Good

Leeds and York Partnership 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)
RGD05	The Mount	Ward 1	LS2 9LN
RGD05	The Mount	Ward 2	LS2 9LN
RGD05	The Mount	Ward 3	LS2 9LN
RGD05	The Mount	Ward 4	LS2 9LN

This report describes our judgement of the quality of care provided within this core service by Leeds and Yorkshire Partnership 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 Leeds and Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and Yorkshire Partnership 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?	Good
Are services effective?	Requires improvement
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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Summary of findings

Overall summary

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

- Staff completed comprehensive assessments of patients' needs, incorporating any specialist care needs. Assessments included nutritional screening and physical health checks. We saw that patients had detailed risk assessments and corresponding management plans for how to manage any risks. Staff reviewed care plans and risk assessments regularly and updated them in response to patients' needs. Patients and relatives were involved in these reviews.
- Wards one and two were undergoing refurbishment to improve the environment in line with good practice for dementia environments. Wards were clean and tidy. Staff completed a number of environmental checks including infection control and health and safety. There were many different rooms and areas for patients to spend time on the wards. Patients had access to an outside garden area via ward on the ground floor. Patients and their relatives felt the environment was safe.
- Staff were knowledgeable about what incidents to report and felt confident in reporting. Incidents reports were detailed and contained clear information about actions that had been taken in response to each incident. Staff reported any safeguarding concerns as necessary to help ensure patients were protected from harm.
- Patients spoke highly of the staff and said they were treated with kindness and respect. Relatives were also complimentary about the staff and said theysupported them in their role as carers. We saw positive and caring staff interactions with patients. Patients and relatives were able to give feedback via community and carers meetings that took place. Patients had access to advocacy support on the wards.
- Although there were times when staff were pressured, there were suitable amounts of staff at the service to meet patient's needs. Patients and relatives said staff were always present and visible. Our observations supported this. We saw activities took place which staff encouraged patients to participate in.
- Staff felt positive in their roles and spoke highly of the support they received from colleagues and managers. We saw managers were visible on the wards. Staff were knowledgeable about the patients they supported and their needs. Managers praised staff attitude and resilience.
- There was useful information on display for patients, relatives and visitors about the service. This included information about how to make complaints. Patients and relatives said they would feel comfortable speaking with staff if they had any complaints to make. Relatives said any issues had been resolved in the past where they had raised them. We saw complaints were dealt with thoroughly.
- Governance meetings took place regularly for senior staff to discuss relevant information about the service. This included learning from incidents. Information from these was fed down to ward based staff in team meetings. Staff participated in clinical audits and we saw that any shortfalls were rectified where identified.

However:

- Staff did not always keep robust records in relation to patient care. There was incomplete and omitted information in relation to patients who required their dietary intake to be monitored. Also, because bank and agency staff did not have access to the trust's electronic system, in some instances temporary staff had recorded details of care interventions separately to the patient's main care records.
- There were shortfalls in some mandatory training compliance and the service had not met the trust target. The areas with lowest compliance were the Mental Capacity Act training, Mental Health Act legislation training and safeguarding children. Three wards were short of the trust target for appraisals and not all wards had met trust supervision targets.

Summary of findings

- Staff demonstrated a good understanding of relevant legislation such as the Mental Capacity Act and the Mental Health Act. However, nursing staff deferred to doctors to make formal assessments of capacity. Capacity assessments did not always show what attempts had been made to support patients with making informed decisions before assessing capacity.
- Staff did not always undertake the necessary checks to ensure patient safety. They did not take the appropriate action in response to excessive temperatures of fridges where drugs were stored. We found some omissions in prescription charts which staff had not identified. Although staff regularly checked emergency equipment, action was not always taken when shortfalls were identified.
- From information available, we could not always be clear how results from clinical audits were used to drive improvement at service level.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Staff completed detailed risk assessments for patients alongside plans for how to manage any risks. They reviewed these regularly and updated them in response to patients' needs.
- Staff identified and acted upon safeguarding concerns. They dealt with these in accordance with necessary procedures to ensure patients were protected.
- Staff reported incidents as necessary and in line with required criteria. There was clear information about actions taken in response to incidents.
- Although there were staffing vacancies, most patients, relatives, and staff said staffing levels were suitable. Managers could adjust staffing levels to suit patients' needs.
- The environment was risk assessed for safety and there was guidance for staff how to mitigate identified risks.
- One ward was mixed gender and this was compliant with Department of Health guidance on same sex accommodation.
- All patients told us that they felt safe. Relatives of patients also felt their family members were safe at the service.
- Measures were in place to promote good infection control and the wards were clean and tidy.

However:

- Although staff checked emergency equipment, we found some items had not been replaced as required.
- Staff had not taken necessary action to ensure that medicines were stored at required temperatures in accordance with their storage instructions. There were some omissions in prescriptions charts.
- There were some shortfalls in mandatory training compliance.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not complete accurate, contemporaneous records in respect of each patient where they were being monitored for nutritional needs.
- Staff did not complete Mental Capacity Act capacity assessments as required in accordance with trust policy which meant we could not ensure the Act was being used correctly.
- Less than half of eligible staff had undertaken training in the Mental Capacity Act and the Mental Health Act.

Summary of findings

- Although staff said they had regular supervision, figures did not reflect that this took place at the required frequency and there was no system to ensure compliance with clinical supervision.
- It was not evident how outcomes from all clinical audits were being used to drive improvement.

However:

- Staff supported patients with ongoing physical health needs and referred them to specialist services and professionals where required.
- Multidisciplinary meetings allowed the team to access patients' notes and pertinent information in real time and was visible to the whole team.
- Care planning and assessment was personalised to patients' individual needs.
- Staff used recognised guidance and best practice within care provision of patients.

Are services caring?

Good

We rated caring as good because:

- Patients and carers spoke highly of the staff and said they were treated with kindness and respect. They described staff as caring and supportive.
- Patients had access to regular advocacy support. This was available to all patients regardless of their status.
- Carers were involved in patients' care and had opportunity to attend reviews of care.
- Several carers told us staff supported their own needs as carers.
- Patients and carers were able to give their views and help influence the service through community and carers meetings.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There were a variety of rooms available to support patients' needs. The wards for people living with dementia were in the process of being refurbished to make these more dementia friendly.
- Patients were able to make their own drinks and snacks with facilities available for them to do so.
- The service could accommodate diverse needs of patients and provided a range of activities seven days a week.
- Discharge planning started upon admission and staff were pro-active in working with other agencies to try to facilitate successful discharge.

Summary of findings

- Patients and relatives felt able to speak with staff about any complaints and concerns they had. Formal complaints were thoroughly investigated.

However:

- The discharge process was sometimes delayed due to lack of appropriate resources for patients to move on to.

Are services well-led?

Good

We rated well led as good because:

- Staff were positive in their roles and said they could approach managers with any concerns.
- Wards had their own team objectives and visions to aspire to. All staff were passionate about the trust values of providing quality care and teamwork.
- Each manager had their own system and oversight of staff training which allowed them to monitor where shortfalls were. Managers communicated information by team meetings and team briefs.

However:

- Staff said there was little involvement from senior staff at trust level and it was rare they visited the service.

Summary of findings

Information about the service

The Mount is the main inpatient site at Leeds and Yorkshire Partnership NHS Foundation Trust for older people who require hospital admission. There are four wards that provide assessment, treatment and rehabilitation for older people with acute mental health needs including dementia. The service provides care for patients who require admission under the provisions of the Mental Health Act 1983. It also provides care for patients who may require a Deprivation of Liberty Safeguards authorisation as well as informal patients who have agreed to receive care and treatment there.

At the time of our inspection, ward one was undergoing refurbishment and not in use. Prior to the refurbishment, the ward had capacity to accommodate 12 female patients living with an organic mental illness such as dementia. On completion of the redesign, the ward planned to accommodate up to 12 male patients living with dementia.

Ward two was a 17 bed ward for male patients living with dementia. At the time of our inspecton there were 16 patients using the service.

Ward three was a 24 bed mixed gender ward for patients with a functional mental illness. These are illnesses which have a predominantly psychological cause and include conditions such such as depression and anxiety. At the time of our inspection there were 25 patients using the service. One of these patients was utilising a place of a patient who was on long term leave. There were 11 males and 14 females

Ward four usually operated as a 24 bed ward for females with a functional mental illness. At the time of our inspection ward four had 11 patients. However, the ward was also temporarily accommodating 13 female patients living with dementia who had come from ward one during the refurbishment. This meant there was a mixture of patients with an organic and funcational mental illness. These patients would be moving to ward two on completion of refubishment work.

The Care Quality Commission has inspected the Mount on two occasions since it was registered. The most recent inspection was in October 2014 when the service was inspected alongside four other older people's services that were part of the trust at that time and which Leeds and York Partnership Foundation Trust no longer have responsibility for. Overall, inpatient wards for older people with a mental health problem was rated inadequate. However, there were no regulatory breaches of the Health and Social Care Act and no requirement notices were served in relation to The Mount location.

Our inspection team

The team was led by:

Chair: Phil Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of inspection: Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Team Leader: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

The team that inspected wards for older people with mental health problems consisted of one CQC inspector, two qualified nurses who specialised in older people's care, one core psychiatry trainee level 3 doctor, an occupational therapist, a Mental Health Act reviewer, a specialist pharmacist inspector and an expert by experience. The expert by experience had experience of caring for people using the type of service we inspected.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

o 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 patients and carers at two focus groups prior to the inspection visit.

During the inspection visit, the inspection team:

- visited all four wards at The Mount, looked at the quality of the environment and observed how staff were caring for patients
- spoke with eleven patients, and eight relatives of patients, who were using the service
- received feedback from two comment cards
- held a focus group which one relative attended
- spoke with the managers of three of the wards
- spoke with the modern matron
- spoke with 25 other staff members; including doctors, qualified nurses, a clinical psychologist, support workers, occupational therapists, administration and housekeeping staff
- spoke with an Independent Mental Health Act advocate
- attended and observed two handover meetings and three multidisciplinary meetings.
- looked at 15 patients' care records
- carried out a specific check of the medication management on Wards one, two and four and reviewed 26 patients' drug charts
- spoke specifically about medicines with managers, nursing staff, the pharmacy and a pharmacist technician.
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with eleven patients, and eight relatives of patients, using the service. We held one focus group attended by one relative. Patients told us the wards were clean, tidy and they were able to personalise their own rooms. They said there were enough staff present on the wards so that activities and leave away from the ward could take place. They described staff as kind, caring, helpful and supportive. Most patients felt the food was good but some thought it was only passable.

Patients could participate in activities where they chose to and described differing activities that took place. One patient felt there could be more activities and another said they did not particularly enjoy the activities on offer. All except one patient said staff encouraged them and promoted independence. One felt they would like to do more for themselves. Patients said they would speak with a staff member if they had any complaints to make. They said they felt safe at the service.

Relatives of patients were also positive about the staff and care provided to their family members. Several highlighted examples of staff supporting them in their role as carers. They said staff were accommodating, friendly and professional. All felt their family members were safe and received a high level of care.

We received two comment cards during out inspection. Both said the staff were good, worked hard and were helpful.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that where staff identify patients as requiring specific monitoring, records should be detailed and accurate so they can be used to inform any treatment decisions in a safe and meaningful way.
- The provider must ensure that records of care and treatment provided to patients are accurate and contemporaneous. All decisions about patient's care and treatment should be contained within their appropriate care records.
- The provider must ensure all relevant staff have received appropriate training in the Mental Capacity Act and the Mental Health Act. Staff must receive clinical and managerial supervision at the necessary frequency and in accordance with trust targets.

Action the provider SHOULD take to improve

- The provider should ensure that all staff supporting and interacting with patients have opportunity to acquire training in the mental and physical health conditions of the patients they support.
- The provider should ensure necessary staff assess and record patient capacity in accordance with trust policy and the provisions of the Mental Capacity Act 2005.
- The provider should review how they can ensure results from clinical audits are used to drive improvement across the service.
- The provider should ensure that staff identify shortfalls or concerns in relation to medicines management and storage and act upon these in a timely manner and take necessary action.
- The provider should ensure notices with regard to the rights of informal patients to leave the wards are displayed on all wards.

Leeds and York Partnership 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
Ward 1	The Mount
Ward 2	The Mount
Ward 3	The Mount
Ward 4	The Mount

Mental Health Act responsibilities

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

Mental Health Act inpatient training was mandatory for staff. Only 41% of eligible staff had completed this. However, staff we spoke with demonstrated a good understanding of the Act.

We saw completed consent to treatment authorisation forms with prescription charts. Staff made referrals to second opinion appointed doctors where required.

Nursing staff informed patients of their rights in accordance with section 132 of the Mental Health Act. Records confirmed this although there were gaps in patients being given their rights. The service was taking action so that the frequency of rights was more personalised to the patient.

The trust had a central Mental Health Act office based at another site that was able to provide administrative support. Staff said they could contact the department for legal advice and guidance about the Act if required.

A senior staff member completed Monthly Mental Health Act audits on each ward. Detention paperwork that we saw in patient records was generally in good order and correctly completed. However, we saw old copies of leave forms present in records that had not been crossed out. We saw good practice whereby staff gave copies of leave forms to the patient or their family member.

Detailed findings

There was an independent mental health advocacy service available to all detained patients. Information about the service was displayed on all wards. Staff referred all detained patients to the service. The advocate visited the wards on a regular basis.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory for staff. Only 43% of eligible staff had completed this as of 30 June 2016. However, staff we spoke with demonstrated an understanding of the Act and the associated Deprivation of Liberty Safeguards.

Nursing staff said they assessed patient's capacity on an ongoing basis whilst assisting patients with daily decisions and supporting them to make informed choices. We observed staff asking patients' consent and encouraging them to make their own decisions.

Recording of capacity assessments was seen primarily the role of the doctors. The trust's Mental Capacity Act policy stated that any relevant professional could assess capacity. Capacity assessment and best interest forms were on the electronic system for staff to complete where necessary. We did not see these present in care records and nursing staff confirmed they did not complete these.

We saw discussions about capacity in doctors' clinical notes on the system. The notes did not always detail what attempts had been made to support people with making informed decisions before assessing their capacity. This meant it was not possible to ensure that the principles of the Mental Capacity Act were always followed where patients lacked capacity.

Eleven Deprivation of Liberty Safeguards authorisation applications had been made between 1 January 2016 and 30 June 2016. Information was displayed in staff offices about which patients had a Deprivation of Liberty Safeguards authorisation in place so that staff were aware of the patients' status.

Good

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 environment layout and staff practice helped promote safety of patients. The wards were open and spacious. Some areas did not allow for clear observation as there were blind spots and restricted lines of sight from bedroom corridors on to main corridors. This had been highlighted on each ward risk register. A local review had determined that visual aids such as mirrors would have limited impact. Therefore, the actions to mitigate these restrictions were staff observations and engagement with patients. We saw staff present and in close proximity where patients were on bedroom corridors.

The latest ligature point audits for each ward had been completed in May 2016. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature outcome reports from the audits contained actions for staff about how to mitigate the risks, for example, supervision of patients in high risk areas. The estates team was undertaking a trust wide program of work to improve safety and ligature risks within inpatient environments. The wards were currently in the process of replacing equipment such as soap and paper towel dispensers with anti-ligature versions.

The wards were compliant with Department of Health guidance on same sex accommodation. Three of the wards were single gender only. Ward three was a mixed gender ward. Males and females each slept on separate halves of a long corridor. The corridor was separated in the middle by double doors that were kept shut at night. There were bathing and toilet facilities in each area which meant males and females did not have to pass through areas of the opposite gender to use these. There was a female only lounge on the ward. The ward manager said they had not, and would never, accommodate a patient if they were not able to maintain the arrangement of gender separation. Patients said they had no concerns with their personal safety on the wards. Relatives of patients felt the environment was safe for their family members.

The clinic rooms on each ward were generally clean and tidy. Resuscitation equipment and emergency drugs were present which staff checked on a daily basis. However, on ward four, these checks were not robust. On some occasions, we saw that items had been reported as missing but no corrective action was documented. For example, no pulse oximeter had been in the emergency grab bag since 4 July 2016 and this had still not been replaced at the time of our visit on 11 July. The majority of items we checked were suitable and in date although we did find some dressings on ward four that had expired in December 2015. Staff removed these on the day of the inspection. We also saw the blood pressure monitor on this ward had not been calibrated since September 2015. As such, the monitor could not be guaranteed to give accurate readings. The rest of the equipment in clinic rooms we checked showed evidence of current calibration and service.

The wards did not have seclusion rooms but each had what staff termed a de-escalation room. These were low stimulus rooms and contained a wipeable couch and bean bag. On wards three and four, the rooms had adjoining toilet facilities. All had nurse call bells in them. The rooms did not fully comply with Mental Health Act Code of Practice guidance for seclusion rooms and were not treated as such. Due to the patient group and infrequent use of seclusion we did not consider that this would have a significant impact on patient safety.

We observed the wards were clean and tidy. Domestic and housekeeping staff were present and cleaning was regularly completed. Patients and relatives said the environment was clean and that their bedrooms were cleaned daily. Cleaning schedules confirmed this. There were up to date cleaning stickers on items and equipment such as commodes and wheelchairs. In the patient-led assessments of the care environment survey for 2015, The Mount scored 100% for cleanliness. This was above the national average of 98%.

There was evidence that equipment such as specialist baths were regularly serviced. Staff kept a log of any maintenance or repair work that was required and requests were passed on to the estates team for action. Recent health and safety assessments had been undertaken on

Good

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the wards to identify and rectify any environmental concerns. For example, we saw actions identified where damaged paintwork and plastering needed rectifying. The actions had timescales for completion.

Staff adhered to good infection control practice. They followed handwashing procedures and antibacterial gel was available on entry to, and at frequent points within the wards. Staff wore personal protective equipment where necessary. Staff offered patients the choice to wear protective items such as aprons during mealtimes. Hand hygiene quarterly audit results were on display on ward notice boards. Staff completed annual infection control audits.

There were nurse call buttons in each room to summons assistance quickly if needed. Staff carried personal alarms and we saw that these were responded to promptly when activated.

Safe staffing

There were a number of staff vacancies across all four wards. Recruitment was ongoing at trust level in order to fill these vacant posts. The average vacancy rate across the Trust was 14%. The number of vacancies on ward two equated to 19%, which exceeded the Trust average. However, the skill mix on ward two had been reviewed in April 2016 with new posts created which had contributed to the vacancy rate. These additional vacancies had been advertised. Ward three had the least amount of vacancies, which equated to 3%.

Ward one had vacancies for 1.4 whole time equivalent qualified nurses and 3.4 whole time equivalent nursing assistants.

Ward two had vacancies for 2.1 whole time equivalent qualified nurses and 6.8 whole time equivalent nursing assistants.

Ward three one vacancy for a 0.9 whole time equivalent qualified nurse.

Ward four had vacancies for 1.7 whole time equivalent qualified nurses and 1.8 whole time equivalent nursing assistants.

The average sickness rate across the trust was 4%. All of the wards had sickness rates above this level. Ward three and four were highest at 10% and 9% respectively. Ward two was at 7% and ward one had the lowest rate out of the wards at 5%.

Bank and agency staff were used to fill vacancies and staff absences. Managers used regular bank workers so they were familiar to the patients and service which helped maintain consistency of care. Staff said there was minimal use of agency workers. Between 1 January 2016 and 30 June 2016, some shifts had not been filled to required staffing levels. On ward one, 30 shifts were unfilled. On ward two, this was 32 shifts. Wards three and four had 19 and 15 unfilled shifts respectively.

Managers reviewed staffing levels daily to ensure the correct mix of staffing numbers and skills was in place. They were able to adjust levels where patient need demanded. Staffing levels were reported each month via an electronic rostering system which the director of nursing reviewed. Where staffing levels had fallen short of a pre-determined tolerance level they were highlighted for further scrutiny. Reasons for under fill were highlighted in order to inform the trust board and identify any mitigating factors. The staffing reports from March, April and May 2016 and staff rotas showed the service had been safely staffed during this period. In 2016, three instances of staff shortage had been reported on the incident reporting system. These had been due to last minute sickness or absence by agency staff. Staff had taken action and attempted to cover these gaps where possible. No harm was reported as a result of these instances.

The majority of patients and relatives felt there were enough staff available and said they were visible on the wards. No patients reported any cancelled activities or leave due to lack of staff. We observed staff present during our inspection including qualified nurses in patient areas. Planned and actual staffing levels were displayed on the wards.

Staff said that in the main, staffing levels were suitable although sickness levels and high patient needs could place demands on them at times. The majority of staff said activities were rarely cancelled but two said this was quite frequent. Staff confirmed that regular bank staff were used to fill shortfalls and one bank worker we spoke with also confirmed this.

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Medical cover was available on site during the week. When doctors were not on site, there was a 24 hour on call arrangement in place so staff could access assistance at all times. Staff told us assistance was available in a timely manner with no undue delays.

Not all staff were up to date with required mandatory training. The trust target for compliance with mandatory training was 90%. The compliance rate for the service as of June 2016 was 77%. Ward one had achieved 81% compliance, ward two and ward four had both achieved 76%, and ward three was at 73%.

Assessing and managing risk to patients and staff

There were five uses of seclusion recorded between 1 January 2016 and 30 June 2016. One of these was on ward one and four were on ward two. Staff demonstrated a good awareness of use of seclusion. They used de-escalation techniques to manage challenging behaviour and described supporting patients to use the de-escalation room for a few minutes where necessary. Staff said if restraint went beyond five minutes they would consider whether the patient was being secluded and follow necessary procedures. There was no use of long-term segregation recorded during 1 January 2016 and 30 June 2016.

Staff were trained in de-escalation and the prevention and management of violence and aggression, which was updated annually. They said they used restraint as a last option. There were 148 episodes of restraint at the service between 1 January 2016 and 30 June 2016 involving 50 different patients. Ward two had the greatest number with 60 restraints recorded. The next was ward one with 47 instances of restraint. Ward three and ward four recorded 21 and 20 episodes of restraint respectively.

Eight uses of restraint were in the prone position. Prone restraint is where a patient is positioned face down during restraint. Prone restraint is high risk as it can seriously impact people's airway, breathing and circulation. We saw corresponding incident records for use of this restraint that showed the position had been used primarily with the patient on a beanbag and for the purpose of administering rapid tranquilisation. The prone position had been used for short amounts of time. Incident records showed that staff actively avoided prone restraint in circumstances such as where patients had physical disabilities or frailties, which would further increase the risks involved with such restraint.

Staff completed a risk assessment for each patient admitted to the wards. The assessment tool used was the functional analysis of care environments tool. The assessment recorded information about known risks, type and history of risk. Staff assessed each risk against a severity score and compiled associated management plans on how the risks should be managed. All care plans we looked at included an initial risk assessment. These were reviewed and updated at regular intervals and in response to any changes. We saw evidence of where changes had been made in response to changes in risk level. Staff also discussed patients' risks in multidisciplinary meetings and handovers including any changes to severity and type of risk.

We did not see any evidence of inappropriate restrictions being applied to patients. The trust had implemented a smoking ban in May 2016. Managers said this had not caused many notable issues. We saw only two incidents reported in 2016 that involved patients' smoking on premises.

A search policy provided guidance in what circumstances searches would be justifiable. For example, if patients were suspected of having prohibited items on their person. Searches were recorded as incidents and we saw that staff recorded the rationale for any searches that they carried out.

Informal patients were able to leave the wards at their own will. The wards were locked with entry and exit being via swipe card on wards three and four and key code on wards one and two. Informal patients on wards three and four were able to have their own swipe cards. Some detained patients were also able to have these if this had been assessed as safe. On ward two, the key code to leave the ward was displayed next to the main door with a notice advising informal patients of their right to leave the ward. Notices for informal patients were not on display on the other wards which meant they might not be fully aware of their rights. However, staff said they told informal patients about their right to leave. Relatives of informal patients told us their family members were able leave the ward.

Good

Are services safe?

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There was an observation and engagement of people policy in place. Observation levels were dependent on the risk the patient presented and would be more frequent where they had been assessed as high risk. Staff observed patients and documented these at minimum of hourly intervals including through the night. Managers reviewed observations levels daily and these were discussed within multidisciplinary meetings. Observation levels were documented on boards in the staff office and discussed in staff handovers so that these remained consistent.

Safeguarding adults and safeguarding children was mandatory training for staff. Ninety one percent of eligible staff across all four wards were current with safeguarding adults training. However, only 31% of eligible staff had completed safeguarding children level two training and 44% of eligible staff had completed safeguarding children level three training. Although there was low compliance with safeguarding children training, staff said they were clear about the procedures to follow and knew how to access safeguarding guidance. All said they would report any concerns directly to a manager in the first instance. Incident reports showed that staff had consulted with safeguarding co-ordinators and made safeguarding referrals where they believed potential or actual abuse had occurred. Between April 2015 and July 2016 there had been four safeguarding alerts in relation to patients at The Mount. None of these related to the care being provided or staff at the service but external situations which staff at the service had reported as necessary.

We looked at the systems in place for medicines management. We saw some gaps in medication administration records on ward four. We were unable to establish whether the medicines had not been administered or staff had omitted to sign. Staff we spoke with were not aware of how these potentially missed doses could affect patients. Ward two had had devised a 'medicines omitted recording sheet' where staff could record the reason why a dose was missed.

Medicines were stored securely with access restricted to authorised staff. There were appropriate arrangements for the management of controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. Medicines requiring refrigeration were stored as necessary. Staff recorded fridge temperatures on a daily basis although each ward did have some omissions. Where temperatures were outside of safe storage range, staff did not contact the pharmacy team as required. Staff did not record room temperatures which meant they could not ensure the safety of medicines that should not exceed specific temperatures. If medicines are not stored at safe temperatures, it can affect their efficacy and make them unsafe to use.

We informed the pharmacy team and ward managers of our concerns about refrigerated medicines that had been stored during times when temperatures were recorded as excessive. They assured us they would take steps to ensure medicines were safe to use, including replacement where necessary. We subsequently saw a new fridge temperature monitoring form that the pharmacy team had devised during our inspection. This was more detailed than the current form and gave specific guidance about actions staff should take.

Patients and relatives did not report any concerns with how medicines were managed. Patients were encouraged to self-administer in order to promote independence. Staff on the wards said the pharmacy team assessed patient's ability to self-administer.

A visitors policy included guidance about how staff should manage situations of children visiting the wards to maintain safety. One relative told us that staff had arranged specific rooms for them to hold visits with their family member on the ward and their grandchildren.

Track record on safety

There had been nine reported serious incidents requiring investigation at The Mount between March 2015 and June 2016. All of these were patient falls that had led to a fracture. Each incident had been the subject of a fact finding investigation and reviewed as part of a falls group. This was a subgroup of a bi-monthly clinical governance council that took place. We saw that these incidents had been discussed with 'lessons learned' documented. Lessons included feedback to ward teams about where improvements could be made such as more detailed recording and inclusion of information.

Reporting incidents and learning from when things go wrong

Staff reported incidents on the trusts' electronic incident reporting system. Staff knew how to make incident reports and all gave consistent examples of the types of incidents

Good

Are services safe?

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

they reported. We saw one staff member completing an incident report following a situation they had been involved in a short time before. Incident reports were detailed and contained actions that had been taken in response to each incident. For example, resulting actions included updating care plans and risk assessments, adjusting observation levels and referrals to other professionals. We saw that incidents were discussed in staff handovers.

Staff received debriefs following incidents and said they felt supported. Psychology support was available to support staff in the debrief process and the psychologist confirmed their role in this. Staff gave varying accounts as to how much feedback they received from incidents. Some said they did not always receive feedback about each individual incident but all received feedback about serious incidents and when any changes were required as a result of these.

Incidents were discussed in clinical improvement forums attended by managers and fed back down into staff meetings. Managers also said they would give individual feedback to staff where necessary.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain 'notifiable safety incidents' and provide reasonable support to that person. Training in the duty of candour was provided to staff however only 23% of staff at the service had completed this. Complaint responses demonstrated openness in response to incidents. Relatives of patients told us they were informed promptly and in detail by staff about any incidents or mistakes that had occurred. We saw evidence of this, for example, where one patient had absconded and staff had contacted their relatives immediately to explain what had happened.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Staff completed initial assessments of patients' needs when they were admitted to the service. We saw evidence of these in care records. Patients received a physical examination and assessment as part of the care planning process. Patients' physical health was monitored and they received ongoing checks such as weight, blood pressure and blood tests. Staff worked with other health professionals such as tissue viability nurses and physiotherapists to help patients with their health needs.

Care records contained personalised information about patients that was holistic, and recovery oriented. Information covered a range of areas including mobility, nutrition, activities, health needs and support with any challenging behaviour. We saw evidence where patients' individualised needs were accommodated. For example, one patient had a disability and needed tailored support with this. Their relative had brought the patient's care plan in from home in so that staff could copy this and there was consistency with how the patient was cared for. A specialist nurse who was a specialist in the disability the patient had, had completed the care plan. The patient also had a specific care plan for an item of equipment they had to use. Patients and relatives felt that the care and support was appropriate to the patients' needs. One relative felt staff could have provided more appropriate personal care for their family member however they acknowledged their family member had refused interventions and had capacity to do so.

On wards three and four, staff assessed patients' ongoing needs in accordance with a rating system to ensure their care was reviewed as necessary. Newly admitted patients were rated as red which meant they were reviewed twice a week by the multidisciplinary team. Patients rated as amber were those who had more stable needs and reviewed weekly. Those rated as green were considered as stable and fit for discharge. This system had initially been pioneered on ward three.

Patient information was stored differently across the wards. On wards one and two, care plans were compiled and stored on a shared drive on the computer network. The care plans were printed off and a paper copy was kept of the patient's care record. Some other information, such as Mental Health Act documentation, was logged on the trust's electronic system for the same patient. On wards three and four, all care plans and relevant information were held on the electronic systems. As wards one and four were temporarily merged, staff were supporting patients whose records were stored in both formats. Some staff were unable to access records, and were unfamiliar with how both systems worked. The manager said they would ensure that a staff member with appropriate knowledge and access would update patients' records as required.

Staff found the electronic system was not user friendly and they had difficulty in locating information due to how it was stored. In some cases, this had led to information being missed or overlooked such as physical health monitoring of patients. Some information was recorded both electronically as well as in paper format which had potential to cause confusion. It also created a risk of information being overlooked or missed.

We found that records did not always provide detailed information in relation to patients' care. A number of patients' nutritional needs were being monitored by way of food and fluid intake charts. We looked at a sample of seven patients' charts. We found these were not all fully completed in relation to what patients had consumed. For example, there were omissions of quantities recorded and some sections had nothing entered at all. Corresponding daily entries were also lacking in detail. For example, these stated 'reasonable diet taken' 'good diet' with no way of establishing what the patient had consumed. This meant there was a risk that a lack of, or incomplete, information could lead to patients not having their nutritional and hydration needs adequately met.

Pharmacy staff completed assessments of patient's competence and ability to self administer medicines. Ward staff administering medicines did not review the assessments and they were not kept within patient's care records which meant there was no record in relation to this decision within the patients' notes. Staff told us that they also carried out a compliance assessment for patients who self administered medicines on the ward. This was a check of their ability to open various types of medicines packaging. At each medicine administration, the nurse was meant to document the patient's progress. On examination of these records, we saw they had not been completed. This meant there was no record of the patient's competence in this area.

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Agency staff did not have access to the electronic systems. Bank staff had access where they had been trained in using the system although this training was not compulsory. Key information about patients was in handover notes and in the staff office which bank and agency staff could access. In one care record we saw bank and agency staff had written daily entries in the patient's paper records due to not being able to access the electronic system. This meant the entries did not chronologically correspond with daily entries on the electronic system due to the different ways information was recorded. This had potential to cause confusion about what support patients had received.

Best practice in treatment and care

Medicines were prescribed in accordance with good practice. For example, baseline electrocardiograms were used prior to patients starting new medicines. We heard the multidisciplinary team discuss an antipsychotic drug and the evidence based protocols in relation to the drug. Another discussion involved the need for diet monitoring of one patient starting a drug that interacted with certain substances in foods. Specific medicines were prescribed appropriately for the age group of the patients.

Each ward funded 0.2 whole time equivalent band 7 psychology time, provided by four psychologists at varied bandings. We spoke with one psychologist who said ward staff understood their role and made appropriate referrals on behalf of patients. The psychologists led weekly formulation meetings where staff focussed on patients who had complex needs. The meeting involved finding techniques and meaningful interactions with the patient to aid their recovery. The psychologists used the clinical outcomes in routine evaluation outcome measure to monitor the effectiveness of their input.

Occupational therapy input was available on the wards. Therapy staff told us they were able to make referrals on behalf of patients for example, for assistive technology devices to support discharge. The therapy team had recently initiated a finger foods trial to identify and monitor alternative ways of meeting patients' nutritional needs. The therapists provided assessments for patients such as activities of daily living, washing, eating, and drinking. However, not all staff were using standardised occupational therapy tools to measure interventions and outcomes for patients.

A consultant geriatrician from the acute trust held weekly reviews and accepted referrals for patients who required support with their physical health. Patients, and relatives of patients, told us they received support with their physical health. Two relatives told us staff proactively monitored their family members regularly as they were prone to urinary infections. Relatives told us, and records confirmed, that staff referred patients to the acute hospital for extra tests and checks where deemed necessary.

Patients had a nutritional assessment as part of their initial assessment completed within 24 hours of admission. Care plans for nutrition highlighted any support or specialised needs they had in this area. We saw evidence of referrals made to dieticians where patients had scored as high risk. Care records evidenced involvement of dieticians and speech and language therapists. However, one patient had scored as high risk in their nutritional assessment in April 2016, which meant they should be referred to the dietician. There was no evidence to show the referral had been made. We asked staff who also confirmed it had not been made. This omission had not been identified. The patient had lost weight in the past but there was no evidence of any action taken. The patient had since regained the weight loss. The manager assured us they would seek advice from the dietician to ascertain whether any specialist input was required.

A number of staff had been trained in dementia care mapping. Two senior staff had completed facilitator training in this tool. Dementia care mapping is an observational tool that looks at the care of a patient with dementia from the viewpoint of the patient. The findings are used to assist with the development of patient centred care. Staff who had completed this training developed a good understating of dementia care.

Staff participated in clinical audits. Care plan audits were completed on wards three and four. The audits completed did not state what actions were required where shortfalls were addressed. Staff did not complete care plan audits on wards one and two. Other audits that took place included infection control, Mental Health Act audits and medicine audits.

Skilled staff to deliver care

The staff team was made up of a range of professionals. This included; mental health nurses, consultant psychiatrists, junior doctors, psychologists, occupational

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therapists and assistants and healthcare assistants. There was regular input from a pharmacy team based on site. Other staff members important to the operation of the wards although not involved in direct care included the administration workers, receptionists, housekeeping and domestic staff.

New staff completed an induction program on commencement of their employment. This involved a trust induction prior to completion of a local induction at service level. Staff also spent a period of time shadowing more experienced staff members. Staff told us their induction had been useful and informative to equip them for their roles. Junior doctors spoke positively about weekly protected teaching time they had in order to discuss cases. They described the service as having a supportive learning environment and said they could always access support from the higher level staff at the service.

Outside of mandatory training, staff could undertake various specialist training. This included dementia care mapping, facilitator training and best practice in dementia care. There was also formulation training available for staff. Physical healthcare training included: wound care, diabetes, venepuncture and nicotine replacement therapy amongst other subjects. We saw that a number of staff had each had completed varying specialist courses. However, it was not clear what requirement there was for staff to undertake role specific training. For example, some staff on wards three and four working with functional patients had not completed dementia training. At the time of the inspection, some patients living with dementia were accommodated on one of the functional wards. Non-clinical staff also interacted with patients on the wards but they had not had specialist training in the conditions the patients presented with.

Trust policy was that management supervision should be held with all staff at least every two months. As at 30 June 2016, wards one and two had only achieved 40% and 36% compliance respectively with this rate. Wards three and four both exceeded 90%. The policy for clinical supervision was that this should take place at least monthly for all appropriate staff .Only 45% of staff at the service were recorded as having clinical supervision. However, managers told us they did not always record when clinical supervision took place as this was not a requirement of the supervision policy. Although figures suggested that supervision was not taking place at the required frequencies, the majority of staff we spoke with said they had regular managerial and clinical supervisions and felt supported in their roles. Managers had regular supervision with the modern matron and felt equally supported. One manager was new in post and had already had a full supervision.

Staff had team meetings and we saw that team briefs were sent out to staff to highlight important team information. We saw minutes of regular joint team meetings between wards three and four. There was a lack of evidence of minutes in relation to ward one and two meetings. The manager of ward two had recently held a meeting and said they intended to hold these regularly going forwards. Staff were kept updated about key information, which was often passed on verbally, and via emails from managers.

The trust target for compliance with staff appraisals was 90%. The overall rate for the service was 82%. Only one of the wards had achieved the 90% target which was ward four with 95% compliance. Ward one had achieved 78% compliance, ward two had achieved 75% and ward three had achieved 67%.

There were processes to address staff performance issues. These included informal discussion in managerial supervisions through to disciplinary procedures where appropriate.

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings occurred regularly and a range of professionals attended these including consultants, nursing staff, allied health professionals and advocates. We attended three multidisciplinary meetings with permission from the attendees. Patients did not attend the meeting but they were given the opportunity beforehand to contribute their views. The ward nurse read these out in the meetings for consideration within the team discussions. An Age UK representative was present in one of the meetings. These meetings were clinically led, however staff did discuss other areas of patients' needs, such as psychological interventions. The multidisciplinary team accessed electronic up to date patient information that was displayed on a projector during the meeting. The team were all able to see patient notes in real time and in one case, they viewed a patients X-ray results and results from a scan. This demonstrated an effective use of resources and ensured all professionals had access to current patient information for use within their discussions

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Staff handovers took place at each shift change. We observed two handovers, one was a combined handover for wards one and four and the other was a handover on ward three. All oncoming staff were present at the handovers. The handover on ward four incorporated discussions of patients from both ward four and ward one. Wards one and two had a different style of handover to wards three and four. For example, staff from ward one discussed each individual patient in turn and any pertinent information relevant to the patient at that time. Ward three and four handover was more task based and discussed specific topics such as risk, diet and escorted leave, and then which patients were relevant to these. Both handovers imparted the same information albeit in different styles.

Staff said they had good working relationships within the multidisciplinary team. They said it was beneficial having doctors on the wards. The service had good working relationships with other internal trust services. This included crisis teams and pharmacy support. One manager highlighted that at times they did not feel some patients had been fully informed about the service by the community team prior to them going on to the ward. Some staff said there was little involvement from the community team at multidisciplinary meetings. Staff reported variable relationships with some external teams. Most said contact with social workers could be problematic which in turn affected patient pathways such as discharge.

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

Mental Health Act inpatient training was mandatory for staff. Only 41% of eligible staff had completed this as of 30 June 2016. Most staff we spoke with told us they had completed Mental Health Act training and they demonstrated a good understanding of the Act. Some staff said their understanding came from what they picked up in their roles.

We saw completed consent to treatment authorisation forms called T2s and T3s, with prescription charts. Staff made referrals to second opinion appointed doctors where required. Whilst awaiting a second opinion appointed doctor, several patients had been treated in accordance with section 62 of the Mental Health Act which allows for urgent treatment.

Nursing staff informed patients of their rights in accordance with section 132 of the Mental Health Act. There was a prompt sheet on the electronic system for staff to complete when they had done this. We looked at four patient's records specifically in relation to their rights. Two records showed staff had reminded patients of their rights regularly. The other two records showed gaps despite a lack of patients' understanding. In one case, the gap was over three months which meant the patient might not have been fully aware of their status. This may have been further impacted considering the patient group, some of whom had memory problems.

However, the patients we spoke with told us staff had read them, and they understood their rights. Some were able to tell us what sections of the Mental Health Act they were detained under and had been detained on in the past. This demonstrated patients had understanding into their status and rights at the service. The issue of gaps between patients being read their rights had previously been identified on ward one in May 2016 during a Mental Health Act reviewer visit. The service provided detail about actions they were taking which included adopting a more person centred approach for frequency of rights in future.

The trust had a central Mental Health Act office based at another site that was able to provide administrative support. Staff said they could contact the department for legal advice and guidance about the Act if required.

Detention paperwork that we saw in patient records was generally in good order and correctly completed. We checked sixteen patients' section 17 leave records across all wards. On wards two and three, we saw old copies of leave forms present in records which had not been crossed out. This had the potential to cause confusion. This same issue had been indented in the Mental Health Act reviewer visit in May 2016. The service provided a response in July 2016 setting out steps they would take to address this which included implementing this as an area for auditing in future. We saw good practice whereby copies of leave forms were given to the patient or their family member. In addition, staff recorded how periods of leave had gone with input from the patient's family where leave had been with them.

A senior staff member completed Monthly Mental Health Act audits on each ward. These were thorough and we saw that they had been successful in identifying issues and shortfalls in the areas being audited. For example,

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omissions in documentation, which had been rectified by the staff member completing the audit. However, it was not evident how learning from the audits was disseminated to the team to prevent the same issues recurring in future.

There was an independent mental health advocacy service available to all patients. Information about the service was displayed on all wards. Staff told us they referred all detained patients to the service. The advocate visited the wards on a regular basis.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was mandatory for staff. Only 43% of eligible staff had completed this as of 30 June 2016. However, all staff we spoke with demonstrated an understanding of the Act and the associated Deprivation of Liberty Safeguards. Most said they had completed online training.

Staff were able to speak about the principles of assuming capacity through to best interest decisions and least restrictive principles. They gave examples of where specific patients' capacity had been assessed in the past in relation to significant decisions such as management of finances and accommodation. Nursing staff said they assessed patient's capacity on an ongoing basis such as assisting patients with daily decisions and supporting them to make informed choices. We saw staff supporting patients to make their own decisions, for example, the choice of what to choose from the menu.

Although understanding of capacity was evident amongst staff, formal recording of capacity assessments was seen primarily as the role of the doctors. There was a Mental Capacity Act policy in place which said that any professional proposing treatment or another act could assess capacity. Capacity assessment and best interest forms were on the electronic system for staff to complete. We did not see these present in care records and nursing staff told us they did not complete these assessments and would defer to doctors. We saw that doctors did record discussions about capacity in their clinical notes on the system but did not use the assessment form. The notes did not always detail what attempts had been made to support people with making decisions prior to assessing their capacity.

There had been eleven Deprivation of Liberty Safeguard authorisation applications made between 1 January 2016 and 30 June 2016. Five of these authorisations were for patients on ward two; four authorisations were for patients on ward three and two authorisations were for patients on ward one. Information was displayed in staff offices about which patients had a Deprivation of Liberty Safeguard authorisations in place so that staff were aware of the patients' status.

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

Interactions between staff and patients were very positive. Staff spoke in a kind, respectful way and tailored their communication styles to meet the needs of each patient. For example, they spoke loudly and clearly where people had hearing difficulties. We saw staff explaining things to people and providing reassurance during care tasks, such as using the hoist to transfer someone. All staff including housekeeping staff and administration interacted with patients such as speaking when passing and engaging in conversation. We observed staff at times were able to sit and chat with patients socially.

Staff we spoke with had a good understanding of the needs of each patient. The service operated a keyworker system where each patient was allocated a named staff member as their first point of contact. Relatives said their family member's key workers attended review meetings.

Staff respected confidentiality and spoke with patients in private about any personal issues. We saw staff provided emotional support and reassured patients if they became upset or distressed. Patients gave examples of staff respecting their confidentiality by actions such as knocking on doors before they entered their rooms. Staff used touch appropriately and to offer reassurance to patients. All wards had exceeded the trust training target for completion equality and diversity training.

Patients and relatives spoke highly about the staff and the care and support they gave. They described staff in terms such as 'excellent', 'great', 'helpful' 'caring' and 'supportive'. They told us said staff treated them with kindness, respect and professionalism. One patient said of the staff, "They all love me." Most patients told us staff encouraged them to be indepdent but one patient said they would like to do more things for themselves. Relatives said staff were always friendly and caring when they visited. Some relatives gave examples of staff supporting them in their role as carers of the patient which they had really appreciated and found very beneficial. One relative said a staff member had referred them to a bereavement service when a family member had passed away. They said staff were empathic and always had time to discuss any worries and concerns.

Most relatives we spoke with named individual staff that they singled out for praise for how they had cared for their family member. None had witnessed any concerns with how staff interacted with patients.

Patients told us staff respected their privacy and described examples of this such as staff knocking on their doors before entering their rooms. We saw one staff member discreetly inform a patient in the lounge that it was time for some medication they required. The staff member offered the patient the choice of having this in the treatment room or the staff member bringing it to the lounge for them. One patient fell asleep in the lounge in line of sunlight for a period of time. Staff kept checking that the patient was not too hot.

The 2015 patient led assessments of the care environment score for privacy, dignity and wellbeing at The Mount was 94%. This was above the national average of 86% and the Trust average of 91%.

The involvement of people in the care that they receive

As most patients were admitted in a crisis, some were unable to recall the admission and initial care planning process. However, relatives told us they were involved in the care planning process for their family member. They attended reviews of their family member's care and staff kept them updated where appropriate. Care plans contained information about patients' likes and dislikes and we saw evidence of involvement and input from relatives in some cases. Some care plans contained 'This is me' documents which are good practice documents providing important information about a patient, including outside of their care needs. For example, they provided information about patients' history, family, likes, dislikes and what was important to them.

There was a section on the electronic care records system to record patients' involvement. We saw evidence where patients had been offered copies of their own care plans. There was evidence of regular review of care plans.

Patients had advocacy support and there was information displayed about how to request this. Some patients confirmed they had advocates in place. We spoke with an independent mental health advocate who regularly attended the service. They said they had a good respectful relationship with staff. Staff made referrals for detained patients and as the advocate was present on a daily basis,

Good

Are services caring?

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

staff kept them updated about any changes. They said occasionally staff overlooked inviting them to care program approach meetings and tribunals which meant that they found out about these at short notice. However, this was not a regular occurrence. The advocate and their colleagues also supported patients who were not detained under the Act, therefore those there informally and under Deprivation of Liberty Safeguard authorisations. The advocate said staff were caring and respectful to patients and they had never witnessed anything of concern whilst at the service.

There were opportunities for patients to discuss the service and give feedback. Community meetings took place and we saw minutes of these that showed a variety of areas were discussed. This included patients' views of food, the environment and activities amongst other things. These were displayed on the wards so that patients and staff could see what had been discussed. Patients told us about these meetings and one patient said they were attending one that afternoon.

Carers meetings took place that relatives and carers of patients could attend. We saw minutes of recent meetings which showed that discussions about updates to the service, events and opportunities to be involved in influencing the service. For example, carers had recently been asked to take part in an upcoming recruitment event for new staff

There was information within patients' care records to record if patients had any advance decisions in place. We saw that it was recorded in patients' records if they did not wish to be resuscitated in the event of an emergency.

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

Referrals and admissions to the service came via the trust crisis team. As such, admissions could sometimes take place at any time including nights. Managers said they were able to manage this. A bed management team liaised with the service to establish availability and capacity for new admissions. Managers said they would endeavour to admit new patients into leave beds only where current patients were on stable leave. They said this was not always possible and short-term leave beds were used at times due to demand.

Guidance from the Royal College of Psychiatrists for inpatient mental health wards states that optimal bed occupancy rate is considered to be 85%. Between 1 January 2016 until 30 June 2016 bed occupancy for ward one was 84%, ward two was 86% and wards three and four were both 95%. These figures had been affected in part by the temporary closure of ward one.

Each ward had a specific function and supported patients that met certain criteria. This meant that patients were not moved between wards without any clinical reason. At the time of our inspection, one patient on ward two had needs which meant they should have been on ward three. Staff were aware of this and the patient was waiting for availability to transfer to ward three. A staff nurse from ward three was the patient's keyworker and had completed the patient's care plans. We spoke with the patient who also understood this and was not concerned about being on ward two. We saw evidence that staff sought alternative placements where patients required more intensive care, such as psychiatric intensive care units.

The average length of stay for current patients as at 13 April 2016 was 105 days. The average length of stay of discharged patients from April 2015 to 31 March 2016 was 115 days. There were two out of area placements at the time of our inspection.

There had been 19 readmissions within 90 days between 1 October 2015 to 31 March 2016 and one patient's discharge was delayed for a total of 43 days during this time. Managers told us that discharge planning was started upon admission and we saw evidence of discharge planning in care records. However, discharging patients was problematic at times due to lack of suitable placements for patients to be discharged to and awaiting suitable care packages in the community. External issues such as funding and reliance from other agencies also affected the discharge process. Relatives we spoke with told us the service was proactive in trying to identify suitable placements but hold ups were often caused by other external agencies who were involved.

The facilities promote recovery, comfort, dignity and confidentiality

At the time of our inspection, ward one was undergoing refurbishment and not in use. The aim of the refurbishment was to redesign wards one and two to make these more dementia friendly. This was being done in line with work from Stirling University in creating dementia friendly environments. During the restructure, patients from ward one were accommodated on ward four. Patients currently on ward two, males living with dementia, were to be moved to ward one on completion of the work. The modern matron and managers had identified that the male patients tended to use the garden area more frequently. Ward two was then due to be refurbished which would accommodate female patients living with dementia. We saw ward one refurbishment in progress and designs of how it would look once completed. We spoke with some relatives several days after our inspection visit when the refurbishment was complete. Relatives spoke positively about the improvements to the environment. One said the ward felt very homely and not like a hospital.

Ward one provided direct access to outside where there was a garden and seating areas. Patients and staff helped to maintain the gardens. There were raised flowerbeds to aid patients to partake in gardening activities. The paths in the garden were gravel and therefore not ideal for patients with limited mobility and those who needed to use mobility aids. The modern matron said they hoped to address this in future as they had realised it did not promote safety. Patients from the other three wards did not have direct access to the garden as these wards were on the floors above. However, staff were able to escort patients from these wards to use the garden. Relatives also supported their family members on other wards to use the outside garden space. We saw patients making use of this during our visits.

There were a variety of different rooms and areas on the wards for patients to spend time. These included lounges, dining room, family rooms, activity and relaxation rooms.

Are services responsive to people's needs?

Good

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

These were open and accessible so patients could spend time alone if they wanted extra privacy and if they were assessed as safe to do so. Relatives and visitors could use these rooms to visit patients as well as visiting them in their bedrooms. There were a number of locked rooms accessible to staff only which stored items such as cleaning equipment and linen. The doors blended in with the corridors to dissuade patients from trying to access these rooms in line with good practice in dementia environments. Patient examinations took place in bedrooms for extra comfort of patients.

There was no phone on ward two however, patients were able to use the office phone if required. There was a payphone in the interview rooms on wards three and four. Patients were able to have their own mobile phones with them on all of the wards. There was internet access on the wards and computerised tablet devices available for patients to use. Notices on display advertised these and patients could request them from staff. Staff told us that there was good usage of the tablets amongst patients.

There were facilities for patients to make their own snacks, light meals and drinks. Patients had access to microwaves, toasters and kettles in kitchen and dining room areas. We saw some patients make themselves a hot drink. There were fruit bowls, biscuits, sandwiches and a variety of other snacks patients could help themselves to. Jugs of juice were available in communal areas and in patients' rooms. Most patients were complimentary about the food and felt it was good although some said the portions were too large for them. Three patients described the meals as poor or passable. Relatives told us they took food in to their family members at times. Patients chose their main meal preferences in advance but we saw that staff willingly changed this if the patient changed their mind.

Patients' rooms were personalised to their own individual tastes. Relatives confirmed their family members were able to have their own items such as photographs and keepsakes. One patient had their own television from home. On ward two, bedroom doors displayed the patient's name and a picture of something personal to them, such as a pet, a past job or a favourite hobby as a visual prompt. Patients were able to have keys to their own rooms if they were assessed as being able to manage these. Some patients we spoke with had their own keys. Relatives said their family members rooms were always kept secure.

Activities were available for patients and advertised on the wards. Occupational therapists led on activity provision throughout the week and staff facilitated these at other times such as weekends. Some staff members worked extra shifts solely to run activities for patients. They were not included in nursing numbers during these times and worked flexibly to meet the needs of the patients. We saw patients' cooking groups and a quiz take place where patients were actively involved. Patients told us about different activities they participated in and said staff encouraged them to attend these. These included gardening clubs, bingo, quizzes, healthy living groups, arts and crafts, music groups, and film nights. Mindfulness groups had recently been reinstated. Staff had arranged for one patient, who did not speak English as a first language, to watch a film in their own language. Relatives told us staff were pro-active in providing activities for patients.

One patient felt there could be more activities and another said they did not particularly enjoy the activities on offer. Some patients tended to gather in the reception areas of the wards. Staff told us this was a common occurrence. Although, this was their choice, we saw there was a lack of stimulation for these patients at times. For example, there was little sensory stimulation or other meaningful resources for them to engage with in these areas despite it being identified as a central point for patients.

Meeting the needs of all people who use the service

Wards were accessible for wheelchair users and patients with mobility impairments. Each ward had accessible bathrooms with height adjustable baths. Each bedroom contained a sink and there were several toilets and bathrooms throughout the wards. Wards designed for patients living with dementia had adjustable profile beds. These were available on the other wards where patients were assessed as requiring these.

There was a variety of information displayed on the wards. This included information for people detained under the Mental Health Act such as their right to appeals and tribunals. We noted the information for detained patients about their right to complain to the Care Quality Commission included an old incorrect address. These were in the process of being replaced with posters displaying the correct address during our inspection after we highlighted this. There was information on display about infection control, healthy living, nutrition, staffing levels, activities

Are services responsive to people's needs?

Good

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

and advocacy services. There were staff display boards naming staff who worked on the ward and their denomination, however, there had been some recent staff changes and the boards were not all representative of the current staffing structures in place at the time.

There was information about how to make complaints and how people could access the Trust patient advice and liaison service. Representatives from this service also attended the wards.

Staff told us they had access to interpreters and these had been used in the past where needed. For example, to help assess patients' needs and explain their rights. Signs and notices around the wards were displayed in pictorial format to help aid patient understanding.

Kitchen staff told us they could serve meals to suit patients' individual dietary requirements. Patients completed their own menu choices where they were able to or staff supported them with this. If someone required a specialised diet or required meals to be prepared in accordance with religious or cultural protocols, they said this was written at the top of the diet sheet to inform the kitchen. Patients and their relatives said they had food to suit their dietary requirements. One patient had a gluten free diet and we saw they had their own clearly labelled bread and own toaster.

Patients could access spiritual support by use of an on site multi-faith chapel. Patients were aware of this facility and some had used this. Staff were able to accommodate requests for spiritual support.

Listening to and learning from concerns and complaints

The service received seven complaints between 1 June 2015 and 30 June 2016. Four related to ward three and three complaints related to ward two. Three were partially upheld by the trust and none were referred to the ombudsman. One complaint had been submitted in February 2016 and was not concluded at the time of our inspection. We saw that current investigator had identified that the 30 working days timescale would need to be exceeded due to the complexities of the complaint. They had met with the complainant to explain this and keep them updated of progress. The expected timescale for completion was August 2016.

We saw completed complaint responses were detailed and comprehensive. The chief executive had signed response letters and there was information about how complainants could escalate their complaint to the relevant ombudsman if they were not satisfied with the trust's response.

All except one patient we spoke with said they would speak to a staff member if they had any complaints. One patient said they were not sure who they would tell. Patients felt comfortable in being able to raise any issues. Relatives also told us they would speak to a staff member or the ward managers if they had any complaints. None had any complaints to make about the service. They said staff had successfully resolved any issues in the past where they had raised any concerns.

Data provided by the trust stated that learning from complaints was disseminated through various governance meetings. Staff also told us complaints and learning from these would be discussed in meetings. However, governance and team meeting minutes did not include complaints on the agenda so we could not see what learning had been derived from previous complaints.

The service also received nine compliments within the 12 months prior to the inspection. Ward one received five compliments and ward three received four. We saw compliments from both patients and relatives were displayed on the wards.

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 trusts values were; respect and dignity, commitment to quality of care, working together, improving lives, compassion, working together and everyone counts. Senior managers said they tried to incorporate the trust visions and values into appraisal discussions so they were continuous practice. We saw wards had their own team mission statements and objectives on display

Staff we spoke with demonstrated their commitment to quality care through their practice. All spoke positively about the importance of patient care and working together as a team.

There were displays on the wards with photographs and job titles of senior staff at trust level. Most staff said they did not know of them visiting the wards, or if so, very infrequently.

Good governance

Ward managers each had systems where they were able to monitor training, appraisals and staffing levels. Some mandatory training figures were lower than the trust target although figures had been improving. Managers recognised this needed to improve further. As the policy did not require clinical supervision to be recorded, there was no robust system to ensure all staff had this and at the required frequency.

Various audits took place on the wards, however it was not always clear how all of these were used to drive improvement. For example, there was no evidence of shared learning from care plan audits and Mental Health Act audits where shortfalls had been identified. However, staff completed monthly prescription chart audits and the outcomes of these were disseminated to doctors and nurses depending on the nature of the results.

The service held monthly clinical improvement forums which were chaired by the consultant psychologist. Senior staff members attended these, including ward managers, consultant doctors and department leads. The forum included discussions relating to clinical quality, risk and incidents, patient experience, workforce development and innovation and research. There were regular medicines management meetings where representatives from each ward shared learning regarding medicines management.

In relation to patient care, managers routinely reported information on a monthly basis such as numbers of falls, number of pressure sores, patients on antibiotics and other relevant information.

Information from each ward was fed into a key performance framework which included figures relating to numbers of admissions and discharges, length of stay, occupancy rates and a range of other data.

Each ward had a risk register that managers could add to. These were shared within the staff team. The risks were each rated in relation to their severity and were subject to regular review. There was action documented as to what current control measures were in place to mitigate each risk.

Leadership, morale and staff engagement

The modern matron had been substantive in post since February 2016 and had overall management of all four wards. The managers of ward three and ward four were acting into post to cover absence of the substantive managers. The manager of ward two was new into post two weeks prior to the inspection. The substantive manager of ward one had taken on a temporary project manager role to oversee the reconfiguration of the wards that was taking place. This meant there had been a number of recent management changes at the service. In addition, ward one and ward four had been amalgamated during the environmental work so staff from both wards were working alongside each other, some in a different environment than they were used to. Ward managers were supported by deputy managers and there was administration support available to the wards

Some staff felt the changes, especially the redesign and temporary merge, had been stressful and challenging. However all staff felt positive about their roles. They said they were supported by their managers. Managers had an open door policy and staff said they could approach them at all times. All said teamwork and supporting each other was important as it helped their personal morale and helped them cope during stressful times. Managers told us they were proud of the staff and the passion they showed in caring and supporting the patients and the resilience they showed during the current changes. Managers said they felt supported by the modern matron. We saw the matron and ward managers were present and visible on the wards.

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.

The service had a raising concerns policy and staff told us they would feel confident to speak out about any concerns. The Care Quality Commission had received information previously through this process which the service had acted upon and responded to appropriately. Issues concerning staff conduct had been dealt with in accordance with necessary procedures.

Commitment to quality improvement and innovation

The service demonstrated commitment to improvement and innovation by way of improvements that were underway of the environment for people living with dementia. The work was being undertaken in line with published good practice for dementia environments, for example guidance published by Bradford and Sterling Universities in dementia care.

The service was also promoting patient engagement and interaction with technology by the provision of electronic tablet devices that were on offer for patients to use during their stay.

In the past, wards three and four had achieved accreditation for inpatient mental health services by the Royal College of Psychiatrists. This is a standards-based accreditation program designed to improve the quality of care in inpatient mental health wards. However, the accreditation had lapsed. The modern matron told us they hoped in future for all four wards to gain recognised accreditation.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not always maintain an accurate, complete and contemporaneous record in respect of each patient. There was incomplete and omitted information pertaining to patients who required their dietary intake to be monitored. Information about patients' ability to self administer medicines and competence to do so was not present in care records. Entries relating to patients' care and treatment were not always complete. Temporary staff had recorded details of care interventions separately to the patients' main electronic care records. Regulation 17 (1) (c)

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Not all staff had received appropriate training, supervision and appraisal necessary for their role. Only 43% of staff had received training in the Mental Capacity Act and 41% in the Mental Health Act. Further mandatory training with low compliance was Safeguarding children level 3 at 44% and duty of candour training at 23%. Only 40% of staff on ward one and 36% of staff on ward two had received managerial supervision.

This section is primarily information for the provider

Requirement notices

Compliance rates with mandatory training, staff supervision and appraisal did not meet the trust's own targets.

Regulation 18 (2) (a)