Care Quality Commission

South West London and St George's Mental Health NHS Trust

Tolworth Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It 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.

Summary of findings

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Summary of findings

Overall summary

Tolworth Hospital is in Surbiton, South West London and is close to a range of local amenities. South West London and St George's Mental Health NHS Trust provides the three inpatient wards that we visited as part of this inspection.

We found that the services were safe, the wards were clean and staff were aware of risks. There were ways to report and learn from incidents, but improvements were needed in assessing and managing risks to people's safety.

Staff interacted with people who used the service in a caring and compassionate way. People and their relatives were involved in planning their own care, although records did not always reflect this. People were engaged in activities they felt were meaningful and therapeutic. Ward staff listened to people’s feedback and involved them in making positive changes.

The Mental Health Act responsibilities were being discharged appropriately. Some actions from previous Mental Health Act monitoring visits had not been fully resolved.

We saw good examples of learning from audits and incidents being shared, and changes to practice being made as a result.

All staff we spoke to on the ward told us they received training for safeguarding children and vulnerable adults as part of their annual mandatory training. They also said they would be confident in reporting safeguarding – either internally or to the local authority.

Staff told us they felt supported by the management on the ward and their immediate managers. Some staff told us they did not always feel involved in conversations about their roles, particularly when organisational changes were taking place.

We visited the following wards at Tolworth Hospital as part of this inspection:

Azaleas Ward

Core service provided: Services for older people

Male/female/mixed: mixed

Capacity: 23 beds

Fuchsias Ward

Core service provided: Services for older people

Male/female/mixed: mixed

Capacity: 5 beds

Lilacs Ward

Core service provided: Acute admissions ward

Male/female/mixed: mixed

Capacity: 23 beds

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Mental Health Act responsibilities

We reviewed the detention papers of several of the detained patients in the hospital.

These showed that people were being legally detained under the Mental Health Act 1983 with good evidence of scrutiny and support from the Mental Health Act administrators based at the hospital.

The wards were locked. People who were not detained formally were aware of their right to leave the ward and we saw notices displayed giving people information about leaving the ward.

Arrangements were in place to ensure people could take authorised leave. Leave was being appropriately recorded and included conditions where appropriate.

Risk assessments were completed for people using the service. Care records demonstrated that individuals' risk assessments were being documented, regularly reviewed and updated as required.

Records showed that each person's physical health was assessed when they were admitted and then reviewed. We saw people being helped to access healthcare services at the time of our inspection

Acute admission wards

Staff were aware of the trust's incident reporting systems. The managers told us that immediate plans were put in place to reduce further similar incidents from reoccurring, where necessary. When serious incidents took place there was an immediate de-briefing with staff involved.

All ward staff told us they received training for safeguarding children and vulnerable adults as part of their annual mandatory training. Staff knew who the safeguarding leads for the ward and the trust were.

Staff told us they would be confident in reporting safeguarding – either internally or to the local authority. We saw that an alert had been raised with the local authority and interim plans were put in place for some people using the service.

Staff were aware of the trust's whistleblowing policy and they said they felt sufficiently confident to use the policy if they were concerned about people’s safety.

Most patients told us they felt safe on the ward. We saw ‘Stop Adult Abuse’ posters in the ward corridor.

Risk assessments were carried out during patients' initial assessment and were reviewed or updated as required. We saw patients were supported with comprehensive risk management plans, including risks to themselves and others, crisis plans, relapse indicators and contingency plans.

People who used the service told us that they had been consulted on their risk assessment and were able to contribute during their care plan review meeting.

The ward manager told us they had access to a ‘virtual risk team’ made up of senior managers. However, they said they had not yet referred any incident to that team.

We saw routes of administration being recorded incorrectly, doses of medicines being recorded in progress notes but not on medicines administration records, and patients who were administered as required lorazepam and promethazine with no record in their progress notes as to why it was being given. This meant it could not be checked if these medicines were being used appropriately.

Summary of findings

Services for older people

There was confusion in the reporting of incidents and learning from these in the service for older people. We found that not all incidents were being recorded and this was putting people at risk.

Staff told us they did not know what happened after they submitted incident forms as they did not get feedback and they were not discussed as a team.

Staff had a good understanding of safeguarding procedures and were aware of how and where reports should be made. We saw that staff had all received training in safeguarding from the trust.

People told us that they felt safe on the wards.

On one of the wards the female patients had to walk through an area for male patients to access the bathroom.

The separate female lounge was used as the ward ‘quiet room’ and for ward meetings which meant there was not always a separate area available for women to spend time in during the day.

We saw that risk assessments were up to date. However some specific tools such as Waterlow assessments were not completed for some people.

We found that some falls risks had not been identified for people and the guidance (Falls: assessment and prevention of falls in older people) issued by the National Institute for Health and Care Excellence (NICE) in June 2013 was not being followed for all of the people using the services.

We reviewed the administration of medication for people using the services for older people. On one ward we saw that some of these charts were not completed fully. We found some charts where it was not possible to tell if a dose of medicine had been administered. We also noted that staff did not always record on the prescription chart when someone was detained under the Mental Health Act (1983).

We saw that medicines were stored securely. Emergency equipment and medicines were checked daily.

Are services effective?

Mental Health Act responsibilities

We saw that people were being legally detained under the Mental Health Act 1983, and that the Mental Health Act administrators, based at the hospital, provided good scrutiny and support.

We found that staff were applying the five principles of the Mental Capacity Act when supporting people and that assessments were specific to each person.

Staff had been issued with trust guidance around consent and capacity updated in January 2014.

Acute admission wards

We were told that NICE bulletins were disseminated and discussed at the business meetings.

Staff told us they completed a monthly monitoring tool called SIREN, which reported against staffing levels/mix, safeguarding, complaints, incidents, care plans and risk assessments.

We saw that people were supported through a multidisciplinary assessment carried out by ward staff, who took account of people’s physical and mental health.

The inpatient team and the home treatment team worked well together.

The ward's 'dashboard' confirmed that staff had completed their mandatory training.

Summary of findings

Services for older people

Staff told us how they used NICE guidance to inform treatment for people who used the services.

Azaleas ward caters for the needs of older adults who have organic brain disorders and functional mental health disorders. There were separate areas within the ward for people with these needs. Staff told us of the higher risks associated with the diverse needs of people using the service and the challenges of the current ward environment in ensuring individuals' privacy and dignity.

We were told how staff liaised with the community mental health teams for older adults to ensure that people were discharged effectively through clear pathways of care.

Staff told us they had completed mandatory training. We saw an appropriate mix of qualified nurses and healthcare assistants on duty to ensure that the needs of people on the ward were met.

Staff told us dementia training was not provided but they had developed skills through experience and discussing issues with their managers.

Staff told us that they felt supported by their managers. We were told by staff that they had received support specifically around person-centred support planning.

Are services caring?

Mental Health Act responsibilities

People using the service told us that staff were friendly, helpful and involved them in the care planning process.

People were aware of their care plans and said they had been involved in their development.

Individuals were reminded of their rights under the Mental Health Act 1983.

We saw that people staying on the wards had regular access to an advocate and feedback was positive about this service.

We noted that staff were aware of the need to consider the least restrictive option for people's care and were aware of their duties and responsibilities under the Deprivation of Liberty Safeguards.

Acute admission wards

People using the service were positive about the staff and the care they had received.

We saw that people had their needs assessed when they were admitted and their views were an integral part of the assessment.

We saw that the patients were reviewed daily by the team and care plans were reviewed and updated after the meetings.

Records we checked on wards contained evidence of care planning and patients confirmed they were given a copy of their care plans.

People who used the service had access to advocacy services and all patients we spoke to were aware of these services.

Staff were able tell us when and how capacity assessments were carried out. We saw 'best interest' meetings had taken place.

Staff told us team meetings occurred weekly and were attended by all staff from the multi-disciplinary team.

We were told that community meetings are held weekly. These meetings were attended by patients and members of the multi-disciplinary staff team.

Summary of findings

Most staff had a good understanding of the needs of the patients on the ward.

We saw that people received appropriate support to enable them to achieve the recovery goals they had agreed.

Staff on wards told us they followed the 'recovery model' when supporting patients. We saw recovery goals were agreed with people to help reduce the likelihood of them being readmitted.

Staff and patients interacted well together on the ward. We observed staff treating patients with dignity throughout our visit.

Patients said staff respect their privacy and dignity.

Care plan review and one-to-one meetings were held in designated rooms to ensure people's privacy was maintained.

All staff told us they had been trained to use restraint. However, they said it was only used as a last resource.

We checked records and saw that, where restraint was used, the necessary follow-up checks and paperwork had been completed.

Services for older people

On both wards, we observed thoughtful and involving care being offered to people who used the service. People told us they were given choices and they felt listened to by members of staff.

We observed someone's family members being involved in a ward review meeting. This was because the person using the service lacked the capacity to engage in care planning discussions.

We checked the records for ward rounds on one ward; we saw that decisions were explained in them, however it was not clear whether people were present or involved in discussions about their care. We saw that nursing notes were very brief and focused on limited issues like eating, sleeping and taking medication. This meant that they did not present a rounded view of individuals who used the service.

On one of the wards, we looked at notes from ward round meetings but did not see evidence that people's views were sought in relation to decisions about their treatment.

Staff told us that they had access to interpreter services when there were people on the ward who did not speak English.

We saw that everyone on both the wards had access to advocacy services, whether they were detained or had been admitted to the wards informally.

We saw that the ward worked with the local community mental health teams for older people and the home treatment teams to ensure that people had access to support when they were moving towards discharge.

We saw that people who used the service were treated with dignity and respect. We observed that staff took time to explain the care being delivered to people who told us that they were treated with respect at all times.

Are services responsive to people's needs?

Mental Health Act responsibilities

We saw evidence of discharge and crisis planning on the wards. The electronic care plans and risk assessments put in place on the ward could be used by community staff once people had been discharged.

People using the service were being involved in the day-to-day running and development of the wards through regular patient forums and community meetings.

Summary of findings

People using the service told us the activities run by occupational therapy staff working alongside dedicated activity staff were good. These included groups for walking, art, exercise and cookery.

Acute admission wards

Information was displayed on noticeboards detailing how to make a complaint, including how to contact Patients Advice and Liaison Service (PALS), advocacy and CQC.

Staff on the ward told us they encourage patients, family and friends to give feedback via the 'real time' feedback system. We saw evidence that patients had used this to make comments.

Staff on the wards told us they felt that patients were not offered enough access to psychological therapies. They said that when people request it and it is agreed by the multi-disciplinary team, then it can take a long time to become available.

All patients told us they knew how to make a complaint and most said, if they had one, they would probably go to their ward manager or allocated nurse in the first instance.

Services for older people

Staff explained the importance of providing specific care to meet individuals' needs, on the basis of their culture, language, religion or sexuality. We saw that people had access to a chaplain who attended on the day of our visit.

We saw close working between the inpatient wards and community mental health teams for older people – both attending the meetings we observed.

People using the wards had access to physical health checks, which were carried out regularly to monitor any changes.

We saw that care plans were adjusted when people's needs changed, particularly their physical health needs.

We were told that there had not been any recent complaints in the wards and that this was a positive sign for the ward. The wards did not have access to information about complaints across the Trust, which may have led to further learning. the trust share learning form complaints and this is available on inSie. This includes teams of complaints and trust wide complaints information and learning. All complaints are analysed and reported to the board these reports are also included. As are compliments that the trust has received.

Are services well-led?

Mental Health Act responsibilities

There was a clear framework for monitoring the provider's duties under the Mental Health Act 1983.

We saw processes were in place for the scrutiny of detention documents and monitoring of consent to treatment.

Auditing tools were seen to be in use by staff to ensure consistent standards, addressing areas such as Section 17 leave, Section 58 treatment requiring consent and the rights of people on the wards – both formal and informal.

Ward staff said they received feedback from the Mental Health Act (MHA) office on the results of these audits and felt well supported by them via their ongoing guidance and training.

Staff working at the MHA office felt able to raise any concerns they had with their line manager.

Acute admission wards

Staff on the wards felt their managers were knowledgeable, supportive and approachable.

Many staff we spoke with felt disconnected from the senior managers at the trust and could not say whether they felt the trust was well-led.

Summary of findings

Some patients told us they felt the real time feedback was a good way of talking to the senior managers. However, most said they had not met any senior managers from the trust. They felt they could always feed back to ward managers.

Services for older people
We were told that there is a lead to coordinate each shift, take handovers and make decisions about the support that people needed.

One member of staff told us that the new modern matron was supportive and had taken decisions which had led to improvements in the working environment.

Most staff told us that they were proud to work for the provider. They recognised the leadership of the Chief Executive and felt a part of the organisation.

Some staff told us that they felt they did not always feel involved and valued by more senior management in the trust. One member of staff told us that they had been redeployed twice and had not been involved in conversations or decisions about where they would be working, and this concerned them.

All the staff we spoke with told us they felt supported by their immediate managers.

We saw that the managers at the ward level had clear understanding of their responsibilities on the ward. We saw that they used the tools, such as the online dashboard, to ensure that they understood the needs of the ward and to identify areas where there needed to be additional work, such as mandatory training records.

Staff told us that they could approach their managers on an ad hoc basis and felt able to raise issues that concerned them.

We saw that feedback had been received from a local clinical commissioning group regarding improvements on the ward when the provider had moved to a single consultant model. This showed how the provider responded to feedback from stakeholders.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

We found there were a number of people who were (or who had recently been) detained under the Mental Health Act 1983 on the wards we visited. All of the patients reviewed were legally detained under sections of the Mental Health Act 1983.

We saw that people were informed of their rights when they were admitted and then reminded of these rights throughout their period of detention.

For people who were detained and required treatment under the special rules in the Mental Health Act, these were in place to ensure that treatment was properly and legally authorised.

There were arrangements in place to ensure that leave under section 17 of the Mental Health Act was authorised and reviewed appropriately.

The trust has in place a Mental Health Act framework for monitoring its duties under the Mental Health Act 1983.

We found that the staff and managers were providing services to people under the Mental Health Act in safe, caring, effective, well-led and responsive ways. However, we felt that improvements were needed to ensure that appropriate action was completed following our Mental Health Act monitoring visits.

Acute admission wards

Patients were referred to the wards by Kingston Crisis & Home Treatment Team. We saw that there were clear referral notes indicating patients care and support needs as well as identified risks. The deputy managers told us they met with the home treatment team monthly.

We saw people had their needs assessed on admission and their views were an integral part of the assessment.

All staff we spoke to on the ward told us they had safeguarding training for children and vulnerable adults as part of their annual mandatory training delivered by the trust. All staff that we spoke with said they would be confident enough to report safeguarding either internally or to the local authority.

The ward used a colour coded zoning rating to identify people’s clinical risk.

People who used the service told us that they had been consulted in the assessment of risk and were able to contribute during their care plan review meeting.

We checked prescription charts for people on the ward, and we saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear, fully completed including people's allergy status, and showed people were getting their medicines when they needed them.

Services for older people

We found that people received caring and thoughtful care on the wards at Tolworth Hospital. We spoke with people who used the service, observed their care and we spoke with family members of people who used the service and people gave very positive feedback about the medical and nursing staff on the wards. We observed positive interaction between staff and people who used the service and saw that people were treated with respect and dignity.

We saw that there were a number of processes to record falls, which were not always consistent, so there was a risk that some fall information would not be registered and could mean there was not enough adequate learning from incidents. Staff gave us mixed feedback about how they would report incidents.

Summary of findings

Medical staff had a good understanding of clinical guidance such as NICE guidelines and it was used to inform the care and treatment of people on the wards. Both wards worked well with multi-disciplinary teams on the wards and in the community to ensure that people received the optimum care and were supported through their discharge.

Staff on the ward recognised the importance of meeting the cultural and spiritual needs of people on the ward. People's physical health needs were monitored to ensure that the care they received met their needs.

Staff told us they felt supported by the management on the ward and by their immediate management. Most people recognised the senior management in the provider organisation. Some staff told us they did not always feel involved in conversations about their roles, particularly when organisational changes were taking place.

Summary of findings

What people who use the location say

Ensure that these is an arrangement in place to record why sedative drugs prescribed 'as required' were given and this is recorded in people's records.We left comment cards at Tolworth hospital, but none of these were completed during our time on site. The comments from people using the service have been included throughout the report.

Areas for improvement

Action the provider MUST take to improve

- Ensure that suitable storage, recording and monitoring systems are in place to ensure medications are handled safely and appropriately.
- On Azaleas, access to the bathroom and toilet required female patients' to walk through an area for male patients. The trust must ensure that these arrangement comply with Delivering same sex accommodation in mental health and learning disability service: Briefing from the NHS Confederation (January 2010).

Action the provider SHOULD take to improve

- Ensure that specialist training is provided to all staff working in specialist areas of the trust.
- Develop and implement the falls recording and learning system to ensure that falls are recorded and learning is put into practice.
- Develop the electronic patient notes system to ensure that is supports and evidences true patient involvement in the planning of their care.

Good practice

Our inspection team highlighted the following areas of good practice:

- There were good systems in place for receiving detention papers when patients were first admitted under the Mental Health Act and ensuring that individuals are explained and reminded of their rights throughout the period of their detention.
- Staff empowered patients and carers to be at the heart of planning their care and treatment. We saw evidence of comprehensive care and risk plans that were developed with reference to relevant National Institute for Health and Care Excellence guidance.
- Knowledge and awareness of local safeguarding reporting procedures.
- Knowledge and awareness of local whistleblowing procedures.

Care Quality Commission

Tolworth Hospital

Detailed Findings

Services we looked at:
Acute admission wards; Services for older people

Our inspection team

Our inspection team was led by:

Chair: Steven Michael Chief Executive South West Yorkshire Partnership NHS Foundation Trust

Team Leader: Nicholas Smith Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultant psychiatrists, junior doctors, nurses, social workers, Mental Health Act Commissioners, psychologists, patient 'Experts by Experience' and senior managers.

Background to Tolworth Hospital

Tolworth Hospital is a location of South West London and St George's Mental Health NHS Trust. Tolworth Hospital is located in Surbiton and is situated close to a range of local amenities

We visited the following wards at Tolworth Hospital as part of this inspection;

- Azaleas Ward - a service for older people with functional and organic psychiatric conditions, illnesses and disorders.
- Fuchsias Ward - a continuing care service for five older people, suffering from dementia illness.
- Lilacs ward - a 23 bed acute admission ward.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Tolworth Hospital was considered to be a <insert risk level> service.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

We held a public listening event on the 10 February 2014 and also met with community groups on 7 and 12 March 2014. During our time on site we also met with individuals who asked to speak with the inspection team.

We carried out an announced visit between 17 and 21 March 2014 and undertook site visits at all the hospital locations. We inspected all the acute inpatient services and crisis teams for adults of working age and older people, visited all of the long stay/forensic/secure wards, child and

Detailed Findings

adolescent mental health service (CAMHS) and all of the learning disability community teams. We also visited the specialist inpatient services and a sample of the community teams.

During the visit we held focus groups with a range of staff in the location, including nurses, doctors, therapists and allied health professionals. We talked with people who use services and staff from all areas of each location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences on the services received from the provider.

Mental Health Act responsibilities

Information about the service

There are two inpatient wards for older people at Tolworth Hospital. Azaleas is an admission and treatment ward for older people with organic brain disorders and functional mental health disorders. Fuchsias is a continuing care ward for older people with dementia. Also on the Tolworth Hospital site is Lilacs Ward which is a 23 bed acute admissions ward for males and females.

Summary of findings

We found there were a number of people who were (or who had recently been) detained under the Mental Health Act 1983 on the wards we visited. All of the patients reviewed were legally detained under sections of the Mental Health Act 1983.

We saw that people were informed of their rights when they were admitted and then reminded of these rights throughout their period of detention.

For people who were detained and required treatment under the special rules in the Mental Health Act, these were in place to ensure that treatment was properly and legally authorised.

There were arrangements in place to ensure that leave under section 17 of the Mental Health Act was authorised and reviewed appropriately.

The trust has in place a Mental Health Act framework for monitoring its duties under the Mental Health Act 1983.

We found that the staff and managers were providing services to people under the Mental Health Act in safe, caring, effective, well-led and responsive ways. However, we felt that improvements were needed to ensure that appropriate action was completed following our Mental Health Act monitoring visits.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

Rights Under the Mental Health Act 1983

People on the wards informally were aware of their right to leave the ward and we saw notices displayed giving people information about exiting the ward. Arrangements to ensure authorised leave were in place. Records demonstrated that leave was being appropriately recorded and included specified conditions where appropriate. The provider may find it useful to note that the leave form in use had no space to record the name of the responsible clinician, only their signature. We also noted the document only had space to allow escorted or unescorted leave with no space to show that people may be accompanied by family or friends.

Risk Assessments

Risk assessments were seen to be completed for people using the service. Care records we looked at demonstrated that individualised risk assessments were being documented, regularly reviewed and updated when needs or risks changed.

Records

Records seen showed that physical health assessments had been carried out and reviewed for each person using the service. Each person had a health check on admission and benefited from access to medical staff on the ward with out of hours cover arrangements in place. We saw examples of people being facilitated to access healthcare services at the time of our inspection

Are Mental Health Act responsibilities effective?

(for example, treatment is effective)

Detention Papers

Detention papers were available for inspection on the provider's electronic information system. The records reviewed showed that people were being legally detained under the Mental Health Act 1983 with good evidence of scrutiny and support from the Mental Health Act administrators based at the hospital.

Capacity and Consent

Improvements were seen around the assessment of individual capacity and consent on Azaleas ward. Records seen showed that staff were now applying the five principles of the Mental Capacity Act when supporting people and that the assessments undertaken were specific to the individual. Staff spoken to had been issued with trust guidance around consent and capacity updated in January 2014 however some individuals would clearly benefit from further training to understand and apply the Mental Health Act and Mental Capacity Act 2005.

Gender Specific Services

We were informed that plans were in place to open new wards at Tolworth Hospital providing separated facilities by gender and need. This would address the current situation on Azaleas Ward which was seen to be a mixed ward providing care for men and women, some of whom were living with dementia. Staff members spoke of the higher risks currently associated with the diverse needs of people using the service and the challenges of the current ward environment in ensuring individual privacy and dignity.

Are Mental Health Act responsibilities caring?

Patients participation in care planning

People using the service spoken to on both wards visited were positive about the care and support being provided to them. They told us that staff were friendly, helpful and involved them in the care planning process.

People spoken to said they were aware of their care plans and said they had been involved in their development. We saw examples of planning involving individuals in setting out goals and first steps for their recovery. Other plans seen addressed areas such as physical healthcare, observation and detention.

Rights under the Mental Health Act 1983

Individuals were aware of their rights. We saw that individuals were being informed of their rights under the Mental Health Act 1983 and care records reviewed showed that they were regularly reminded of these by staff. A leaflet about 'Your Rights and Responsibilities' was also available to people staying on wards informally. We saw that people staying on the wards had regular access to an advocate

Mental Health Act responsibilities

and feedback was positive about this service. Leaflets and notices were displayed across both wards visited however we noted that some out of date information was displayed about how to contact the CQC.

Least Restrictive and Deprivation of Liberty Safeguards

We noted that staff were aware of the need to consider the least restrictive option for people's care and were aware of their duties and responsibilities under the Deprivation of Liberty Safeguards. Two examples were seen where staff had considered the need to apply to a supervisory body to deprive a person of their liberty.

Are Mental Health Act responsibilities responsive to people's needs?
(for example, to feedback?)

Care Planning

We saw evidence of discharge and crisis planning on both wards visited. Plans to discharge the person were included as part of the care planning process and we saw recovery plans written in the first person focused on 'going home'. The electronic care plans and risk assessments put in place on the ward could be used by community staff once discharge had been achieved.

Patient Involvement

People using the service were being involved in the day to day running and development of the wards through regular patient forums and community meetings. The practices on Lilacs Ward were noted with people using the service saying they felt involved in the running of the service. Feedback was positive on both wards regarding the provision of activities from occupational therapy staff working alongside dedicated activity staff. We saw weekly groups were scheduled for activities such as walking, art, exercise and cookery.

Are Mental Health Act responsibilities well-led?

Mental Health Act Framework

A framework for monitoring the provider's duties under the Mental Health Act 1983 was in place at Tolworth Hospital. We saw processes were in place for the scrutiny of detention documents and monitoring of consent to treatment. Auditing tools were seen to be in use by staff to ensure consistent standards addressing areas such as Section 17 leave, Section 58 treatment requiring consent and the rights of people on the wards both formal and informal.

Staffing

Ward staff spoken to said they received feedback from the Mental Health Act (MHA) office as to the results of these audits and felt well supported by them via their ongoing guidance and training. It was noted that the Mental Health Act administration staff did not however routinely spend time on wards with people using the service. There may be opportunities to further develop the role of administrators in providing guidance and information both to people using the service and the staff on each ward.

Staff working at the MHA office felt able to raise any concerns they had with their line manager. We noted that this office had assumed responsibility for Community Treatment Orders (CTO) since 2008 without any change to the staff allocation for the increased workload.

Acute admission wards

Information about the service

Lilacs Ward is a 23 bed mixed gender acute mental health admission ward serving the catchment area of the Royal Borough of Kingston. They provide an inpatient service for people who are in the acute phase of their mental health problems, utilising the recovery and social inclusion process. Referrals come through the Kingston Crisis & Home Treatment Team.

Summary of findings

Patients were referred to the wards by Kingston Crisis & Home Treatment Team. We saw that there were clear referral notes indicating patients care and support needs as well as identified risks. The deputy managers told us they met with the home treatment team monthly.

We saw people had their needs assessed on admission and their views were an integral part of the assessment.

All staff we spoke to on the ward told us they had safeguarding training for children and vulnerable adults as part of their annual mandatory training delivered by the trust. All staff that we spoke with said they would be confident enough to report safeguarding either internally or to the local authority.

The ward used a colour coded zoning rating to identify people's clinical risk.

People who used the service told us that they had been consulted in the assessment of risk and were able to contribute during their care plan review meeting.

We checked prescription charts for people on the ward, and we saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear, fully completed including people's allergy status, and showed people were getting their medicines when they needed them.

Acute admission wards

Are acute admission wards safe?

Learning from incidents

Staff we spoke with were aware of the trusts incident reporting systems. We were told staff involved would enter the details onto the system and these were then checked by the ward manager. They would then send the information to the trust's incident team. The managers told us, where necessary, immediate plans were put in place to reduce further similar incidents from reoccurring. We were told when serious incidents took place there was an immediate de-briefing with staff involved.

Learning from incidents was discussed during team meetings which occurred either weekly or monthly. Records we checked contained detailed information about incidents.

Safeguarding

All staff we spoke to on the ward told us they had safeguarding training for children and vulnerable adults as part of their annual mandatory training delivered by the trust. They were able to describe the different forms of abuse and how they would respond to any allegation of abuse and this was consistent with the local policy. Staff were aware of who the safeguarding leads for the ward and the trust were.

All staff that we spoke with said they would be confident enough to report safeguarding either internally or to the local authority. Staff told us there had been occasions when people had not wanted to be discharged due to them being concerned that their family would not allow them access to community treatments.

We saw that an alert had been raised with the local authority and interim plans were put in place to allow the people to get their medication.

Safe Environment

The design and layout of the ward meant that staff had adequate visibility of people to enable safe practice. We saw that where there were blind corners appropriate measures had been put in place to improve visibility.

Most patients' we spoke with told us they felt safe on the ward. We saw that ‘Stop Adult Abuse’ posters were visible in the ward corridor.

Risk Management

Risk assessments were carried out during patients' initial assessment and reviewed or updated during care plan review meetings or if people’s needs had changed. We saw patients' were supported with comprehensive risk management plans. Both risks to self and others were assessed. Crisis, relapse and contingency plans were very clear, identifying relapse indicators and warning signs.

The ward used a colour coded zoning rating to identify people’s clinical risk.

People who used the service told us they had been consulted in the assessment of risk and were able to contribute during their care plan review meeting.

The ward manager told us they had access to a ‘virtual risk team’ made up of senior managers. However, they said they had not referred any incident to that team as yet.

Medication

We checked prescription charts for people on the ward, and we saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear, fully completed including peoples' allergy status, and showed people were getting their medicines when they needed them. There were no gaps on the administration records and any reasons for not giving people their medicines were recorded by nursing staff. We saw that if people were detained under the Mental Health Act, the appropriate authorities were in place for medicines to be administered to them. We saw that the ward pharmacist provided training, attended medicines reviews and added additional information to prescription charts to help nursing staff to give medicines correctly. We saw that people were prescribed medicines for minor ailments, such as coughs and indigestion, as well as medicines for their mental health issues. Staff on the ward were aware of the process for reporting medicines incidents. All prescribed medicines were available, and staff told us that medicines were dispensed without delay by the on-site pharmacy, which was run by Kingston Hospital. This meant people were receiving their medicines safely, as prescribed and without delay.

Emergency equipment and medicines were checked daily. Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, and so would be fit for use. We noted that the

temperature of the room, in which medicines were stored, was not monitored; therefore we could not be assured that these medicines were being stored at the correct temperature to remain fit for use.

The use of Rapid Tranquilisation (RT) fell within the trust's policy, 'Rapid Tranquilisation - Trust wide Clinical Policy'. Compliance with this policy was monitored via three monthly audits. The results of the audits showed there was a lack of consistent and complete application of the policy. This was confirmed when we looked at records on these wards. We saw routes of administration being recorded incorrectly, doses of medicines being recorded in progress notes but not on medicines administration records, and patients who were administered as required lorazepam and promethazine with no record in their progress notes as to why it was being given. This meant it could not be checked if these medicines were being used appropriately.

Whistleblowing

Staff were aware of the trust's whistleblowing policy and they felt sufficiently confident to use the policy if they were concerned about people's safety.

Safe Staffing Levels

Staff we spoke with on the wards told us they felt the level of staff and skills mix was adequate. The manager told us that on occasions they are able to book extra staff if the needs of the patients required it, such as high numbers of detained patients that required one to one support and observations.

At the time of our visit the only vacancy on the ward was the manager post. There were two deputies sharing management tasks. However the new manager was due to start in May.

Patients we spoke with said they felt there was a lot of staff around all the time.

Are acute admission wards effective?
(for example, treatment is effective)

Use of clinical guidance and standard

The deputy manager told us NICE bulletins were emailed to them regularly and they would disseminate and discuss the information at the monthly business meetings. Staff we spoke with told us they had recently discussed improvements in Schizophrenic care and treatment.

Monitoring quality of care

The deputy managers told us they completed a monthly monitoring tool called SIREN. They said they reported against staffing levels/mix, safeguarding, complaints, incidents, care plans and risk assessments.

Collaborative multi-disciplinary and multi-agency working for assessments, care planning and access to health services

We saw good evidence that people were supported through a multi-disciplinary assessment carried out by ward staff. They took account of people's physical health needs as well as mental health. Information included access to occupational therapy and considerations about people's weight, dental needs and smoking cessation.

Patients were referred to the wards by Kingston Crisis & Home Treatment Team. We saw that there were clear referral notes indicating patients' care and support needs as well as identified risks. The deputy managers told us they met with the home treatment team monthly.

Are staff suitably qualified and competent

All staff we spoke with told us they had access to regular mandatory training. The deputy manager told us all staff on the ward were up to date with their mandatory training. We saw evidence on the wards dashboard to confirm most staff were up to date.

Most staff told us they had regular supervisions, at least every six weeks. The deputy manager told us they had managerial supervision every four weeks and clinical supervision every six to eight weeks. We saw notes from the last meetings.

Are acute admission wards caring?

Choice in decisions and participation in reviews

Most of the patients we spoke with were positive about the staff and the care they had received.

We saw people had their needs assessed on admission and their views were an integral part of the assessment.

There was evidence that multi-disciplinary meetings about each patient took place regularly. We saw that ward rounds occurred weekly and care plans were reviewed and updated after the meetings. The consultant told us care plan review meetings were usually attended by the patient,

their relative, a social worker and their allocated nurse. They said they always tried to take the needs of family and carers into account and patients were encouraged to make contributions to their care plan and treatment.

Record's we checked on wards contained evidence of care planning and patients confirmed they were given a copy of care plans.

We were told patients had access to advocacy services and all patients' we spoke to were aware of the advocacy service. We saw that posters were displayed in the ward with contact details for Mind and Rethink.

Staff we spoke with said they felt that people received good care on the ward.

Staff had a good understanding of the Mental Capacity Act. Staff were able tell us when and how capacity assessments were carried out, which were mainly carried out by the doctors. However there had been occasions where the deputy ward manager had carried out capacity assessments. We saw 'best interest' meetings had taken place.

Effective communication with staff

Staff told us team meetings occurred weekly. They said they discussed patients care packages. We looked at notes from some of these meetings and saw they were usually attended by all staff from the multi-disciplinary team.

We were told that community meetings are held weekly. We saw notes from some of these meetings. The agenda included activities, hygiene on the ward and health and safety of patients'. The meetings were attended by patients' and members of the multi-disciplinary staff team.

We observed good interaction between staff and patients' on the ward.

Do people get the support they need

Most staff we spoke with demonstrated good understanding of the needs of the patients' on the ward.

Some staff expressed concern that when the shift patterns change they will not have enough time to carry out one to ones or meet all the patients' accompanied leave commitments. At present there is a two hour overlap of shifts during the day. However this will be changing to a 40 minute overlap across all shifts in August 2014.

We saw that people received appropriate support to enable them to achieve the recovery goals they had agreed.

Recovery services

Staff on some wards told us they loosely followed the 'recovery model' when supporting patients'. We saw recovery goals were agreed with people on admission to help to reduce re-admission.

Privacy and Dignity

We observed staff treating patients with dignity throughout our visit. Patients' we spoke with said staff respected their privacy and dignity. Patients' we spoke with told us staff knocked on the door before entering.

Care plan review meetings and one to ones were held in designated rooms to ensure people's privacy was maintained.

Restraint

All staff we spoke with told us they had been trained to use restraint. However they said it was only used as a last resource.

We checked records and saw that where restraint was used the necessary follow up checks and paperwork had been completed.

Are acute admission wards responsive to people's needs?
(for example, to feedback?)

Service meeting the needs of the local community

We saw information was displayed on notice boards detailing how to make a complaint, including how to contact Patients' Advice and Liaison Service (PALS), advocacy and CQC.

Staff on the ward told us they encourage patients', family and friends to give feedback via the 'real time' feedback system. We saw evidence that patients' had used this to make comments..

Staff on the wards told us they felt that patients' were not offered enough access to psychological therapies. They said that when people requested it, and it is agreed by the multi-disciplinary team, then it can take months before it starts.

Acute admission wards

Learning from complaints

All patients' we spoke with told us they were aware of how to make a complaint and most said if they had a complaint they would probably go to their ward manager or allocated nurse in the first instance.

We were told complaints were recorded by the team managers and forwarded to the trusts' complaints team. They would then investigate and respond directly to the complainant and send a copy to the ward managers.

Staff told us a quarterly report was produced by the trust which analysed complaints. We were provided with this as part of the information gathered prior to the inspection. We also noted that complaints were discussed at team meetings.

Are acute admission wards well-led?

Engagement with staff

Staff on the wards felt their managers were knowledgeable, supportive and approachable. We found that although the deputy managers were acting up they had a very good understanding of the support needs of both staff and patients'.

Most staff we spoke with felt disconnected from the senior managers at the trust and could not comment as to whether they felt the trust was well-led.

Engagement with people who use the service

Some patients' told us they felt the real time feedback was a good way of talking to the senior managers. However most said they had not met any senior managers from the trust. They felt they could always feedback to ward managers.

Services for older people

Information about the service

There are two inpatient wards for older people at Tolworth Hospital. Azaleas is an admission and treatment ward for older people with organic brain disorders and functional mental health disorders. Fuchsias is a continuing care ward for older people with dementia.

Summary of findings

We found that people received caring and thoughtful care on the wards at Tolworth Hospital. We spoke with people who used the service, observed their care and we spoke with family members of people who used the service and people gave very positive feedback about the medical and nursing staff on the wards. We observed positive interaction between staff and people who used the service and saw that people were treated with respect and dignity.

We saw that there were a number of processes to record falls, which were not always consistent, so there was a risk that some fall information would not be registered and could mean there was not enough adequate learning from incidents. Staff gave us mixed feedback about how they would report incidents.

Medical staff had a good understanding of clinical guidance such as NICE guidelines and it was used to inform the care and treatment of people on the wards. Both wards worked well with multi-disciplinary teams on the wards and in the community to ensure that people received the optimum care and were supported through their discharge.

Staff on the ward recognised the importance of meeting the cultural and spiritual needs of people on the ward. People's physical health needs were monitored to ensure that the care they received met their needs.

Staff told us they felt supported by the management on the ward and by their immediate management. Most people recognised the senior management in the provider organisation. Some staff told us they did not always feel involved in conversations about their roles, particularly when organisational changes were taking place.

Are services for older people safe?

Learning from incidents

We asked staff and management on both wards how they reported incidents. Staff told us that incidents such as falls, were logged on the provider's electronic database system (RiO). Staff on Azaleas told us they had a book where they recorded falls and also used a system to log incidents via the provider intranet. When we checked the recording of falls on Azaleas, we saw that there were some inconsistencies in the way they were recorded. For example, we saw some falls which were recorded on the RiO daily recording notes but were not entered on the incident reporting system. We also saw that some falls, which were reported in RiO, were not entered manually into the book which was used to record falls. One member of staff told us that not all fall incidents are recorded and reported to the central electronic database but they go onto the RiO progress notes and are written in the book".

We had mixed feedback from staff about learning from incidents. One member of staff on Fuchsias told us the ward manager gave feedback to the team after an incident occurred whereas a member of staff on Azaleas told us they did not know what happened after they submitted incident forms as they did not get feedback and they were not discussed as a team.

We asked about when there was time to discuss incidents and learning from incidents on Fuchsias. We were told that this happened as a part of the daily handover however these discussions were not minuted. We asked the ward manager how they ensured that people, who were not on duty when the handover happened, had these conversations and they told us that they ensured that everyone was up to date when they were next on duty as it was a small staff team. This means there is a risk that some information, which could inform the learning of the team, would be missed if staff were not present.

Keeping people safe

Staff we spoke with on both the wards we visited had a good understanding of safeguarding procedures and were aware of how and where reports should be made. We saw that staff had all received training in safeguarding from the provider. People we spoke with told us that they felt safe on the wards. We saw that on Azaleas, while there were separate sleeping areas and toilets for male and female patients', access to the bathroom and toilet required female patients' to walk through an area for male patients'. This meant there was a risk that the environment was not effective in ensuring the privacy and dignity of people was maintained. We saw there was a separate lounge, which was used for female patients', however it was also used as the ward 'quiet room' and for ward meetings which meant there was not always a separate area available for women to spend time in during the day.

Staff we spoke with told us they felt able to raise concerns if they had them and were aware of the process to do so.

Risk Management

We checked the records and risk assessments. We saw that risk assessments were up to date. We saw that some documentation, such as Waterlow assessments which identify risks related to skin integrity and pressure ulcer management, were not completed for some people which meant there was a risk that people would not have some physical care needs addressed.

Staff told us that they update risk assessments following incidents to ensure they are current. We looked at records on Azaleas ward and saw that some fall risks had not been identified for people. NICE guidance (Falls: assessment and prevention of falls in older people), issued in June 2013, advised that older people should be asked about whether they have had falls in the past year and that, if they have had a fall, should be offered a multifactorial assessment. We saw that one person, whose records we checked, had had an assessment related to their falls risk four days after their admission. This meant there was a risk that some of their needs were not met on admission.

Safe Staffing Levels

We saw that the staffing levels on Azaleas and Fuchsias were sufficient to meet the needs of people on the ward. There was a consistent team of staff on Fuchsias and we were told that there was little use of temporary staff. On Azaleas there were at least two qualified nurses on duty on every shift and that while there were two vacancies, these posts had been recruited into.

Medicines Management

We visited Azaleas ward to assess the management of medicines. We checked prescription charts on the ward, and we saw that although supplies of medicines were available, some of these charts were not fully completed. We noted some gaps on charts where it was not possible to

tell if a dose of medicine had been administered. There was evidence that the ward pharmacist had highlighted this to ward staff, and we were told that these gaps were due to ward staff not signing when doses were given rather than doses being omitted. However it was not possible to check this. We also noted that staff did not always record, on the prescription chart, when someone was detained under the Mental Health Act 1983. Therefore we were not assured, from prescription charts, that people were getting all of their doses of prescribed medicines.

We saw that the ward pharmacist attended the ward every weekday, and provided detailed clinical input on medicines, for example what monitoring was needed. They had also provided training to ward staff on the trust's rapid tranquilisation policy to improve compliance with this policy, and had started a medicines awareness group for patients.

We saw that medicines were stored securely. Emergency equipment and medicines were checked daily. Medicines requiring cool storage were stored in a medicines fridge and records showed that they were kept at the correct temperature, and so would be fit for use. We noted that the temperature of the room in which medicines were stored was not monitored; therefore we could not be assured that these medicines were being stored at the correct temperature to remain fit for use. The trust's Medicines Code states that "Medicines must generally be stored at temperatures of 25 degrees C or below".

When we visited Fuchsias Ward to assess the management of medicines we saw that the records were up to date, comprehensive and medicines were stored safely and appropriately.

Are services for older people effective?
(for example, treatment is effective)

Use of clinical guidelines and standards

We asked staff how clinical guidance is embedded in the practice on the wards. Staff told us that this information was passed on from the management. We could not see evidence of the discussions regarding clinical guidance in team meetings or in clinical or management supervision. We spoke with the ward consultant on Azaleas Ward who knew, and had an awareness, of the NICE guidance for the use of anti-psychotic medication for people with dementia. They were also aware of the latest guidance related to the treatments for anxiety and depression. This meant that people on the ward were provided with care in accordance with the clinical guidance set. Azaleas Ward is a ward which catered for the needs of older adults who had organic brain disorders such as dementias and functional mental health disorders such as depression. The Royal College of Psychiatrists Faculty Report (Inpatient care for older people within mental health services 2011) recommends inpatient areas should be separate and dedicated where possible. We were told that there were plans to implement this later in the year when another ward was scheduled to open on the Tolworth site. The ward consultant for Azaleas told us that there were separate areas within the ward for people with organic disorders and people with functional mental health disorders.

Collaborative and Multidisciplinary working

We saw that both wards had access to an occupational therapist. The wards did not have a dedicated psychologist however staff told us they could make referrals to the clinical psychologists who are based in the community mental health teams for older adults. On Azaleas we looked at records which demonstrated that the occupational therapist on the ward had planned their sessions with people according to their preferences. We spoke with the occupational therapist who explained to us how they developed goals with people which were meaningful to them over a number of sessions. On Azaleas Ward we were told by staff that the pharmacist for the ward takes the role to explain people's medication to them and people who are treated on the ward have access to a "know your medication" session once a week.

Staff on Azaleas Ward told us that they liaised with the relevant community mental health teams for older adults to ensure that discharges were facilitated and that they worked with the relevant Home Treatment Teams when necessary. This meant that services acted together to ensure that people's pathways were clear.

Staff qualifications, competence and experience

We checked the training records of staff on Azaleas and Fuchsias. Most staff told us they had completed the relevant mandatory training which was updated annually. We saw that the shifts on both of the wards we visited had a mix of qualified nurses and health care assistants on duty to ensure that the needs of people on the ward were met. We asked staff about specific training that they had received in areas which were not covered in mandatory

training, for example, dementia training. Staff on Fuchsias told us that they had not had specific training in this area but had developed skills through experience and discussing issues with their managers. Staff on both wards told us that they had completed their appraisals however we saw that supervision of staff was not consistently documented. For example, on Fuchsias Ward, the manager showed us two supervision records for clinical supervision which had taken place and told us that management supervision took place as a part of the handover sessions, but was not documented.

Staff told us that they felt supported by their managers. We were told by staff that they had received support specifically around person centred support planning internally.

Are services for older people caring?

Choices, decisions and participation

On both wards we observed thoughtful and involving care being offered to people who used the service. People we spoke with on Azaleas Ward told us they were given choices and they felt listened to by members of staff. We spoke with family carers on Fuchsias Ward who told us “there cannot be a better place to care for [my relative] and that the staff do a fantastic job".

We observed a ward review meeting on Fuchsias Ward and saw that a family member was involved in discussions about their relative's care and expressed their views for them as the person who used the service lacked the capacity to engage in care planning discussions. This meant that people, and their representatives, were involved in decisions around care planning. One family member of someone who used the service on Fuchsias told us "I feel very involved [with the care plan]".

We checked the records for ward rounds on Azaleas Ward. We saw that while the records which were kept explained the decisions made, it was not clearly documented whether people were present or involved in discussions about their care. This meant that there was a risk that people might not be fully involved in decisions made about them. We also saw that nursing notes were very brief and focused on limited issues like eating, sleeping and taking medication so did not present a rounded view of individuals who used the service. We looked at notes from ward round meetings and did not see evidence indicating that people's views were sought in relation to decisions about their treatment.

We observed care being delivered on Fuchsias ward and spoke with some family members as the people on Fuchsias were not able to communicate directly with us due to the level of their cognitive impairments. We observed care which was delivered in a caring and respectful manner. Family members we spoke with told us “the care is exceptional” and “they [the nursing and medical staff] all know how to help and all of their needs”.

Effective communication with staff

Staff told us that they had access to interpreter services when there were people on the ward who did not speak English. We saw that everyone on both the wards had access to advocacy services whether they were detained or had been admitted to the wards informally. We observed many examples of very positive interaction between people who used the services and staff, for example, during the mealtime on Azaleas, we saw that staff explained to people what the meals were and showed the options to them which helped people to understand the choices which they had.

Support for people's needs

We saw that both wards had information available on boards and in leaflet form about local services. We saw that the ward worked with the local community mental health teams for older people and the home treatment teams to ensure people had access to support when they were moving towards discharge. For example, representatives from the relevant community mental health teams attended ward rounds and meetings to ensure they were involved and informed about the needs of people in their teams and that information was not lost between services.

Staff told us that care planning started in the initial 24 hours after someone was admitted. The primary nurse then developed a longer term care plan to meet people's specific needs. Staff told us they involved relatives and the ward consultant on Azaleas told us they ensured family meetings took place. We observed a family meeting on Fuchsias Ward and saw that views were sought and the family were involved and informed.

Services for older people

Privacy and dignity

We spoke to people on Azaleas Ward and observed care which was being provided. We saw that people who used the service were treated with dignity and respect. We observed that staff took time to explain the care being delivered to people and people we spoke with told us that they were treated with respect at all times.

Are services for older people responsive to people's needs?
(for example, to feedback?)

Meeting the needs of the local communities

We spoke with staff on both wards who told us they had an understanding of the importance of providing care which was specific to individuals on the basis of their culture, language, religion or sexuality. We saw that people had access to a chaplain who attended Azaleas Ward on the day of our visit.

Working together in periods of change

From observation we saw the inpatient wards worked closely with community mental health teams for older people by involving them in meetings. We saw that when people were discharged to the community information was shared from the ward which ensured there was continuity in care. We saw that people on both the wards we visited had access to physical health checks which were carried out regularly to monitor any changes or needs which differed. One member of staff on Azaleas told us that the older adults home treatment team, in the community, helped to facilitate discharges and could be accessed for people on the ward, depending on which borough they lived in. The ward consultant on Azaleas told us that discharge planning had become more streamlined with the move to the single consultant model and they told us "things have improved".

We saw that care plans were adjusted when people's needs changed, particularly their physical health needs. We observed a handover on Fuchsias Ward and saw that people's needs were discussed as well as updates on how physical health needs were monitored. This meant that any changes in people's needs were identified and followed through.

Learning from feedback and complaints

We were told there had not been any recent complaints in the wards and this was a positive sign for the ward. The wards did not have access to information about complaints across the trust which may have led to further learning. This meant there was an opportunity to learn from feedback beyond the ward level which was at risk of being lost.

Are services for older people well-led?

Governance

On a local level, each ward has a manager. We were told that there is a lead on each shift who coordinated the shift, took handovers and made decisions about the support that people needed.

One member of staff told us that the new modern matron, who had started, was supportive and had taken decisions which had led to improvements in the working environment such as cleaning out the clinical room.

Staff engagement

Most staff we spoke with on the two wards told us they were proud to work for the provider. They recognised the leadership of the Chief Executive and felt a part of the organisation. Some staff told us that they felt they did not always feel involved and valued by more senior management in the trust, for example, they told us that changes took place in their services without them being fully involved and informed. One member of staff told us they had been redeployed twice and had not been involved in conversations or decisions about where they would be working and this was concerning to them. All the staff we spoke with told us they felt supported by their immediate managers. One member of staff told us they felt the provider was improving. They told us "They [the trust] are ok, there is some improvement, they've got better".

Effective leadership

We saw that the managers at the ward level had a clear understanding of their responsibilities on the ward. We saw that they used the tools such as the online dashboard to ensure they had an understanding of the needs of the ward and to identify areas where there needed to be additional work, such as mandatory training records. We saw that some of the information on the dashboard, such as supervision schedules, we not used and we saw that staff had not been having clearly defined supervision as

protected individual time with their managers. Staff told us that they could approach their managers on an ad hoc basis and felt able to raise issues that were concerning to them.

We saw that feedback had been received from a local clinical commissioning group regarding improvements on the ward when the provider had moved to a single consultant model on Azaleas. This showed that the provider responded to feedback from stakeholders.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of Medicines** **How the regulation was not being met:** People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to record medicines administered. The reasons why sedative drugs prescribed ‘as required’ were given were not recorded in people’s records. This means that we could not be assured that people were being given their medicines appropriately and consistently. This was a breach of Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** This regulation was not being met as patients were not always cared for in an environment that assured their safety and welfare. On Azaleas, while there were separate sleeping areas and toilets for male and female patients', access to the bathroom and toilet required female patients' to walk through an area for male patients'. This means there was a risk that the environment was not effective in ensuring the privacy and dignity of people was maintained.