Good

Sheffield Health and Social Care NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Fulwood House
Old Fulwood Road
Sheffield
South Yorkshire
S10 3TH
Tel: 0114 271 6310
Website: www.sct.nhs.uk

Date of inspection visit: 27 - 31 October 2014
Date of publication: 09/06/2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Grenoside Grange	TAHXP	Ward G	S35 8QS
Michael Carlisle Centre	TAHFC	Dovedale ward 1 Dovedale ward 2	S11 9BF

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care 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 Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care 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 wards for older people with mental health problems	**Good** 
Are wards for older people with mental health problems safe?	**Requires Improvement** 
Are wards for older people with mental health problems effective?	**Good** 
Are wards for older people with mental health problems caring?	**Good** 
Are wards for older people with mental health problems responsive?	**Good** 
Are wards for older people with mental health problems well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

Services for older people with a mental health problem overall receive a good service though there are areas which require improvement to make this a safe effective service to provide patients with the standards of care they expect to receive.

The wards were clean and well maintained. At Grenoside where the environment posed a risk to patients, staff had monitored the risks and taken action to mitigate the risks. At Dovedale 2 the environment was refurbished and more anti-ligature fixtures and fittings were fitted. However on both Dovedale 1 and 2 there still remained ligature points which had not been mitigated.

At both sites we saw the management of medicines needed to be improved.

Within the wards for older people with mental health problems, we found significant differences between the Dovedale acute wards and Grenoside. The wards had sufficient staff to meet the care and treatment needs of the patient's. Safety was important at all levels, however safety on Dovedale 1 was not sufficiently managed as we saw fire door with self closing devices fitted to them held open with waste disposal bins.

Levels of staff training around safeguarding adults were also low on the Dovedale wards. However, when there are changes to safeguarding practice or policy, this is cascaded down to staff through the relevant Trust directorates

Patients received care, treatment and support that achieved good outcomes, promoted a good quality of life, and was based on the best practice guidance. At Grenoside there was a more proactive approach to the development of best practice, with the team being entered in the Royal College of Psychiatrists team of the year awards. Patients had access to occupational therapy and psychology. This meant patient outcomes were being improved through practice development.

Discharge was planned as part of the admission process so future patient care was being considered. Feedback from patients, families and carers was positive about the way staff treated patients.

At Grenoside we found there were concerns among nursing staff about who provided medical cover to meet the physical health needs of patients due to the availability of junior doctor cover. However, despite these comments from staff there were in fact arrangements in place for out of hours and in hours to sufficiently cover patient care

On both sites we found adherence to the Mental Health Act (1983) Code of Practice was inconsistent. We saw responsible consultants (RC) had sought a second opinion approved doctor (SOAD) to agree to the treatment plan in the "best interests" of the patient. We could not find evidence of documentation of the RC discussing with the patient or their carers the recommendation made by the SOAD.

On both sites we found figures for the completion of mandatory and specific training including supervision of staff was low in comparison to the England national average. This meant staff were not consistently being supported.

Services were responsive to patient needs and involved patients, relatives and carers in the development of their care pathway.

Services were locally well led and staff understood the vision of the local leadership and the positive developments planned for the future.

Summary of findings

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

Are services safe?

Requires Improvement

We found the wards were clean and well maintained. Where the environment had posed a risk to the patient's by fixed ligature points, staff had monitored the risks and there were actions in place to mitigate the risk. However on Dovedale 1 there was not sufficient assurance patients were protected from the risk of self harm.

On Dovedale 1 we saw fire doors fitted with self closure devices were held open by small waste disposal bins. This meant the fire safety of the fire doors was compromised and patients were at risk. Patients had unsupervised access to an area of the ward where fixed ligature points were located. This area had been the site of a patient death. Staff managed other risks locally by closer observation of patients when they were assessed at being at risk of self-harm.

The wards had sufficient staff to meet the care and treatment needs of the patient's. Flexible staffing allowed the appropriate numbers of staff to be provided to meet the needs of patients.

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 Dovedale 1 and 2 this did not include individual risk to fixed ligature points.

At both sites we found the temperatures of the medication fridges were not carried out regularly to make sure medicines were stored safely. Of 215 entries in the controlled drug register, 5 did not include the signature of the witness observing administration.

Staff reported incidents and safeguarding concerns appropriately, and trust wide learning was cascaded to staff. With the exception of Dovedale 1 and 2 were we saw low numbers of staff completing safeguarding training on local staff training records.

Are services effective?

Good

We found staff assessed patient needs and planned for their care and treatment. The multi-disciplinary team were effective, through good communication and leadership.

We found inconsistencies on Dovedale wards 1 and 2 regarding the completion of mandatory, role specific training and completion of supervision. This was included on the trust's risk register and there was an action plan in place to address staff training.

The wards followed best practice guidelines, for example NICE guidance, and were proactive in ensuring patients received good outcomes and experiences.

Summary of findings

On both sites we found adherence to the Mental Health Act (1983) Code of Practice was inconsistent. We saw responsible consultants (RC) had sought a second opinion approved doctor (SOAD) to agree to the treatment plan in the patients'' best interests. We could not find evidence of documentation of the RC discussing with the patient or their carers the recommendation made by the SOAD.

Are services caring?

Good

During the inspection, we spoke with six patients and four relatives and reviewed comment cards from both patients and relatives. We attended three staff handovers, a recovery group and a community meeting.

During the inspection, we spoke with six patients and four relatives and reviewed comment cards from both patients and relatives. We attended three staff shift handovers, a recovery group and a community meeting.

Most of the feedback received from patients and their families was positive. Patients and relatives reported they were satisfied with the service and staff treated them with privacy and dignity. We also received some negative comments about one of the wards, when a patient told us they felt that a staff member was disrespectful to them.

We saw staff involved patients in their care, though there were inconsistencies. At Dovedale we saw patients were not consistently involved in care planning and at Grenoside patients were involved in their life stories and person centred plans.

Are services responsive to people's needs?

Good

There was an effective approach to the assessment and admission of patients onto the wards.

Patient discharge was planned as part of their admission and was only delayed due to a lack of suitable placements in the community.

The service ensured patient's equality and diversity needs through access to interpreting and advocacy services as necessary. The Dovedale wards were having interactive information screens fitted so patients could access information about their care, treatment and service information. Both sites had invested in information technology to promote a safer environment and reduce the number of falls.

Summary of findings

Staff were able to explain the complaints procedure and were aware of the trust's policy and procedure if someone wanted to make a complaint. Patents and relatives were aware of the information about complaints and how they could use this. At Dovedale we saw this information was discussed as part of the community meeting.

Are services well-led?

Good

Services were locally well led and staff understood the vision of the local leadership and the positive developments planned for the future. Senior managers were involving staff in the developments of the services. For example at Dovedale the proposed re location of the wards.

Staff described their morale as good, with good local leadership. Staff said there was engagement with trust headquarters through the non-executive directors, which included ex patients. We saw evidence of staff involvement in the fifteen step challenge.

Staff said they were supported and listened to by the local management teams and would feel confident in raising any concerns. For example we saw team meeting minutes were staff were asked about their ideas for service improvement.

Summary of findings

Background to the service

The wards for older people with mental health problems were based on two hospital sites. Dovedale wards 1 and 2 were based at the Michael Carlisle Centre and ward G1 at Grenoside Grange Hospital.

Dovedale 1 Ward is an acute admissions ward for older people. The ward is predominately female only.

Dovedale Ward 2 is an acute admissions ward for older people. The ward is a male only ward.

The wards have a staff group including Nurses, Psychiatrists, Psychologists, Support Workers and Occupational Therapists.

G1 Ward is a mental health ward with twenty beds for the assessment and treatment of people who have dementia. Patients admitted to the ward had highly complex behaviours which presented a significant challenge.

The ward has a staff group which included nurses, psychiatrists, support workers, occupational therapists, and a physiotherapist. A podiatrist visited the ward every six to eight weeks.

Our inspection team

Our inspection team was led by:

Chair: Alison Rose-Quirie, Chief Executive Officer, Swanton Care.

Team Leader: Graham Hinchcliffe, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including a consultant psychiatrist, expert by experience, mental health act reviewer, psychologist, registered nurses and social worker. The expert by experience was a person who had used a service or a carer of someone using a service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before 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 Dovedale wards 1 and 2 on the 28th and 29th October 2014. We spoke with three patients and one relative and observed how staff interacted with patients in the lounge and at lunchtime. We spoke with one patient and two relatives and observed how staff interacted with patients in the lounge and at lunchtime. We observed the recovery and reflective practice groups as well as attending two shift handovers. We spoke with 14 staff including the associate medical director, junior doctor, service manager, ward manager, pharmacist, psychologist, occupational therapist, deputy manager/

Summary of findings

discharge coordinator, staff nurse, health care support workers and housekeeper. We looked at 10 patient records to check what had been recorded about their care and treatment.

We visited Grenoside Grange ward G1 on the 29 and 30 October 2014. We spoke with three patients and two relatives and observed how staff interacted with patients in the lounge and at lunchtime. We observed the Halloween party and non structured activity groups and attended one handover. We spoke with eight staff including a junior doctor, nurse consultant, ward manager, occupational therapist, deputy manager/ discharge coordinator, staff nurse, health care support workers and housekeeper. We looked at seven patient records to check what had been recorded about their care and treatment.

What people who use the provider's services say

Relatives told us staff were respectful and caring; they were well informed and had no concerns regarding their relatives' care and treatment. One relative told us, "I think this is the best place dad can be, I know he is safe here as I am brought up to date when I visit".

Patients were complimentary about 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. One patient told us, "Staff are very caring and especially patient with me".

Good practice

At Dovedale 1 and 2 the psychologist led formulation meetings. This involved in focusing on patients who were hard to engage with or had behaviour which challenged. The meeting mapped out the patient core values and motivations to find ways patients of engaging in successful and meaningful interactions with the patient to aid their recovery.

At Grenoside the team were using an excellent 'antipsychotic checklist' to monitor the impact of changes to a person's prescribed medicines. This meant changes to patient medicines were regularly monitored to see the effect this had upon them so their medicines were regularly reviewed.

At Grenoside we saw the use of soft dolls placed about the two areas of the ward. These were not toys but could be used as part of patents' treatment to lessen their distress. We saw patients using them as a means of comfort, by touching and stroking them.

At Grenoside ward was involved in research on the use of a robotic seal. It had the ability to learn and remember its own name, and learned the behaviour that resulted in a pleasing stroking response and repeated it. The seal was an interactive toy used to managing distressed and disturbed behaviour. This was not used to deceive patients. The seal was being used by the trust as part of a clinical joint project with the University of Sheffield.

At Grenoside the consultant psychiatrist had completed work on the development of a clinical leadership model using a person centred approach and evidence based practice. For example using a neuro psychiatric inventory, this was used to assess neuropsychiatric symptoms of patients with Alzheimer's disease and other dementias. It captured treatment related behavioural changes in patients receiving anti dementia medication and other psychiatric medicines. The RC used this on the admission and discharge assessment of patients and used outcome measures to improve care and treatment.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust must ensure that on Dovedale ward 1 the risk of access by patients to unobserved areas of the ward were fixed ligature points are located is reduced.

The trust must ensure the temperature monitoring of medication fridges are carried out to make sure medicines are stored safely. Entries in the controlled drug register must include the signature of the witness observing administration and correct recording of the dosage of medication given to patients.

The trust should ensure staff complete all the required mandatory and role specific training required to provide safe and effective care to patients.

The trust should ensure patients at Dovedale 1 and 2 are consistently involved in the planning of their care.

The trust should ensure the responsible consultant (RC) seeks a second opinion approved doctor (SOAD) to agree to the treatment plan in the patients'' best interests and document that the RC had discussed with the patient or their carers the recommendation made by the SOAD so they understood why a second opinion was being sought about their care and treatment.

sheffield health and social care NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Dovedale ward 1 Dovedale ward 2	Michael Carlisle Centre
Ward G1	Grenoside Grange

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.

We found the trust were adhering to the Mental Health Act 1983 (MHA) and patients were legally detained.

We saw most of the documents were in order and patients were lawfully detained. All the 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 responsible consultants (RC) had sought a second opinion approved doctor (SOAD) to agree to the treatment plan in the patients'' best interests. We could not find evidence of documentation of the RC discussing with the patient or their carers the recommendation made by the SOAD.

Mental Capacity Act and Deprivation of Liberty Safeguards

Deprivation of liberty safeguards (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.

Detailed findings

We found staff had referred appropriate patients for a Deprivation of Liberty Safeguard (DoLS) assessment. Assessment of the patient's capacity had been carried out at Grenoside, but at Dovedale this was not routinely considered.

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

We found the wards were clean and well maintained. Where the environment had posed a risk to the patient's by fixed ligature points, staff had monitored the risks and there were actions in place to mitigate the risk. However on Dovedale 1 there was not sufficient assurance patients were protected from the risk of self harm.

On Dovedale 1 we saw fire doors fitted with self closure devices were held open by small waste disposal bins. This meant the fire safety of the fire doors was compromised and patients were at risk. Patients had unsupervised access to an area of the ward where fixed ligature points were located. This area had been the site of a patient death. Staff managed other risks locally by closer observation of patients when they were assessed at being at risk of self-harm.

The wards had sufficient staff to meet the care and treatment needs of the patient's. Flexible staffing allowed the appropriate numbers of staff to be provided to meet the needs of patients.

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 Dovedale 1 and 2 this did not include individual risk to fixed ligature points.

At both sites we found the temperatures of the medication fridges were not carried out regularly to make sure medicines were stored safely. Of 215 entries in the controlled drug register, 5 did not include the signature of the witness observing administration.

Our findings

Location 1 Dovedale wards 1 and 2

Dovedale wards 1 and 2 were located on the ground and first floor of the Michael Carlisle Centre. Dovedale 1 Ward was an acute admissions ward for 16 older patients and accommodated female patients. Dovedale Ward 2 was an acute admissions ward for 14 older patients and accommodated male patients. Both wards were managed by the same ward manager.

Access to the wards was via electronic key pads, which patients had to ask staff to activate to let them through. Patient's bedrooms were located off two main corridors on Dovedale 1 which meant staff had a large environment to observe. On Dovedale 2 there was one main corridor which bedrooms were located on.

We saw Dovedale 1 had several 'blind' spots where patients would have been unobserved. For example we observed a small dormitory area located at the end of one corridor. This had a shower room/ toilet facility being used by patients on the adjacent corridor. The dormitory was not locked so patients had unobserved access to this area. The shower room/toilet had been the site of a patient death in April 2014. The Trust had responded to this by enclosing the access to the fixed ligature point used to reduce the risk. However there were other ligature points including pedestal taps, fixed hand and toilet rails. This meant patients had unsupervised access to an unobserved area with fixed ligature points. These ligature points were not identified on the October 2014 risk register for the inpatients directorate, ongoing risks.

Ligature risk assessments were managed by clinical staff and carried out not less than annually or more frequency in line with Trust procedure if changes took place. A process was in place to escalate actions if these were not completed promptly. There was no evidence that an independent risk assessor had looked at ligature and other risks in the ward setting. We saw action had been taken on Dovedale 1 to enclose the ligature point in a bathroom following the death of a patient in April 2014.

Both wards had similar ligature points in toilets bathrooms and shower rooms. The ward ligature assessments completed in May and August 2014 did not identify these items as hazardous. We saw risks were managed locally by more frequent observations of patients when they were at risk. Modifications had been made to the wards to make them safer, such as collapsible curtain rails. Ligature risks

Requires improvement

Are services safe?

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

were also identified in the locally managed risk reports for Dovedale 1 and 2 from July 2014. All the patient individual risk assessments we saw did not identify if patients were at risk from the ligature points.

The locally managed risk reports for Dovedale 1 and 2 identified the risk of ligature from current bedroom furniture as wardrobes and clothing rails. This was also identified on the trust risk register. The control measures were to replace single standing wardrobes with new ones and adapt existing ones by removing the clothing rail and replace with secure shelving.

We noted the staff room and nurses office doors in the ward were help open by small metal waste disposal bins, despite them having self closing devices on them and being fire doors. This meant staff were not adhering to the trust fire policy and placing patients at risk.

We found the ward was clean and well maintained and observed domestic staff cleaning the areas. We spoke with one domestic staff on duty and were shown the cleaning schedules for both wards. The cleaning schedules reflected the cleanliness of the ward environments. Information provided by the trust for infection control (Local competence) to October 2014 showed 174 out of 289 staff had completed this, which was a 60% completion rate. For infection control level 2106 out of 1343 staff had completed this, which was a completion rate of 7.89%. Hand hygiene (local competence) figures were 951 out of 2976 completed this, a completion rate of 31%. Hand hygiene figures for the three year update were 98 out of 508 staff completed this, a completion rate of 19%. The infection control reports for Dovedale 1 and 2 were last completed in September 2013 by the senior nurse for the prevention and control of infection. The 2014 infection control report was delayed due to redecoration of the wards. The wards achieved a pass rate of above 90%. However the hand hygiene audit confirmed staff had not received instruction on hand washing techniques. This meant not all staff were aware of the infection control and hand washing practices to ensure the prevention and risk of infection was promoted.

We saw the clinical rooms were clean and tidy and equipped with examination equipment, resuscitation equipment and emergency drugs which had been checked weekly by the staff and labelled as being in date for use.

The wards did not have seclusion rooms but de-escalation rooms referred to as 'green rooms'. The green room on Dovedale 1 was not in use. The green room on Dovedale 2 provided staff with clear observation of the room with no blind spots. The room did not have toilet facilities as it was not used to provide a segregated area away from other patients. The green room was used as short term measure to support distressed patients to de stress in a quiet environment. The room provided comfortable fixed soft furnishings. This meant if necessary patients could be secluded in this area and safely observed by staff. The ward manager assured us patients were not left unsupervised when using the green room and a member of staff was always outside.

Safe staffing

We saw the staff roster for 6 September to 2 October 2014. At the time of our visit there were 17 staff on duty to cover both wards. This included the ward manager, deputy managers/ discharge coordinator, staff nurses, health support workers, psychologist and occupational therapist. On the later shift there were nine staff for the two wards, including one registered nurse per ward and seven health care assistants On night duty there were seven staff for the two wards including one registered nurse per ward. The ward manager showed us the electronic staffing roster and how they were able to use 'flexible staffing'. This system allowed staffing levels to increase as levels of acuity or risk increased. Flexible staffing was the Trust's internal staff bank and meant staff had been recruited by and completed the Trust induction programme.

Information provided by the trust prior to the inspection showed there were no vacancies for Dovedale 1 and 2. The Trust provided us with information about locations where over 100 shifts had been filled by flexible staffing staff to cover sickness, absence or vacancies in the last three months. No dates were provide by the Trust so it was not clear which three months the data related to. Dovedale1 had 342 shifts and Dovedale 2 had 237 shifts covered.

In interview with the ward manager we were told there were now four deputy managers supporting the ward manager and this arrangement had been agreed with the assistant services and clinical directors. The ward manager said they had enough autonomy within their budget to cover the long term sickness of a registered nurse. They said they had previously used bank staff to cover this. Another arrangement was to use the budget to convert posts on a short term basis. For example using the budget for a health care assistant post to cover registered nurse

Requires improvement

Are services safe?

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

hours. This meant the skill set and mix of staff could be flexible to meet the changing needs of patients. The ward manager clarified there were no current vacancies on Dovedale wards 1 and 2.

We were told the ward manager was responsible for monitoring the registration of nurses with the nursing and midwifery council (NMC). The ward manager said NMC registration was tracked electronically for existing registrants. When individual staff members' registration was due the human resources (HR) department would sent an e mail to the ward manager which required the staff member to produce evidence of registration. They said only one registrant had failed to provide evidence and until they had, had been downgraded to a health care assistant.

The trust was using an external consultancy agency Meridian to provide information and guidance about service development and workforce planning. The ward manager said this included figures about the future staffing figures and skill mix and said, "This has injected pace into change and I will be able to make decisions about the skill and skill set of the team".

Two staff told us the wards usually had enough staff to facilitate individual and group activities. However the planned activities were led by the occupational therapy staff. They told us the planned activities did not always take place as they also had to cover assessment of patients in the community. This meant there was less occupational therapy input into the ward when the demand for community assessments increased.

There was one consultant for the ward and a junior doctor worked directly to the consultant. The consultant was responsible for Dovedale 1 and 2 wards which consisted of 30 beds. There was input from a psychologist and occupational therapist for group and individual therapy sessions. The ward manager said despite an occupational therapist and consultant psychiatrist being on long term sick this had not affected the care of patients. This had impacted upon patients as sometimes planned activities had not taken place.

Assessing and managing risk to patients and staff

We observed a shift handover on both wards. On Dovedale 1 we noted the handover was less risk based than on Dovedale 2. A registered nurse led the handover on each ward. There was reference to patient's risk status changing and information about the previous shift. The handovers were different in that the Dovedale ward 2 handover summarised the previous 24 hours care and any important information from the last 48 to 72 hours where staff had not been working. This meant staff on Dovedale 2 had a more risk based handover.

We saw that daily records were used to provide staff with detailed information on patients on Dovedale 2. Mental health status was also discussed at the handover as well as diagnosis and history of new patients. On Dovedale 1 we saw a less risk based and detailed handover. As a result we judged the Dovedale 2 handover provided staff with more information about patient related risk.

The ward manager told us restraint to the floor was never used and we saw the wards did not have a seclusion room. This was confirmed by information received from the trust prior to the inspection which showed there had been 4 restraints on Dovedale 1 and 1 restraint on Dovedale 2 carried out from the 1st February 2014 to 31 July 2014 and there was no face down (prone) position restraint. Staff described working to the least restrictive practice with patients and they used the 'respect' model, which meant patients were able to be de-escalated effectively.

The ward used the detailed risk assessment and management plan (DRAM) which was completed when a patient was admitted to the ward and then reviewed daily. We looked at two patient's records on each ward and saw the assessment required the staff to update the most recent incidents we saw when incidents had occurred following admission the forms had been scanned into the patient electronic records system and the DRAM updated. This meant the number and severity of incidents was measured and staff were able to accurately assess the risk to the patient and others.

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

We found policies were in place to instruct staff about the safe handling of medicines. Entries in the controlled drug register did not always include the signature of the witness observing administration. Of 215 entries in the controlled drug register, 5 did not include the signature of the witness observing administration.

Ward treatment rooms were and refrigerators were not always properly monitored by ward and pharmacy staff to

Requires improvement

Are services safe?

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

make sure that medicines were always stored at the correct temperature. This meant there was a risk that medicines were stored at the wrong temperature and might not be safe to use. On Dovedale 1 we saw evidence of a patient's controlled drugs records, were multiple incomplete records did not have the date and specific medicines recorded. The manager told us this was due to only one registered nurse being on duty at time of administration.

Pharmacists were fully integrated into MDTs for inpatient services to support and ensure best outcomes from the use of medicines. An electronic prescribing and medicines administration system was in place on all wards and helped support safe and effective prescribing. Pharmacists also attended MDT meetings and monitored the reconciliation of patient medicines.

The trust information technology (IT) system was fully integrated with primary care and the acute trust. This meant the mental health services had access to all blood investigations, scans, outpatient letters and discharge summaries from all the primary care services in Sheffield.

The medication prescriptions were part of the I.T system, which highlighted potential drug interactions. We spoke with the ward pharmacist and looked at all medicine administration records. The ward pharmacist had a full understanding of medication use for all the patients on both wards. The pharmacist carried out full drug histories of all patients who were admitted, and provided consultations to any patient who wished to question their medication.

Reporting incidents and learning from when things go wrong.

We saw that information about safeguarding was available to staff and patients on the wards. The staff we spoke with told us they reported safeguarding incidents through the 'safeguard' electronic reporting system. Staff described the local policy was to report safeguarding incidents to the manager or nurse in charge and they would send alerts to the local authority. We saw information could be completed within the system and the information faxed electronically to the local authority.

All staff told us they had completed training in safeguarding vulnerable adults and knew how to respond appropriately to any allegations of abuse. The trust had arrangements in place to ensure staff were aware of safeguarding arrangements and had ensured all teams received appropriate information in the previous year. We found evidence of this in our discussions with staff. The Trust was developing its central monitoring systems to allow it to effectively track through which staff have received appropriate training. Until these were fully in place the trust was not able to effectively monitor its provision of training. Staff we spoke with were aware of how to refer safeguarding concerns and obtain safeguarding advice if needed. However the local ward training records recorded only 2 out of 52 staff had completed safeguarding training. We saw evidence of a safeguarding workbook pilot, where 20 staff had been given a workbook to assess their competence about safeguarding. This was being used to determine if staff needed a higher level of safeguarding training.

We saw there were systems in place to capture and review patients individual incidents and accidents which enabled staff to identify potential risk to them. We reviewed four patients over the two wards. These demonstrated the incident report forms were completed by staff on the paper system and the forms were scanned into the IT system by clerical staff. These were reviewed by the ward or deputy managers and assessed regarding cause or severity. Data was collected centrally and used by the Trust to focus on reducing incidents. The NHS Safety Thermometer reported for both Dovedale 1 & 2 and G1 for the period April to October 2014 reported no data indicated no falls with harm across both wards.

Staff told us that trust wide lessons learnt were disseminated to staff by e-mail. We saw that the patient death was referred to in the minutes of the ward meetings from October 2014. The minutes recorded the report was nearing completion and due to be released with an action plan.

The largest proportion (57%) of incidents reported between September 2013 and August 2014 occurred within inpatient areas. A majority (58%) of incidents did not have a specialty recorded. For older adult mental health in patient services a total of 17 incidents were reported. These were reported as abuse 1 incident, death 3 incidents and 13 of moderate harm.

The Trust reported that no deprivation of liberty safeguard (DoLS) applications were made between February 2014 and August 2014. The trust serious incidents requiring investigation (SIRI) data. The trust reported a total of 33 SIRI's were recorded between May 2013 and June 2014. 10

of these incidents occurred at a trust location whilst the remaining 23 occurred in the community. One SIRI that occurred was on Dovedale 1 ward, which involved the death of a patient.

Location 2 Grenoside Grange ward G1

Grenoside ward accommodated twenty patients for the assessment and treatment of dementia. Patients had highly complex behaviors which presented a significant challenge. The ward was divided into two ten bedded areas of female and male accommodation. This included three self-contained flats for patients that needed additional space due to the complexity of their needs. All bedrooms had en suite facilities.

Regular environmental safety checks were carried out on the ward. This helped identify the need for any repairs and protect patients from general risks in the ward environment. A ligature risk assessment was conducted on 9 October 2014 and, was reviewed monthly as part of patient individual risk assessment. Modifications had been made to the ward to make it safer, such as collapsible curtain rails. The ward manager told us there was a balance between managing existing ligature risks and having an environment that was helpful and appropriate for patients with dementia. Risks had been further reduced by the use of assistive technology. The ward area had been fitted with door alarms and sensors in rooms so patients who were at risk of falling or walking around at night would alert staff to this because these were linked into the call system. This included motion sensors in bathrooms and toilets so lights would operate upon entering a darkened room or toilet. Sensors also alerted staff if patients got out of bed or opened bedroom and bathroom doors.

Three independent flats had been created within the existing building. There were fixed ligature points in bathrooms, toilets and bedrooms, with pedestal taps, fixed hand and toilet rails. We saw evidence that individual risk assessments were completed on patients identifying the control measures to be used to prevent access to these areas. This meant that patients did not have unsupervised access to an unobserved area with fixed ligature point.

There were good systems in place for infection prevention and control. Senior managers maintained oversight of housekeeping staff. There were audits of infection control and prevention and health and safety, which included staff hand hygiene to ensure that patients and staff were protected against the risks of infection.

We found the ward was clean and well maintained and observed domestic staff cleaning the areas. We spoke with one domestic staff on duty and were shown the cleaning schedules for both wards. The cleaning schedules reflected the cleanliness of the ward environments. We saw that the ward was clean and patients and carers told us that standards of cleanliness were usually good. The ward was well-maintained and the corridors were clear and clutter free. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. We saw these were not over-filled.

Emergency equipment, including automated external defibrillators and oxygen, was in place and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices were also checked regularly to ensure they were working correctly.

Staff had undertaken training in life support techniques. Regular fire risk assessments and fire tests were carried out including practice evacuations of the ward. This helped protect patients from the risk of harm.

Staff were confident in being able to report incidents appropriately. Information on the DRAM and paper recording system was collected from a range of sources to monitor performance, this included information on incidents and trends were identified. The service had a good track record on safety. The overall reporting of incidents from April 2013 to March 2014, in the service for older patients as a whole, was low. No serious incidents or incidents involving restraint were reported on the Grenoside ward.

The ward did not have a seclusion facility and staff used the flats or a corridor as a low stimulus, or de-escalation area. However these areas were used as a seclusion space when staff had to withdraw for their own safety. Staff followed the ward policy on intensive nursing observation by ensuring they could access a low stimulus area to lower the distress levels of patients. The areas used had good lines of observation in the corridors and flats. There was heavy durable furniture which could not be thrown around. Individual risk assessment of patients identified where they could not be observed in the toilet and bathroom areas these needed to be locked to ensure they could not be accessed without support. When staff had to withdraw from the flat or low stimulus corridor for their own safety and the patient remained in the flat or corridor area this became seclusion.

Requires improvement

Are services safe?

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

Paragraph 3 of the MHA code of practice- 15.43 states, 'Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others'. We saw evidence that each time seclusion was used it was recorded on the patient records in details as to why seclusion was necessary. I

Safe Staffing

Staffing levels on the ward was sufficient to meet the needs of patients. The ward manager told us they were able to obtain additional staff when the needs of patients changed and more staff were required to ensure their safety. The manager confirmed the ward was using the flexible staffing bank to cover vacancies. Regular 'bank' staff were used wherever possible so that care and treatment was provided by staff who were familiar with the ward routines and patients' needs. Bank staff were part of the trusts' bank of staff so had completed the trust induction programme. Staff told us bank staff were given a brief induction to the ward, which included orientation to the layout of the ward.

There was one consultant psychiatrist providing care and treatment to patients on the ward. The manager told us the consultant contacted the ward everyday which enabled discussion of any concerns about patients' care and treatment.

When staffing shortages needed to be filled, this was generally done through the use of bank staff. This was well managed on the ward, and regular staff, who were familiar with the ward, were used to cover shift vacancies where possible. This meant most staff had knowledge of the ward and patients and were able to understand and manage foreseeable risks as a result.

Training records showed most staff had been trained in how to restrain patients safely using the respect model. Training included the use of breakaway techniques and how to deescalate or divert patients who were distressed. Staff told us they rarely needed to use physical intervention but sometimes used 'safe holds' as part of respect training. This was confirmed by trust records which showed there had been no recorded incidents of use of restraint in the last six months. There was written guidance for staff on the use of respect interventions. This helped ensure the practice was lawful, carried out safely and was not excessive.

Staff were aware of the needs of patients and were able to explain how they were supporting them. Appropriate nursing handover took place between shifts. We observed a handover on the ward. The meeting included detailed discussion of patients' needs, including any potential risks to their safety and how these should be managed or mitigated.

We observed how staff managed a patient who posed a risk to themselves and others. Staff had completed training on the respect model. The ward manager told us restraint to the floor was never used and we saw the ward did not have a seclusion room. This was confirmed by information received from the trust prior to the inspection which showed there had been 0 restraints at Grenoside carried out from the 1 February 2014 to 31 July 2014. Staff described working to the least restrictive practice with patients and they used the 'respect' model, which meant patients were able to be de-escalated effectively. We saw records were restraint had been recorded as the circumstances met the description in the Mental Health Act (MHA) code of practice. Where ligature points had been identified in en suite bathrooms, individual risk assessments identified the controls in place to reduce access to ligature points. For example one patient's en suite facilities were locked by staff before the left the patient's bedroom. The bedroom door was then locked thus secluding the patient.

The ward used the detailed risk assessment and management plan (DRAM) which was completed when a patient was admitted to the ward and then reviewed daily. We looked at seven patient's records and saw the assessment required the staff to update the most recent incidents. We saw when incidents had occurred following admission and the forms had been scanned into the patient electronic records system and the DRAM updated. This meant the number and severity of incidents was measured and staff were able to accurately assess the risk to the patient and others.

Where patients posed a risk to themselves or others we saw levels of observations were adhered to by staff. Patients where on 10 or 15 minutes observations or one to one staffing, dependent upon risk.

Assessing and managing risk to patients and staff

Requires improvement

Are services safe?

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

We found policies were in place to instruct staff about the safe handling of medicines. Entries in the controlled drug register did not always include the signature of the witness observing administration and sometimes the dose given was not recorded.

Ward treatment rooms were and refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature. This meant there was a risk that medicines were stored at the wrong temperature and might not be safe to use. Pharmacists were fully integrated into MDTs for inpatient services to support and ensure best outcomes from the use of medicines. An electronic prescribing and medicines administration system was in place on all wards and helped support safe and effective prescribing.

At Grenoside the team were using an excellent 'antipsychotic checklist' to monitor the impact of changes to a person's prescribed medicines.

The trust information technology (IT) system was fully integrated with primary care and the acute trust, and the mental health services had access to all blood investigations, scans, outpatient letters and discharge summaries from the primary care services in Sheffield. The medication prescriptions were part of the I.T system, which highlighted potential drug interactions. We spoke with the ward pharmacist and looked at all medicine administration records. The ward pharmacist had a full understanding of medication use for all the patients on the ward. The pharmacist carried out full drug histories of all patients who were admitted, and provided consultations to any patient who wished to question their medication.

Reporting incidents and learning from when things go wrong

We saw information about safeguarding was available to staff. Limited information for patients was displayed on the ward. The staff we spoke with told us they reported safeguarding incidents through the 'safeguard' electronic reporting system. Staff described the local policy was to report safeguarding incidents to the nurse consultant, manager or nurse in charge and they would send alerts to the local authority. We saw information could be completed within the system and the information faxed electronically to the local authority.

All staff told us they had completed training in safeguarding vulnerable adults and knew how to respond appropriately to any allegations of abuse. The trust had arrangements in place to ensure staff were aware of safeguarding arrangements and had ensured all teams received appropriate information in the previous year. We found evidence of this in our discussions with staff. The Trust was still developing its central monitoring systems to allow it to effectively track through which staff have received appropriate training. Until these were fully in place the trust was not able to effectively monitor its provision of training. Staff we spoke with were aware of how to refer safeguarding concerns and obtain safeguarding advice if needed.

Staff had received training in safeguarding vulnerable adults and staff we spoke with knew how to recognise a safeguarding concern. Staff told us safeguarding was discussed at ward team meetings and during individual supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures.

Staff were aware of the trust's safeguarding policy. They knew who to inform if they had safeguarding concerns. There was good, clear information available for staff on the safeguarding process. There was limited information displayed on the ward with a noticeboard holding brief safeguarding information. This information was behind a Perspex cover as we were told patients tended to remove notices displayed without one.

We saw there were systems in place to capture and review patients individual incidents and accidents which enabled staff to identify potential risk to them. We reviewed seven patients on the ward. These demonstrated the incident report forms were completed by staff on the paper system and the forms were scanned into the IT system by clerical staff. These were reviewed by the nurse consultant or ward manager and assessed regarding cause or severity. For example we saw that one patient had over one hundred incidents recorded and the risk assessments were reviewed after each incident. This had resulted in the patient needing a higher level of staff input and observation, which in turn had reduced more serious incidents because staff had learnt lessons and supported the patient more effectively.

The trust serious incidents requiring investigation (SIRI) data. The trust reported a total of 33 SIRI's between May 2013 and June 2014. Ten of these incidents occurred at a trust location whilst the remaining 23 occurred in the community. No SIRI occurred at Grenoside ward.

Requires improvement

Are services safe?

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

Staff told us reporting incidents was encouraged. Incidents were investigated and the outcome shared with staff and more widely at local governance meetings. Staff told us incidents were discussed in team meetings and changes were made to the care of patients as a result of any learning identified. We found learning within the team took place. Staff told us, and we observed safety and risk was discussed in team meetings and handovers. We saw evidence in recent team meeting minute's staff had been advised to see the revised health and safety risk assessment for safe working practice.

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

We found staff assessed patient needs and planned for their care and treatment. The multi-disciplinary team were effective, through good communication and leadership.

We found inconsistencies on Dovedale wards 1 and 2 regarding the completion of mandatory, role specific training and completion of supervision. This was included on the trust's risk register and there was an action plan in place to address staff training.

The wards followed best practice guidelines, for example NICE guidance, and were proactive in ensuring patients received good outcomes and experiences.

On both sites we found adherence to the Mental Health Act (1983) Code of Practice was inconsistent. We saw responsible consultants (RC) had sought a second opinion approved doctor (SOAD) to agree to the treatment plan in the patients'' best interests. We could not find evidence of documentation of the RC discussing with the patient or their carers the recommendation made by the SOAD.

Our findings

Location 1 Dovedale wards 1 and 2

Assessment of needs and planning of care

We saw that patients had an initial detailed risk assessment and management plan (DRAM) completed which highlighted their individual risks. We saw the DRAM was linked through the IT system to assessments for risk of falls, nutrition and skin integrity. We saw these assessments were completed in all the four patient records we reviewed. The system included the most recent incidents and saw risk assessments and management plans were reviewed as a result. This meant that risk assessments were reviewed following incidents so staff had the most up to date information about patient risk indicators.

We saw that risk management and care plans were amended as a result of reviews so staff had up to date information on how to manage risks. One patient told us, "I had never been in hospital before. I took an overdose and asked to be taken somewhere I would be safe from myself. At first I was observed, but as the medication prescribed worked I got better. Now I'm not a risk I can go out by myself. I am glad I came here it is the right place for me".

We saw evidence of joint assessment on admission between medical and nursing staff. A single record keeping format was used by all different disciplines so different professionals had access to relevant information. We saw detailed records of physical health checks being completed and reviewed. Physical healthcare screening included blood tests requested by doctor, review of medication with the pharmacist and referral where necessary to physiotherapy when patients were identified at risk of falling. Patients if required were referred to the dietician, speech and language therapist and for other diagnostic tests.

Patients told us their physical health was assessed on admission. One patient told us, "Soon after I arrived, I had wires attached to my chest and the doctor said he was monitoring my heart rate. After that it was blood tests".

We saw that assessment and care planning involved occupational therapy and psychology professionals linked to the wards. This meant patients had a more rounded assessment of need.

Best practice in treatment and care

The ward manager told us that currently the wards were not involved in any best practice or the peer review process such as The Royal College of Psychiatry quality assurance initiatives. They said the ward had been involved in the NHS Institute for Innovation and Improvement 'the productive mental health ward' initiative. The manager described this as a 'common sense' approach to improving the quality of life for patients and focused on:

- Increased engagement in ward activities, for example time with patients and one-to-one contact time increased.
- Improved focus on reducing incidents with better recognition of potential problems and timely intervention to make changes to care plans.
- Improved levels of safety.

However this was not being used now but the principles of the initiative were used to provide more effective care to patients. The ward manager said staff were working toward the move to a new unit in 18 months so this was the focus

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.

of the staff team at the moment. They said staff were involved in the development of the recovery care plan, which was being used on the ward and had also developed a falls risk assessment and management tool based on the national institute for health and care excellence guidance (NICHCE) used as part of the assessment and prevention of falls. We did not see evidence of a recovery care plan in use, but saw that patient' 'green goals' for positive health were completed, however these did not link to patient care plans, so staff may not be aware of the interventions needed to support patients to meet their identified goals.

We saw evidence that the falls risk assessment tools linked to individual patient care and risk assessments and there were detailed management plans in place to reduce individual patient risk of falling. Trust data for 2013-2014 recorded falls had reduced to 10% then 5%. On admission to the ward falls screening was completed. There was a physiotherapist and two technical instructors based in the service to provide activity based therapy and a falls prevention group patients could access.

The ward manager showed us evidence of a recent contact with the director of nursing regarding the introduction of a portable alarm system for patients. This was a bracelet worn by patients who were at risk of falling and linked to the call system on the ward. Twenty four bracelets had been ordered as well as 4 bed sensors to start monitoring/ reducing the number of falls at night.

We found patient fluid intake and nutrition was being adequately monitored and saw the DRAM assessment was completed and staff were recording individual fluid intake where necessary.

We talked with the psychologist, who told us they were involved in the recovery group which we observed. The recovery group met weekly and gave patients the opportunity to talk about the problems they would face when discharged and to develop relapse prevention strategies. The group was observed to be person centred and encouraged patients to interact or they could just listen. The group was inclusive and encouraged patients to share their experiences. The psychologist told us that information from the group was fed back into recovery and discharge care plans. The psychologist told us how the recovery model was introduced and the recovery care plans were being developed on the wards as a trial. These would be linked to individual patient goals. The psychologist clarified this was still work on progress and they had looked at a Northumberland model. The recovery group was based on cognitive behavioural therapy and supported patients to develop their own coping strategies. From our observation of the recovery group we concluded patients were benefiting from talking therapies.

Skilled staff to deliver care

The ward had occupational therapy and psychology input for individual patients. The information provided by the trust regarding mandatory training, demonstrated some levels of compliance were below the trust and national averages for NHS Trusts in England. The trust rated itself red in a risk category of red, amber and green for the percentage of staff with health and safety training. The figure provided for the trust was 48% of staff completing training and the national average 78%. The trust rated itself as amber for staff with completed appraisals in past twelve months, with 76% of staff having and appraisal and then National average was 87%. The percentage of staff completing equality and diversity training was 35% against the expected trust figure of 67%.

The ward manager provided us with the most up to date figures for training completed at ward level for Dovedale wards 1 and 2. There were 52 staff on the spreadsheet. Only 50% of staff were recorded as completing the trust training for the management of distressed behaviour 'Respect' training or mandatory update. Immediate or basic life support and first aid was 32%, Infection control 0% staff, medicines management 3%, clinical risk 4%, mentor update 7% and safeguarding children and adults 3%. Eight registered nurses were recorded as having a performance development review by the ward manager and there were no figures for health support workers recorded on the spreadsheet provided. The ward manager told us the training budget had to be prioritised to ensure that respect and safeguarding training were completed and this was the main focus of training at the moment and said other training such as equality and diversity was not a priority as part of the trust initiative to improve prioritised training. We were told by the ward manager but were not provided with evidence that two of the deputy manager were undertaking 'mindfulness' training with a view to this being cascaded down to all staff.

Staff and the psychologist told us about the 'reflective practice' support group, which we observed. This group was held with staff to help them discuss working with

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.

patients and formulate risk assessment, care and management plans. We saw this was a valuable means of support and helped them to discuss working with complex patients through a psychologist led formulation meetings

We observed a 'recovery' group on the ward and two occupational therapists used mindfulness relaxation techniques during the group work.

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. We were unable to attend a multidisciplinary team meeting but spoke with individual members of the team. We were told there was access to multi-disciplinary resources, with occupational therapy staff being part of the team as well as a psychologist. There was access to other professionals such as a physiotherapist, and/or speech and language therapists. Equipment to assess patients was available on the unit so patients could have their mobility assessed and a recovery programme started while in hospital. There was also a therapy kitchen were patients could be assessed on their ability to prepare drinks and meals.

Multi-disciplinary meetings included relatives. One relative told us they were involved in the meetings and said, "The occupational therapist is involved with my relative they have had individual sessions. I'm not sure about a care plan but I am from time to time invited to meetings as a relative. At one meeting I had to agree my relative being sectioned so they could try ECT" (electro convulsive therapy).

The consultant psychiatrist was on leave at the time of our visit so we spoke with the assistant medical director who was covering the ward. There were weekly reviews of the patients within the MDT, which included a medical review, which could result in extended stay in hospital.

We were told that a ward round/MDT took place once or twice a week for two to three hours where six or seven patients were reviewed. Some patients did not take part due to the acuity of their mental health, so the consultant would make contact with the patients following the meeting. The consultant, a nurse in charge or discharge coordinator, occupational therapist, psychologist, community mental health team or another allied health professional such as a physiotherapist always attended these meetings. Information was provided directly from the DRAM and used by the MDT team to make decisions about patient on going treatment.

We looked at a sample of records and found incidents of patient ill health or distressed behaviours were recorded as discussed at the meetings.

Patients who were detained under the Mental Health Act 1983 had their care programme approach meeting (CPA) during their stay and prior to discharge. We were told the average length of stay was 85 days. The CPA meeting assessed patient needs and planning it included staff from both health and social care services. If a patient stay in hospital was beyond the average length of stay their CPA meeting would reflect this.

Adherence to the MHA and the MCA Code of Practice

We looked at six patient's records who were detained under the Mental Health Act (MHA) 1983. We saw all the documents were in order and patients were lawfully detained 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. However when we looked at patients' treatment plans where the responsible consultant (RC) had sought a second opinion approved doctor (SOAD) to agree to the treatment plan in the patients'' best interests. We could not find evidence of documentation of the RC discussing with the patient or their carers the recommendation made by the SOAD.

We found there were no patients referred for a deprivation of liberty Safeguard, (DOLS) assessment by the local authority. DoLS is a framework for approving the deprivation of liberty for patients who lack the capacity to consent to treatment or care to make sure it is in their best interests. The Trust reported that no DoLS applications were made between February 2014 and August 2014. We asked the ward manager about what changes had been introduced since the Cheshire West decision about DoLS. The ward manager told us staff focused on risk and were more likely to use section 5(4) of the mental health act 1983 to detain patients who they deemed to be a risk to them self or others. The manager said, "It would be nice to get a

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.

clear steer on this as we assume capacity and test for this, but we are more likely to use 5(4) and focus on the mental health act so there is no dilemma as we can get the patient assessed by the RC".

Location 2 Grenoside Grange ward G1

Assessment of needs and planning of care

Patients' needs were assessed and care was delivered in line with their individual care plans. Assessments included a review of the person's physical health with specific assessments of infection risks, skin integrity, and risk of falls and nutritional risks. Where physical health concerns had been identified care plans were put in place to ensure the patients'' needs were met. Records showed risks to physical health were identified and managed effectively.

The ward manager provided us with figures from the ward governance report for April to September 2014.

Between July 2014 and September 2014 100% of physical health assessments had been completed within 72 hours. This was an improvement of 91% from April 2014 to June 2014.

One hundred percent of nutritional assessment had been completed between July 2014 to September 2014 and improvement from 91% in April 2014 to June 2014.

Falls assessment within 72 hours had decreased form 91% in April 2014 to June 2014 to 75% from July 2014 to September 2014. In the same time period falls had increased form 14 between April 2014 to June 2014 to 27 in July 2014 to September 2014 and increase of almost 50%.

We reviewed seven care plans on the ward and these showed individual plans were in place which addressed patients' assessed needs. We saw these were reviewed on a regular basis and updated or discontinued as appropriate.

Best practice in treatment and care

The nurse consultant and ward manager carried out regular audits as a way of ensuring high quality care was provided to people. For example, we saw audits of patients' care plans had been undertaken and detailed feedback provided to nurses to enable improvements.

The ward was not formally benchmarked in relation to other services and no formal accreditation for the ward had been sought. However, the ward manager had visited other services, was aware of current research in the field of dementia care and actively sought to implement improvements in care and practice based on upon robust evidence. For example using Stirling University best practice in dementia care to improve the environment. A psychologist visited the ward each week and offered staff advice and support on how to manage patients' distressed behaviour.

There was a full range of activities for patients on the ward. The ward had two activity coordinators so activities were provided seven days a week. Activities for some of the patents were on a 1 to 1 basis because of their levels of distress and complexity of their need. We saw activities were based on patient's choices and derived from information taken from that patient, family and life story work. We spoke with patients about the level of activities on the ward. One patient told us, "There's plenty to do, and I needed some help getting my words to match what I was saying. So they got me involved in relaxation, exercise and quizzes. It helped me get my confidence back, and my speech is a lot clearer now. One staff brought me a guitar in and said 'I know you used to play'. It's been twenty or more years and I picked it up and I remembered I could play red robin". Another patient said, "This lovely lady here keeps me company and occupied. I agreed to come here on respite. I get a bit over excited, so I join in the activities as it helps me relax. I have only known her a few days, but we get on well and she keeps me busy. I can make a drink and when I want have some quiet time".

On the day of our visit there was a Halloween party on and the staff had dressed up and themed activities and food was available. Patients and their family members and carers joined in the activities and seemed to enjoy the festivity.

We saw the use of soft dolls placed about the two areas of the ward. These were not toys but could be used as part of patients' treatment to lessen their distress. We saw patients using them as a means of comfort, by touching and stroking them. The dolls were available for patients to pick up. We saw one staff member using a doll to engage with a patient, by asking if the doll had a name. The patients responded by smiling and sharing their thoughts about the doll.

The occupational therapist attached to the ward had looked at research on the use of a robotic seal.It had the ability to learn and remembered its own name, and learned the behavior that resulted in a pleasing stroking response

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.

and repeated it. The seal was an interactive toy used to managing distressed and disturbed behavior. This was not used to deceive patients. The seal was being used by the trust as part of a clinical joint project with the University of Sheffield. The effectiveness of the robot seal was being evaluated on the ward. We saw it being used with patients in structured therapeutic sessions. We saw patients responded to the seal and were stroking and interacting with it. The occupational therapist said the focus was not the seal itself but the interaction it created. We saw one patient smile when their grandchild played with the seal and it responded. The relative of the patient who was visiting said, "It has an amazing effect. They have been quite depressed for the last week, and this is the first time we have seen them smile".

We spoke with the consultant psychiatrist who was the responsible clinician (RC) for the ward and had worked in the service since it was established. The RC showed us the work he and the team were doing on the ward which had led them being in the final three services for the royal college of psychiatrists mental health team of the year. The RC has led on the development of a clinical leadership model using a person centered approach and evidence based practice. For example using a neuro psychiatric inventory, this was used to assess neuropsychiatric symptoms of patients with Alzheimer's disease and other dementias. It captured treatment related behavioural changes in patients receiving anti dementia medication and other psychiatric medicines. The RC used this on the admission and discharge assessment of patients and used outcome measures to improve care and treatment. The RC said, "Some dementia services don't strive to improve the situation but the team approach is anything you can do is so worthwhile".

We saw a presentation the RC and nurse consultant had done on a presentation poster at a Royal College of Psychiatrist regional forum. This was a poster presentation entitled 'How good is your dementia assessment ward', encouraging other providers to share data and develop specific standards around benchmarks for similar services. The nurse consultant said this was to develop standards around expected length of admissions, discharge pathways and resources. For example to develop standards for commissioning of services. The nurse consultant said as a result a regional event was held which was attended by 7 areas. The ward had been given governance approval to proceed further with project but need to evaluate this against the cost of becoming accredited with the Royal College of Psychiatrists. The wards also won the local Sheffield awards team of the year 2013 as well as a poster presentation of Paroseal evaluation in 2013 dementia congress.

We saw staff using dementia friendly I pads with patients to do puzzles and crosswords as well as cognitive stimulation boxes. The ward was using person centred plans called 'This is me'. We saw these had been developed with patients' families and saw some very good examples of communication plans developed for two patients. The ward also used 'Told in South Yorkshire' a resource pack for developing life story work. This had bene incorporated into patients' person centred plans.

Skilled staff to deliver care

The team was led by the ward manager and nurse consultant wo held a master's degree in dementia care. We were shown records to evidence staff had received appropriate training, though supervision had fallen behind. Staff told us they had undertaken training relevant to their role including safeguarding vulnerable adults, fire safety and basic life support techniques. Records showed that most staff were up-to date with statutory and mandatory training requirements and their individual training records provided evidence of this.

New staff undertook a period of induction before being included in the staffing numbers. The ward manager had access the electronic staff records which allowed them to maintain oversight of staff progress in respect of training completion. The trust used a record of learning and training record for staff to record ward based, mandatory, e learning and other training. The training provided helped ensure staff were able to deliver care to people safely and to an appropriate standard. Staff told us there was in house training every week on different subject matter related to the ward and this contributed to the learning and development.

All staff told us they had undergone a performance appraisal within the last year which confirmed performance figures we saw on the ward. Individual supervision meetings took place every two months and formal records of the meetings were kept. Staff told us supervision usually took place as planned.

The ward manager provided us with the most up to date figures for training completed at ward level for Grenoside.

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.

From July to September 2014, 52% of staff completed safeguarding training, which was 3% lower than quarter one. 97% of staff completed respect and equality and diversity training and 73% of staff completed mandatory training which was 12% lower than quarter one. 40% of staff completed supervision, which was 33% lower than quarter one1.

Multi-disciplinary and inter-agency team work

The multidisciplinary team (MDT) met twice a week. Patients and relatives were invited to take part in the MDT meeting to be involved in their assessment and treatment plan. A patient and their partner told us they attended the MDT meetings and said, "About two weeks after their admission we were asked to the ward meeting. We met with Dr… and the team. They gave us an update as to what they thought had happened. Their tests showed an infection and that explained why they went so confused, as it happened very quickly. They were prescribed an anti-biotic and they had seen the dietician as they had lost weight in the general where they were assessed. Since being here they have improved. Staff are marvellous; they wanted me to tell them all about them so they knew about their life and our family. We were invited again last week and they talked about discharge, when they have improved physically".

Assessments of patients were multidisciplinary in approach, with involvement from medical, nursing and occupational therapists. The staff group including, nurses, psychiatrist; support workers, occupational therapists, and a physiotherapist. A psychologist visited every week to support the team and occasionally attended the MDT meetings. A podiatrist visited the ward every six to eight weeks.

There was evidence of effective MDT working in patients' records. Patients had access to a range of professionals with specialist skills where needed. We saw that care plans included advice and input from different professionals involved in patients care. We observed a thorough discussion of patients' needs involving the ward manager and occupational therapist, when a patient was considered not well enough to attend a group activity.

Staff described good working relationships with the dementia rapid response and home treatment team and told us systems worked well in terms of effective discharge planning, care programme approach and seven-day follow-up post discharge.

Adherence to the MHA and the MHA Code of Practice

We looked at the detention of six people at Grenoside Grange. Original detention papers were available for 5 out of the 6 notes we looked at. The one outstanding set of detention papers were for a person detained over two years ago. There were no approved mental health practitioner (AMHP) reports on any files, though we saw evidence the MHA administrator had written to the AMHP's requesting information on who the patients'' nearest relative was.

There was evidence of MHA tribunals and managers' hearings taking place and evidence patients were read their rights under section 132. We saw evidence discussions had taken place with patients to explain they understood their detention. The ward used a capacity assessment to determine whether patients would ever be able to understand their rights. Staff used a sensitive approach to this by starting to understand what patients understood about their detention. We saw evidence staff had discussed that using words like detained or hospital, could be difficult. As a result staff approached patients' families and carers and involved them in supporting their family members where possible to understand their rights.

Patients' care records held copies of section 17 leave authorisation. The information in these was appropriate but would have benefited from more details what had been authorised. The ward was recording what section 17 leave patients had taken. We looked at capacity to consent to treatment for the two patients this related to. Where the responsible consultant (RC) had sought a second opinion approved doctor (SOAD) to agree to the treatment plan in the patients'' best interests. We could not find evidence of documentation of the RC discussing with the patient or their carers the recommendation made by the SOAD.

Information on the rights of patients who were detained was displayed on the ward notice board and independent mental health advocacy services were available to support patients. Staff were aware of the need to explain people's rights to them. There was information for patients and relatives in the patient and relative information booklet about the rights of patients who were detained under the

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.

mental health act 1983 (MHA). This information also included information for patients who were informally admitted to the ward about their legal rights while in hospital.

Good practice in applying the MCA

The Trust reported that no deprivation of liberty safeguard (DoLS) applications were made between February 2014 and August 2014. There were two existing patients with DoLS restrictions in place and the ward was waiting for Sheffield council to authorise a further urgent application.

We saw capacity assessments were discussed in multidisciplinary team meetings and documented, with good detail. Care plans were in place for patients where necessary which explicitly addressed issues of capacity and consent.

Information in the patient and relative information booklet about the mental capacity act 2005 (MCA) described the process for involving patients in decisions about their care and treatment. The information described the process for involving them, their families and advocates in best interest decisions about their care and treatment.

Good

Are services caring?

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

Summary of findings

During the inspection, we spoke with six patients and four relatives and reviewed comment cards from both patients and relatives. We attended three staff handovers, a recovery group and a community meeting.

During the inspection, we spoke with six patients and four relatives and reviewed comment cards from both patients and relatives. We attended three staff shift handovers, a recovery group and a community meeting.

Most of the feedback received from patients and their families was positive. Patients and relatives reported they were satisfied with the service and staff treated them with privacy and dignity. We also received some negative comments about one of the wards, when a patient told us they felt that a staff member was disrespectful to them.

We saw staff involved patients in their care, though there were inconsistencies. At Dovedale we saw patients were not consistently involved in care planning and at Grenoside patients were involved in their life stories and person centred plans.

Our findings

Location 1 Dovedale wards 1 and 2

Kindness, dignity, respect and support

We talked with patients and observed their care and interactions with staff. Patients were engaged in activities on the ward during our visit. We spoke to patients about their care and some of our conversations were brief yet complementary, for example one patient told us "I have to have things to do to keep me busy. I like to a bit of cleaning, if I don't do something I get quite worried and have to ask staff if I'm doing alright. Staff are quite patient with me and giving me something to do or helping out works". Another patient told us, "I think the staff here do a very good job. I have never needed to ask for anything or complain." We observed patients approached staff for support and time was given to them to ask and explain about why they were anxious. We observed another patients shouting for assistance and trying to get up out of a chair. They did this for about five minutes but no staff responded to them despite staff being sat in the office. As the patients' distress level increased a staff member responded to the patient with kindness and understanding.

The involvement of patients in the care they receive

We were told patients and their relatives were included in the ward rounds if necessary and relatives were invited to the CPA meetings.

Observation care plans were comprehensive but did not reflect patient involvement. This meant care planning did not consistently reflect patients were consulted about their care.

We saw there was information from the patient advice and liaison service (PALS) displayed, which asked for patients and relatives comments.

We were not provided with written relative feedback about the ward during our visit. The manager told us relatives were consulted about patients care and treatment and feedback was given then.

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

Our expert by experience spoke with two patients and one relative. Patients said they thought the environment was comfortable and they felt safe. Patients also told us they were not involved in discharge planning and some staff were uncaring in their attitude. One informal patient said they did not understand their admission so an advocate was arranged to visit them and they benefitted from this. The patient said, "They arranged for an advocate to visit me as I really didn't understand what was going on. I had tried to top myself and just didn't understand the mess I was in. The advocate was really good and helped me understand what is going on". Another patient said they were aware of the activities on offer and has joined in some, but were not involved in planning their care and said, "There are meetings about pottery and exercise. You can play games here on the computer or watch TV and plan table tennis We have weekly meetings and at one they explained benefits and helped me to find a flat, but I am not aware of any plan to help support me when I leave here. I don't know about a care plan". Another patients told us, "I feel bullied over the meal time stuff, being rushed, 'Have you finished'…(care support worker) always in my eyes. I can't imagine how he

Are services caring?

Good

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

was chosen to work on a mental health ward. He is causing me huge anxiety over this, it's upsetting me. I have been told I will be leaving soon, 'Got to keep things moving', 'You have to start looking into events and groups you can attend when you leave'. I was surprised by this as I thought my medication was being reviewed". A relative said discharge planning included relatives wishes, but they needed to be more involved in care planning. The relative said, "I think that mum changes in her mood so much that's the reason we don't have a care plan, which is bizarre here as sometimes she refuses to eat and drink. A discharge plan was started but stopped because mum kept changing. As a relative I was reassured by this, as I don't want mum forced out".

Our expert by experience sat in on the community meeting between the two Dovedale wards. This was attended by three staff and four patients. Patients told us the meeting was held every two weeks and it was an open meeting to talk about suggestions from patients or the suggestion boxes on the wards. Patients said the purpose of the meeting was to 'help the ward run smoother'. We were told by patients an action plan was developed as a result of the meeting. We saw the minutes from the last meeting were read and matters arising from this discussed. We saw patients were able to raise questions. The quality and variety of food was discussed in detail. Patients had raised concerns about the quality of deserts as the pastry being too hard. Some improvement had been noted but staff from the kitchen said the food was not cooked on site so it was hard to change. Patients were told custard could not be changed so a dietician was involved in looking at this. One patient raised concerns about the high calorific content of meals and why potatoes were on the menu so often. The guest speaker was from 'Activity Sheffield' a council funded scheme looking to get patients involved in physical activity. Patients were introduced to the activities available and some signed up for 'tai chi'.

The patient exit questionnaire was discussed as new poster and leaflets were available on the wards. These would be given to patients at discharge. Information was shared about the new interactive information service. Patients commented on the groups available and how good the pat dog service was. There was discussion about the spirituality group in the afternoon and how patients enjoyed this. We had feedback from patients that the service had improved. One patient commented, "It's less violent than four years ago". We saw minutes from previous meetings were available for patients on the ward notice boards.

Location 2 Grenoside Grange ward G1

Kindness, dignity, respect and support

Patients' privacy and dignity were respected. Patients and their family members and carers told us staff treated them with respect. We observed staff interacting with patients in a caring and compassionate way. Staff responded to patients in distress in a calm, gentle and respectful manner. They appeared interested and engaged in providing good quality care to patients and anticipated their needs. Patients and relatives told us they were treated well and supported by staff. One patient said, "They are really lovely girls. When I was getting angry with myself as the words just wouldn't come out they just sat and held my hand and said to take my time". A relative told us, "The care here is great; the layout of the building really suits my relative and they have the freedom to walk around. Lots of other people here enjoy walking the square corridors and have always felt they are safe". Another relative told us, "They listened to me and updated my relatives plan and I am aware of and involved in the care and discharge plan. On the whole it is a great place".

We saw many examples of kind, caring and sensitive interactions between staff and patients. During our visit the staff priority was to ensure we did not distress patients and they explained who we were and the purpose of the visit. This helped to promote and sustain the very calm and peaceful atmosphere within the ward. Patients were encouraged to take regular drinks and were assisted to sit comfortably in their chairs. Staff asked patients how they were feeling. Staff positioned themselves at the same height as patients when they were talking to or assisting them. Staff were not over familiar and used touch appropriately to gain and maintain patients' attention. Patients who needed help to eat or drink were given one to one assistance. Staff worked with patients with a person-centred approach.

The involvement of patients in the care they receive

Patients and relatives told us about they were included in the ward rounds if necessary and relatives were invited to the CPA meetings.

Good

Are services caring?

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

We saw patients were given information about Grenoside prior to their admission, which was available in large print. This also included information about accessing the chaplaincy and interpreter services as well as information about complaints. Limited information was displayed on the ward areas, but the ward also had patients I pads, which could be used to provide information about the service to patients. There were no community meetings held on Grenoside but carers reported positive feedback through questionnaires about the support group.

We saw good examples of life story work in patients care plans, which helped staff to understand patients' lifestyles prior to their diagnosis.

Good

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

There was an effective approach to the assessment and admission of patients onto the wards.

Patient discharge was planned as part of their admission and was only delayed due to a lack of suitable placements in the community.

The service ensured patient's equality and diversity needs through access to interpreting and advocacy services as necessary. The Dovedale wards were having interactive information screens fitted so patients could access information about their care, treatment and service information. Both sites had invested in information technology to promote a safer environment and reduce the number of falls.

Staff were able to explain the complaints procedure and were aware of the trust's policy and procedure if someone wanted to make a complaint. Patents and relatives were aware of the information about complaints and how they could use this. At Dovedale we saw this information was discussed as part of the community meeting.

Our findings

Location 1 Dovedale wards 1 and 2

Access discharge and bed management

We were told the wards had a total of 16 beds on Dovedale 1 and 14 beds on Dovedale 2 for the assessment and treatment of older people. Information was available on the trust website and on the ward. Referrals were also accepted from the community mental health teams, the adult liaison psychiatry service and the older adult liaison psychiatry service. Emergency referrals were considered from the on-call registrar under the guidance of the on-call duty psychiatric consultant.

On admission patients were assessed on the ward for psychiatric and physical needs by the junior doctor on site. We reviewed four patients' records which confirmed this.

The ward manager told us there were not active pathways in place but they used the recovery pathway. We noted patients were staying for up to 85 days.

We saw the bed management monitoring tool used for assessing the capacity of bed occupancy within the trust. This confirmed Dovedale 1 had 13 beds occupied and one patient on leave. Five of the patients on Dovedale 1 were detained under the mental health act 1983. On Dovedale 2 there were nine patients with one on leave. For both wards there were two patients on extended leave and one patient to be admitted and one bed available. The ward had a bed management coordinator who was also one of the deputy managers. Weekly bed management meetings were attended by the discharge coordinator and consultant psychiatrist. The bed management coordinator told us their role was to gather information from daily handovers and weekly MDT meetings about patients' continuing health care and social care needs. This was done after admission to facilitate discharge and look at contributory factors to potential delayed discharges.

The ward manager told us there was active discharge planning by the ward. The wards worked closely with DART (the Discharge and Rehabilitation Team) and the older adult community mental health teams to support discharges from the ward. The trust provided us with information that there has been a gradual reduction in the number of delayed days at the trust from a peak of 422 in November 2013 to 237 in August 2014. The number of patients with a delayed transfer of care has fluctuated between nine in September 2013 to a peak of 16 in May 2014 to eight in August 2014.Between January and June 2014 there had been a total of 36 re-admissions in five locations. During the same time, there were 29 delayed discharges in six locations. Dovedale 1 and 2 had one readmission within 90 days and seven delayed discharges over the last six months. The ward manager told us delayed discharges were due to finding suitable nursing home placements and for one patient while their accommodation was refurbished.

The Trust had clear care pathway arrangements in place to support effective follow up post discharge. This was reflected in its performance for follow up of people discharged on the care programme approach (CPA). Trust performance during 2013/14 was in line with expected standards and national averages, and the most recent quarter, June 2014 showed a rate of 97%, in line with the national average of 97%

The ward environment optimises recovery, comfort and dignity

Good

Are services responsive to people's needs?

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

We found Dovedale 1 ward was very large and although it was commissioned for 16 bedrooms there was an additional four bed dormitory. Dovedale 2 had been refurbished in recent years and provided accommodation and communal facilities off one main corridor with single bedroom accommodation. Both wards were connected by a corridor which sloped upwards from Dovedale 1 to Dovedale 2. This provided disable access to both wards There were rooms where patients could meet with or call their relatives in private and an outside garden area which patients had access to.

We saw there were rooms available which could be used for activities/rehabilitation and there were activities taking place during our visits.

We saw the ward had a private room where patients could make telephone calls. We observed that; and were told by staff snacks and drinks were available over 24 hours if requested.

We saw there was information on the notice boards about the ward and activities available, advocacy services, the complaints process and information about the mental health act.

Ward policies and procedures minimise restrictions

The wards had electronic locks but we were told informal patients were told of their rights and how to access and egress the ward. Staff described the ward doors as 'locked doors'. We spoke with two informal and one detained patient. The detained patient told us they could not leave the ward without a staff escort and understood this restriction. The two informal patients told us they were aware the doors were locked and had to ask staff to let them out when they wanted to leave. One patient told us, "When I first arrived here I was being watched all the time as I had tried to top myself. I understood why, but it was a bit scary. Now I can go out shopping or leave the ward when I want to, but have to ask staff to leave. I don't think there is a way around it".

We found access to the garden was available to patients throughout the day. Patients could have keys to their bedrooms but were able to lock the rooms from the inside when they went into them. When we visited we observed the bedroom doors were not locked.

Meeting the needs of all the patients who use the service

We saw information was in English however there was access to information in other languages and interpreters should they be required. At the time of our visit we saw one example of how a patient's cultural needs had been responded to. The wards were also being fitted with a touch screen information board. This was put in place to provide patients with interactive information about the Trusts' services, visions and values and what patients should expect to meet their care needs during their stay. This provided information to patients on the mental health act, advocacy and other useful information and could be available in different languages.

We met with the chaplaincy team leader based at the hospital. The team leader told us there was an active team with two support workers attached to the team. A Muslim chaplain had joined the team at the time of our visit. The team leader said they attended patients' discharge meetings and could arrange some support from local churches if necessary. They said their role was to support patients 'spiritual' needs and raise their profile. They told us, "We see our role as delivering spiritual care. We do support the staff team and leading on the introduction of mindfulness ideas. We are always trying to raise our profile and send staff e mails, this seems to work well. We work with occupational therapy and the recovery support group and try to enable patients to be aware of the benefits. I think this service supports the patients effectively, I see really ill patients admitted and I see real and powerful transformations and positive changes in them".

Listening and learning from concerns and complaints

We saw there was a complaints policy displayed in the ward and information about the PALS, which support patients to raise concerns. Some information was in an easy read format. We were told most concerns were resolved locally at ward level, if the manager was unable to do this they would be raised through the trust complaints procedure or to the chief executive officer (CEO) by the 'fastrack' form. This was system which allowed patients to send their complaints directly to the CEO. We saw the patients' handbook on the ward, which included information about the complaint procedure and a copy of the fastrack form. This book was in the process of being reviewed with patients and staff to reflect more patient led and recovery focused information.

From information provided by the trust prior to the inspection, (The internal audit for 2013/14 for incidents and

Good

Are services responsive to people's needs?

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

complaints published April 2014), which reported on data collected in 2012/13. The report included the actions the trust needed to take to ensure it was listening, responding to and learning from complaints. In the period 2013 to 2014 the Trust informed us of 164 complaints, 122 (78%) were not upheld. The ward manager showed us the complaints records for Dovedale 1 and 2. We saw one complaint had been received and we saw the ward manager had responded to this appropriately. However another patient told us they had written to the manager about meal times, as staff were rushing patients to finish their meals. The patient said they had met with the manager who had explained "It was policy" to have the room cleaned and tidied quickly. We were not told about or shown this complaint.

Location 2 Grenoside Grange ward G1

Access, discharge and bed management

Referrals to Grenoside were through the dementia rapid response and home treatment team. The ward consisted of two ten bed units.

On admission patients were assessed on the ward for psychiatric and physical needs by the junior doctor on site. We reviewed seven patients' records which confirmed this.

Care was delivered in the ward by a multidisciplinary team. Most admissions to the ward came via a consultant psychiatrist. The aim of the service was to discharge patients once they had reached an optimal level of functioning. Occupational therapists were able to carry out home assessments and were able to ensure necessary arrangements were in place before patients were discharged.

A target of seven-day follow-up post-discharge by community staff was in place and mostly achieved.

Discharge summaries were sent to patients GPs by the administration staff to ensure they were kept informed of patients' progress and on-going needs, including prescribed medicines.

Ward staff reported that people's care co-ordinators were invited to care programme approach (CPA) meetings and usually attended.

The ward manager told us there was not an active pathway in place but they were used the recovery pathway. We noted patients were staying for up to 85 days, apart from one patient whom had been on the ward for two years. The ward was operating at 60% occupancy because it had in place good discharge planning and ward gate keeping processes. In addition, alternatives to inpatient care were offered to patients by the dementia rapid response and home treatment teams. We saw evidence of discharge planning for patients with one patient due to be discharged. We saw evidence that the patient who had been on the ward for two years had been discharged but had to be readmitted as the provider could not meet the patients' needs. Grenoside had no re-admissions within the last 90 days and 13 delayed discharges in the last six months. The ward had a bed management coordinator who was also one of the deputy managers, who undertook this role two days a week. Weekly bed management meetings were attended by the discharge coordinator and consultant psychiatrist. The ward manager provide us with figures from the governance report which recorded the average length of stay between July and September 2014 was 85 days. Between April and June 2014 it was 106 days. The average length of stay excluding delayed discharges was 44 for April to June 2014 and 62 between July to September 2014.

The ward environment optimises recovery, comfort and dignity

We found Grenoside ward was large and although it was commissioned for 20 bedrooms three of these offered larger living accommodation for those patients who needed additional space or more independent living. These bedrooms had been created by the refurbishment of existing internal facilities. Both the male and female accommodation had its own communal rooms consisting of lounge, dining and quiet rooms. There were plenty of additional internal areas patients could safely walk around with seated area for their comfort. There were rooms where patients could meet with or call their relatives in private and outside garden areas which patients had access to. In addition there were clinic areas were patients could have physical examinations and medicines were stored safely.

We saw there were rooms available which could be used for activities/rehabilitation and there were activities taking place during our visits.

We saw there was limited information on the notice boards about the ward and activities available, advocacy services, the complaints process and information about the mental health act.

Good

Are services responsive to people's needs?

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

Ward policies and procedures minimise restrictions

We did not see any restrictive practice on the ward. The wards had electronic locks but we were told informal patients were reminded of their rights and how to access and egress the ward. Staff described the ward doors were locked due to the risk to vulnerable patients leaving the ward areas and not being familiar with the external surroundings. There were also some patients who had complex needs and the level of observation and risk management of them, meant the ward doors were locked. We spoke with two informal patients and two relative about the security arrangements on the ward. The informal patients said they could go for a walk outside by themselves, with relatives or staff if needed. One patient said, "I was that confused as to where I was I needed someone to help me get about. I wasn't right enough to care. Now I can get out with my relative or staff". A relative told us, "They need to be safe. The staff lock the rooms that they don't need to get into or they would get more distressed. They try to get them out as much as possible".

We found access to the garden was available to patients throughout the day. Patients could have keys to their bedrooms, if this was appropriate, but were able to lock the rooms from the inside when they went into them. When we visited we observed patients' bedroom doors were not locked unless they had to be. Other bedroom, toilet and bathroom doors were locked when there was an identified risk to individual patients.

Meeting the needs of all patients who use the service

Information was available to patients and relatives in an information booklet provided information about the ward and its purpose. This was written in plain English and incorporated information about assessment and treatment. MDT team, bedroom and other accommodation additional services, monies and valuables, laundry and mealtimes and refreshments as some examples.

Patients' diversity and human rights were respected and attempts were made to meet their individual needs including cultural, language and religious needs. Arrangement for accessing representatives from different faiths or interpreter services were detailed in the patient and relatives' information booklet. We saw there were large print versions available for patients and staff said the booklet could be uploaded onto patient I pads.

A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to access appropriate meals.

Listening to and learning from concerns and complaints

We saw there was information about the complaints displayed in the ward as well as being included in the ward information booklet, with information about the complaints manager contact details. Relatives we spoke with were aware of the 'fastrack' form, which allowed patients or relatives to send their complaints directly to the CEO.

From information provided by the trust prior to the inspection, (The internal audit for 2013/14 for incidents and complaints published April 2014), which reported on data collected in 2012/13. The report included the actions the trust needed to take to ensure it was listening, responding to and learning from complaints. In the period 2013-2014 the Trust informed us of 164 complaints, 122 (78%) were not upheld. The nurse consultant provided us with evidence the ward had not received any complaints for over two years. We saw evidence of positive comments and compliments received from relatives and carers about the care patients had received while at Grenoside.

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

Services were locally well led and staff understood the vision of the local leadership and the positive developments planned for the future. Senior managers were involving staff in the developments of the services. For example at Dovedale the proposed re location of the wards.

Staff described their morale as good, with good local leadership. Staff said there was engagement with trust headquarters through the non-executive directors, which included ex patients. We saw evidence of staff involvement in the fifteen step challenge.

Staff said they were supported and listened to by the local management teams and would feel confident in raising any concerns. For example we saw team meeting minutes were staff were asked about their ideas for service improvement.

The Grenoside ward had good governance systems in place to ensure patients received a quality and innovative service, which met patient needs. For example in being nominated for the royal psychiatrist team of the year and evaluation of the robotic paroseal with Sheffield university.

Our findings

Dovedale wards 1 and 2

Vision and values

We found the staff had their own vision and values about the service. Staff were aware the two wards were to move to a new site in the next eighteen months, Staff told us they were part of a number of groups which were involved in the planning for the move. This included staff being involved in the recovery model of care. We saw for Dovedale wards 1 and 2 staff were waiting to access e learning training on the recovery model and write recovery based care plans which the wards were to introduce.

A registered nurse who had transferred to the service told us they had chosen to relocate to the Dovedle wards and said, “I was offered re deployment after an accident and had quite a bit of choice as to where I could go. I chose Dovedale as it has a good reputation. The staff have been welcoming and supportive and I was supported through the transfer until I felt comfortable. What I like is the values of the team, as patients always come first”. All staff we spoke with told us they were aware of whom the chief executive was as well as having visits from the executive team.

The managers in the service whom we spoke with had a clear understanding of where the service’s strengths and weaknesses were. Managers were able to identify them as well as recognise areas to focus upon for future service development. One manager told us, “The trust did a full consultation when we moved here. This was good for Dovedale as we haven’t lost the focus. The non-executive team include a former patient, someone who has been involved in the production board for the reconfiguration of services”.

Good governance

The ward manager said there had been a review of all the Dovedale wards and there was a plan in place to move to a new site in the next eighteen months. The trust provided us with information on how they were to use the model for the transfer to Dovedale 1 and 2 to the Longley Centre. This involved patients and family consultation and work streams for staff to be involved in.

The governance structure consisted of monthly team governance meetings on each ward and a quarterly core governance meeting which included the consultant psychiatrist, and clinical director. Team governance meetings followed on from the core governance meetings where information would be cascaded about performance. The manager told us the senior management team would invite ward managers to the core governance meetings and they would attend usually twice a year. The manager told us there was a two weekly senior management team meeting on the ward which included the psychologist, lead OT, deputy ward managers and housekeeper responsible for domestic and catering arrangements. The ward manager said there was a series of away days for staff and managers as part of the reconfiguration of services this involved sharing the plans for the reconfiguration of service including Dovedale wards 1 and 2. The manager said, “This allows us to plan and manage what’s coming and a good way of sharing information, which takes away the distraction and frustration. This was shared on the away day we had for the two wards.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We saw minutes of meetings from October 2014. The minutes referred to the CQC inspection of the service and advised staff to go about their duties as normal. There was information about how the governance meetings minutes were available to staff and the importance of reading them to keep up to date with changes. For example new term of reference for governance meetings. The meeting covered local and trust governance including the 15 step challenge and core governance meeting.

We were provided with information about staff training within the trust for the last twelve months. The information provided by the trust indicated training for a number of areas was below the national average for English NHS Trusts. The trust rated itself red in a risk category of red, amber and green for the percentage of staff with health and safety training. The figure provided for the trust was 48% of staff completing training and the national average 78%. The trust rated itself as amber for staff with completed appraisals in past twelve months, with 76% of staff having and appraisal and the national average was 87%. The percentage of staff completing equality and diversity training was 35% against the expected trust figure of 67%.

We saw there was evidence of ward based audits such as infection control, hand hygiene, care planning and health and safety. We were provided with information by the ward manager, which demonstrated local governance was proactive. We saw the audit system for care documentation. Weekly reports of all risk assessments were sent to the consultant psychiatrist, ward manager, discharge coordinator/deputy manager and junior doctor; the deputy ward managers audited the electronic records to identify issues around record keeping standards. For example to check if care plans were being reviewed and if registered nurses were countersigning notes by junior staff if this was required.-led,

At ward level we found there were no systems in place to ensure staff received the necessary training, and support. There was appropriate consistent medical cover and the care documentation was accurate. We also found activities taking place and there was evidence of local engagement with patients and relatives.

Leadership, morale and staff engagement

We found there had been changes to the management structure of the service with the ward manager supported by four deputy managers. The ward staff told us they regularly saw the ward manager as there were daily meetings on the ward. They said they felt the management were approachable.

We saw evidence of formal staff engagement, supervision, appraisal and clinical supervision for the staff on the ward.

The associate medical director told us they were aware of the consultation and planning for the move to the new location for the Dovedale wards despite not being the lead clinician for them.

Staff told us about the working practice groups they were involved in. The different groups included developing the recovery model, staff training and leadership. The aim of the groups was to ensure all staff were engaged in the development of the systems, processes and practices to support the move to the Longley Centre where Dovedale was relocating to. This meant staff were engaged in supporting the development of a recovery focused service.

Commitment to improvement and innovation.

Across the service, we saw that local auditing of procedures, such as medicines management, infection control and health and safety were completed. Gaining feedback from patients about the treatment programme and services offered was a large part of how local improvements were achieved. Exit questionnaires were sent to each patient following discharge however the trust was only receiving a 10% return rate. However we did not receive any figures regarding feedback from patients exit questionnaires for the Dovedale wards.

Feedback was sought through the community meetings on the ward and patients could make a complaint or compliment through the fastrack form. We saw feedback form the 15 step challenge visits from non-executive directors and patients' representatives to Dovedale wards 1 and 2 for August and September 2014. Feedback was provided about positive and good practice for the welcome the visitors received, safe care of patients and the environment and caring and involving patients. Positive feedback included comments from staff and patients, "I would leave my relative here", "Staff wore identity badges" and "The calmness of the environment". Negative feedback included a blocked fire exit, the de-escalation room being used as storage room, limited staff patient interactions and potential trip hazards.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The chaplaincy team leader told us leadership within the trust was committed to improving services offered and said, "I followed up complaints that the trust staff were not always giving the chaplains good support. I raised this with the senior management team and things quickly changed and the trust are now brilliant at supporting our work. We have a spiritual care strategy plan for the next three years in place. The trust board have agreed to discuss this with us in detail and we are pleased with this".

Grenoside Grange ward G1

Vision and values

We found the staff had their own vision and values about the service. Staff were aware of the work in progress for potential accreditation with the Royal College of Psychiatrists as well as the nomination for team of the year. Staff said they were involved in the therapeutic activities in the ward and this contributes toward good patients care. Staff told us the team worked together and this was a result of the leadership and values of the managers of the service.

The managers in the service whom we spoke with had a clear understanding of where the service's strengths and weaknesses were. Managers were able to identify them as well as recognise areas to focus upon for future service development. One manager told us, "We just keep working at understanding the patients' perception of how they see their admission and care, and try to understand so we can improve".

Good governance

The ward manager provided us with information about the service review for 2014 - 2015 for Grenoside, which included achievements and future plans for 2015 - 2016. The review highlighted achievements in the number of patients being discharged home had increased, as well as assessment of the home environment prior to discharge through better liaison and collaborative work with families. This had been supported through 'let's talk about dementia' carer sessions. The safety of the care and treatment of patients had been improved through non pharmacological interventions, introduction of the paroseals and empathy dolls. Staff had completed respect training. A dietician was visiting the ward on a weekly basis and the introduction of equipment and assistive technology had reduced the number of falls. Plans for 2015 – 2016 included the introduction of non pharmacological interventions using NICHE guidance and living well with dementia.

The governance structure consisted of a bi monthly directorate governance meeting, weekly supervision with the directorate line manager, monthly meetings for the staff team, registered nurses, supervision and development groups. Weekly MDT meetings quarterly and an annual governance meeting. The nurse consultant told us there was six weekly staff supervision, which included management supervision. Figures provided by the ward manager for quarter 1 and 2 was supervision figures had reduced to 40% in quarter 2 form 73% in quarter 1.

We saw a comprehensive audit of the health and safety risks associated with practice, policy and procedures on the ward. This was reviewed annually and identified the controls in place to minimise and reduce risk in the ward environment. All staff had to confirm they had read and understood the outcome measures of the audit.

We saw the specialist service governance template for Grenoside which set the service objectives for 2014 - 2015. This linked to the trust risk register and highlighted both the trust and service objectives. For example the trust risk register highlighted the reduction of staff sickness and need to increase staff mandatory and statutory training. Both of these objectives were highlighted on the governance template. Service specific objectives were meeting the nutritional needs of patients, moving toward outcome measures and cleanliness and infection control.

Sickness figures highlighted short term sickness had fallen in quarter 2 from 3% to 2%, while long term sickness had risen from 5% to 5%. Long term sickness was being dealt with in line with the trust policy. Mandatory figures for training had improved with 85% of staff up to date with mandatory training and 97% of staff up to date with respect training. Nutritional screening by the dietician had identified patients who needed specialist input. This was supported by menu planning involving the dietician. Occupational therapist and clinical team. Monthly audit of infection control were being completed and the trust Place annual audit recorded the figures for the ward had risen from 2013-2014. Cleanliness was 99/68%, Food hygiene 95%, privacy dignity and wellbeing 83% and appearance and maintenance 100% a significant risk from the previous year.

We saw minutes of meetings from October 2014. The minutes referred to the CQC inspection of the service and advised staff to go about their duties as normal. There was information about how the governance meetings minutes

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.

were available to staff and the importance of reading them to keep up to date with changes. For example new term of reference for governance meetings. The meeting covered local and trust governance including the 15 step challenge and core governance meeting.

We saw there was evidence of ward based audits such as infection control, hand hygiene, care planning and health and safety. We were provided with information by the ward manager, which demonstrated local governance was proactive. We saw the audit system for care documentation. Weekly reports of all risk assessments were sent to the consultant nurse and ward manager and deputy managers. The ward and deputy managers audited the electronic records to identify issues around record keeping standards. For example to check if care plans were being reviewed. The dietician also monitored record to ensure patients' nutritional needs were being monitored and met.

Leadership, morale and staff engagement

The ward manager was supported by the consultant nurse and two deputy managers. The ward staff told us they regularly saw the ward manager as they led the clinical team. Staff told us managers were supportive and approachable.

We saw evidence of formal staff engagement, supervision, appraisal and clinical supervision for the staff on the ward. However the information noted in quarter two supervision levels had fallen and as a result the manager had introduced a record for staff to capture how they received supervision and support.

Staff told us about the development groups on the ward and spoke enthusiastically about the Paroseal, empathy dolls and outcome measures introduced and training they had. Staff said they were supported and despite vacancies had regular support staff from flexible working. They said this helped as staff they had from flexible working tended to know the patients. Staff said moral was good but there was anxiety as the ward manager was due to retire and the ward manager's leadership style was supportive and inclusive. Staff said the aim of the development groups was to ensure all staff were engaged in the development of the systems, processes and practices to support the development of the ward. This meant staff were engaged in supporting the development of a recovery focused service.

Commitment to quality improvement and innovation

Across the service, we saw that local auditing of procedures, such as medicines management, infection control and health and safety were completed. Gaining feedback from patients about the treatment programme and services offered was a large part of how local improvements were achieved. Fifty five compliments were received from patients and relatives between April and September 2014.

Feedback was sought through the community meetings on the ward and patients could make a complaint or compliment through the fast-track form.

The entry application for the royal college of psychiatrist team of the year explained how the service had.

- Introduced a new formal senior clinical management system, care pathways were refined for the whole team to introduce a robust, forward thinking, compassionate, person centred model of care.
- All care on the ward became overseen and coordinated by a senior nurse.
- Frequent staff training now focuses on models of dementia care which are reinforced in every MDT and staff handover.
- Use of technology was proactively introduced. 24/7 consultant gate-keeping of new admissions was introduced.
- The average length of stay has reduced from 122 days to 62 days, bed numbers were reduced from 55 to 20, but occupancy rates also reduced from 98% to 65%, so admissions were no longer delayed.
- Positive comments in staff surveys have increased from 25% to 90% with 100% reporting training as positive.
- Sickness reduced from 8% to 3%. Engaging patients and carers is more proactive and included in care plans as are formal, regular meetings with relatives. New educational seminars for carers receive excellent feedback.
- Documented compliments have increased from 0 to 125 per year.
- Serious untoward incidents have reduced from 3-5 per year to zero, at this point.
- Low use of antipsychotic is specifically targeted and rating scales of target symptoms versus side effects administered.
- Clinical outcome data now show an average reduction in the neuropsychiatric inventory (NPI) score of 70%. The average of 65 on admission is reduced to an

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.

average of 19 pre-discharge. All data indicate we are admitting the most distressed patients and are now providing a high quality team based intervention of substantial benefit to patients.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person had not protected service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of service. On Dovedale ward 1 patients had unobserved access areas of the ward where fixed ligature points are located is reduced. **Regulation 15(1)(c)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not protected people against the risks associated with medicines because there was not a sufficient systems in place to manage medicines in the forensic services. Temperature monitoring of medication fridges was not being carried out. Entries in the controlled drug register did not include the signature of the witness observing administration and correct recording of the dosage of medication given to patients. **Regulation 12(f)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**