Kent and Medway NHS and Social Care Partnership Trust

Frank Lloyd Unit

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXYF6	Frank Lloyd Unit	Hearts Delight Ward	ME10 4DT
RXYF6	Frank Lloyd Unit	Woodstock Ward	ME10 4DT

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership 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 Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust.

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.

Summary of findings

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

Summary of findings

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Summary of findings

Overall summary

- This was a second follow up inspection to an unannounced focussed inspection on 18 and 19 January 2016. During the inspection in January, CQC found the trust had breached regulations 11, 12, 13 and 18 of the Health and Social Care Act 2008. CQC issued a warning notice to the trust on 8 February 2016 for significant improvement in these areas.
- The warning notice stated that the trust must take action within six weeks regarding risk assessments, the use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the safe management of medicines and reporting and recording safeguarding incidents.
- The warning notice stated that the trust must complete a comprehensive review of patient assessment and care planning and to review staffing levels and skill mix within three months of the date of the warning notice.
- This inspection was to ensure that the trust had completed all actions set out in the warning notice and was delivering a safe, effective and caring service for patients.

Summary of findings

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

Are services safe?

- The trust had introduced systems and processes to improve the safe management of medicines. Staff stored medicines, including controlled drugs (CDs) correctly and medication levels were appropriate with no signs of overstocking. Staff had received medicines management training. A pharmacist completed a weekly audit of medicines management on both wards.
- The trust was actively recruiting to vacancies on the ward. Regular staff from the NHS Professionals were used to fill shifts.
- The trust had arranged face to face safeguarding training for staff to improve their understanding of the timeliness and threshold for reporting incidents. However, further work was required concerning the quality and detail of safeguarding alerts.
- The trust had taken actions to address the actions outlined in the warning notice.

However:

- We saw evidence of non compliance with some mandatory and statutory training.

Are services effective?

- The trust had started to develop procedures and training to make sure that staff applied the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) correctly. However, although staff demonstrated an improvement in their knowledge and understanding of the MCA and DoLS, further work was required so that staff could use the legislation with confidence to protect peoples' rights.
- Staff completed a comprehensive assessment of patients that were admitted. This included a good assessment of people's physical health needs. There was a designated nurse to monitor patients' physical and psychological health. The trust had an electronic system for recording and storing information about the care of patients.

Summary of findings

Are services caring?

- Staff spoke respectfully about patients and were aware of patients' individual needs. Staff were interested and engaged with patients and used de-escalation techniques to calm patients. Staff demonstrated dignity and respect for patients and knocked on bedroom doors before entering.
- However:
- There was no information regarding advocacy on either Hearts Delight or Woodstock ward and staff were unable to find telephone numbers for this service.
- There was no carers' information pack available for patients/ carers which could contain information regarding DoLS assessments and what they mean, advocacy, obtaining power of attorney or general information such as times of multi-disciplinary team meetings and other information relating to end of life care services.

Summary of findings

Information about the service

The Frank Lloyd unit provides continuing care for older adults with a diagnosis of dementia or challenging behaviour that cannot be managed in a nursing home. The unit is a GP led service, which is reassessed every six months by the Clinical Commissioning Group (CCG).

There were two wards at the Frank Lloyd unit. Hearts Delight ward was on the ground floor and Woodstock ward was on the first floor. At the time of our inspection, there were 19 patients on Hearts Delight mixed gender ward, consisting of 15 female and four male patients. Woodstock ward was a male only ward and there were 19 patients at the time of our inspection. Access to the unit and both wards was via keypad entry and the door was locked at all times.

The Frank Lloyd unit was registered for the assessment and medical treatment for persons detained under the Mental Health Act 1983 and the treatment of disease, disorder and injury. There were no patients detained under the Mental Health Act (1983) at the time of our inspection.

The unit was inspected on 18 and 19 January 2016 where the trust was found to be in breach of regulations 11, 12, 13 and 18 of the Health and Social Care Act 2008. The trust was issued with a warning notice in relation to these breaches where need for significant improvement was identified. The trust was given six weeks and three months respectively to take action to improve areas of the service. CQC completed a follow up inspection six weeks later, on 22 March to ensure that the trust had taken action to address the identified areas of concern. This inspection was the three month follow up inspection to check that the trust had completed all identified actions in the warning notice.

The Frank Lloyd Unit was closed to admissions at the time of our inspection.

Our inspection team

The lead inspector for the team that inspected the Frank Lloyd Unit was Shelley Alexander-Ford with an inspection manager, three inspectors and two Mental Health Act reviewers.

Why we carried out this inspection

This was a follow up inspection to an unannounced focussed inspection on 18 and 19 January 2016 after a Mental Health Act reviewer had raised concerns after they had visited the service in November 2015. During our inspection in January, we found the trust in breach of regulations 11, 12, 13 and 18 of the Health and Social Care Act 2008. On the 8 February 2016, CQC issued a warning notice to the trust for significant improvement in these areas.

The warning notice stated that the trust must take action within six weeks to address concerns regarding risk assessments, the use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the safe management of medicines and the detail, timeliness and threshold for reporting and recording safeguarding incidents. CQC completed a six week follow up inspection on 22 March to check that the trust had completed the identified actions in their action plan for this period. This inspection was to ensure that the trust had completed the identified actions for the three month period contained in the warning notice, within the agreed timescales.

Summary of findings

How we carried out this inspection

Before the inspection visit, we reviewed the trust's action plan and information we held about the service.

During the inspection visit, the inspection team:

- Spoke with 13 members of staff including a member of staff from the Kent County Council Deprivation of Liberty Safeguards team, the interim service director, the assistant director for older adult inpatient care, the clinical quality coordinator, a ward manager, a deputy ward manager, a pharmacist, the Mental Capacity Act lead, an occupational therapist, a psychology assistant, nurses and health care assistants.
- Spoke with three patients.
- Spoke with 14 carers.
- Observed two handovers.
- Looked at 21 patient's care and treatment records.
- Reviewed 21 patient's risk assessments.
- Carried out a specific check of the medicine management on both wards.
- Reviewed 38 medicine charts.
- Reviewed systems and processes for recording and monitoring DoLS applications.
- Reviewed the timeliness, detail and threshold for reporting incidents.
- Completed an observation using the short observational framework tool.
- Reviewed staffing rotas for the previous six weeks before our inspection.

What people who use the provider's services say

We spoke to three patients and fourteen relatives who spoke highly of the care that they or their relatives were receiving.

Patients told us that staff were approachable and caring. Relatives told us that communication was good and that staff 'did their best'. Relatives told us that staff had invited them to care planning meetings and that staff had contacted them regarding DoLS applications. One relative said that they felt things had improved recently on the wards. However, two relatives said that they were concerned that the wards did not provide a chiropody service.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards and the trust's policies are adhered to. The trust must accelerate the work it has started to develop procedures, training and management to ensure the effective use of the Mental Capacity Act and Deprivation of Liberty Safeguards. This is vital to ensure that staff can use the legislation with confidence to protect people's human rights.
- The trust must ensure that all staff are compliant with completion of mandatory and statutory training.

Action the provider SHOULD take to improve

- The trust should continue to actively recruit to vacancies and ensure safe staffing levels.
- The trust should ensure that face to face training is comprehensive and relevant for staff.
- The trust should ensure that safeguarding alerts are attached to safeguarding incidents reported on the electronic incident reporting tool.
- The trust should act in an open and transparent way and accurately describe incidents to relatives.
- The trust should ensure staff knowledge and understanding regarding the trusts policy concerning the use of hoists.
- The trust should ensure that patients are able to safely reach lights without risk of harm.

Summary of findings

- The trust should ensure that The National Institute for Health and Care Excellence guidelines and trust policies are followed concerning monitoring patients physical health after a fall.
- The trust should ensure consistency and sharing good practice regarding recording information on wards.

Kent and Medway NHS and Social Care Partnership Trust

Frank Lloyd Unit

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hearts Delight Ward	Frank Lloyd Unit
Woodstock Ward	Frank Lloyd Unit

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.

Staff did not make use of the MHA despite being a registered service for 'assessment or medical treatment for persons detained under the Mental Health Act 1983'. Staff told us that the trust was considering re-registering the service so that it did not include using the Mental Health Act.

All staff on Hearts Delight and Woodstock ward had completed the online mandatory Mental Health Act training. Minutes of team meetings recorded discussions regarding the Mental Health Act and where staff could find the relevant paperwork if required.

There was no Mental Health Act advocacy services displayed on the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

Since our last inspection, the trust had introduced face to face training for staff concerning the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw that training had been arranged for permanent and bank and agency staff the week after our inspection.

Data provided by the trust showed that 87% of staff on Hearts Delight ward and 94% of staff on Woodstock ward had completed the online MCA and DoLS training.

Detailed findings

Staff had introduced a system to record and monitor the status of patients DoLS applications and authorisations, although more work was required regarding staff reporting changes in a patient's presentation to the local authority so that their application could be reviewed.

However:

Staff had not recorded mental capacity assessments for each aspect of a patient's treatment in patient records. For example, for prescribed medication. Staff had not always recorded a best interests meeting for patients who had been assessed as lacking capacity.

There was no information regarding Mental Capacity Act and Deprivation of Liberty Safeguards advocacy services displayed on the wards.

Are services safe?

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

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

Our findings

Safe and clean environment

- The entrance to both Hearts Delight and Woodstock ward was via keypad entry directly into the foyer area of the ward. Each ward was a mirror image of the other consisting of two 10-bedded corridors, one to the right of the entrance foyer and the other facing the entrance door.
- Hearts Delight ward was a mixed gender ward on the ground floor. There were 15 women and four men on Hearts Delight ward at the time of our inspection. The ward had separate sleeping and bathing areas for men and women that were compliant with Department of Health guidance on same sex accommodation. Woodstock ward was on the first floor and was for male patients only. There were 19 patients using the service at the time of our inspection.
- The layout of the wards provided limited observation for staff. Light sensors were used on the wards which automatically switched off if there had been no activity in the corridor for 15 minutes. As soon as there was activity, such as staff or a patient entering the corridor, the lights turned back on.
- Since our first inspection in January, the trust had fitted sensory alarms on the doors of patients who were nursed in bed. Staff had a key to switch off the alarm before entering these rooms. If somebody entered rooms fitted with a sensory alarm without first switching off the alarm, it alerted staff that somebody had entered the patient's bedroom. The alarm was linked to a system in the staff office which showed the location. This meant that staff could go straight to the relevant room and assess and manage risk accordingly. We saw that staff had not switched on the alarm to one patients room. We informed a member of staff who immediately turned the alarm on. We heard the sensory alarm sound several times during our inspection.
- Call bells were fitted in all of the patient bedrooms and in the toilets on both wards. The call bells had been designed so that they were user friendly for patients and were large brightly coloured buttons with 'Help' written on them. On Hearts Delight ward, most call bells were not easily accessible by patients whilst lying in bed This was raised with the interim service line manager who informed us that the trust would act on this information. The bathrooms did not have a call bell. Staff explained that this was because staff always accompanied patients in the bathroom.
- The ward manager had previously completed a ligature audit, which had identified the light pull cords in patient's ensuite toilets as a ligature risk. A ligature point can be used by a patient to harm themselves. The trust had cut the pull cords short and out of patients' reach to manage this risk. However, ligature risks remained in the form of electric plugs and cables in many of the call bell units. Woodstock ward was piloting a metal rod which had been placed over light pull cords so that risk was mitigated and patients could reach to turn on their light. Inspectors asked if the rods could be used on Hearts Delight ward. The interim service line director told us that the trust would act on this immediately.
- The ward areas were clean and clutter free and the furnishings on Hearts Delight and Woodstock ward were appropriate and well maintained. Both Hearts Delight and Woodstock ward had two domestic staff that were responsible for the cleanliness of the wards.

Safe staffing

- The trust had carried out a review of nurse staffing since our inspection in January and were actively recruiting to vacancies. The trust had determined that safe staffing levels consisted of two registered nurses and seven health care assistants (HCA) on the early and late shift and two registered nurses and five HCAs for the night shift. This had been increased from two registered nurses and five health care assistants for the early and late shifts and one registered nurse and four health care assistants for the night shift.
- We reviewed the staff rotas for the six weeks prior to our inspection and saw that staffing levels were mostly in line with the levels and skill mix determined by the trust as safe. The only exceptions occurred when cover could not be found to replace staff who had notified their absence late. The number of shifts that had not met the trust's identified staffing were: nine early shifts, which had been one member of staff short: eight late shifts, which had been one member of staff short and one late

shift that had been short staffed by two members of staff. Two night shifts had been short staffed by one member of staff. However, we also saw that some shifts had more than the required number of staff during this period. Bank staff were regularly used to try to ensure a full complement of staff. However, the trust used regular bank and agency staff where possible. This included permanent members of staff who were also registered with NHS professionals and could cover vacant shifts where possible. Bank staff completed the same mandatory and statutory training as permanent staff.

- The ward managers were qualified nurses and supported staffing levels where possible. Occupational therapists and psychologists provided therapeutic activities for patients. However, they were also used to support staffing numbers and therefore were sometimes unable to deliver planned activities for patients.
- There were notices in the staff office that stated a minimum of two staff, one being permanent, were required to use hoists for patients. However, some staff were uncertain of the policy concerning using hoists. Some staff told us that there had to be three members of staff or that agency staff could not help permanent staff.
- The service was GP led and patients were registered with a local on site practice. The GP visited the ward twice a week. Staff could contact the GP service for advice and out of hours. Patients had access to a minor injuries unit which was a short walk away. In the event of a medical emergency, staff called the emergency services rather than using the trusts emergency cover. The trust had arranged for a junior doctor to join the continuing care service with effect from 1 June 2016 who would oversee medical treatment and provide feedback and advice for the service. A consultant psychiatrist attended the service one afternoon a week to complete care reviews.

Assessing and managing risk to patients and staff

- Staff had completed individual risk assessments for patients. Staff reviewed risk assessments and updated them following incidents, such as a fall or abuse. Staff had recorded measures that had been put in place to mitigate risks. For example, where staff had increased the level and frequency of observations of patients. However, we saw that staff did not always record that they had taken the patient's blood pressure both sitting and lying down after a fall, which was in line with the trust's policy and NICE guidelines.
- Staff had completed a falls risk assessment for all patients. However, in one record, we saw that staff had not updated the risk of falls for one patient after they had fallen twice in a week. Staff had downgraded concerns regarding the risk of falls for the patient five days after the patient had experienced a significant fall. Staff had been told to be extra vigilant if patients were on four or more prescribed medicines due to the increased risk of falls. However, staff had not recorded monitoring a patients physical observations after rapid tranquilisation had been used.
- Staff discussed individual risks to patients and the level of observation required for each patient during handover meetings. Staff were allocated observation responsibilities at the handover meeting. Staff placed patients on eyesight, intermediate; every 15 minutes and general; hourly observations dependent upon need and presentation of the patient that day. The trust was developing a new observational tool for staff to use and record patient activity. Qualified staff were involved in its development to support staff concerns regarding the level of paperwork they were expected to complete.
- Staff used de-escalation techniques to calm patients. Staff told us that incidents were usually associated with physical care. We saw that staff used restraint for one patient in order to take bloods and had recorded consent from the patient's next of kin to allow this. Staff had used the trust's incident recording tool to report when restraint had been used. Staff used the incident recording tool to record the number and type of restraint holds used for patients. The trust had arranged additional training for staff concerning the different types of holds and how and when these should be recorded. Staff could contact a named person in the trust for advice regarding using and recording holds used for patients.
- Staff received training in safeguarding adults at risk and children and staff we spoke with knew how to recognise a safeguarding concern. However, data provided from the trust showed that staff on Hearts Delight had not met the trust's target for completing safeguarding adults

Are services safe?

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level one and two training. Staff on Woodstock ward had not met the trusts target for completing training for safeguarding adult's level one and two and safeguarding children level two.

- We saw guidance concerning the threshold for safeguarding alerts. Staff were aware of the trust's safeguarding policy and could name the safeguarding lead. They knew who to inform if they had safeguarding concerns. The managers on both wards completed a spreadsheet to monitor open safeguarding alerts. Staff provided examples of safeguarding referrals that had been made. However, the quality and detail contained in safeguarding alerts was variable.
- Pharmacy staff had delivered medication management training to staff on both wards. The training included general information regarding record keeping, monitoring temperatures of the fridge and clinic room, storage of keys and medication, expiry dates, sharps and the medication administration process. A pharmacist had written guidance and support for staff on various aspects of medicines management.
- A pharmacist had completed weekly medicine management audits for both wards and sent an email with any findings to the ward managers and the acting assistant director for continuing care. The audits included information regarding blank boxes, covert medication, monitoring fridge and clinic room temperatures, medication administration rounds, controlled drugs and patient specific issues. A pharmacist had provided guidance for staff concerning covert administration of medicines.
- Staff stored medicines correctly, including controlled drugs (CDs). The clinic room and fridge temperature were recorded daily and within range. Medicine levels were appropriate and the ward did not overstock medicines. A registered nurse had protected time to administer medicines to patients. The other registered nurse on duty provided support for the health care assistants (HCAs).
- We reviewed 38 medicine charts which had been completed well. However, eight of the medicine charts did not have a photo ID. The medicine charts showed that as required medicines (PRN) had been prescribed for 19 patients, and not been administered for two weeks. We were told that medicine to manage anxiety or agitation was routinely added to medicine charts. This was to support patients in case they needed calming down, not because they had been assessed to need it. This meant that staff were able to administer medicine dependent on their own interpretation of anxiety or agitation, and possibly lead to inappropriate administration. Pharmacy staff had discussed this with the prescribing doctor but the practice had continued. Staff used covert medication plans correctly. The pharmacists were auditing the use of covert medication and had requested the consultant psychiatrist to review and update where appropriate.
- The GP who was attached to the unit was responsible for the physical health of the patients. The GP wrote prescriptions for patients on a FP10 to facilitate the supply of medication from the pharmacy associated with the unit. Nursing staff used prescription repeat slips to request medication. The GP visited the service every Monday and Thursday.
- Data provided by the trust showed that on Hearts Delight ward, 54% of staff had completed the physical interventions training and 63% had completed the personal safety breakaway training. On Woodstock ward, 71% of staff had completed the physical interventions training and 74% had completed the personal safety breakaway training. This did not meet the trust's target concerning completion of mandatory and statutory training.

Track record on safety

- The trust had not reported any serious incidents since our last inspection. Most reported incidents concerned unwitnessed falls or allegations of patient to patient abuse. Staff recorded incidents in patients' progress notes and reported incidents using the trust's electronic incident recording system.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the trust's clinical governance team, who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and respond to these. Ward managers maintained an overview of all incidents reported on

their wards and updated the reports with information and actions taken. The manager on Hearts Delight ward completed a spreadsheet to monitor incidents. However, this did not happen on Woodstock ward.

- We reviewed five datix reports and found that staff had not attached a safeguarding alert to any of the three incidents that had been recorded as a safeguarding incident. This meant that it was not possible to cross reference if staff had completed a safeguarding alert.
- We observed that staff discussed incidents during handover meetings. We saw that staff recorded incidents in the patients' progress notes but did not always update risk assessments or care plans. However, minutes of team meetings recorded discussions taking place regarding the correct process for recording incidents.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Staff had recently completed physical health care assessments for patients. Staff were expected to update assessments with any change of situation for patients and monthly as a minimum. Staff with line management responsibilities monitored assessments during supervision. Staff used an assessment calendar to keep a record of when assessments have been done or were due. Staff on Woodstock ward used this calendar more successfully than staff on Hearts Delight ward.
- Care plans were in place that reflected patients' needs. Care plans were comprehensive and detailed and demonstrated ongoing care. Care plans were holistic and recovery orientated and staff recorded a full range of patients' needs. Care plans were not always personalised although staff had recorded relative's views. We saw that staff reviewed care plans on a regular basis and updated as appropriate. However, we saw that staff had not updated one patients care plan to reflect that, after a fall, she was now in a chair and staff needed to use a hoist.
- Staff completed food and fluid charts for all patients which were uploaded onto the electronic recording system. Staff maintained a running total of fluids on patients charts. A nominated nurse monitored patients food and fluid charts and staff sat with patients to encourage them to eat. Staff discussed patients' food and fluid intake during handover meetings.
- Staff had placed information in covered notice boards in each of the patients' bedrooms. The information included moving and handling, what type of sling staff should use and the patients likes and dislikes.
- Staff had completed turning charts for patients who were nursed in bed. However, staff had not recorded 'how' the patient had been repositioned but had simply recorded 'repositioned'.
- Staff completed bathing charts for all patients. We reviewed personal care records for patients on Hearts Delight and Woodstock ward which showed that staff provided a full body wash for patients on a daily basis as a minimum. Staff recorded when patients had baths, bed baths, shaves, hair wash, foot care and oral hygiene.
- All staff had access to patient records which were stored on the trust's electronic recording system. This meant that patient records could be accessed by other staff within the trust which promoted multi-disciplinary working.

Best practice in treatment and care

- Staff followed the National Institute for Health and Care Excellence guidelines, The Nursing & Midwifery Council (NMC) Standards for Medicines Management and the trust policy concerning medicines management.
- The trust was in the process of introducing a dementia care toolkit and 'The Triangle of Care Carers included: A guide to Best Practice in Mental Health Care in England'. Staff we spoke to told us about the implementation of the dementia toolkit.
- A psychology assistant and occupational therapist provided therapeutic interventions for patients. However, staff told us that they were often used to complement staff and provide personal care for patients which affected the therapeutic work for patients.
- There was a good system to ensure that staff completed daily or weekly physical health observations for all patients. The modified early warning score (MEWS) chart had a good algorithm to guide staff concerning what actions to take if physical observations were out of range. We saw evidence of staff repeating observations by following the algorithm. Staff used sterile wipes, and equipment to dispose of them, to ensure equipment was cleaned before moving onto the next patient.
- There was an allocated nurse for patients' physical health care. Staff used appropriate physical health assessment tools to identify if actions were required and included information on patients care plans where appropriate. Staff had completed a falls risk assessment for all patients.

Skilled staff to deliver care

- There was a range of staff working on the wards which included nurses, medical, consultant psychiatrist, occupational therapists, psychology and pharmacists. There was a designated nurse to monitor patient's physical health.
- Staff received appropriate training, supervision and professional development. Records showed that most

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staff were up-to-date with statutory and mandatory training. However, staff on Hearts Delight were showing as 'red' for the following training: Cardiopulmonary resuscitation and automated external defibrillator (CPR and AED) 80%; Fire training 70%; Health and Safety 83%; immediate life support 11%; information governance 77%; local induction 93%; personal safety breakaway 63%; physical interventions yearly 54%; rapid tranquilisation two yearly 80%; safeguarding adults level one 80% and safeguarding adults level two 60%.

- Staff on Woodstock ward were showing as 'red' for the following training: immediate life support 30%; infection control 79%; information governance 71%; medicines calculation 70%; moving and handling patients 82%; personal safety breakaway 74%; physical interventions 71%; safeguarding adults level one 57%; safeguarding adults level two 67% and safeguarding children level two 80%. Information provided by the trust documented that the trust had arranged training during June, July and August, which included immediate life support and physical intervention training.
- We saw that face to face safeguarding training had been delivered to staff with additional dates in place for those who had not been able to attend the training. Training was available for permanent and agency staff.
- New staff had a period of induction before being included in the staff numbers. Ward managers were sent a staff training matrix so that they could monitor training and see when training was due/overdue.
- We saw that supervision for staff on Hearts Delight ward was mostly up to date. Where supervision was not up to date, we saw that it was out of date by no more than two weeks. We were unable to see supervision records for staff on Woodstock ward as the manager was on annual leave. However, staff told us that they received regular supervision.
- There were regular team meetings and handovers on both wards.

Multi-disciplinary and inter-agency team work

- The handover meetings were attended by a range of disciplines including the ward manager, nurses, occupational therapist, psychologist and health care assistants. We observed comprehensive handovers on both Hearts Delight and Woodstock ward where the senior nurse in charge handed over to the oncoming shift. Information handed over included monitoring patient's physical health needs, legal status, allergies, food and fluid intake, medicines, open safeguarding alerts, presentation and behaviour, falls and MEWS charts.
- We spoke to the local authority safeguarding team who told us that staff regularly contacted them for advice concerning safeguarding alerts.
- We spoke to the local authority Deprivation of Liberty Safeguards (DoLS) team who told us that they had regular discussions with staff concerning DoLS applications. However, the quality and detail of the DoLS applications were limited which affected how they were triaged by the local authority. Staff had not told the local authority of any changes in a patient's presentation so that they could amend the patient's priority for triage.

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

- All staff on Hearts Delight and Woodstock ward had completed the online mandatory Mental Health Act training. Minutes of team meetings recorded discussions regarding the Mental Health Act and where staff could find the relevant paperwork if required.
- Staff told us that the trust was considering re-registering the service so that it did not include 'assessment or medical treatment for persons detained under the Mental Health Act 1983' because they did not consider it appropriate for the patients in their care. However, patients where a DoLS assessment had been breached were not being considered for a MHA assessment, which may have offered them more protection and rights.
- There was no Mental Health Act advocacy services displayed on the wards and staff did not provide information to carers.

Good practice in applying the Mental Capacity Act

- We found that the trust had not achieved the following actions concerning MCA and DoLS:
- 1(iv) Each patients will have regular mental capacity assessments for each aspect of treatment (including prescribed medications, use of therapeutic restraint, continued inpatient admission).
- 1(v) Each patient who has been assessed as lacking capacity to consent to an aspect of treatment will have a best interest meeting.

Are services effective?

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.

- 1(vi) Significant changes to any patients behaviour or mental state who is awaiting a DoLS assessment by the local authority will be escalated to the local authority and this will be evidenced in the patients' health care record and interventions to mitigate against risk to the patient will be included within the care plan.
- We found that in all cases reviewed this was not happening.
- We specifically reviewed 21 care records concerning MCA and DoLS. We found that staff did not always record best interest meetings or report changes in a patient's presentation to the local authority. There was often only one capacity assessment which related to place of abode that had been completed some months previous. Staff regularly did not refer to previous DoLS applications that had been refused by a best interest assessor (BIA) when they were completing a new DoLS application.
- We found inconsistencies which indicated a lack of understanding of the MCA and requirements of DoLS and best interest meetings. One patient had been assessed as having capacity but staff had recorded that the patient would be placed under another urgent DoLS if the patient tried to leave the ward. However, we saw evidence of staff considering using the Mental Health Act for another patient who had been assessed as having capacity.
- The trust had arranged for face to face training in the MCA and DoLS for permanent and agency staff. Staff had completed mandatory online training for MCA and DoLS and knew who to contact for advice. The trust had two MCA leads who delivered half a day's training to staff concerning the MCA and DoLS. The training material was extensive and gave a wide overview of the legislation. However, it did not provide staff with practical advice and support. For example, there was no specific training for staff on specialised units such as the Frank Lloyd unit so that staff knew how to complete DoLS applications properly to enable them to be triaged correctly. Inspectors fed this back to the MCA lead who said that this would be included in future training.
- The trust had introduced DoLS information spreadsheets which included patient name, status, date of DoLS application, date of DoLS assessment and expiry date. Staff recorded the outcome of DoLS assessments, priority and where they had been breached. For example, where the assessment had expired. Seven DoLS assessments had breached on Woodstock ward and four had breached on Hearts Delight ward.
- There was no information on the wards for relatives and carers regarding MCA and DoLS.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with three patients who told us that staff were approachable, they felt safe and that their care was excellent.
- We observed staff interacting with patients in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner. They de-escalated situations by listening to and speaking quietly to people who were frustrated or angry. Staff appeared interested and engaged in providing good quality care to patients. We saw that staff treated patients with dignity and privacy and knocked on patients' bedroom doors before entering their room.
- Staff spoke respectfully about patients during handovers and demonstrated a good understanding of individual needs.

The involvement of people in the care that they receive

- We saw that care plans were not personalised although did record the family's views. We saw evidence that staff contacted carers if an incident occurred which involved their relative. In one record reviewed, staff had recorded that a patient had fallen after making jerking movements. However, we spoke to the carer who told us that staff had described the incident differently.
- We spoke with fourteen carers who were mostly pleased with the care that their relatives were receiving. Carers told us that they were invited to care planning assessment meetings and that they felt involved in the care planning for their relative. One carer told us that the wards were better than they used to be. However, two carers told us they were concerned about the level of personal care that their relative received and that clothing often goes missing.
- We saw that staff had recorded advance decisions for patients. Staff were able to tell us about these decisions and they were recorded in patients' records.
- We saw no information regarding advocacy on either Hearts Delight or Woodstock ward and staff were unable to find telephone numbers for this service.
- There was no carer's information pack available for patients/carers which could contain information regarding DoLS assessments and what they mean, advocacy, obtaining power of attorney or general information such as times of MDTs and other information relating to end of life care services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care & Treatment of service users must only be provided with the consent of the relevant person Regular capacity assessments for each aspect of patient's treatment did not take place. Best interests meetings did not always take place for patients who had been assessed as lacking capacity to consent to an aspect of treatment. DoLs applications provided little detail to allow correct triage. Significant changes to a patient's behaviour or mental state were not reported to the local authority. There were inconsistencies in staff knowledge and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. This was in breach of Regulation 11 (1), (2), (3)

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 Safe care and treatment The trust did not ensure staff compliance with mandatory training to ensure that staff were competent to provide safe care and treatment. This was in breach of Regulation 12 (1), (2) (b), (c)