags had been removed and some of the work surfaces had been cleared of clutter. The storage room on Willow ward was also untidy. We saw stock stacked on the floor which meant that staff could not clean under the items.

The service had an up to date risk assessment of hazardous substances. However, staff did not always follow guidelines when storing materials. For example, we found items identified as flammable left on radiators on Willow ward.

Cleaning records were up to date and demonstrated regular cleaning. Housekeeping staff were aware that cleaning strategies had been enhanced due to the Covid-19 pandemic and had changed their practice accordingly.

Staff followed infection control policy, including handwashing. All had received the appropriate training. All wards achieved 100% compliance with their hand hygiene audits for February 2022.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

All wards had a dedicated room for administering medicines, which were organised and clean. Staff did not consistently check the medicine fridge and clinical room temperature daily. There were five days on Chestnut ward in February 2022 where staff had not recorded the medicine fridge checks and two occasions on Mulberry ward where clinical room temperature recordings were above 25 degrees. This means medicines may be stored at the wrong temperature and could be less effective.

Our findings

Emergency equipment and medicines were stored in the wards' clinic rooms. Physical health equipment and resuscitation equipment were available. Staff had undertaken the required checks.

Safe staffing

The service did not always have enough nursing staff.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe.

The wards operated on an early, late and night shift with an overlap between the shifts for handovers. The hospital worked with an extra night shift nurse so they could be used flexibly across the wards to support any staff shortages and maintain patient safety. Following the inspection, the trust informed us they were developing a business plan to enhance nursing night cover with a view of reducing the challenges identified thus improving the delivery of safe care.

Managers used a staff a staff escalation tool to review the staffing requirements for the wards. There was a weekly touch point meeting which reviewed the staffing requirements. Ward managers said they could not always increase staffing to manage enhanced observation levels, and to cover sickness or leave due to the lack of staff. Ward managers often had to be part of the numbers due to staffing shortages which meant they could not always oversee the day to day running of the wards. Senior staff told us they were moving towards to using the Mental Health Optimal Staffing Tool (MHOST) which calculates clinical staffing requirements in mental health wards based on patients' needs.

The trust had offered a financial bonus to staff to work additional shifts. Some staff told us they worked between 60 and 70 hours a week.

Staffing rotas confirmed that shifts were not always filled. For February and March 2022, the records identified a total of 38 unfilled shifts across the wards. Staff were frequently transferred between wards due to staff shortages. Staff told us they felt pressurised to support other wards and were often placed in a position where they felt they had to help.

We noted that on 1 March 2022 a registered nurse and a health care assistant had not arrived for their shift on Mulberry ward which meant that the ward was only staffed by two healthcare assistants from 11pm onwards. The additional night shift registered nurse had already been allocated to another ward due to staff shortages. While support was available from the other wards if needed, there was a potential risk to patients, particularly in an emergency situation.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Patients did not always have regular one-to-one sessions with their named nurse due to staffing shortages. This was confirmed by staff and patients we spoke with.

Staff ensured they kept patients safe when handing over their care to others.

While patients did not always have their escorted leave or activities at the planned time, staff confirmed escorted leave often occurred during or after handover due to additional staff being on shift. Patients we spoke with confirmed they received their escorted leave.

Our findings

The service maintained the carrying out of any physical interventions safely.

Medical staff

The service had enough daytime and night-time medical cover. While there was no weekend consultant cover, the service had access to an on call consultant psychiatrist on an out of hour's basis, seven days a week. Staff said they responded quickly in an emergency.

The service operated with a dedicated consultant psychiatrist for each of its three wards. The responsible clinicians specialised in older adults' mental health care including advanced dementia. The wards also had access to junior doctors.

Managers could access locums when they needed additional medical cover. Doctors we spoke with said they ensured all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. All mandatory staff training was within the trust target of 95% except for resuscitation training which ranged from 59% to 68%. Managers told us they had arranged additional training in April 2022 to address this.

Assessing and managing risk to patients and staff

Staff knew about risks to each patient and acted to prevent or reduce risks. However, on the three wards, staff had not included reference to environmental risk, such as ligature points and blind spots when developing risk management plans for patients presenting with risk to self. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. However, these did not identify actions to mitigate environmental risks such as ligature points. This information fed into the patients' care plans.

New admissions had a period of isolation and testing for Covid when they first entered the service. There were designated bedrooms for this that were separate from the main ward area.

Management of patient risk

Staff were aware of individual patient risks. The dementia lead confirmed they had been working with staff in the use of the Gloucestershire "5 Step Approach." This is an initiative to develop a person-centred care planning approach across Gloucestershire for people with dementia who experience behaviours that challenge.

Staff followed trust policies and procedures and were confident in the use of different levels of observation. We observed two handover meetings where staff were allocated their duties for the day. It was noted that staff discussed individual patient risks including their mood, skin integrity, medicine review and individual patient observation levels.

The physical care nurse worked across all three wards. They had a list of patients to review daily which included wound and oral health assessments. They supported staff with catheter care, syringe drivers and the changing of patient dressings.

Our findings

Staff told us they used the “This is me” tool. This tool is for anyone receiving professional care who is living with dementia or experiencing delirium or other communication difficulties. The dementia lead confirmed this had been recently introduced and continued to be a work in progress.

The service had processes in place for patients with dementia to receive a delirium assessment. The delirium assessment is used to predict poor outcomes such as falls, medical complications, new institutionalisation, and mortality. Managers ensured screening was being completed effectively for the benefit of patients.

The trust had a policy for searching patients. Staff gave patients and carers information about restricted items and searches in patients’ welcome packs on admission. Staff checked patients’ belongings on admission to the ward.

The service had a fire evacuation procedure which included staff responsibilities and what to do on discovering a fire. Staff told us that should a patient have difficulty in being evacuated this would be documented in their care plan. The trust informed us that they were reinstating face to face fire training commencing March 2022.

Use of restrictive interventions

Staff told us they only used restrictive interventions when necessary. Restrictive interventions refer to the restricting of a patient's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken.

The matron and managers had identified concerns which had been raised about the inappropriate use of restraint when reviewing incidents. To mitigate the risk additional support was being provided by the safeguarding team and the clinical lead for dementia. Staff confirmed they had received additional training in the use of restraint as well as de-escalation techniques which was helpful in their understanding of managing conflict in a crisis.

From October 2021 to March 2022 there had been a total of 180 incidents relating to restraint. While the matron received a positive behaviour management report weekly which outlined the number and types of restraint used, we saw no evidence of how this was shared with the managers and the staff team. There was no action plan linked to the report to follow any identified concerns.

Staff followed the National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

Safeguarding

Most staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and most knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. The inspection team were made aware of occasions where some staff had not followed trust guidance in recognising and reporting abuse. We saw that additional teams were supporting staff on wards to understand safeguarding better, for example, the safeguarding team, freedom to speak up champions and the clinical dementia lead.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Our findings

Managers took part in serious case reviews and made changes based on the outcomes**.**

Staff access to essential information

Not all staff had access to clinical information, and it was unclear who maintained the information contained within the clinical records.

The provider used an electronic system for the recording of essential information on patient care and treatment. Most staff were provided with updates on patients' care, routine and health during handovers. However, wards were heavily dependent on agency staff who did not have access to the electronic recording system. There was no clear process on how these staff would input any relevant information to ensure records were up to date with any identified concerns. We were told agency staffs' observations and feedback reports were either written up by a substantive staff or verbally handed over to staff who input the information on the trust's system. There was no process/oversight for this information to be input into the electronic system in a timely way.

The records audit for March 2022 identified areas of concern including; risk assessments not completed weekly, no evidence of either patient or carer views and care plans not being updated to reflect current conditions. The audit did not have an associated action plan.

Staff told us they found it difficult to maintain their workload and write up their notes. Most staff said they worked during their breaks to keep up with the demand.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service did not always safely administer, record and store medicines. Staff reviewed the effects of medicines on each patient's mental and physical health.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines.

The trust had rolled out an electronic prescribing and medicine administration (EPMA) system between February and July 2021.

Staff were unclear how controlled drugs should be managed effectively. While these were stored appropriately in locked cupboards staff did not carry out a running balance or stock check to ensure irregularities were identified quickly. This was brought to the attention of the managers and matron. We saw no evidence this had been identified by the pharmacist during their routine visits to the service.

Following the inspection, the senior executive team told us they had implemented a new controlled drugs policy. They were in the process of updating this policy to state that the order book was now the legal receipt for controlled drugs and did not need to be recorded in the controlled drugs register. They confirmed all teams were to be made aware of the new process.

Staff did not always learn from safety alerts and incidents to improve practice. For example, several patients across all wards were prescribed transdermal patches. The wards did not have a process for the administration of transdermal

patches. A transdermal patch is a patch that attaches to your skin and contains medication. The electronic prescribing and medicine administration system did not prompt the dispenser/administrator to record the removal of the previous patch, to ensure the safe rotation of the new application site. This meant that we could not be assured that patients were not receiving too high a dose of their medicine.

Some patients were on time-critical medicines; for example, patients with a diagnosis of Parkinson's or diabetes. We found discrepancies between the time of dispensing and the time of administration of up to two hours in some medicines. This meant there was a risk of patients not receiving their medicines appropriately.

We reviewed three diabetic patients' blood glucose levels and identified gaps within the documentation. This meant there was a risk to the patients of staff not recognising if they may become hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar).

We found patient medicines not stored in their original container. There was no medicine data sheet available to support staff should they have any concerns or required additional information about these medicines.

On Willow ward we found medicines which had been opened but not dated. For example, morphine oral solution medicines used in the management of pain relief. These medicines often have a short shelf life and may not work as intended once they have been left open for a long time. Managers confirmed they would arrange for these to be destroyed.

Across the three wards we also found out of date medicines.

We reviewed the missed dose audits for February 2022. There were three recorded for Chestnut ward, 18 for Mulberry ward and 54 for Willow ward.

Reporting incidents and learning from when things go wrong

The service had a good track record on safety.

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff raised concerns and reported incidents and near misses in line with the trust's policy.

Staff understood the duty of candour and gave patients and families a full explanation if things went wrong.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service.

There was evidence that changes had been made as a result of feedback.

Managers debriefed and supported staff after any serious incident.

Our findings

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a mental health assessment of each patient either on admission or soon after.

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

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. This included interventions and therapies provided by occupational therapists, physiotherapists and clinical psychologists. All ward staff said they aimed to provide meaningful activities and supported patients to become more independent.

Activities on Chestnut and Mulberry wards were facilitated by staff on the wards. Willow ward had an allocated activity coordinator and we observed a music therapy session with good interaction between staff and patients.

Staff delivered care in line with best practice and national guidance. Staff completed training in prevention and management of violence and aggression. Staff told us they would firstly attempt to use de-escalation techniques when patients were distressed. Examples included talking with patients in a calm manner. This was observed during the inspection.

While staff identified patients' physical health needs these were not always recorded appropriately. Examples included the omission of blood glucose levels. However, it was difficult to verify if these omissions related to a recording error or that the blood glucose levels had not been taken.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff used technology to support patients. Patients had access to electronic tablets to make video call friends and families.

Our findings

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. The trust's audit programme covered areas such as; inpatient falls, diabetes management in inpatients and physical health examinations.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Ward staff included registered nurses, healthcare workers, medical staff, occupational therapists, physiotherapists, dieticians, clinical psychologist and speech and language therapists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. All bank and agency were provided with an overview of the ward and what to do in the event of an emergency.

Managers supported staff through regular, constructive appraisals and supervision of their work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, the dementia lead was providing bite size training in staff awareness and management of dementia.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. While they had effective working relationships with other relevant teams within the organisation they did not always work well with external teams.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation but care records did not identify discussions and/or correspondence with external teams regarding discharge planning.

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

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

Our findings

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had access to an Independent Mental Health Advocate (IMHA). We spoke with staff who confirmed that advocates attended the wards regularly. While staff informed us the IMHA attended the wards regularly to see patients so that they could explain what they could offer, this was not documented within the care records.

Section 132 of the Mental Health Act requires the manager of a hospital to inform a detained patient of their legal position and rights. Staff explained to each patient their rights in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The Mental Health Legalisation Operational Groups meeting minutes for February 2022 regarding the monitoring of provision of patient's rights showed the wards achieving between 73% and 92%.

Section 17 leave (permission to leave the hospital) was reviewed weekly in the multidisciplinary team. Staff told us that this could on occasions be a challenge, but all patients spoken with confirmed they had received their leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care. However, it was not clear that they understood how to work within the Mental Capacity Act for patients who might have impaired mental capacity.

Staff confirmed they had received training in the Mental Capacity Act. However, while staff appeared to understand the basics of the Act, this was not reflected in the records. We found several records where there was a lack of clarity as to the legal status of patients. For example, one patient's record detailed that they were an informal patient but also that they could not access leave from the hospital without the agreement of the multidisciplinary team. Another patient's records showed a lack of clarity and understanding as to whether they were an informal patient who had mental capacity to consent to remain on the ward or were detained under the Mental Health Act 1983.

We reviewed the records of six patients who were receiving covert medicines on Willow ward. Guidance on covert medicines states there should be a full assessment of capacity. Records showed a lack of clarity around the best interests decision making process under the Mental Capacity Act where covert medicines were being used. Of the six records seen only two had a completed mental capacity assessment and best interest decision making recorded.

Our findings

While there was a policy on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards, which staff knew how to access, staff did not always consider capacity on a decision specific basis. For example, where mental capacity assessments were completed, these included minimal information and were not decision specific in six of the 12 records reviewed.

Staff made applications for a Deprivation of Liberty Safeguards authorisation only when necessary and monitored the progress of these applications.

Is the service caring?

Good 

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it. They supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each patient.

There had been concerns identified regarding staff raising awareness of disrespectful, discriminatory or abusive behaviour or attitudes towards patients. This was being addressed by the trust and staff and patients were being supported by the dementia lead, senior leadership team and the freedom to speak up guardian. There was an action plan in place to manage this and staff spoken with said they were very happy with the support given and felt more comfortable in raising concerns. This continued to be a work in progress.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Our findings

Patients told us they felt involved in their care and care planning.

Staff ensured patients understood the arrangements for their care and treatment and communicated this with patients in a way they could understand, especially where patients had communication needs. Staff said they used communication books and confirmed some staff had been trained to use sign language to support patients.

Patients could give feedback on the service and their treatment and staff supported them to do this. The friends and family test results for January and February 2022 showed that 100% of patients had said that staff delivered safe care and that the overall experience was good.

Patients were given the opportunity to provide feedback on the service at their weekly community meeting.

Staff supported patients to make decisions on their care.

Involvement of families and carers

Staff told us they supported, informed and involved families or carers. However, six of the nine carers we spoke with said that communication to families could be improve but all said that they felt their relatives were safe on the wards.

Most carers and families said staff were considerate of their specific needs when organising family visits.

The service was following the John's campaign initiative. This campaign advocates for the right of people with dementia to be supported by their carers in hospital. Staff told us that this underlined the belief that carers should not just be allowed but welcomed to the service, and supported carers to be as involved in the patient's care as possible.

The trust had arrangements for carers and families visiting the wards during the Covid pandemic as well as ensuring carers and families could contact patients virtually and on the telephone. However, five of the nine carers said that updates regarding visiting was not good and they considered the location for seeing their relative unsuitable.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients rarely stayed in hospital when they were well enough to leave.

Bed management

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. Staff did not move or discharge patients at night or early in the morning.

The matron attended a daily bed management meeting to review their bed stock. The data for January to March 2022 showed that the bed occupancy for the hospital averaged 97%.

Our findings

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay refers to the average number of days that patients spend in hospital. The data for quarter four (January to March 2022) showed patients stayed between 87 days and 195 days. The matron and the managers told us the main reason for any extended length of stay was due to the complex needs of the patients and the lack of available placements in nursing and care homes.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

The local psychiatric intensive care unit had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

The service had low number of patients who had experienced a delay to their discharge in the last year. Staff told us that the main reason for delays in a patients discharge was lack of available nursing and residential home beds that patients could move to when they no longer needed hospital care.

Although staff started to complete discharge paperwork on admission, discharge planning was not clearly documented in patients records and staff did not always document when discussions about discharge had taken place with patients.

This was identified as an issue in the clinical audit report regarding personalised discharge care planning for October to December 2021. This was also reflected in the feedback from carers we spoke with who said communication between staff and families "could be better."

Therapy staff told us there were significant delays in accessing essential equipment such as shower chairs, walking aids and pressure mattresses. While this had impacted on the discharge process for some patients there had been no identified patient harm. Senior staff were addressing this with the external supplier.

The service had access to three social workers who said they were aiming to improve the support provided to help reduce delays in patients discharge.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise.

Patients could make phone calls in private.

The service had an outside space that patients could access.

The service offered a variety of good quality food. Patients could make their own hot drinks and snacks. Some patients had to ask staff for drinks and snacks due to the choking risks of leaving these times unattended.

Our findings

Patients' engagement with the wider community

Staff supported patients with activities outside the service, and family relationships.

Staff helped patients to stay in contact with families and carers. Carers told us they could visit the wards to see their relatives as well as visiting their families at home.

The wards displayed information to patients which included a list of useful contacts in the local community that patients could approach for support. These include services provided by Age UK, Alzheimer's Society and MIND who provide mental health advice, support and services to empower anyone experiencing a mental health problem.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, cultural and spiritual support.

The service could support and adjust for disabled people and those with communication needs or other specific needs.

Wards aimed to be dementia friendly environments and supported disabled patients.

Patients had access to the Reminiscence Interactive Therapy Activity (RITA) tool. RITA is a touch screen solution which can help patients to recall and share events from their past through listening to music, watching news reports of significant historical events, listening to war-time speeches, playing games and watching films.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Staff confirmed they could obtain information leaflets in languages spoken for patients as required.

Managers made sure staff and patients could get help from interpreters or signers when needed. Senior staff informed us some staff had been trained to use British Sign Language to support patients who may be deaf.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Our findings

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders generally had the skills and knowledge to perform their roles. All leaders were new to their role and were continually gaining experience to perform their jobs. They understood the services they managed and were visible and approachable for patients and staff.

All the ward managers and matron were new to their role having been in post up to six months. The matron confirmed they received support from the deputy director for mental health and learning disabilities when required. All ward managers confirmed they received continuous support from the matron to enable them to settle into their role.

Ward managers were visible on the wards and sometimes made up staffing numbers when there was a low fill rate. Staff we spoke with felt well supported by their ward managers and matron. They reported that the matron was visible and keen to support the service. Staff reported that morale had been low, but this was gradually improving.

The wards' matron and deputy director for mental health and learning disabilities had regular contact with all staff and patients and they regularly visited the services. Most staff knew who the manager and deputy director for mental health and learning disabilities were and felt confident to approach them if they had any concerns. However, staff had little knowledge of who the trust's executive team were and said they weren't aware of any visits to the wards.

Vision and strategy

Most staff knew and understood the provider's vision and values and how they applied them to the work of their team.

The trust's vision, values and strategies for the service were evident and on display on information boards throughout the wards. Staff we spoke with understand the mission and vision of the organisation.

Staff were able to relay that the trust's core vision was to enable people to live the best life they can while working together to provide outstanding care. The staff appraisal process incorporated the trust values and behaviours to ensure staff worked in accordance with them.

Culture

Staff felt respected, supported and valued by their line manager. Most staff told us the trust promoted equality and diversity in their daily work and provided opportunities for development and career progression. However, concerns that had been raised with us highlighted issues with staff culture and the need to provide additional support to staff.

Staff understood the whistleblowing process for raising concerns. While the trust had a Freedom to Speak up Guardian and speak up champions, most staff told us they were not aware of their existence. Most staff said they did not feel confident in raising concerns even though they knew how to do this. This was brought to the attention of the matron who confirmed they were aware of the concerns and this continued to be a work in progress.

Our findings

Most staff told us they felt disillusioned with their role because they were not achieving everything they wanted. They said they would like better organisation of their workload and breaks which are being encroached with providing extra support to patients. Most staff felt that quality time with patients was missing and the wards often felt like a care home rather than a place where patients could get better and be successfully discharged.

Staff told us they were supported by the ward managers and matron. Most staff said they found working on the wards over the last few months very challenging due to ongoing staffing shortages but felt this was slowly improving.

Staff said the trust responded efficiently during the coronavirus outbreak and had taken steps to demonstrate their support for the team and understanding of their experience. Most staff told us they felt respected, supported and valued in their work. Staff were proud to be working for the trust.

Staff reported that the trust promoted equality and diversity in its day-to-day work and provided opportunities for career progression. For example, staff described being able to have flexible working practices which enabled them to maintain a good work life balance.

Governance

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

The ward managers could access information from a variety of sources that allowed them to understand their team's performance against identified key performance indicators. There were clinical governance meetings to review incidents and the care provided and ensure any learning was shared both within the wards and outside the service.

Ward staff completed clinical quality audits and data on incidents and complaints. The ward manager's meetings for January and February 2022 identified areas where clinical audits had been completed but required action. However, there was no action plan attached to the minutes which made it unclear as to whether areas identified had been addressed. Managers we spoke with were inconsistent in their implementation of the most up to date processes to monitor and improve quality and performance.

The ward managers, senior managers and senior clinicians attended meetings where they looked at the management of the service. While there were processes in place for the teams to apply controls and procedures these were not always effective. This included for example, the oversight of medicine management and the concerns identified with staffing.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care.

Identified risks were escalated through the hospital governance structure and opened centrally on the trust risk register. All risks were managed in line with the Risk Management Policy and Pathway with oversight at hospital and senior operational governance forums.

Due to Covid pressures with staffing there had been no team meetings on Willow ward since November 2021. Staff we spoke with said they had not attended a team meeting for a while.

The service had business continuity plans in place in the event of an emergency that threatened service delivery.

Managers had access to dashboards and key performance indicators through the trust electronic system.

Our findings

Managers received feedback on their key performance indicators from the matron. Ward managers were not able to provide any narratives or action plans in response to dashboard data as necessary.

The ward managers and the matron could escalate issues and concerns to quality divisional and locality meetings.

Information management

Staff engaged actively in local and national quality improvement activities.

The trust used several tools and audits to collect data on the service. The performance reports provided information on areas such as mandatory training, appraisal rates, occupied bed rates, length of stay and discharges.

While this gave the ward managers a breakdown of their current position and an overview of areas such as staffing, we did not see evidence of how this was cascaded to staff to improve the service.

Not all staff had access to the electronic equipment to enable them to do their work. However, staff did have access to the paper documents they needed.

The electronic system supported staff to report incidents and manage their own performance.

The managers had oversight of the information they needed to support their roles. There was enough equipment and information technology available for staff to do their work.

The service made notifications to external bodies as required.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The trust worked closely with external stakeholders such as commissioners and NHS England/Improvement. Commissioners had recently visited the service to see the standard of care and treatment provided. The service was waiting the outcome of their visit.

Staff had access to the trust's intranet through which they received emails and updates about the trust.

Patients and carers could access information about the service through the trust website. The information available on the website gave a brief description of each ward and the contact details for each location.

Everyone had opportunities to give feedback about the service. This could be formal through surveys and comment cards or informal by attending various meetings. Patients told us that they were able to feedback at their patient carer meetings and directly to staff.

Learning, continuous improvement and innovation

The matron and managers worked together as a team to make improvements in the running of the service.

Leaders were responsive to concerns raised and performance issues and sought to learn from them to improve services.

Our findings

Staff said they were given the time and opportunity to learn.

Our findings

Areas for improvement

Action the trust MUST take to improve:

- The service must have processes in place to oversee staffs' understanding and application of the Mental Capacity Act. (Regulation 11 (1) (3) (4))
- The service must ensure that there are systems and processes to safely prescribe, administer and store medicines. (Regulation 12 (1) (2) (a))
- The service must ensure that dedicated female lounges are provided and are not used for other reasons in order to meet Department of Health guidelines. (Regulation 15 (1) (c) (d))

Action the trust SHOULD take to improve:

- The trust should ensure that cleaning items are stored appropriately and that the sluice and storage rooms are free of clutter to allow easy access. Items on the floor in the storage rooms should be cleared to allow access to cleaning.
- The trust should ensure all relevant staff complete their resuscitation training.
- The trust should ensure that it has processes and procedures for the management of blind spots and ligature risks on the wards.
- The service should ensure that there are enough staff on duty to care for patients and keep them safe.
- The service should ensure that agency staff have access to the trust's electronic system to access clinical information.
- The service should ensure that it is able to evidence the attendance of the Independent Mental Health Advocate (IMHA) to support the people who use services.
- The service should ensure that it effectively records the patients discharge pathway within the care records.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, an inspection manager, one specialist nurse and an expert by experience (a person with experience in using the services).

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 HSCA (RA) Regulations 2014 Need for consent