Inadequate

Leeds and York Partnership NHS Foundation Trust

Services for older people

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Peppermill Court Community Unit for the Elderly	RGDY3	Peppermill Court Community Unit for the Elderly	Peppermill Court Ramsey Close York North Yorkshire YO31 8SS
Meadowfields Community Unit	RGDO9	Meadowfields Community Unit	1a Nelsons Lane York North Yorkshire YO24 1HD
Worsley Court Community Unit for the Elderly	RGDY6	Worsley Court Community Unit for the Elderly	Doncaster Road Selby

Summary of findings

			North Yorkshire YO8 9BX
Bootham Park Hospital	GDX4	Ward 6	Bootham Park Hospital Bootham York North Yorkshire YO30 7BY
The Mount	RGDO4	Ward 1, Ward 2, Ward 3, Ward 4.	The Mount 44 Hyde Terrace Leeds LS2 9LN

This report describes our judgement of the quality of care provided within this core service by Leeds and York 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 York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York 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 Leeds and York Partnership NHS Foundation Trust	Inadequate 
Are Leeds and York Partnership NHS Foundation Trust safe?	**Inadequate** 
Are Leeds and York Partnership NHS Foundation Trust effective?	**Inadequate** 
Are Leeds and York Partnership NHS Foundation Trust caring?	**Good** 
Are Leeds and York Partnership NHS Foundation Trust responsive?	**Requires Improvement** 
Are Leeds and York Partnership NHS Foundation Trust well-led?	**Inadequate** 

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

The wards were clean. Where the environment posed a risk to the patients, staff had monitored the risks and taken action to mitigate the risks.

Within the wards for older people with mental health problems, we found significant differences between the Leeds and York services. The wards at the Mount had sufficient staff to meet the care and treatment needs of the patient's. Safety was a priority at all levels. Patients received care, treatment and support that achieved good outcomes, promoted a good quality of life, and was based on the best available evidence. Patients had access to occupational therapy. Discharge was planned for from admission. Feedback from patients, and those who were close to them was positive about the way staff treated patients.

However, at the York services, we found patients had not had the same experience.

Many staff in York described low morale caused by insufficient staff and a lack of engagement with trust headquarters. At ward 6, Bootham Park staff said they did not feel listened to by the trust.

At ward 6 Bootham Park hospital, staff and a patient told us, insufficient staff and the use of agency and bank staff had affected the patient's experience

The trust had recognised that Peppermill Court, Worsley Court and Meadowfields had insufficient medical staff and had plans to increase them. There had been limited imput of dedicated doctor cover on a day to day basis and this meant that patients may not have received pro-active and consistent medical input which could have resulted in their medical care and treatment needs' being overlooked or not being met.

We found this had resulted in Peppermill Court, and Worsley Court had not always planned for patient's care appropriately or ensured patients had access to physical health care. Multi-disciplinary teams had not planned patients discharge effectively.

At Peppermill Court, we found there was confusion among nursing staff and they did not know who provided medical cover to meet the physical health needs of patients.

Meadowfields, Worsley Court and ward 6 Bootham Park hospitals were breaching same sex accommodation guidance as specified in the Mental Health Act (1983) Code of Practice.

At Worsley Court, we found patients' medication had not been administered promptly or safely.

However, we found the trust had recognised prior to our inspection that improvements needed to be made in York and had started to look at ways of improving the wards. The trust provided CQC with a copy of an improvement plan for Peppermill Court, Meadowfields and Worsley Court and a specific improvements plan for Worsley Court. Both identified where improvements had to be made, and how the trust planned to make the improvements. We found managers had started to make changes but had not completed the work at the time of the inspection. On the 15 October 2014, Worsley Court closed for one month for staff training.

Summary of findings

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

Are services safe?

Inadequate 

Overall, we found the wards were clean. Where the environment had posed a risk to the patients', staff had monitored the risks and there were actions in place to mitigate the risk. Staff managed risks locally by closer observation of patients when they were at risk of self-harm.

However Meadowfields, Worsley Court and ward 6 Bootham Park hospitals were breaching same sex accommodation guidance as specified in the Mental Health Act (1983) Code of Practice.

The wards at the Mount had sufficient staff to meet the care and treatment needs of the patient's. The trust had recognised that Peppermill Court, Worsley Court and Meadowfields had insufficient medical staff and had plans to increase them. However, there had been a lack of dedicated doctor cover on a day to day basis and this meant that patients may not have received pro-active and consistent medical input which could have resulted in their medical care and treatment needs being overlooked or not being met. In addition, there continued to be a lack of occupational therapists and psychologists. At ward 6 Bootham Park hospital, staff and a patient told us, insufficient staff and the use of agency and bank staff had affected the patient's experience. At Peppermill Court, we found there was confusion among nursing staff about who provided medical cover to meet the physical health needs of patients.

At the Mount and ward 6 Bootham Park hospitals we found comprehensive patient risk assessments. Where risks had been identified, there was a plan in place to reduce or manage the risk to make sure patients were safe. However, at Peppermill Court, Worsley Court and Meadowfields, some of the risk assessments contained insufficient information or did not have management plans in place to manage the risks. In, addition where restraint was part of a planned intervention at Peppermill Court, Meadowfields and Worsley Court, staff were not following the trust policy regarding the recording of restraint.

At Peppermill Court and Worsley Court some of the medication sheets did not contain patients' photographs. This is important to ensure that new members of staff are able to identify the correct patient for medication they are giving. In addition, on three of the wards we found the temperatures of the medication fridges were not checked regularly to make sure medicines were stored safely.

Summary of findings

At Worsley Court, we found that some patients had not been administered medication promptly and safely. We found five instances when the staff had failed to record on the administration card whether the patient had received the medication. We also found out of date medication.

Although we concluded that overall, staff reported incidents and safeguarding concerns appropriately, and trust wide learning was cascaded to staff. We found at Peppermill Court following an incident no improvements had been made.

Are services effective?

Inadequate

Although we found the Mount was effective, and people's care and treatment and support achieved good outcomes and promoted a good quality of life based on the best available evidence because of our findings at the York Services we have found this domain to be inadequate.

At the Mount, we found staff assessed patient needs and planned for their care and treatment. The multi-disciplinary team were effective.

At the York service, we found inconsistencies at Peppermill Court, and Worsley Court regarding the assessment of patient needs and planning of patients' care and the effectiveness of the multi-disciplinary team. Where insufficient medical staff, occupational therapists and psychologists may have meant that patients' may not have received pro-active and consistent medical input, which could have resulted in their care and treatment needs' being overlooked or not been met.

The wards at the Mount followed best practice guidelines and were proactive in ensuring patients received good outcomes and experiences. At Peppermill Court and Worsley Court, we found staff had not always followed good practice guidelines when deciding upon patients care. Also, the wards did not have a system in place to ensure patients had the necessary annual physical healthcare screenings.

We found inconsistencies across wards regarding the completion of mandatory and role specific training. However, staff had escalated this onto the trust's risk register and there was an action plan in place to address staff training.

Overall, the wards had adhered to the Mental Health Act 1983.

In regards to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), at the York services, although we found staff had referred appropriate patients' for a Deprivation of Liberty Safeguard

Summary of findings

(DoLS) assessment. We saw in some the cases, assessment of the patient's capacity had not been carried out prior to their referral and at Worsley Court, referrals for DoLS assessments had not occurred prior to the recent changes in management.

Are services caring?

Good

We held a series of focus groups and listening events prior to and during the inspection to gain feedback from patients and carers. During the inspection, we spoke with 29 patients, seven relatives and reviewed comment cards from both patients and relatives. We attended a handover, MDT and a formulation meeting.

Most of the feedback received from patients and their families was positive. Patients and relatives reported they were satisfied with the service and that staff treated them with respect and dignity.

We found inconsistencies on the wards regarding how staff involved patients in their care. At the Mount, they were very involved but at Worsley Court and Peppermill Court there was little evidence of involvement or engagement.

From our observations, we saw staff were mostly attentive to patient needs and responded promptly when patients requested support.

Are services responsive to people's needs?

Requires Improvement

Overall, there was an effective approach to the assessment and admission of patients onto the wards. Worsley Court that was closed to new admissions during inspection and on the 15 October closed for one month for staff training.

There was inequity between the Leeds and York services in regards to patient's discharge. At the Mount, patients discharge was planned for from admission and was only delayed due to a lack of suitable placements in the community. At the York services, there had sometimes been delays in patient's discharge due to insufficient medical staff, occupational therapists and psychologists and a lack of suitable placements locally.

Information provided by the trust following the inspection demonstrated the trust had recognised this and had taken action.

The trust ensured that patients' needs were met in terms of equality and diversity. Patients had access to interpreting and advocacy services on site if necessary.

Overall staff were able to explain the complaints procedure and were aware of the trust's procedures and policy if someone wanted to make a complaint

Summary of findings

Are services well-led?

Inadequate 

We found inequity between the Leeds and York wards in staff morale. Staff at Leeds services described their morale as good, whilst many staff in York services described low morale caused by insufficient staff. At ward 6 Bootham Park staff said they did not feel listened to by the trust.

Overall, all the staff said they were supported and listened to by the local management teams and would feel confident in raising any concerns.

The Mount had good governance systems in place to ensure patients received a high quality and innovative service, which met patient needs.

At Peppermill Court, Meadowfields and Worsley Court the trust had identified where improvements had to be made and provided us with comprehensive action plans. Managers had started to make changes but had not completed the work at the time of the inspection. Also, some actions had not been completed despite the action plan stating they had. For example, the staff had not improved the quality of care records and medical cover to the wards remained inconsistent.

On the 15 October 2014 we were informed Worsley Court closed to allow for staff training.

Summary of findings

Background to the service

The wards for older people with mental health problems were based on five hospital sites. One was in Leeds (The Mount), one in Selby (Worsley Court Community Unit for the Elderly) and three in York (Peppermill Court Unit for the Elderly, Meadowfields Community Unit and Ward 6 at Bootham Park Hospital).

The Community Unit Elderly Services (CUES) in York consisted of Worsley Court, Peppermill Court and Meadowfields. Worsley Court and Meadowfields admitted women and men with dementia and Peppermill Court admitted men with dementia and complex behavioural needs. During our inspection, Worsley Court closed. The services had not been inspected since registration with the Care Quality Commission (CQC).

Ward 6 at Bootham Park Hospital provided assessment and treatment for older people. The last CQC inspection in December 2013 found Bootham Park Hospital to be non-compliant with some of the essential standards of quality and safety. This was because patients, staff and visitors were not protected against the risks of unsafe premises due to ligature risks, which were not being managed effectively. Following the inspection the trust wrote to CQC with the actions they would take to ensure they were compliant with the essential standards. At this inspection, we looked at what progress the trust had made in relation to the action plan.

The Mount had four older person wards:

- Ward 1- Women with dementia.
- Ward 2- Men with dementia.
- Ward 3- Wen and women for assessment and treatment of mental health problems.
- Ward 4- Women for assessment and treatment of mental health problems.

The Mount was last inspected on 16 January 2014 and was found to be compliant with the essential standards of quality and safety.

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt, Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

Team Leader: Jenny Wilkes , Head of Inspection, North East Care Quality Commission

The team included CQC inspectors and a variety of specialists. These included two consultants, a two qualified nurses, a speech and language therapist, a mental health act reviewer, a social worker and a expert by experience who has had experience of caring for a person who has used a similar service and a hospital manager.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

Before this inspection, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We visited Peppermill Court on 30 September and 16 October 2014. We spoke with nine patients and two relatives and observed how staff interacted with patients in the lounge and at lunchtime. We received two comment cards. We spoke with 11 staff including the modern matron, ward manager, clinical nurse lead, staff nurses, health care support workers, a chaplain and a consultant psychiatrist. We looked at 10 patient records to check what had been recorded about their care and treatment.

We visited Meadowfields on 30 September and 16 October 2014. We spoke with one patient and two relatives and observed how staff interacted with patients in the lounge and at lunchtime. We received four comment cards. We spoke with 11 staff including the modern matron, ward manager, clinical nurse lead, a bed manager, staff nurses, health care support worker and an advocate. We looked 13 patient records to check what had been recorded about their care and treatment.

We visited Worsley Court on 31 September 2014 and spoke with three patients, two relatives and observed how staff interacted with patients in the lounge and at lunchtime. We spoke with 10 staff, including the deputy director of nursing, the service manager, modern matron, ward manager, clinical nurse lead, staff nurses, health care support workers, and an occupational therapist. We looked at seven patient records to check what had been recorded about their care and treatment.

We visited Bootham Park Ward 6 on 30 September 2014 and we spoke with two patients and observed how staff interacted with patients in the lounge. We spoke with seven staff, including the ward manager, clinical nurse lead, staff nurses, student nurses, a dietician, a physiotherapist, health care support workers, a chaplain and two junior doctors. We looked at eight patient records to check what had been recorded about their care and treatment.

We visited all four wards at The Mount on 1 October 2014. We spoke with 14 patients and one relative. We spoke with 21 staff, including the modern matron, ward managers, deputy ward managers, an occupational therapist assistant, staff nurses, health care support workers, two junior doctors and a specialist doctor. We looked at 18 patient records to check what had been recorded about their care and treatment. We attended a formulation meeting where staff discussed patient care.

What people who use the provider's services say

At Peppermill Court, we spoke with nine patients and two relatives. Patients we spoke with were complimentary about the service.

At Meadowfields, we spoke with one patient and two relatives and looked at four comment cards. All were very complimentary about the service. They told us staff was respectful and caring, they were well informed and had no concerns regarding their relatives' care and treatment. We observed staff were respectful and kind in their interactions with patients.

At Worsley Court, patients told us the staff were kind and treated them with respect and dignity. We observed lunchtime and activities in the lounge area and saw good interactions between staff and patients.

At the Mount, all the patients were complimentary about the staff and told us the staff were kind, caring and treated them with dignity. On the wards, we saw patients were being supported by kind and attentive staff. We observed that staff showed patience and gave encouragement when supporting patients.

At Bootham Park Hospital, Ward 6 we were told that the staff were "kind and helpful". However, another patient told us that they did not have a key to their bedroom so they could not protect their possessions. They also told us that escorted leave into the community was often cancelled due to shortages of staff.

Summary of findings

Good practice

At the Mount the psychologist led formulation meetings every week where all the staff were involved in focusing on patients who were hard to engage with or had behaviour which challenged. The meeting mapped out the patients core values and motivations to find ways of successful and meaningful interactions with the patient to aid their recovery.

The Mount sent out to all patients on ward 3 and ward 4 a monthly questionnaire that enabled the staff to evaluate and improve the patients experiences. Patients and their relatives designed the questionnaire.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- At Peppermill Court, Worsley Court, Meadowfields and Ward 6 Bootham Park hospital the trust must ensure there are sufficient skilled staff at all times to meet the treatment and care needs of the patients.
- The trust must ensure it adheres to the guidelines for mixed sex wards under the MHA Code of Practice (Chapter 16.9), at Meadowfields, Worsley Court and ward 6 Bootham Park Hospital.
- At Worsley Court the trust must ensure that there no delays to the administration of patients medication.

Action the provider SHOULD take to improve

- At Peppermill Court the trust should ensure there are clear arrangements in place to provide patients with the appropriate physical health monitoring and treatment.
- At Peppermill Court, and Worsley Court staff should follow the trust policy in regards to the recording of restraint.
- At Peppermill Court, Meadowfields, Worsley Court, the trust should ensure they continue to implement the 'Quality improvement plan for the Community unit elderly services (CUES) and provide CQC with a monthly update of the progress.
- At Peppermill Court, Meadowfields, Worsley Court, The Mount and Bootham Park Hospital ward 6 the provider should ensure the environment is reviewed to ensure staff have clear lines of sight throughout the wards to ensure patients safety.

Leeds and York Partnership NHS Foundation Trust

Services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Peppermill Court Community Unit for the Elderly	Peppermill Court Community Unit for the Elderly
Meadowfields Community Unit	Meadowfields Community Unit
Worsley Court Community Unit for the Elderly	Worsley Court Community Unit for the Elderly
Bootham Park Hospital	Ward 6
The Mount	Ward 1, Ward 2, Ward 3, Ward 4.

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.

Overall we found the trust were adhering to the Mental Health Act 1983 (MHA).

At The Mount wards 1,2, and 3 and Bootham Park Hospital Ward 6, a Mental Health Act reviewer visited the wards as part of this inspection. They reviewed the detention documentation for detained patients.

Overall, we saw most of the documents were in order. All the patients' nearest relatives had been consulted during the assessment procedure. Patients had been made aware of their rights under the MHA 1983 and section 17 leave forms had been completed. However, we found that one person's medication documentation was incorrectly completed.

Mental Capacity Act and Deprivation of Liberty Safeguards

A DoLS is a framework for approving the deprivation of liberty for patients who lack the capacity to consent to treatment or care in a hospital, to make sure it is in their best interests.

We found staff had referred appropriate patients for a Deprivation of Liberty Safeguard (DoLS) assessment.

Detailed findings

However, we saw in some the cases, assessment of the patient's capacity had not been carried out and at Worsley Court, referrals for DoLS assessments had not occurred prior to the recent changes in management.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Overall, we found the wards were clean. Where the environment had posed a risk to the patients', staff had monitored the risks and there were actions in place to mitigate the risk. Staff managed risks locally by closer observation of patients when they were at risk of self-harm.

However Meadowfields, Worsley Court and ward 6 Bootham Park hospitals were breaching same sex accommodation guidance as specified in the Mental Health Act (1983) Code of Practice.

The wards at the Mount had sufficient staff to meet the care and treatment needs of the patient's. The trust had recognised that Peppermill Court, Worsley Court and Meadowfields had insufficient medical staff and had plans to increase them. However, there had been a lack of dedicated doctor cover on a day to day basis and this meant that patients may not have received pro-active and consistent medical input which could have resulted in their medical care and treatment needs being overlooked or not being met. In addition, there continued to be a lack of occupational therapists and psychologists. At ward 6 Bootham Park hospital, staff and a patient told us, insufficient staff and the use of agency and bank staff had affected the patient's experience At Peppermill Court, we found there was confusion among nursing staff about who provided medical cover to meet the physical health needs of patients.

At the Mount and ward 6 Bootham Park hospitals we found comprehensive patient risk assessments. Where risks had been identified, there was a plan in place to reduce or manage the risk to make sure patients were safe. However, at Peppermill Court, Worsley Court and Meadowfields, some of the risk assessments contained insufficient information or did not have management plans in place to manage the risks. In, addition where restraint was part of a planned intervention at Peppermill Court, Worsley Court and Meadowfields, staff were not following the trust policy regarding the recording of restraint.

At Peppermill Court and Worsley Court, some of the medication sheets did not contain patients' photographs. This is important to ensure that new members of staff are able to identify the correct patient for medication they are giving. In addition, on three of the wards we found the temperatures of the medication fridges were not checked regularly to make sure medicines were stored safely.

At Worsley Court, we found that some patients had not been administered medication promptly and safely. We found five instances when the staff had failed to record on the administration card whether the patient had received the medication. We also found out of date medication.

Although we concluded that overall, staff reported incidents and safeguarding concerns appropriately, and trust wide learning was cascaded to staff. We found at Peppermill Court following an incident no improvements had been made.

Our findings

Peppermill Court Community Unit for the Elderly

Safe and clean ward environment

The trust provided us with information before the inspection that demonstrated the service had commenced a ligature and risk project group in York. The group had met regularly to look at the ward environment in order to identify, remove or manage the ligature risks on the wards. The ward manager told us removal of the ligatures points at Peppermill Court was incomplete and there were outstanding risks. The ward had carried out a ligature risk audit on the 29 August 2014 and managed any risks locally by increasing observation levels of patients assessed as being at risk.

We saw there were ligature points throughout the building including; window handles, taps and waste pipes on basins. In addition, bedroom 11 had a metal partition with bolts that protruded off the frame. The ligature points were in places where patients were unsupervised. We saw the ward had many 'blind' spots where patients could be

unobserved by staff. Staff told us they managed this by assessing whether patients were at risk of self-harm and increasing observation levels for patients assessed as at risk.

We found the ward was clean and well maintained. Information provided by the trust showed 29 out of 31 staff had completed their infection control training.

We saw that staff checked the clinical room regularly. It was clean, tidy and equipped with appropriate resuscitation equipment and emergency drugs.

Safe staffing

There were two qualified nurses, four health care assistants during the day, and one qualified nurse, three health care assistants during the evening, with one qualified nurse, and two health care assistants at night. Staff told us the number of staff increased if patients were at higher risk and needed closer observation. At the time of our visit, 14 of the 24 bedrooms were in use.

Information provided by the trust prior to inspection showed between 1 March and 31 May 2014 there were six vacancies for qualified staff. 331 individual shifts had been covered by agency or bank. However, they had been unable to fill 61 shifts. Staff told us that despite this; escorted leave took place most of the time and the ward usually had enough staff to facilitate individual and group activities. In addition to ensure consistent care, they used the same bank or agency staff.

However, we saw health care assistants were cleaning the kitchen because there was not enough cleaning staff during the evening. Staff told us the trust was in the process of recruiting cleaning staff.

The consultant psychiatrist for Peppermill Court provided six hours of medical cover a week on the ward. The ward manager told us in practice this meant the consultant was only present on the ward once a week for ward rounds for approximately two to three hours. They told us that ward round meetings were sometimes cancelled and they were concerned about what would happen when the consultant went on leave as the ward did not have any dedicated junior doctor provision. We were told that if patients required any urgent treatment, this was provided by two trainee doctors based at Bootham Park Hospital who attended the ward as and when requested by nursing staff. The medical staff told us they were extremely busy and they had raised this with the trust. The lack of dedicated doctor cover on a day to day basis meant that patients did not receive pro-active and consistent medical input which could result in their medical care and treatment needs being overlooked or not being met.

Information provided following the inspection demonstrated that the modern matron had identified insufficient medical cover, was raised as a risk, on 9 September 2014 on the North Yorkshire care risk register. In addition, it was included in the 'Quality improvement plan for the community unit elderly services (CUES) which had been updated on 3 September 2014.

Following the inspection, we asked the trust for further information to clarify the medical cover at Peppermill Court. The trust confirmed there was a consultant psychiatrist for six hours per week and there was no regular scheduled presence of junior doctors. The trust informed us this was increasing by one specialist doctor for one and a half days from 24 November 2014.

We found the nurses did not all know who provided medical cover to meet the physical health needs of patients. In June 2014, the contract the trust had with a GP practice to provide weekly GP visits to the ward was terminated. Some staff told us the junior doctors provided medical cover, whilst other staff told the patient's GP provided this. This demonstrated a lack of clarity about medical provision.

There was no occupational therapist input. The psychologist was available once a month for group supervision for staff but did not provide input for individual patients. This had been raised as a risk by the modern matron and was included in the quality improvement plan for the CUES.

Assessing and managing risk to patients and staff

The ward manager told us they did not use restraint to the floor and they did not have a seclusion room. Staff described using the least restrictive practices with patients and said the large space at Peppermill Court meant that incidents of disturbed behaviour were de-escalated effectively. Information provided by the trust following the inspection showed that 21 out of 31 staff had completed their prevention of and management of violence and aggression training (PMVA).

However, staff told us that where use of restraint was part of an established care plan to meet the personal care needs of a patient; they did not report it using the incident

reporting system. This was not in line with the trusts, 'procedure for the therapeutic clinical management of challenging, violent & aggressive behaviour' policy which stated that all incidents involving the use of restraint should be reported.

The ward completed the safety assessment and management plan (SAMP) for patients on admission to the ward and reviewed them monthly. We looked at two patients records. We saw in both records that incidents had occurred following admission. However, staff had not updated the records. This meant staff did not measure the number and severity of incidents and were unable to assess accurately the risk to the patient and others.

Due to the size of the ward, patients could be out of line of sight of staff for long periods. It was therefore important that staff assessed individual patient risk to ensure they were cared for on the most appropriate observation level in line with best practice. At inspection, we concluded this was not always the case. We found in two care records we looked at conflicting information about the frequency of observations for those patients. One patient who was assessed as being at high risk due to their impaired vision was not under observations consistent with the outcome of their assessment.

We found policies were in place to inform staff about the safe handling of medicines and for obtaining medication out of hours. We checked a sample of medication and controlled drug records, which were in order. However, we found the front sheets did not contain patient's photographs. This is important to ensure that new members of staff are able to identify the correct patient for medication they are giving.

We saw information about safeguarding was available to staff and patients on the wards. The clinical lead told us the computer system (DATIX) alerted senior staff to any safeguarding concerns. The ward manager told us and records confirmed that staff made the alert to and liaised with the local authority safeguarding team. Information provided by the trust showed 21 out of 31 staff had completed annual safeguarding training. Staff we spoke with were aware of how to refer safeguarding concerns and obtain safeguarding advice if needed.

Reporting incidents and learning from when things go wrong.

There were systems in place to capture and review individual incidents and accidents that enabled staff to identify potential risks. We reviewed a sample of incident report forms completed by staff on the computer (DATIX) system. We saw the ward manager assessed the forms regarding severity and sent the forms to the modern matron and risk manager. We were provided with a copy of York and North Yorkshire statistical breakdown of incidents April – June 2014 which provided the manager with an overview of the incidents which had occurred on the ward. This information showed there had been 141 incidents at Peppermill court, 63 classified as violence, 31 as falls, and 19 as clinical incidents.

Staff told us there was a de-briefing process following incidents and incidents were discussed at a bi-monthly clinical supervision session facilitated by the psychologist. However, the ward manger could not tell us of lessons learnt from incidents on the ward. One member of staff who had been involved in a serious incident told us there had been no lessons learned from this incident on the ward. The ward manager and clinical lead told us they had not used any analysis of incidents to inform individual patient care or ward safety. Analysis of this information may have enabled the management team to learn lessons and to minimise risk to patients and staff.

Meadowfields Community Unit

Safe and clean ward environment

The trust provided us with information before the inspection that demonstrated the trust had commenced a ligature and risk project group in York. The group had met regularly to look at the ward environment in order to identify, remove or manage the ligature risks on the wards. We saw the environmental risk assessment had identified ligature risks and staff said there were plans to replace these items.

We saw there were ligature points throughout the building including, window handles, taps in a basins and cables in bedrooms. The ligature points were in places where patients were unsupervised. We also saw there were many areas in the ward that had 'blind spots'. The staff told us they managed these by assessing whether patients were at risk of self-harm and then increasing observations of patients who were determined at risk.

Requires improvement

Are services safe?

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

We saw staff checked the clinical room regularly. It was clean, tidy and equipped with appropriate resuscitation equipment and emergency drugs.

The ward was clean and well maintained. Information provided by the trust showed 18 out of 36 staff had completed their infection control training.

The ward was a mixed gender ward. The bedrooms were not segregated although there was scope for this to happen. Members of one gender had access to areas occupied by the other including bedrooms. Toilets were labelled gender specific and the ward had a female only lounge. We observed there was one shower room located within the female corridor, which meant males would have to pass along the female corridor to access the shower. This meant the ward was not complaint with the Single Sex Accommodation (SSA) Department of Health guidance or the application of the MHA Code of Practice. (Chapter 16.9).

Safe staffing

The ward manager told us that the staffing establishment was sufficient to meet patients' needs. They told us when absences occurred they would use bank or agency staff who had worked on the ward before. The ward manager and two health care assistants said that sometimes activities and community outings were cancelled when staff were absent due to unplanned sickness. Information provided by the trust prior to the inspection showed there were no vacancies on the ward and staff sickness was three percent of the staff establishment. This is lower than the national average.

The ward manager told us there was one consultant psychiatrist for the ward but at present no other doctors who worked directly to the consultant. The consultant carried out one session a week on the ward for three or four hours which included the ward round and the review of one patient. The consultant told us they had raised this as a risk with the trust. Two, 'on call' doctors based at Bootham Park Hospital provided cover for the ward. Staff were also able to access the on call doctor for community if required. Staff told us they were able to get a doctor when needed.

Following the inspection, we asked for further information to clarify the medical cover at Meadowfields. The trust stated there was a consultant psychiatrist for approximately four and a half hours and there was no regular scheduled presence of junior doctors. The trust informed us this was increasing by the consultant cover raising to one and a half days and one specialist doctor for two days from 24 November.

Information provided following the inspection demonstrated that the modern matron had identified insufficient medical cover, as a risk on 9 September 2014 on the North Yorkshire care risk register. In addition, it was included in the 'Quality improvement plan for the community unit elderly services (CUES) which had been updated on 3 September 2014.

There was a contract with a local General Practitioner (GP) practice to provide physical healthcare, and a GP came to the ward once a week. If the patients required any treatment for physical illness, they would use the GP out of hours' service.

There was a lack of a psychologist or occupational therapist input for patients. Information provided by the trust showed the modern matron raised this as a risk on the 9 September 2014 on the North Yorkshire care risk register.

Assessing and managing risk to patients and staff

The ward did not have a seclusion room. When patients became distressed, staff supported them in the quiet or low stimulus rooms. Staff described working to the least restrictive practice with patients and told us they rarely used restraint. Information received from the trust indicated there had been two incidents where restraint had been used between 1 May to 31 July 2014 and neither had been in the face down (prone) position.

Information provided by the trust following the inspection showed that 30 out of 36 staff had completed their prevention of and management of violence and aggression training (PMVA).

The records demonstrated that staff assessed patients to establish potential risks on admission and the ward used the Safety Assessment and Management Plan (SAMP). Staff reviewed the SAMP monthly regarding levels of risk to patients but did not add the most recent incidents onto the SAMP. This may have prevented staff from identifying any patterns or triggers of behaviour.

Where risks were identified, risk assessments were in place to minimise the risks. We saw safety, assessment and management plans for falls, skin integrity and nutritional

risk assessments were in place. Where patients posed a risk to themselves or others we saw staff adhered to the levels of observations and patients were on 10 or 15 minutes observations dependent upon risk.

We found policies were in place to instruct staff about the safe handling of medicines. We checked a sample of medication and controlled drugs recording sheets and found them to be correct.

We saw information about safeguarding was available to staff and patients on the wards. The clinical lead told us the computer system (DATIX) alerted senior staff to any safeguarding concerns. The ward manager told us and records confirmed staff made the alert to and liaised with the local authority safeguarding team. Staff we spoke with knew how to respond appropriately to any allegations of abuse. Information provided by the trust showed 30 out of 36 staff had completed the annual safeguarding training. One patient and three relatives told us they felt safe on the wards and would be confident to raise any safeguarding concerns with the staff or the advocate.

Reporting and learning from incidents when things go wrong

We saw there were systems in place to capture and review individual incidents and accidents, which enabled staff to identify potential risks to them. The ward managers told us staff completed the incident report forms on the computer (DATIX) system. We talked to two health care support workers who told us they were confident to raise incidents using this process and provided examples of how they had done so. However, staff told us that where use of restraint was part of an established care plan to meet the personal care needs' of a patient; they did not report it using the incident reporting system. This was not in line with the trusts, 'procedure for the therapeutic clinical management of challenging, violent & aggressive behaviour' policy which stated that all incidents involving the use of restraint should be reported.

The ward manager told us they assessed the incident forms regarding severity and sent the forms to the modern matron and risk manager. For example, we saw the clinical lead had investigated a falls incident and lessons learnt had been cascaded to staff at handover. We were provided with a copy of York and North Yorkshire statistical breakdown of incidents between April to June 2014. However, the ward manager told us the ward did not use the data to analyse incidents for individuals.

Worsley Court Community Unit For the Elderly

Safe and clean ward environment

The trust provided us with information before the inspection that demonstrated the trust had commenced a ligature and risk project group. The group had met regularly to look at the ward environment in order to identify, remove or manage the ligature risks on the ward.

We saw there were ligature points throughout the building, for example on window handles and cables in bedrooms, where patients were unsupervised. We observed bedrooms had detachable rails in the wardrobes that could be used as weapons. There were many areas in the ward that had 'blind spots' where it would have been difficult for staff to observe patients easily. The staff told us they managed these risks by assessing whether patients were at risk of self-harm and then increasing observation levels for patients who were determined at risk.

We saw the clinic room was clean and tidy. However, there was no examination couch and doctors examined patients in their own bedrooms. We saw staff had not signed to demonstrate they had checked the emergency equipment regularly to confirm it was in date and correct. This meant there was no evidence to demonstrate the equipment was checked regularly as per trust policy.

The ward accommodated both male and female patients. Bedrooms were not en-suite. Although there was the opportunity for separated male and female bedroom areas, we found patient bedrooms were not segregated. Male and female patients had to pass each other's rooms to access the toilet, bathroom and shower areas. This meant that patients' privacy and dignity was not always maintained as intrusions into either gender bedrooms were accessible. This meant the ward was not complaint with the Single Sex Accommodation (SSA) Department of Health guidance or the application of the MHA Code of Practice (Chapter 16.9).

Safe Staffing

The managers said in the week prior to our inspection in response to safeguarding concerns, there had been an increase in staffing levels whilst the trust carried out an investigation in relation to the concerns. On the day of the inspection, there were two qualified nurses and four health care assistants for eight patients. The trust provided us with an action plan that stated staffing for Worsley Court had to

be at least the minimum agreed establishment and include a registered general nurse. The modern matron told us the increased numbers and skills of the staff were in response to the safeguarding concerns raised on the ward.

Information provided by the trust prior to the inspection reported that from 1 March to 31st May 2014 agency or bank staff had been used on 151 occasion and for 31 occasion they had not been able to find cover. The sickness rate for 12 months prior to 30th June 2014 had been 7%.

Information provided by the trust following our inspection stated there was approximately six hours a weej consultant psychiatrist cover. From 24 November 2014, the trust told us this was to increase to a full day for the consultant psychiatrist and one specialist doctor for one and a half days. There was no regular scheduled presence of junior doctors.

In regards to physical health care patients registered with Selby GP practices received the input of their GP. Patients not already registered with Selby GP practices were registered with Beech Tree Surgery. The GPs provided physical health care to patients when needed. The trust provided a copy of the action plan for Worsley Court that included the action, 'All service users to have an up to date medical review', which was required to be completed by the 29 September 2014 .A psychologist was available once a month for group supervision for staff but did not provide input for individual patients.

Information provided by the trust following the inspection demonstrated the modern matron had raised insufficient medical cover as a risk on 9 September 2014 on the North Yorkshire care risk register. In addition, it was included in the 'Quality improvement plan for the community unit elderly services (CUES) which had been updated on 3 September 2014. This included an issue as, 'The need for appropriately staffed wards, with adequate capacity and appropriate professional skill mix. Currently the CUES have no occupational therapy, psychology and stretched psychiatry provision'.

Assessing and managing risk to patients and staff

We found care management plans were in place, which instructed staff to use prevention and management of violence and aggression (PMVA) and record this in the patient's progress notes. However, we found the care management plans did not instruct staff about the type of restraint they had to use and staff did not monitor what triggered the use of the restraint or who was involved. This meant that any patterns of behaviour, which triggered the need for the use of restraint, would not have been identified.

Training information provided by the trust showed 19 out of 25 staff had completed their PMVA training.

Patients had individual risk assessments; however, we found they did not provide sufficient detail or were not completed fully.

During the course of this inspection, the management team told us about safeguarding concerns they were currently investigating on the ward. There was evidence the trust had followed their own procedures, and had contacted the relevant authorities and was responding appropriately to the concerns. The investigation into the safeguarding concerns had not been completed at the time of our inspection.

We reviewed the systems for administering medicines and found that three patients had not been administered their medicines promptly and that the medication policy had not been adhered to. For example, one patient had been prescribed an anti-fungal cream on the 4 September 2014 but this was not administered until the 8 September 2014, four days late. Another patient was prescribed drops for an ear infection on 5 August 2014, but this was not available and the alternative was not prescribed until the 12 August 2014. Their ear was noted as having a, 'foul smell'. Another patient was prescribed an antibiotic on 19 September but the treatment was not commenced until 22 September 2014. The staff had also failed to record on the administration card five times if the patient had received the medication. We also found out of date medication.

Reporting incidents and leaning form when things go wrong

At the inspection, we found inconsistencies in the reporting of incidents and a member of staff told us they would only complete an incident form if the patient was injured. The modern matron and the temporary ward manager told us they had found that incidents and learning from incidents had not been robust. The trust closed Worsley Court on the 15 October 2014 for intensive staff training.

Bootham Park Hospital – ward 6

Safe and clean ward environment

The last Care Quality Commission (CQC) inspection in December 2013 found Bootham Park Hospital was non-

compliant with some of the essential standards of quality and safety. This was because patients, staff and visitors were not protected against the risks of unsafe premises due to ligature risks the ward failed to identify or manage effectively. Following the inspection the trust wrote to CQC with the actions they would take to ensure they were compliant with the essential standards.

At this inspection, the manager said two independent advisers had reviewed the ligature risks and made changes. A project group reviewed the risks that the building presented twice a month. The manager walked around the ward weekly and assessed for any ligature risks and the modern matron and directors informed of their findings. They also explained that staff were reminded of the risks at each handover. However, we saw the main corridors continued to have suspended ceiling lights, sash windows, and other areas of concern. The staff told us they managed these risks by assessing whether patients were at risk of self-harm and then increasing observation levels for patients who were assessed at risk. The ward was due to move to a newly refurbished location at Cherry Tree House in the Tang Hall area of York. The ward manager told us they hoped this would be around February 2015.

We found the ward was clean and well maintained. The ward had two cleaners who completed cleaning schedules and this had improved the cleanliness of the ward. In addition, the modern matron completed a monthly tour of the ward to monitor the control of infections and diseases. Information provided by the trust showed 12 out of 26 staff had completed their infection control training.

We found patients' bedrooms were not segregated. Male and female patients had to pass each other's rooms to access the toilet, bathroom and shower areas. We found male and female toilets were clearly signposted. However, male and female patients shared access to shower and bathing areas. This compromised patients' privacy and dignity. This meant the ward was not complaint with the Single Sex Accommodation (SSA) Department of Health guidance or the application of the MHA Code of Practice (Chapter 16.9).

Safe staffing

The manager told us they regularly reported insufficient nursing and healthcare assistants as an incident using the trust reporting system and the ward risk register. They said the staff establishment had recently increased to two qualified nursing staff during the day, but this did not always happen. We reviewed the staffing numbers for September and found the ward regularly used bank or agency staff.

Information provided by the trust prior to the inspection showed from 1 March 2014 to 31 May 2014 agency staff had been used on 293 occasions and on 43 occasions, they had been unable to cover the shift.

Staff and a patient told us sickness absence rates were high and this had impacted negatively on both patients' experience and staff morale. Bank and agency staff mostly covered the absences but occasionally it was not possible to cover them. The impact on patients was inconsistent care, because the agency staff did not know the patients or the care and treatment they needed. This was confirmed when we saw a patient ask a member of agency staff for assistance to the toilet and they were unable to locate the toilets. In addition, when we talked with the member of agency staff they were unaware of the patients care and treatment needs. The staff said they regularly cancelled activities on the ward and escorted leave into the community due to staff shortages.

Agency staff completed a full induction to the ward. However, the agency staff we talked to on the day said they had an introduction to the ward, but did not complete the checklist. From this we could conclude that it was not possible to evidence these staff had received the required induction.

A group of 13 health care assistants, who worked across all the older people's wards in York and Selby, told us there were low staffing levels across all wards, and that patients leave was often cancelled. On ward 6, no activities were carried out and qualified staff were paid to work through their breaks at night.

Information provided by the trust following our inspection stated there was a locum consultant psychiatrist for three days a week, two full time core psychiatry trainees, GP trainee or F2 doctors and one full time doctor . From 24 November 2014, the consultant post would become substantive. However, one patient told us they had seven different consultants in eleven months and they believed this had slowed down their discharge process. The ward manager told us there had been five locum consultants.

The staff said there was limited access to the occupational therapy and psychology resources.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

The ward manager and staff told us did not use restraint regularly, and they did not use restraint to the floor. They did not have a seclusion room. All staff talked about working to the least restrictive practice with patients. They provided examples such as de-escalation, "talk down" and removing any stimulation. Information provided by the trust showed 17 out of 24 staff had competed the prevention and management of violence and aggression training (PMVA).

The records demonstrated staff assessed patients to establish potential risks on admission and the ward used the safety assessment and management plan (SAMP). Staff reviewed the SAMP monthly at the ward round, regarding levels of risk to the patient. Where there were identified risks, risk assessments were in place to minimise the risks. We saw there were additional risk assessments in place for example for falls and nutrition. The physiotherapist confirmed they carried out a falls assessment as part of the admission process. The doctors and nursing staff then decided upon the level of observations using the patients assessed risk levels. One member of staff commented how robustly these were adhered to would be dependent upon the number of staff on duty. We looked at a sample of four risk assessments and found one did not have management plans in place for all the areas of risks identified.

We found policies were in place to instruct staff about the safe handling of medicines. We checked a sample of medication recording sheets and found them to be correct. We saw medication was stored in a locked cabinet in the patients' bedroom to enable the patients to self-administer.

We saw information about safeguarding was available to staff and patients on the wards. The ward manager told us they would make the alert and liaise with the local authority. Seven staff told us they knew how to respond appropriately to any allegations of abuse. Information provided by the trust showed 20 out of 31 staff had completed the annual safeguarding vulnerable adults training. Staff we spoke with were aware of how to refer safeguarding concerns and obtain safeguarding advice if needed.

However, staff were concerned that Band 5 nurses were asked to hold the 'key set', and were not provided with the appropriate training for this role. The role included arrangements of staff cover, fire drills, and dealing with emergencies.

Reporting incidents and learning from when things go wrong

We saw there were systems in place to capture and review patients' individual incidents and accidents that enabled staff to identify potential risks to the patient or themselves. The ward manager assessed the forms regarding severity and dependent upon the severity informed the modern matron and the health and risk manager. We reviewed a sample of incident reports that confirmed staff followed the system.

We were provided with a copy of York's and North Yorkshire statistical breakdown of incident April – June 2014 which provided the manager with an overview of the incidents on the ward. This information showed there had been 92 incidents on ward 6. Five had been classified as violence, 15 as falls, 33 as clinical incidents and nine as security. Two members of staff told us that following an incident staff were offered time and support to de-brief and review any lesson learnt and information from this was shared at staff handovers.

The Mount – Wards 1, 2, 3, 4

Safe and clean ward environment

We visited four wards and observed all the wards were clean with personal protective equipment and hand wash available for staff to use. Documents we saw confirmed that monitoring of infection control was in place to make sure the wards were clean and to prevent the spread of infections. We saw infection control audits displayed on the notice boards in the wards to show the adherence to hand hygiene. Information provided by the trust showed 92 out of 115 clinical staff had completed their infection control training in 2013 to 2014. This was highlighted as amber on the risk register with actions to target staff who had not completed the training.

The four ward managers told us they were confident that environmental risks were managed and actions taken to minimise any risks. They showed us the environmental inspection and ligature risk assessment documentation. These highlighted any specific ligature risks and the actions for ward staff to take. The managers told us where patients were assessed and considered a risk, extra precautions

Requires improvement

Are services safe?

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

were put in place such as, increased observation levels. The modern matron reviewed these and there was a process in place to ensure these were raised up to the operational managers and directors of nursing. They provided us an example of how a possible ligature points had been identified on ward 3 and this had been shared with the whole trust.

We saw that staff checked the clinical rooms regularly. They were clean and tidy and equipped with appropriate resuscitation equipment and emergency drugs.

Safe staffing

We spoke with the ward matron, four ward managers, nursing staff and health care support workers. They told us there were enough nursing and health care assistants to meet patients' needs during the day. In addition, staffing numbers were reviewed daily and increased if needed. They told us recruitment was taking place and either staff worked overtime or they used staff from the hospital bank to cover any vacancies. Patients told us the staff were very busy but were mostly available when they needed them.

The complement of medical staff for each ward was a half time consultant psychiatrist, and a junior doctor. Four doctors were available from 5 pm and two remained on call overnight. The doctors were not based at the Mount and covered three other sites. One doctor told us the cover arrangements were robust. A consultant geriatrician provided advice on any physical treatments. Staff told us there was a GP in-reach service that visited the wards once a week. There were two psychologists and two occupational therapists that were supported by three therapy assistants.

The Mount did not have a speech and language therapist, however the modern matron told us this was resourced from a private provider if required.

Assessing and managing risk to patients and staff

The modern matron told us the staff received bespoke training in restraint and between 90% and 100% of staff across the wards had completed the training. Staff told us about their training and described working to the least restrictive practice with patients and most of the wards confirmed a low use of restraint as a result. They reported when restraint was used this was in order to prevent patients harming themselves or when treatment was being provided. One patient told us their restraint had been "Resolved well". On one ward, we observed staff providing appropriate support when a patient became distressed to prevent them from harming themselves. Information provided by the trust confirmed from 1 May to 31 July 2014, where restraint had been used 25 times at the Mount, none of these were in the face down position (prone).

We found policies were in place to instruct staff about the safe handling of medicines. We checked a sample of medication recording sheets on two wards and found them to be correct. Staff on ward 4 told us three patients were self-medicating to encourage independence. However, on three of the wards we found that the checks on the temperatures of the medication fridges were not carried out regularly.

The records demonstrated staff assessed patients to establish potential risks. Where risks were identified, risk assessments were in place to prevent harm. The risk assessments were reviewed by the multi- disciplinary team regularly. The levels of observations were determined by the doctors and nursing staff and were dependent upon the patients' assessed risk. The levels followed the National Institute of Health and Care Excellence (NICE) guidance and staff said they reviewed them daily. We looked at a sample of observation records on ward 4 and saw staff had completed them as per trust policy.

We saw information about safeguarding was available to staff and patients on the wards. Staff told us they had completed training in safeguarding for vulnerable adults and knew how to raise concerns. We found two examples where safeguarding allegations had been raised and these had been investigated and acted upon by the trust. From information provided by the trust, we saw from training figures that 102 out of 115 staff had completed the protection of vulnerable adults training.

Reporting incidents and learning from when things go wrong

There were systems in place to capture and review information about incidents and accidents, which enabled staff to identify potential risks to them. Staff completed incident report forms. These were reviewed by the ward managers and sent to the modern matron and the risk management team. The ward matron told us the trust was going through a procurement process for DATIX. They said this information system would meet the requirements to provide in depth information about individual patients and ward groups and would provide a more functional analysis for staff of the ward incidents.

Requires improvement

Are services safe?

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

Staff told us about examples of incidents where learning had taken place and actions had been taken both on the ward and throughout the trust. Where a serious incident had occurred, staff described having been provided with support and a forum for discussion.

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.

Summary of findings

Although we found the Mount was effective, and people's care and treatment and support achieved good outcomes and promoted a good quality of life based on the best available evidence because of our findings at the York Services we have found this domain to be inadequate

At the Mount, we found staff assessed patient needs and planned for their care and treatment. The multi-disciplinary team were effective.

.At the York services found the services were inconsistencies at Peppermill Court, and Worsley Court regarding the assessment of patient needs and planning of patients' care and the effectiveness of the multi-disciplinary team. Where insufficient medical staff, occupation therapists and psychologists may have meant that patients' may not have received pro-active and consistent medical input, which could have resulted in their care and treatment needs' being overlooked or not been met.

The wards at the Mount followed best practice guidelines and were proactive in ensuring patients received good outcomes and experiences. At Peppermill Court and Worsley Court, we found staff had not always followed good practice guidelines when deciding upon patients care. Also, the wards did not have a system in place to ensure patients had the necessary annual physical healthcare screenings.

We found inconsistencies across wards regarding the completion of mandatory and role specific training. However, staff had escalated this onto the trust's risk register and there was an action plan in place to address staff training.

Overall, the wards had adhered to the Mental Health Act 1983.

In regards to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).. At the York services, although we found staff had referred appropriate patients' for a Deprivation of Liberty Safeguard (DoLS) assessment. We saw in some the cases, assessment of the patient's capacity had not been carried out prior to their referral and at Worsley Court, referrals for DoLS assessments had not occurred prior to the recent changes in management.

Our findings

Peppermill Court Community Unit for the Elderly

Assessment of needs and planning of care

The ward accommodated men with dementia and complex behavioural needs. At the inspection, we found one patient had moved on to the ward from another ward. We observed the patient had been on the ward for approximately 48 hours and staff had not reviewed the risk assessment or observation levels since admission.

The clinical lead told us that the ward had recently introduced new care plans and staff were in the process of implementing these. Patients had an initial safety assessment and management plan (SAMP) that highlighted any risks to the patients. We saw further risk assessments had been carried out for the risk of falls, nutrition and skin integrity. However, when the staff reviewed the SAMP they had not included information regarding the most recent incidents of risk. We found in some cases where risks had been identified care management plans were not in place to instruct staff how to manage the risks. For example, on our first visit patients who had a diagnosis of epilepsy and diabetes did not have care plans. We noted following informing the clinical lead, these were in place by our second visit. Also for a patient referred to the dietician for assessment, there was no evidence of evaluation of the treatment or the nutritional screening tool used to monitor improvements.

We found patients' fluid intake and nutrition was not being adequately monitored. For example,

three patients on the ward were on fluid and nutrition monitoring charts but one of the charts had not been completed for a patient who had recently lost weight. For this patient, the amounts of fluids was unmeasured preventing collation at the end of the day to ensure adequate fluid intake.

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.

We found that patients had access to prompt physical care when needed. However, we found there was no system in place to ensure patients had the necessary annual physical healthcare screenings.

The records confirmed the pharmacist requested blood tests to make sure the medicines were safe for the patient.

Information provided by the trust following the inspection demonstrated, 'Inconsistency of quality across the wards' was raised as a concern in the 'Quality improvement plan for the Community Unit Elderly Services (CUES). This involved documentation, therapeutic interventions, pathway issues, training and development and helping staff to understand their individual accountability to ensure that care was safe and effective. Actions to promote improvements included a review of the documentation and funding for a six-month secondment for a development nurse to focus on documentation and interventions, and the prioritising of training for dementia care mapping. The actions had a completion date of the 14 November. Our inspection demonstrated the changes had not sufficiently improved patient care at Peppermill Court.

Best practice in treatment and care

The ward matron explained there was an ongoing review of all of the York older age services. This included the development of a dementia care pathway agreed by the medical staff and managers but they said this was not ready for implementation. We asked the clinical lead for any evidence of best practice in treatment and care, such as analysis of individual's behaviour or dementia care mapping. They were unable to provide us with any current examples on the ward.

We observed staff walking about without clear purpose, and not actively interacting with patients, unless they made a specific request. In patient records, we found assessments for activities but these had no evidence of staff assessing the benefit of the activities.

The GP contract had terminated eight weeks prior to our inspection but it was unclear of how this was to be resolved by the medical staff.

The psychologist, told us they would try to respond to any referrals within six weeks. However when we looked in a sample of care records and talked to staff we could not find referrals to or involvement of the psychologist in patient care

Skilled staff to deliver care

The ward did not have occupational therapy or psychology input for patients.

The information provided by the trust regarding mandatory training, demonstrated levels of compliance were low in some areas. For example, the trust had a target of 90% for staff to achieve compulsory training by April 2015 from the current target rate of 85%. We saw essential life support (ELS) and intermediate life support (ILS) that 17 of 31 staff had completed training, and three out of 11 nurses had completed clinical risk training. Also 20 out of 31 had completed the health and safety training. These were below the trust target rates. We saw information from the trust that they had recognised the need for improvements to the clinical risk training and planned to roll this out to staff in late 2014.

We asked about role specific training and found staff had not completed training in regards to physical health such as dementia awareness, dementia care mapping, epilepsy or diabetes.

Prior to the inspection, we were provided with information regarding staff appraisal in the 12 months prior from September 2013 to September 2014. Peppermill Court had failed to achieve the staff appraisal target for the full period recorded. Their lowest was in January 2014 at 23 %, their highest was 57% in July 2014. For September 2014, they scored 44%.

The ward manager and clinical lead told us that group clinical supervision occurred twice a month and the staff were supervised by their line manager regularly, but often this was not recorded. We looked at the minutes for the clinical supervision meetings and saw that between 11 March 2014 and September 2014 there had been four meetings recorded. In addition, we found there was no system in place to monitor whether qualified staff had received regular supervision.

Multi-disciplinary and inter-agency team work

A multi-disciplinary team meeting (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patients' needs and the condition or disease being treated.

The modern matron had raised concerns on the 8 September 2014 through the York and North Yorkshire care

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.

group regarding the lack of multi-disciplinary resources across the dementia inpatient areas including Peppermill Court. There was no occupational therapy or psychology input and limited access to physiotherapy.

The ward manager told us the ward had a MDT meeting once a week for two to three hours where the team reviewed the care and treatment of six or seven patients. Patients did not always take part, so the consultant psychiatrist would make contact with the patients following the ward round. Staff who attended included the consultant psychiatrist, a nurse, a health care assistant and, occasionally the physiotherapist and the pharmacist. Staff provided information about the patients' progress via a summary sheet that was then used by the consultant psychiatrist to make decisions about patients' ongoing treatment. We looked at a sample of the summary sheets and the patients' records. We found that incidents of patient ill health had not been recorded on some sheets. For example, one patient had been seen by a GP for vomiting during the week but there was no record in the nursing or doctor's notes that this had been considered at the ward round. Nursing staff could not demonstrate how they were robustly monitoring and reviewing incidents of challenging behaviour to inform the ward round. The ward manager told us the ward rounds did not always happen due to sickness, but was unable to be specific about how often this happened. There was no evidence that social services and continuing care had been invited to MDT meetings.

Staff said every six to 12 months, patients would have a Care Programme Approach meeting (CPA). The CPA meeting assessed and planned care to meet patients' needs and included staff from both health and social care services. On our second visit to the ward, staff said these were now being carried out every three months.

Adherence to the MHA and the MCA Code of Practice

We looked at seven records of patients detained under the Mental Health Act 1983. We saw all the patients' documents were in order, detention was lawful and all the patients nearest relatives have been consulted during the assessment procedure. Patients had been made aware of their rights under the MHA 1983 and section 17 leave forms had been completed. We looked at the patients' medication charts. We found one chart where the consultant had sought a second opinion approved doctor (SOAD) to agree that the medication prescribed was in the patient's best interests. The form which recorded the agreement was not kept with the medication chart and because of this, the on call doctor had prescribed a drug which had not been agreed by the SOAD, as in the patient's best interests.

We found three patients had been referred for a Deprivation of Liberty Safeguard (DoLS) assessment by the local authority. A DoLS is a framework for approving the deprivation of liberty for patients who lack the capacity to consent to treatment or care, in a hospital, to make sure it is in their best interests. We saw in all the cases, assessment of the patient's capacity had not been carried out.

Meadowfields Community Unit

Assessment of needs and planning of care

Staff assessed patients' needs on admission. Where staff had identified a risk to a patient there was a risk assessment and management plan in place to reduce or manage the risk. If needed, patients had been referred to the appropriate health professionals. Staff wrote patient records in the first person to demonstrate the involvement of the patient.

We were told by the clinical lead that the ward had recently introduced a new format for the care plans and staff were in the process of implementing these. We found two gaps in the care documentation, which the clinical lead responded to immediately. We saw that patients had an initial Safety Assessment and Management Plan (SAMP) completed to highlight possible risks to them. Further assessments were carried out for risk of falls, nutrition and skin integrity. The review of the SAMP did not include information regarding the most recent incidents or risk.

There was evidence that physical health examinations were carried out on admission and ongoing physical care was provided where necessary. We saw patient had interventions by a physiotherapist where needed.

Best practice in treatment and care

The ward matron explained there was currently an ongoing review of all of the York older age services and this included the development of a dementia care pathway. They had been agreed by the medical staff and managers but had not been implemented yet. We asked the clinical lead for

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.

any evidence of best practice in treatment and care such as dementia care mapping. We found there was references to National Institute for Health and Care Excellence guidance (NICE).

The ward manager told us that the psychology input to the ward was one and a half hour, once a month, this was used to provide clinical supervision for staff.

Staff said there was no occupational therapist input on the ward. There was a programme of activities for patients to take part in, but this was dependent upon the number of staff on the ward. During both our visits, we saw staff sat in the lounge talking with patients. One member of staff and a relative told us there were activities throughout the week and volunteers would often help.

Staff told us there was an agreed contract with a GP who visited the ward weekly and reviewed the physical needs of patients. The care records demonstrated staff assessed patients' physical needs.

Skilled staff to deliver care

The ward did not have occupational therapists. Staff told us they felt patients would benefit from the input of an occupational therapist. The ward did not have dedicated psychology input for individual patients. We talked with the psychologist, who told us that they aimed to respond to any referrals within six weeks.

The information provided by the trust showed us that 30 out of 36 staff had completed all their mandatory training, with the exceptions of essential life support training where 9 out of 23 staff had completed training, and clinical risk training where 3 out of 13 nurses had completed training. We saw from the information from the trust that they had recognised the need for improvements to the clinical risk training and had made plans to roll this out to staff in autumn 2014.

We asked the ward manager about role specific training. They told us three members of staff had completed skin integrity and epilepsy training. One had completed dementia care to level six, and dementia care mapping. Two had completed a course in palliative care. Staff said one of the difficulties for the staff, was that training sessions were in Leeds and travelling sometimes proved difficult for them.

The annual appraisal information provided by the trust showed us that 75% of staff had completed their annual appraisals in September, which is below the trusts' own target of 90%. Staff were offered the opportunity of monthly clinical supervision with the clinical psychologist and supervision with their line manager, we were told by nursing staff they felt supported by the manager.

Multi-disciplinary and team involvement

A multi-disciplinary team meeting (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the person's needs and the condition or disease treated.

The ward manager told us patients' care and treatments was discussed at MDT meetings once every three weeks or more often if needed. The consultant visited the ward once a week for three or four hours, when they carried out the ward round.

Adherence to the MHA and MCA Codes of Practice

We looked at approximately 16 patient records, six of whom were detained under the Mental Health Act 1983. We saw all patients' documents were in lawful order and all the patients' nearest relatives consulted during the assessment procedure. Patients were aware of their rights under the MHA 1983 and section 17 leave forms were completed. We found that the outcome of leave periods was not recorded so it was not possible to determine if this had been a positive or negative experience for the patient.

Staff and the Independent Mental Health Advocate (IMHA) told us there was a system in place to ensure that patients who were detained under the MHA 1983 were visited by the IMHA. We confirmed this in the records we reviewed.

For one patient we saw there was easy read mental health information.

We found there were four patients who were subject to a deprivation of liberty safeguard, (DoLS) and six patients had been referred for a DoLS assessment by the local authority. A DoLS is a framework for approving the deprivation of liberty for patients who lack the capacity to consent to treatment or care, in a hospital, to make sure it is in their best interests. We looked at all of the patients' documentation and found one instance where the documentation was incorrect. The trust informed us they were planning to roll out MCA training from the 10 November 2014 and a trust wide communication was sent out in early October informing staff of the change.

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.

Worsley Court Community Unit for the Elderly

Assessment of needs and planning of care

The modern matron and ward manager had commenced reviewing all of the care documentation to establish whether there was sufficient information in the care documents to ensure they met patient needs. We saw that the new documentation was in place but not embedded and there continued to be gaps in the risk assessments and the care plans. For example, a patient who had regular falls did not have a falls diary. For one patient where risks had been identified, care management plans were not in place. There were also inconsistencies in the daily recording of patients' food and fluid intakes. The action plan provided to CQC following the inspection confirmed that the trust had recognised that the quality of the care plans required improving. The action was for there to be oversight of the quality of care delivered with support provided to the nursing team by a consultant practitioner in dementia care to be completed by 10 October 2014.

The modern matron and ward manager told us that there was a registered general nurse on duty each day to attend to the patients' physical needs.

Following our visit, Worsley Court closed on the 15 October 2014.

Best practice in treatment and care

We saw activities taking place in the lounge and a patient told us staff took them shopping regularly.

At our inspection, the consultant dementia practitioner from the Leeds area told us this was their second visit to the ward and they had commenced an assessment of the environment, the activities, staff skills and training and review the quality of the care plans.

We saw in two action plans provided to us following the inspection there were plans in place to improve the quality of the treatment and care for patients.

Skilled staff to deliver care

The modern matron told us staff had not completed the necessary mandatory training. This was confirmed by information provided by the trust, which stated that no staff had completed essential life support training or intermediate life support training. There was also no evidence of staff competing any role specific training, such as epilepsy or diabetes or skin integrity.

There was no evidence staff had formal supervision with their line managers and only four out of 25 staff had completed their annual appraisal.

Multidisciplinary and inter-agency team work

We observed a nurse handover, which consisted of a brief update of the presentation of patient's physical health and diet. There was no information shared about the patient's mental health or capacity.

We were told that most of the patients' discharges had been delayed. This demonstrated that there had been a lack of inter-agency team working and referrals to a care coordinator.

Adherence to the MHA and the MHA Code of Practice

The modern matron and ward manager told us that they had identified deprivation of liberty assessments (DoLS), should have been carried out for most of the patients. They explained they planned to complete these by the end of the week and they were aware some were urgent. A DoLS is a framework for approving the deprivation of liberty for patients who lack the capacity to consent to treatment or care, in a hospital, to make sure it is in their best interests.

Bootham Park Hospital ward 6

Assessment of needs and planning of care

The ward accommodated men and women for the assessment and treatment of mental health problems. We looked at four patients care records and found the risk assessments were in place for all of the patients. However, some management plans were not in place for all of the risks identified. For example, where a risk assessment on admission had identified a high risk of falls and where the patient had a wound there were no care plans in place to instruct staff how to manage these. Also one patient had a fracture but there was no body map completed to monitor any further issues.

On admission the patient's physical health was reviewed by the doctor and this included appropriate blood tests and a physical examination. There was ongoing monitoring. We also saw the physiotherapist carried out a risk assessment to assess patient's risk of falling. At the time of our visit there was a general practitioner trainee allocated to the ward.

Are services effective?

Requires Improvement

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

Best practice in treatment and care

We asked the staff what best practice they followed. Nursing staff were aware of the National Institute of Health and Care Excellence guidance (NICE) and the occupational therapist told us they benchmarked the service provided against other wards in the trust.

Staff said there were limited occupational therapy resources (OT) and that the OTs mainly delivered individual assessments. A member of the nursing staff was allocated to carry out activities on the ward but due to a shortage of staff, these had not been occurring.

The physiotherapist told us they covered all three wards at Bootham Park hospital. On ward 6 they carried out a full muscular skeletal and falls assessment, and ran a relaxation group twice a month and a chair based keep fit group twice a week.

There was access to a speech and language therapist if required. The psychologist attended MDT meetings. They told us they aimed to assess patients within six weeks of referral.

In the four records we looked at, we saw evidence of physical care and treatment being offered to patients.

Skilled staff to deliver care

The information provided by the trust and from the ward regarding mandatory training, demonstrated levels of compliance were low in some areas. For example, for safe and essential handling, 19 out of 30 staff had completed training, and no nurses had completed clinical risk training. Also 19 out of 30 had completed the health and safety training. Staff told us they had difficulty in been released from ward duties to attend training. We saw from the information provided by the trust that they had recognised the need for improvements to the clinical risk training and had made plans to roll this out to staff in autumn 2014.

Following our inspection we asked the trust to send the CQC information about role specific training such as dementia awareness, at the time of writing this we have not received this information.

Prior to the inspection, the trust provided information regarding staff appraisals in the 12 months from September 2013 to September 2014. This demonstrated the ward had failed to reach their appraisal targets with the lowest scores being 14% however; they had achieved over 70% in September and have maintained this. The ward manager told us that all staff except one who was on sickness absence leave had completed their annual appraisals.

Staff said supervision for nursing and health care assistants was carried out monthly.

Multi- disciplinary and inter-agency Working

A multi-disciplinary team meeting (MDT) consists of a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the person's needs and the condition or disease being treated.

We were told patients' care and treatment was discussed in the ward round, and patients' were seen by a consultant psychiatrist each week following the ward round. The staff who attended the ward rounds varied and consisted of nurses, physiotherapist, psychologist and a pharmacist. The ward tried to make contact with the crisis teams to facilitate discharge and described having good links with the local authority social services.

The occupational therapist told us they occasionally attended the daily nurse meetings where staff discussed patients' needs.

Adherence to the MHA and MCA Codes of Practice

A Mental Health Act reviewer visited the ward as part of this inspection they reviewed the detention documentation for the three detained patients and found it to be in order. One of the Approved Mental Health Practitioner (AMHP) reports supporting the application for detention was not in the file, but the ward manager advised that they sometimes arrive on the ward later.

We saw that patients were explained their rights on admission to the ward and then subsequently at regular intervals. Patients were informed of their right to an IMHA, and this was evidenced both in the patient's file and by patients themselves in our discussions. One patient told us they appealed against being detained and had received the support of the Independent Mental Health Advocate (IMCA) and a solicitor.

The three detained patients were treated under the three-month-rule at the time of our visit. We did see, however, in one patient's file that the doctor and nurses had completed medication documents incorrectly.

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.

We could not find the doctors' documented assessment of capacity to consent at the time of admission in any of the three detained patient's files. We found one brief note by the doctor of a patient's capacity to consent made several weeks after admission to the ward.

We looked at two patient's records who were referred for a Deprivation of Liberty Safeguard, (DoLS) assessment by the local authority. A DoLS is a framework for approving the deprivation of liberty for patients who lack the capacity to consent to treatment or care, in a hospital, to make sure it is in their best interests.

The Mount - Wards 1,2,3,4.

Assessment of needs and planning of care

We talked with 21 staff and found they were knowledgeable about patients' care and treatment needs. We reviewed 14 care records and saw the multi-disciplinary team reviewed care and treatment. Care plans were in place to meet patient's needs. Where staff had identified risks to a patient, there were risk assessments and management plans in place to help minimise those risks to the patient.

Staff referred patients to the appropriate health professionals. There was evidence that physical health examinations were carried out on admission and ongoing physical care provided where necessary. Three doctors told us that on admission they always carried out a physical examination, which included blood, heart tests and neuropsychological testing.

Within multi-disciplinary team meeting minutes, we saw patients discharge was being planned for. We saw evidence in the records and most patients told us they were involved in some way with their care and treatment and plans for discharge.

The trust's quality dashboard for August and 2014/2015 showed the wards had achieved from 88 to 100% for nutritional screening for patients assessed within 72 hours of admission.

Best practice in treatment and care

We talked with three doctors who told us they followed National Institute of Health and Care Excellence guidance (NICE) guidance when prescribing medications. We looked at six medication records on ward one and found that very low doses of antipsychotic medication had been prescribed which was in line with NICE guidance. Four ward managers and five nurses all told us they followed NICE guidance and were able to give us examples to demonstrate this.

On wards 1 and 2 the dementia care-mapping tool had been used to look at group behaviours on the ward and for individual patients to inform their care and treatment plans. 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. We saw the staff gave patient's relative a copy of an information leaflet to explain the process.

The Mount had two psychologists and there was evidence of their involvement in patients' care. The psychologist led formulation meetings every week where all the staff were involved in focusing on patients who had the most complex needs. The meeting mapped out the patient's core values and motivations to find ways of successful and meaningful interactions with the patient to aid their recovery.

Nursing staff told us a consultant geriatrician visited the hospital weekly to provide specialist support. We saw evidence in the records of involvement of associated health care professionals such as the physiotherapist, speech and language therapist and the dieticians. The wards had Band 4, health care associate practitioners who had skills regarding nutrition, diabetes and carrying out blood and heart tests.

The staff provided information about a work stream project that had looked at patient safety at night and how to promote and improve sleep on the ward in addition to a proposal to develop a nurse led sleep clinic to improve and bring the service in line with NICE guidelines.

An occupational therapist team provided group and individual therapy and home assessments. We saw ward activities displayed on the notice boards. Five patients told us they took part in meaningful activities and provided examples such as cooking or gardening. One patient told us there was not much to do. A patient survey on wards 3 and 4 asked patients how they rated the availability of activities. These showed in August that 50% thought they were good.

Skilled staff to deliver care

The records on the wards demonstrated the nursing and support staff had completed between 80 to 100% of

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.

compulsory training, such as first aid, mobility assistance and prevention and management of violence and aggression training tailored to the needs of older patients. The nursing staff confirmed training was provided to enable them to carry out their work safely.

Role specific training was available. Approximately 50% of staff on wards 1 and 2 had completed dementia competencies. Staff on ward 4 had dementia awareness training and following an incident on the ward they had received diabetes training. On wards, 1 and 2 some staff had completed dementia-mapping training and the modern matron told us they planned for more staff to complete this training.

The associated mental health care professionals also confirmed they had access to mandatory and role specific training. The doctors confirmed they had completed mandatory training and had received supervision and appraisals. The information provided by the trust prior to the inspection confirmed this.

The records on the wards confirmed nursing and support staff had regular supervision and support and annual appraisals. Staff we spoke with confirmed this.

Multi-disciplinary and inter-agency team work

A Multi-Disciplinary Team meeting (MDT) consists of a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patients' needs and the condition or disease treated.

Staff said the MDT included the medical and nursing staff, the occupational therapist, the psychologist, the intensive community team, advocacy and Age UK. Their attendance would depend upon their involvement with the patient.

Staff on wards 3 and 4 told us MDTs happened daily and there was a traffic light system in operation, so patients who were at most risk were seen promptly. Patients told us that they could attend and listen. On wards 1 and 2, we were told there were weekly meetings were relatives and patients were invited to attend. One doctor told us the MDT approach was healthy and mutually respectful. The health care assistants told us they did not attend the meetings but could write their views down which were included in the review.

The Care Programme Approach (CPA) requires that health and social care services jointly assess the needs of patients and provide a written care plan with details of how their needs will be met. This is overseen by an allocated care coordinator and regularly reviewed in keeping with the National Health Service and Community Care Act 1990. The trust quality dashboard showed that wards 1, 3 and 4 had achieved 100% for carrying out CPA and a review within 12 months; however, ward 2 had completed 67%.

Staff described good links with the community teams and between all allied healthcare professionals.

Adherence to the MHA and MHA Code of Practice

We looked at 10 patient records and saw the Mental Health Act (MHA) 1983 Code of Practice was mostly adhered to. Patients had access to an Independent Mental Health Advocate (IMHA) and Mental Health Act tribunals to request their detention ceased. We saw there was a system in place, which identified when patients MHA sections needed reviewing and when patients' rights under the MHA should be revisited with the patient.

We found on instance in a care record we examined where the patient's medication authorisation was incorrect. We informed staff who took prompt action to rectify the error and to authorise the medication. We also saw there was a lack of an Approved Mental Health Practitioner's (AMHP) reports on some patient care records and there were delays in accessing IMHAs. Also on both wards 1 and 3, the consultant had not written a record of their discussions with the second opinion doctors in the patient notes.

Records sampled showed that capacity to consent to their treatment was considered for all patients on the wards with the exception of ward 2, where there was a lack of recording of the mental capacity and best interest's assessments in relation to physical health treatment of patients under the Mental Capacity Act.

Good

Are services caring?

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

Summary of findings

We held a series of focus groups and listening events prior to and during the inspection to gain feedback from patients and carer. During the inspection, we spoke with 29 patients, seven relatives and reviewed comment cards from both patients and relatives. We attended a handover, MDT and a formulation meeting.

Most of the feedback we received was positive. Patients and relatives reported they were satisfied with the service and that staff treated them with respect and dignity.

We found inconsistencies on the wards regarding how staff involved patients in their care. At the Mount they were very involved but at Worsley Court and Peppermill Court there was little evidence of involvement or engagement.

From our observations, we saw staff were mostly attentive to patient needs and responded promptly when patients requested support.

Our findings

Peppermill Court Community Unit for the Elderly

Kindness, dignity, respect and support

We talked with nine patients and two relatives. Some of our conversations were very short but all were complimentary. For example, one patient told us "I have plenty to eat and they are nice people." Another patient who was unable to communicate verbally nodded enthusiastically when we asked if the breakfast was good. One told us the staff were, "great, they look after me." One told us "they had been there for years but it was alright."

We observed that staff supported and respected patients, but staff often only interacted with patients when patients asked for support or when they required help with personal care.

The involvement of people in the care they receive

A relative told us staff welcomed them and the patient when they arrived on the ward. They had been involved in planning the care from admission. Staff always treated their relative with dignity and respect. The staff provided their relative with the "room to be himself or herself."

Staff told us patients and their relatives were not always included in the ward rounds but relatives were invited to the CPA meetings.

There was information from the patient advice and liaison service (PALS) which asked for comments from patients and relatives. However, the ward manager explained that many of the patients were unable to make verbal or written comments.

We saw information was available about the advocacy services and the ward manager told us that patients had used the advocacy services.

Following our first visit we were provided with information from the trust 'Quality improvement plan for the Community unit elderly services (CUES, this includes Peppermill Court) which had been updated on the 3 September 2014. This demonstrated the trust had identified the need for further engagement with patients and relatives.

Meadowfields Community Unit

Kindness, dignity, respect and support

We had positive responses from the patients. Relatives confirmed that staff treated patients with kindness, dignity and respect. They said staff responded to patient needs and were prompt to offer support.

We observed staff were attentive. They listened and talked with patients and were kind and respectful. They provided patients with choices. We found the atmosphere on the ward was relaxed with friendly interactions between patients and staff. We saw some patient's bedrooms were personalised.

The involvement of patients in the care they receive

We saw the care records were written in the first person for example "I would like" and this helped to ensure patients were involved in the planning of their care.

Good

Are services caring?

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

The wards noticeboards displayed information about advocacy services and community support groups for relatives.

The ward manager told us they did not have relative's meetings but had a suggestion box where relatives and patients could provide feedback. They also received feedback from patients relatives informally. We observed relatives made welcome by staff when they visited patients on the ward.

Worsley Court Community Unit for the Elderly

Kindness, dignity, respect and support

Patients told us the staff were kind and treated them with respect and dignity. We observed a lunchtime meal and activities in the lounge area and saw good interactions between staff and patients. Patients smiled at the staff. The activity session we observed was for over an hour and the health care assistant ensured everyone was included.

The involvement of people in the care they receive.

A relative told us they had felt fully informed about their relative's care and treatment. They told us they got answers that were truthful and the staff treated them and their relative with respect.

Staff told us if advocacy was needed, they would arrange this for patients.

Following our first visit, we were provided with information from the trusts, 'Quality improvement plan for the Community unit elderly services (CUES, this includes Worsley Court) which had been updated on the 3 September 2014. This identified the need for further engagement with patients and relatives.

Bootham Park Hospital Ward 6

Kindness, dignity, respect and support

We observed staff interactions with patients and we saw they were kind and respectful. However, one patient said, "Some are aggressive in manner and not polite." Another said that sometimes staff attitude on a night was not good. We also observed an incident where the response from a member of agency staff due to lack of knowledge of the environment did not support the patient.

The involvement of people in the care they receive

We were told there was a patient meeting called, 'Drink and a chat', and normally the main topic of conversation was the activities, but these had not happened recently due to permanent staff absences.

We saw there was information on the ward to inform patients about the advocacy and IMHA services.

One patient told us they were fully involved in their care and treatment and had taken part in their discharge planning. We also found information in some of the care records, which demonstrated patients' views had been taken into consideration when planning their care.

The Mount Wards 1,2,3,4.

Kindness, dignity, respect and support.

We talked with 14 patients who were all complimentary about the staff. They told us the staff were kind, caring and treated they with dignity. Comments patients made about staff included; "very good", "very helpful", "they go the extra mile", and that "they are compassionate." They told us all of the staff including the doctors knocked on their bedroom doors before entering and asked for their agreement before entering.

On the wards, we saw staff were kind and attentive when supporting patients. We observed that staff showed patience and gave encouragement when supporting patients. For example, we observed an incident where one patient wanted to leave the ward. We saw staff listened to the patient, and they were caring and respectful. We found the atmosphere in the wards was relaxed with friendly interaction between patient and staff. We saw some patient's bedrooms were personalised.

The involvement of patients in the care they receive

Staff told how they met and greeted patients on admission to orientate them to the ward. They said there was a monthly carers group and they had helped to develop the welcome pack for patients. Health care assistants told us how they always ensured the safety of patient's possessions and told them about the advocacy services.

Each ward had a notice board, which had pictures and roles of the members of staff, so patients and their relatives were aware of who their named worker was and who the team manager and ward manager were. We saw

Good

Are services caring?

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

information about activities, dementia care mapping, ward meal times, results from the inpatient survey, the number of complaints and compliments, and ward cleanliness audits, complaints and advocacy. Bedrooms had signage so patients were able to locate their rooms.

On wards 3 and 4, we saw there were community meetings where information about the ward was discussed and explained. For example; the MDT traffic light system, environmental issues, and mealtimes.

We saw from the records, staff asked patients if they wanted to attend the meetings and patients who talked to us confirmed they were involved in their care. For patients who were unable to talk with us, we saw in nine patients care record there was evidence they or their relatives were involved in their care and treatment plans. A member of staff on ward 4 also said if patient's relatives were unable to attend MDT meetings, they could make arrangements for them to telephone into the meeting.

Requires Improvement

Are services responsive to people's needs?

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

Summary of findings

Overall, there was an effective approach to the assessment and admission of patients onto the wards. Worsley Court that was closed to new admissions during inspection and on the 15 October closed for one month for staff training.

There was inequity between the Leeds and York services in regards to patient's discharge. At the Mount, patients discharge was planned for from admission and was only delayed due to a lack of suitable placements in the community. At the York services, there had sometimes been delays in patient's discharge due to insufficient medical staff, occupational therapists and psychologists and a lack of suitable placements locally.

Information provided by the trust following the inspection demonstrated the trust had recognised this and had taken action.

The trust ensured that patients' needs were met in terms of equality and diversity. Patients had access to interpreting and advocacy services on site if necessary.

Overall staff were able to explain the complaints procedure and were aware of the trust's procedures and policy if someone wanted to make a complaint.

Our findings

Peppermill Court Community Unit for the Elderly

Access discharge and bed management

The ward had 14 beds for the assessment and treatment of older people with dementia and complex behavioural needs. Staff said patients accessed the service by referral from community and crisis services. Staff did not report any issues with patients accessing the service. Some patients were transferred to Peppermill Court from other wards when they had become at risk or presented with increased complex needs. During our first visit, we saw one patient had been admitted as an emergency from another ward 48 hours before. At our second visit; a further four patients had been moved to the ward.

On admission, the doctor from Bootham Park hospital assessed patients on the ward for psychiatric and physical needs. We reviewed two patient records, which confirmed this. The ward manager told us there was no care and treatment pathway in place at the time of our visit but they had agreed and intended to implement the new dementia care pathway.

We found there was no active discharge planning by the ward and that some patients did not have identified care co-ordinator. We confirmed this by reviewing the records and talking with the modern matron and ward manager. In addition, they and the consultant psychiatrist said a further cause of the delay was the lack of involvement of social services and a lack of appropriate residential accommodation in York. The consultant psychiatrist informed us of the two discharges attempted over the preceding six months, both of which resulted in readmission within three months. In response to delayed discharges, the trust had employed a bed manager. Their role was to review patients and help move patients towards discharge though liaising with the local authority care managers.

The modern matron had raised a risk that there was a lack of multi-disciplinary resources across the dementia inpatient areas and this may have affected patients discharge from hospital.

The ward environment optimises recovery, comfort and dignity

The ward was very large and had 24 rooms but accommodated only 14 patients. The staff told us this was beneficial to patients because it enabled them space to move around without intruding on others. The ward had rooms where patients could meet with or telephone their relatives in private and an outside locked courtyard area that patients had access to when escorted by staff.

We saw there were activity rooms available but we did not see any activities taking place during our visits. We saw the ward did not have a phone booth but we were told that patients could use the ward telephone in private if requested. We observed and staff confirmed that snacks and drinks were available over 24 hours if requested by patients.

Ward policies and procedures minimise restrictions

Peppermill Court was a locked ward and informal patients were informed of their rights and how to access and egress the ward. The doors to the internal garden were locked and patients could only use the garden if escorted.

Requires Improvement

Are services responsive to people's needs?

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

Patients did not have keys to their bedrooms but were able to lock the rooms from the inside. When we visited, we observed the bedroom doors were unlocked and there were no restrictions about when patients could access their bedrooms.

Meeting the needs of all the people who use the service

We saw all of the information available on the ward was in English however; staff told us they had access to interpreters if required. Staff were sensitive in responding to and meeting the cultural needs of patients.

Listening and learning from concerns and complaints

The trust had a complaints procedure and guidance on this was summarised and advertised on the ward. Information about the Patient Advice and Liaison Service (PALS) was also available which supported patients to raise concerns. Some of the information was in easy read format. Staff said most concerns were resolved locally at ward level. If unresolved they would be escalated to the modern matron and would be investigated by a member of staff independent to the ward.

Other information provided by the trust prior to our inspection showed there had been three formal complaints at Peppermill Court in the twelve months prior to April 2014.

Meadowfields Community Unit

Access, discharge and bed management

The ward had 17 beds for older people with dementia and one bed for respite care. Patients accessed the service by referral from the crisis service. Staff did not report any issues with patients accessing the service.

We found where patients were assessed as ready for discharge into 24 hour care, their discharge had been delayed. Staff said this was due to "hold ups" by the local authority care managers, and relatives unable to find suitable placements. In response to delayed discharges, the trust had employed a bed manager. Their role was to review patients and help move patients towards discharge though liaising with the local authority care managers. On our second visit, we saw in the records that staff discussed discharge at the ward rounds and there were two patients that staff were preparing for discharge.

The modern matron had raised a risk that there was a lack of multi-disciplinary resources across the dementia inpatient areas and this may have affected patients discharge from hospital.

The ward environment optimises recovery, comfort and dignity

We saw this was a well-maintained environment with quiet lounges and spaces where activities could take place. There were rooms where patients could meet with or call their relatives in private. We saw some patients had personalised their bedrooms. All the patients had access to an outside courtyard.

We observed and were told by staff that snacks and drinks were available over 24 hours if requested.

Ward Policies and procedures

Meadowfields was a locked ward but we saw there was signage at the exits to inform informal patients about how to exit the building. We did not see any blanket restrictions on the ward and we saw in one patients care records they were enabled to hold their own cigarettes but staff held their lighter due to the potential risks.

Meeting the needs of all of the patients who use the service

The trust had provided access to interpreting services and advocacy if required.

Listening and learning from concerns and complaints

The trust had a complaints procedure and the guidance of which was summarised and advertised on the ward. There was information about the Patient Advice and Liaison Service (PALS), which supported patients to raise concerns. Staff said most concerns were resolved locally at ward level. If unresolved they would be escalated to the modern matron and would be investigated by a member of staff independent to the ward. The staff told us at ward level there were lessons learnt from complaints.

There had been three complaints in the twelve months prior to April 2014. The ward manager told us they had responded to the complaints.

Worsley Court Community Unit for the Elderly

Access, discharge and bed management

The modern matron told us there was a difficulty in finding placements for patients in the community and most of the eight patients at Worsley Court were suitable for discharge.

Requires Improvement

Are services responsive to people's needs?

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

They had a bed manager in place who was liaising with the local authority to find suitable placements and plan for patient's discharges. The modern matron informed us the ward had closed to admissions. On the 15 October 2014, the ward was closed for a month for staff training.

The ward environment optimises recovery, comfort and dignity

There was a courtyard space, but we saw the grounds were uneven and this could have presented a risk of patients falling. There was an activity room available but it was not in use at the time of our inspection. A patient told us drinks were available**.**

Ward policies and procedures minimise restrictions

A patient told us they could always have a, "smoke if they wanted one.

We saw personal photographs displayed in patient bedrooms.

One patient told us staff locked their room but this was to prevent others from entering.

Meeting the needs of all people who used the service

The Vicar visited once a month. Staff provided patients with adapted plates and cutlery at lunchtime. Information about training provided by the trust following our inspection demonstrated 16 out of 26 staff had completed equality and diversity training.

Listening to and learning from concerns and complaints

The trust had a complaints procedure the guidance of which was summarised and advertised on the ward. Information about the Patient Advice and Liaison service (PALS), which supported patients to raise concerns, was displayed. Staff said most concerns were resolved locally at ward level. If unresolved they would be escalated to the modern matron and would be investigated by a member of staff independent to the ward. The modern matron told us there was an on-going complaint that they were investigating. A member of staff told us at ward level, lessons were not learnt from complaints.

A relative told us they had received a complaints leaflet.

Bootham Park Hospital Ward 6

Access, discharge and bed management

The ward had 16 beds for the assessment and treatment of older people with mental health problems. At the time of the inspection, there were 15 patients on the ward. Staff said patients accessed the service by referral from the crisis service. Staff did not report any issues with patients accessing the service. We saw there was information available to patients on admission to orientate them to the ward.

The medical staff said that normally patients stayed two to three months. The GP registrar told us this was due to a lack of joined up working with social services, a general slow pace of treatment planning, limited occupational therapy input and a lack of patient activities during the day.

The ward manager reported good links with community mental health teams, who would attend meetings at short notice and that handover of patient care to the community mental health teams was normally smooth. However, for one patient who had been on the ward for over a year, we saw there was no evidence of progression or planning for discharge to a residential or nursing home. One patient told us they had a discharge plan but they felt it was delayed due to having seven different consultants over 11 months.

The ward environment optimise recovery, comfort and dignity

The ward accommodated both male and female patients. Bedrooms were not en-suite. A separate quiet lounge was available for female patients.

We observed there were alcove areas for quiet and confidential chats and quiet rooms where visitor could see relatives. There was a clock in the lounge to orientate patients to the time. There was a pay phone available and if patients did not have any money, the phone from the office was available. We saw patients had use of a well-equipped gymnasium.

On the ward noticeboards, we observed the names of staff were displayed and which ones were allocated to care for individual patients. There were also leaflets about different treatments, the MHA, MCA and the advocacy service.

Requires Improvement

Are services responsive to people's needs?

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

We heard differing views regarding the quality of the food on the ward. One patient described it as, "rubbish" whilst another said that it was, "alright most of the time." The staff told us there were facilities for patient to have a drink and a snack throughout the day and night.

Ward policies and procedures minimise restrictions

The ward was locked on the day of our visit and informal patients needed to ask staff if they wished to leave the ward. Most of the areas on the ward were open for patient use. However, areas containing risks were kept locked when not in use.

Patients said that they did not have keys to their bedrooms, nor did they have a lockable space within their rooms. This had led to one patient having a number of items taken by another patient and some difficulty in retrieving them.

Meeting the needs of all the people who use the service

The ward had pictorial signage that helped patients with dementia locate the bathrooms and toilets. There was also a Chaplain available within the hospital.

The ward had access to advocacy and translation services if required.

Listening to and learning from concerns and complaints

The trust had a complaints procedure the guidance of which was summarised and advertised on the ward, with information about the Patient Advice and Liaison Service (PALS), which supported patients to raise concerns. Staff said most concerns were resolved locally at ward level. If unresolved they would be escalated to the modern matron and would be investigated by a member of staff independent to the ward. The modern matron told us there was an on-going complaint that they were investigating.

The ward had received one complaint in the twelve months prior to April 2014.

The Mount Wards 1,2,3,4.

Access, discharge and bed management.

We found patients had been able to access care and treatment at The Mount. This was demonstrated by information provided by the trust prior to the inspection that informed us the bed occupancy for the six months prior to July 2014 for the ward 1 had been 62%, ward 2, 98% and ward 3, 85% and ward 4, 95%. One manager said when they had been unable to admit patients onto ward 2; ward 4 had accommodated the patients.

A bed manager reviewed and looked at delays in discharge. The managers said that and provided examples of how discharge planning was part of the care planning process.

Information provided by the trust informed us there had been six delayed discharges on wards 1 and 2, and one on ward 4 in the six months prior to July 2014. When we asked staff on ward 4, they were able to provide us with appropriate reasons why the discharge was delayed. On wards 1 and 2 staff told us delayed discharges were often due to social services being unable to find appropriate placements when patients were unable to return to their own homes. This demonstrated staff were proactively planning for patients discharge from hospital.

The ward environment optimises recovery, comfort and dignity

Wards 1 and 2 admitted patients for assessment and treatment of dementia. Wards 3 and 4 admitted patients with acute mental health problems for assessment and treatment.

The wards were modern and looked well maintained. We saw a full range of rooms to support patients with their treatment and care which contained the appropriate equipment. Each ward had a communal lounge, activity room and dining room. The clinical rooms were clean and equipped with the necessary equipment to enable medical staff to examine patients. The wards had been adapted to meet patient's needs with pictorial signage on the bathroom and toilet doors. Ward 1 had access to an enclosed outdoor garden; however on wards 2, 3 and 4, detained patients had to be escorted by staff to the garden area.

Ward 3 had mixed accommodation but we saw bedrooms were segregated and there were separate male and female bed areas. There was a female only lounge and the communal toilets were designated for either males or females. The staff told us that any risk to patients was managed by the use of observation levels.

Requires Improvement

Are services responsive to people's needs?

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

There were quiet rooms on each ward and rooms where patients could meet privately with their relatives. The modern matron told us they had secured further funding to enable the refurbishment of wards 1 and 2 to improve the environment to meet the needs of patients with dementia.

The notice boards displayed information such as; staff names and roles, complaints, advocacy, information about care pathways, results of patient surveys, and cleanliness audits. Information about the ward activities and meal times was also displayed.

Ward policies and procedures minimise restrictions

We found the practices on the ward minimised restrictions to patients. This was because some patients told us they had access to keys to their bedrooms and a swipe card so they could leave the ward when they chose. We observed patients were moving around the ward as they chose.

Patients had personalised their bedrooms and had their own televisions. Staff said patients could leave the ward to have a cigarette when they chose although they were supervised when they did to ensure their safety.

What articles patients brought onto the ward and whether they were searched was dependent upon their individual risk and their agreement. Patients had their own mobile phones or access to one on the ward.

We saw on the wards patients had access to a drink throughout the day in the lounge area. When we talked with patients, they said that there was a choice of food and it was good. The staff told us if a person did not like a meal or the patient was away from the ward at mealtimes they would make them an alternative snack.

Meeting the needs of all patients

Written information that enabled patients to be aware of the ward activities and services was available on the wards. Patients had access to interpreting and advocacy services if necessary. For example, one patient had access to an interpreter at their request three times a week.

We saw there was information about the multi-faith centre within the hospital, which displayed the times of services for the different denominations. On ward 1, the ward manager told us the Chaplain visited the ward.

We saw there was information about the advocacy services on the notice boards and staff told us the advocate visited regularly and the patients who used the service confirmed this. Although staff told us there could be difficulties accessing the involvement of an Independent Mental Health Advocate, (IMHA). An IMHA is an independent advocate who is specially trained to work within the framework of the Mental Health Act 1983 to support patients to understand their rights under the Act and participate in decisions about their care and treatment.

Listening and learning from concerns and complaints

All the patients told us they felt able to raise any concerns or complaints they might have. Where they had raised concerns or complaints, they told us the trust had responded to their concerns. We saw there was information on the wards to inform patients and their relatives about how to raise concerns and complaints. We saw the number of complaints and compliments displayed on the notice boards in the wards. Ward 3 and 4 also held community meetings where patients could raise general concerns about the ward.

The trust had a complaints procedure the guidance of which was summarised and advertised on the ward. Information about the Patient Advice and Liaison Service (PALS), which supported patients to raise concerns was also displayed. Staff said most concerns were resolved locally at ward level. If unresolved they would be escalated to the modern matron and would be investigated by a member of staff independent to the ward. We found evidence that lessons had been learnt from complaints.

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.

Summary of findings

We found inequity between the Leeds and York wards in staff morale. Staff at Leeds services described their morale as good. Many staff in York services described low morale caused by insufficient staff . At ward 6 Bootham Park staff said they did not feel listened to by the trust.

Overall, all the staff said they were supported and listened to by the local management teams and would feel confident in raising any concerns.

The Mount had good governance systems in place to ensure patients received a high quality and innovative service, which met patient needs.

At Peppermill Court, Meadowfields and Worsley Court the trust had identified where improvements had to be made and provided us with comprehensive action plans. Managers had started to make changes but had not completed the work at the time of the inspection. Also, some actions had not been completed despite the action plan stating they had. For example, the staff had not improved the quality of care records and medical cover to the wards remained inconsistent.

On the 15 October 2014 we were informed Worsley Court closed to allow for staff training.

Our findings

Peppermill Court Community Unit for the Elderly

Vision and values

Staff told us they had been visited by one of the directors of the Trust. We found that staff had developed their own vision and values, which were in line with the trust's visions and values. These included treating patients with compassion, respect and dignity. The ward manager told us, "Patients come first."

A group of 13 health care assistants who worked across all the older people's wards told us they were aware of whom the chief executive was, but had not been present when they had visited.

Good governance

The ward matron explained that their post was new and they had commenced in July 2014. They said there was an ongoing review of all of the York older age services and this included the development of a dementia care pathway agreed by the medical staff and managers, which there were plans in place to implement.

The trust provided us with the document 'quality improvement plan for the community unit elderly services (CUES which included Peppermill Court) which had been updated on the 3 September 2014. This demonstrated the trust had identified and was responding to, many of the issues we had identified during our inspection including; staff resources and training, environment, delayed discharges, lack of an effective system to regularly assess and monitor the quality of service that patients received and patient engagement. The modern matron had also raised concerns regarding inconsistent medical resources on to the risk register on the 8 September 2014.

During our inspection, we found the implementation of changes by the trust were ongoing and had not been embedded sufficiently to improve patient care and experience at the time of our visit. At ward level, we found there were not adequate systems in place to ensure staff received the necessary training, and support, learnt from incidents and completed accurate care documentation. We also found there was a lack of appropriate and consistent medical staff. No activities were taking place and there was no evidence of local engagement with patients and relatives.

Leadership, morale and staff engagement

There had been changes to the management structure of the service and a modern matron post introduced from July 2014 who was responsible for the older people's services at Meadowfields, Worsley Court and Peppermill Court. The ward staff told us they saw the modern matron regularly on the ward. They said they felt the management were approachable. We spoke with consultant psychiatrists who told us the trust had consulted them about the planning of the memory services and the management of organisational risk to the trust.

There were limited formal staff engagement, supervision, appraisal and clinical supervision for the staff on the ward. We found staff morale was variable because of changes to the ward.

Commitment to improvement and innovation.

There was evidence of ward-based audits such as infection control, hand hygiene, and health and safety. Information

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provided by the trust prior to our inspection showed that the modern matron made regular checks on the environment. The ward manager said there had been an audit for care documentation but because this had not been effective and the staff had stopped it.

We met with the service manager and clinical service manager who told us there were plans in place to improve the older patient's services in York. Following the inspection, we were provided with an extensive action plan for all of the community services that did address many of the issues we identified during this inspection. Some of the aims of the action plan were to ensure a systematic programme of work was undertaken to ensure patients received safe, effective, compassionate and high quality care. This included; building a shared recovery and person-centred culture of care on the wards and establishing a multi-disciplinary forum to oversee and drive improvements in the quality and safety of care, fully co-produced with patients and carers'. The plan contained information, which showed it was active however; for some points of action that were completed, we could not find evidence of the impact on the ward such as care records and engagement.

The trust also provided information about the new dementia care pathway that was part of the action plan which the trust planned to implement.

Meadowfields Community Unit

Vison and values

We found that the trust vision and values not were embedded at Meadowfields. Staff told us they had not met or seen the directors of the trust on the ward. A group of 13 health care assistants who worked across all the older people's wards told us they were aware of whom the chief executive was, but had not been present when they had visited..

We found the staff had their own vision and values, which were to treat patients with compassion, respect and dignity. One told us they would treat patients as if they were their "Own mother and father."

Good governance

The modern matron explained that their post was new and they had commenced work in July 2014. There was currently an ongoing review of all of the York older age services and this included the development of a dementia care pathway that had been agreed by the medical staff and managers, which the trust intended to implement.

Following our first visit, the trust provided us with the document 'Quality improvement plan for the Community unit elderly services (CUES which includes Meadowfields)', which had been updated on the 3 September 2014. This demonstrated the trust had identified and were responding to many of the issues we had identified during our inspection. This included staff resources and delayed discharges. The modern matron had also raised the concern regarding inconsistent medical resources on to the care risk register on 8 September 2014.

On our first visit, we were told the ward was nurse led and we found that the ward manager was fully informed about the resources available to the ward and utilised them. Where they had found shortfalls, they had raised these with the trust. We found that on the ward within the limited resources the manager had, they ensured there were sufficient staff and skilled staff to meet patient needs. They were reporting incidents and had made sure MHA and MCA procedures were followed, but the lack of access to medical, occupational and psychological input may have impacted on patient discharge. In addition, staff needed to take further action to protect patients' privacy and dignity in the mixed gender environment.

Leadership, morale and staff engagement

There had been changes to the management structure of the service and a modern matron post introduced from July 2014 who was responsible for the older people's services at Meadowfields, Worsley Court and Peppermill Court. The ward staff told us they saw the modern matron regularly on the ward. They said they felt the management were approachable.

Four staff members said the ward manager supported them and they felt the ward team worked well together. They said the ward manager and clinical manager provided very good leadership.

We were told that staff meetings were monthly but we only found records of three since the 9 April 2014. One member of staff said the discussions about the changes to the older patient's services in York and the uncertainty of the forthcoming re-tendering process had affected morale.

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.

Commitment to quality improvement and innovation

We saw there was evidence of ward-based audits such as care documentation, infection control, hand hygiene, and health and safety.

We met with the service manager and the clinical service manager who told us there were plans in place to improve the older patients units in York. Following the inspection, the trust provided an extensive action plan for all of the community services that did address many of the issues we identified. One of the aims of the action plan was to ensure a systematic programme of work was undertaken to ensure patients received safe, effective, compassionate and high quality care. Another was to build a shared recovery and person-centred culture of care on the wards and establish a multi-disciplinary forum to oversee and drive improvements in the quality and safety of care, fully co-produced with service users and carers.

The trust provided information about the new dementia care pathway that they planned to implement which was one of the tasks on the action plan.

Worsley Court Community Unit for the Elderly

Vision and values

The week prior to our inspection, the line management of the ward had changed. The service manager and director told us they had kept the staff informed about the changes.

Good governance

The modern matron explained their post was new and they had commenced work in July 2014. There was currently an ongoing review of all of the York older age services. This included the development of a dementia care pathway, agreed by the medical staff and managers, which the trust planned to implement.

We found that staff had not been provided with the appropriate training and support, and care documentation was not in place. In addition, staff needed to take further action to protect patients' privacy and dignity in the mixed gender environment and to ensure the safe and prompt administration of medicines to patients. These issues had not been identified through the ward existing governance system.

Following the inspection, we were provided with information from the trust 'Quality improvement plan for the Community unit elderly services (CUES which included Worsley Court)'which had been updated on the 3 September 2014. This demonstrated the trust had identified and were responding to many of the issues we had identified during our inspection which included; staff resources and training, environment, delayed discharges, lack of an effective system to regularly assess and monitor the quality of service that patients received and patient engagement. The modern matron had also raised the concern regarding inconsistent medical resources on to the risk register on the 8 September 2014. In response to the recent safeguarding concerns identified, the modern matron had implemented an action plan, closed the ward to admissions, moved some patients to other wards and changed the management of the ward. The trust informed us the ward closed on the 15 October 2014 to allow for staff training for one month.

This demonstrated the trust had put an action plans in place but our inspection found that the plans had not yet impacted upon patients experience or care.

Leadership, morale and staff engagement

We talked with the service manager and assistant director of nursing who told us that they had engaged with the staff but due to the recent changes, staff morale was low.

Staff told us they had no support in the last year but due to the commencement of the modern matron role, they had a positive attitude and believed it would improve.

Commitment to quality improvement and innovation

The modern matron was working to put systems in place to monitor the quality and safety of the service. The new systems had not fully embedded in staff practices.

The modern matron, service manager and deputy director of nursing explained the trust was committed to the improvement of the York services.

The trust provided information about the new dementia care pathway that they planned to implement which was one of the tasks on the action plan.

Bootham Park Hospital Ward 6

Vision and values

Permanent staff told us they were following the trust vision and values of providing good patient care and positive patient experience. A group of 13 health care assistants

Are services well-led?

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who worked across all the older people's wards told us they were aware of whom the chief executive was but no one ever visited and the majority said they were not involved in trust wide decisions.

Good Governance

Although the ward manager had made efforts to maintain continuity, we found the lack of permanent medical and nursing staff and health care assistants was having an impact on both staff morale and staff training. In addition, the lack of a consistent approach by staff may have affected patient care. Staff reported incidents. Patient needs were assessed and care and treatment planned for and there was access to medical staff and health professionals such as a physiotherapist, dietician but there was limited occupational therapy resources. In addition, staff needed to take further action to protect patients' privacy and dignity in the mixed gender environment.

Leadership and morale

Staff on the ward said that the issue of insufficient staff numbers had affected staff morale.

A group of 13 health care assistants who worked across all the older people's wards told us that the morale was low and staff were a lot happier last year. They said they did not feel informed by the trust. For example, they had to work night shifts but were not told why. The majority complained of low morale and felt not listened to. They reported raising concerns with managers but reported that nothing happened. They said they felt, "tired" and "run down" and that, "no one will help."

Commitment to quality improvement and innovation

We saw there were a number of audits on the wards carried out to measure standards of care and to make improvements. These included medication, checks on emergency equipment and environmental and ligature checks.

Ward managers and pharmacists reported patients were provided with medication choices and discussions with patients took place regularly.

The trust had introduced a quality dashboard onto the wards, to enable the managers to monitor the quality of the service provided on the ward.

The Mount – Ward 1,2,3,4

Vision and values

The managers told us the modern matron and clinical service manager supported them and were both visible on the ward. They were all aware of the vision and values and how these impacted positively on patient care. They were aware of whom the executive team was and there was occasional contact. One manager provided an example of when the chief executive had visited the ward to offer support following an incident.

Some staff told us they had seen the chief executive on the ward, others said they had not but knew who they were from the photographs and commented about the information they were sent from the Trust. All said the morale was very good and they enjoyed working at The Mount.

Staff who worked on the dementia ward told us their vision was to improve the dementia care pathways and they said they wanted their work to improve patient care.

Good governance

The ward managers told us they had sufficient authority to increase the number of staff on the wards. We found they had systems in place to ensure there was enough staff to meet patient needs, who were skilled and supported to carry out their work effectively and efficiently. Where there were any issues the ward managers had identified them and were putting measures in place to mitigate them. Incidents were reported and within The Mount. There was cross-ward learning from incidents and other incidents in the trust. Two ward managers reported a low sickness absence rate and we saw from information provided by the trust the level of sickness absence for August 2014 was from 4 to 8%.

Leadership, morale and staff engagement.

All of the staff told us they enjoyed their work, they were part of a, "good" team and morale was very, "good". The ward managers supported them. Comments made included, "I am proud to work here."

The managers told us they could raise any concerns or issues with the clinical service manager or modern matron. Documents provided by the trust, demonstrated there were monthly unit meetings that staff from all of the wards attended. The agenda covered issues such as lessons learnt, CPA meetings, records, safe sharp devices, staffing and weekend activities.

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.

All the doctors told us the medical group was, "cohesive", had "strong leadership" and was "well led." All commented there was, "plenty of training" and a "robust appraisals" system.

Commitment to quality improvement and innovation

At the Mount, we were provided with evidence to demonstrate there was a commitment to quality improvement and innovation. This was because the trust had recently implemented a quality dashboard, which had information at ward level about incidents, CPA, staffing, discharge. It used a traffic system to highlight any areas of concern.

Ward 3 and 4 had achieved the Accreditation for Inpatient Mental Health Services (AIMS) by the Royal College of Psychiatrists. AIMS is a standards-based accreditation program designed to improve the quality of care in inpatient mental health wards.

We saw there was a dementia inpatient project steering group. The managers of wards 1 and 2 told us they had secured further funding to improve the environment and they were benchmarking the service using recognised national guidelines. They were also aware of the work at Bradford and Sterling Universities.

Ward risk registers had been introduced and there was a system in place to ensure anything raised was seen by the modern matron and service managers.

On wards 3 and 4; monthly inpatient pictorial questionnaires were carried out. These asked patients about their experience of the ward and covered areas such as food, staff, and activities. The staff collated the results and these were displayed on the ward noticeboards. There was a patient involvement group, which invited present and past patients to be involved in the development of the service. We saw the minutes of a meeting held on 22nd July where they had reviewed the patient survey results.

We saw evidence of the development of a sleep clinic on ward 4 for present and past patients.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **At Worsley Court the trust must ensure that there no delays to the administration of patients medication.**