Walton 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 we hold about quality, and information given to us from patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Walton Hospital is a local community hospital providing care for older people with mental health needs who may require assessment or rehabilitation. There are two inpatient wards, Linacre and Melbourne, each with 24 beds. Patients may be detained under the Mental Health Act 1983. There is a day hospital on site, Lea Hurst. This is one of two community day hospitals in the area and also provides the base for the community outreach team. At the time of the inspection there were no patients using Lea Hurst day hospital as services alternate between the two locations. Linacre and Melbourne wards are purpose built one storey buildings which opened in 2010. Both wards provide acute admission services for older people with mental health problems. There are 24 beds on each ward.

Walton Hospital was inspected by the CQC twice in 2013. At the last inspection in July 2013, we found concerns in relation to respecting and involving people in their care, and record keeping. At this inspection we found the provider was now meeting these essential standards.

Some aspects of patients' safety were well managed, such as the prevention and control of infection and the management of medicines. The admission of patients detained under the Mental Health Act was effectively managed. There were systems and procedures in place to safeguard vulnerable patients and to identify, assess and manage risks. However, the systems and procedures were not always used consistently or effectively which meant that patients were not always protected from abuse or avoidable harm.

Patients and their families / carers were satisfied with the care and treatment provided and reported good outcomes for patients. There was generally effective collaboration and communication amongst members of the multidisciplinary team to support the planning and delivery of patient care. Staffing was stretched at times where the level of support needed by patients was not matched by an increase in staff. Staff were supported with clinical supervision, appraisal, and relevant training. However, there was a lack of clarity about the provider's expectations for the nature of clinical supervision.

Patients and their families / carers said they were treated with kindness and respect and they were involved in making decisions about care and treatment. However, we found that patients' views about their care and treatment were not always recorded or taken into account. The ward environment did not always promote the wellbeing of patients.

Patients, or their families / carers, told us their needs were usually met by the service. However, we found that care was not always planned or delivered to meet patients' individual needs or to ensure the safety and welfare of the patient. Care plans lacked detail of how people's physical and mental health needs should be met. Care plans to support people with behaviours that challenge were standardised and not specific to individuals and their needs. Mental health care plans were rudimentary and process focussed rather than person centred. Staff did not always understand or apply the requirements of the Mental Capacity Act 2005 when considering people's consent to treatment or the Deprivation of Liberty Safeguards when delivering care. Patients' records were filed separately by different professionals which could lead to lack of consistency of care and treatment.

Planning for the patient leaving hospital started on the day of admission. Discussions about discharge from hospital involved the patient and their families and carers. Most staff we spoke with were aware of the Trust's vision and values. Staff told us they enjoyed working at Walton Hospital. They felt there was good team working and they were well supported by their managers.

As a result of our concerns about inadequate care planning and consideration of consent, we judged the provider was not meeting Regulation 9, Care and welfare of people who use services and Regulations 18, Consent to care and treatment. We have asked the provider to send us a report that tells us what actions they are taking to meet these essential standards.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

Some aspects of patients' safety were well managed, such as the prevention and control of infection and the management of medicines. The admission of patients detained under the Mental Health Act was effectively managed. There were systems and procedures in place to safeguard vulnerable patients and to identify, assess and manage risks. However, the systems and procedures were not always used consistently or effectively which meant that patients were not always protected from abuse or avoidable harm. Patients' records were filed separately by different professionals which could lead to lack of consistency of care and treatment.

Are services effective?

Patients and their families / carers were satisfied with the care and treatment provided and reported good outcomes for patients. There was generally effective collaboration and communication amongst members of the multidisciplinary team to support the planning and delivery of patient care. Staffing was stretched at times where the level of support needed by patients was not matched by an increase in staff. Staff were supported with clinical supervision, appraisal, and relevant training.

Are services caring?

Patients and their families / carers said they were treated with kindness and respect and they were involved in making decisions about care and treatment. However, we found that patients' views about their care and treatment were not always recorded or taken into account. The ward environment did not always promote the wellbeing of patients.

Are services responsive to people's needs?

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Planning for the patient leaving hospital started on the day of admission. Discussions about discharge from hospital involved the patient and their families and carers.

Are services well-led?

Most staff we spoke with were aware of the Trust's vision and values. Staff told us they enjoyed working at Walton Hospital. They felt there was good team working and they were well supported by their managers.

Summary of findings

What we found about each of the core services provided from this location

Community inpatient services

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Other services

Mental Health Act responsibilities

We found that there were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act. The detention documents were available and contained all the required information including the views of the patients and the nearest relative as appropriate. Although for one patient no nearest relative had been identified by the Approved Mental Health Professional (AMHP) at the point of admission. There was no evidence of any further attempts to rectify the situation. This is important in ensuring the least restrictive option was considered and the views of the patient and nearest relative were considered. All detentions appeared to be lawful.

We found evidence that the hospital managers discharged their duties to review the detention of patients. This included holding full panel meetings when patients appealed against their detention and also when the responsible clinician renewed the detention, whether or not the patient contested the renewal.

We found that the lead pharmacist and technicians visited the wards every two weeks to monitor stock levels, undertake general medication audits and provide advice on the use of covert medication. They referred to the mental

Summary of findings

health trust, (Derbyshire Healthcare NHS Foundation Trust), pharmacist for specialist advice relating to medicines used in the treatment of mental illness. The monitoring and audit against the National Institute for Clinical Excellence (NICE) guidelines relating to anti-psychotic medication prescribed by the responsible clinician was undertaken by Derbyshire Healthcare NHS Foundation Trust.

In respect of the operation of Part IV of the Mental Health Act, we found inconsistency in the recording of discussions between the patients and responsible clinicians regarding their capacity to consent to medication at initial administration or prior to the end of the first three months. There was no system in place to ensure that the start of the three month period included medication given prior to commencement of compulsion.

Responsible clinicians are employed by Derbyshire Healthcare NHS Foundation Trust and operate in Derbyshire Community Health Services NHS Trust under a service level agreement. We found a lack of clarity over which organisation's policies and procedure medical staff are working to when on the wards. There was duplication of information as a result of patients' notes from two organisations being used. Staff had access to clinical and managerial supervision, but there were no formal monitoring arrangements.

We found that detained patients were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in compliance with the Mental Health Act Code of Practice. Patients' capacity to understand their rights was assessed and recorded by nursing staff. We found that information about patients' rights was not provided in alternative formats other than the standard rights leaflet.

We found that the mental health care plans were rudimentary, formulaic, and process focused, rather than person centred. Patients' views of their care were not always recorded or taken into consideration.

Information on the role of the Independent Mental Health Advocacy service was provided. We found automatic referrals to the Independent Mental Health Advocacy (IMHA) service in place for all new patients, though staff also made referrals when necessary for individuals who lacked capacity. IMHA and Independent Mental Capacity Advocate (IMCA) supported patients at ward rounds, multi-disciplinary team and discharge planning meetings.

We found evidence of consideration of the least restrictive treatment option. This included documented discussion of the use of the Deprivation of Liberty safeguards.

Summary of findings

What people who use the community health services say

Patients and their families / carers were satisfied with the care and treatment provided and reported good outcomes for patients. They said they were treated with kindness and respect and they were involved in making decisions about care and treatment.

Areas for improvement

Action the community health service MUST take to improve

- Ensure that arrangements for obtaining the consent of patients or for acting in their best interests are followed in practice, monitored and reviewed.
- People's care must be planned and delivered with sufficient detail and regular review to meet people's individual needs and to ensure their safety and welfare.

Action the community health service SHOULD take to improve

- Ensure that patients' notes are maintained so as to provide a consistent record from different professionals involved in their care.
- Enhance staff understanding of clinical supervision and ensure processes are in place to monitor clinical supervision received per individual member of staff.
- Improve the training and support provided for hospital managers in respect of their responsibilities under the Mental Health Act 1983.
- Review the use of seclusion and staff understanding and application of the Trust's seclusion policy.
- Review staffing levels, particularly during the night
- Review the provision of occupational therapy and physiotherapy services
- NICE guidance should be followed in respect of mental health treatment with audits to monitor outcomes.

Action the community health service COULD take to improve

- Look at how the ward environment can be better managed and physically improved to promote the wellbeing of patients, particularly patients with dementia.

Good practice

Our inspection team highlighted the following areas of good practice:

- The appointment of a specialist mental health trainer with a focus on dementia care in practice. This has been well received by staff.

Walton Hospital

Detailed findings

Services we looked at:
Community inpatient services; Mental Health Act responsibilities

Our inspection team

Our inspection team was led by:

Chair: Helen Mackenzie, Director of Nursing and Governance, Berkshire Healthcare NHS Foundation Trust

Head of Inspection: Ros Johnson, Care Quality Commission

The team visiting Walton Hospital included CQC inspectors and a Mental Health Act Commissioner, a mental health practitioner, a rehabilitation therapist and an expert by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to Walton Hospital

Walton Hospital is managed by Derbyshire Community Health services NHS Trust which delivers a variety of services across Derbyshire and in parts of Leicestershire. It was registered with CQC as a location of Derbyshire Community Health Services NHS Trust in May 2011. It is registered to provide the regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures, Surgical procedures and Treatment of disease, disorder or injury.

Walton Hospital is a local community hospital providing care for older people with mental health needs who may require assessment or rehabilitation. There are two inpatient wards, Linacre and Melbourne, each with 24 beds. Patients may be detained under the Mental Health Act 1983. There is a day hospital on site, Lea Hurst. This is one of one of two community day hospitals in the area and also provides the base for the community outreach team. At the time of the inspection there were no patients using Lea Hurst day hospital as services alternate between the two locations.

Walton Hospital was inspected by the CQC twice in 2013. At the last inspection in July 2013, it was found to be non-compliant with Regulation 17, Respecting and involving people who use services, and Regulation 20, Records.

Why we carried out this inspection

This location was inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team looked at the following core service areas at this inspection:

Community inpatient services

In addition, the inspection team looked at

Mental Health Act responsibilities

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

We carried out an announced visit on 26 February 2014 and an unannounced visit on 4 March 2014. During our visit we observed how people were cared for. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We talked with people using the service, with their carers and / or family members, and with staff. We held a focus group with qualified nurses providing care on Linacre and Melbourne Wards.

Community inpatient services

Information about the service

Linacre and Melbourne wards are purpose built one storey buildings opened in 2010 at Walton Hospital. Both wards provide acute admission services for up to older people with mental health problems. There are 24 beds on each ward.

The wards provide accommodation for both male and female patients in single occupancy ensuite rooms. Shared dining and lounge areas are provided along with access to an enclose courtyard and garden area. All patients have access to their own rooms throughout the day and although rooms are not normally locked patients can request that they are locked by staff. Male and female patients are accommodated on separate but adjoining wings of the ward and each has a small quiet area. There is a separate wing with occupational therapy (OT) rooms, sensory room, pamper area and hairdressing facilities.

Lea Hurst is one of two community day hospitals in the area and also provides the base for the community outreach team. The team provides a 'Living well with dementia programme' and a 'life styles' programme with onward referral of the specialist services in the day hospital if required. At the time of the inspection there were no patients using Lea Hurst as services alternate between the two locations.

Summary of findings

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Community inpatient services

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Are community inpatient services safe?

Safety in the past

Patients were not always protected from abuse and avoidable harm. We received information about a patient who had been subject to physical abuse from other patients on several occasions. The patient's care plan was not reviewed or updated following the incidents to show how their safety should be maintained. One patient was assessed on admission as being at high risk of falls. However, a care plan to ensure the patient's safe mobility was not written until 13 days after admission. The patient had a fall on the day before the care plan was written.

Staff told us they had received training in safeguarding vulnerable adults. They were able to give examples of what they would consider to be abuse and knew the procedures to follow to report abuse. The provider told us that 98% of staff on Linacre and Melbourne wards had received training in safeguarding vulnerable adults. Staff were aware of the whistleblowing policy and felt confident to use it if they needed to.

Staff we spoke with were confident about reporting safety incidents and could give examples of what incidents they would report. Incidents were reported and recorded electronically. All incident reports were seen by the ward managers and by the patient safety team. Staff told us that a root cause analysis was carried out in specific circumstances, such as pressure ulcers of grade three or above and falls that resulted in significant injury to the patient.

Learning and improvement

Staff told us that lessons learned following incidents were cascaded to them through shift handovers, supervision, team meetings, and emails from senior managers. They said that new procedures had been implemented and changes to practice made as a result of learning from incidents. An example given was an incident where a wheelchair was not correctly used and so relevant training was arranged for staff.

A monthly clinical quality and patient safety report is completed by the Trust. Within this report insulin administration was identified as an area of concern across inpatient services. Since April 2013 there had been seven inpatient incidents regarding the administration of insulin. A root cause analysis was conducted by the Insulin Review

Group and changes put in place to prevent incidents occurring to other patients. Staff told us that all insulin was now checked by two members of staff before it was administered and they had been provided with e-learning training on the administration of insulin. Most staff said they had completed this training.

Systems, processes and practices

Staff we spoke with told us they had access to all of the provider's policies and procedures electronically using the intranet.

Staff told us their line managers were supportive and approachable. This meant that staff felt able to report incidents or raise concerns without fear of negative consequences.

We found that the rate of reported venous thromboembolism (VTE) for the provider was below the England average for the period December 2012 to December 2013. This measure records whether or not a patient is being clinically treated for a VTE of any type. The provider's policy was that all patients were assessed on admission to hospital for their risk of developing VTE. We saw that VTE assessments had been completed in most of the patient records we looked at.

We observed appropriate practices to protect patients against the risks of acquiring infections. This included provision of hand washing facilities for patients, staff and visitors, and staff following hand hygiene guidance. There were suitable arrangements for the disposal of waste, including clinical waste. Both wards looked and smelled clean in the areas we saw. Patients and relatives said the wards were, "Always clean." and, "Spotless."

Details of patients' food allergies and dietary needs were noted in their records and on a laminated card used by staff when serving meals and drinks. The card had photographs of patients to aid identification. This system helped to reduce the risk of patients being given food or drink that could cause them harm.

Patients were observed according to their needs and the risks presented by their own, or others, behaviour. Observation charts were not always fully completed by staff. The level of observations should be reviewed by the nurse in charge at least once during every shift. However, without proper information from the monitoring charts it was not possible to do this meaningfully or effectively. This meant that patients may not have sufficient observation or may be subject to a level of observation that was more intrusive than necessary.

Staff told us that restraint was used when necessary using approved techniques. Staff had attended training every year in managing violent and aggressive behaviour. The provider told us that 95% of staff on the wards had received this training. When restraint was used this was documented in the patient's notes and reported as an incident on an electronic incident reporting system. Patterns and trends of incidents were fed back to the matron and shared with the team.

Neither of the wards had formal seclusion facilities; however, the seclusion of patients in individual bedrooms was reported by staff. Staff were not clear about what might constitute seclusion or about the Trust's policy on its use.

Monitoring safety and responding to risk

Patients told us they felt safe on the wards, and relatives we spoke with echoed this. Patients said, "Staff keep me safe if someone tries to get at me. All I have to say is 'nurse' and they come quickly." and, "I didn't feel safe at first but I do now I'm more settled." A relative told us, "I've no worries about her safety."

The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms. It allows staff teams to measure harm and the proportion of patients that are harm free during the working day. Staff were fully aware of the NHS safety thermometer and were able to report good results from it. We saw recent positive results displayed on the wards.

Appropriate risk assessments were completed on or soon after admission for most patients. This included the risk of falls, inadequate nutrition and hydration, and of developing pressure ulcers. Risk assessments were not always regularly reviewed and so the risk was not being adequately monitored. A member of staff told us the risk assessments should be reviewed at least weekly but many we saw had not been reviewed that regularly. For example, one patient was assessed as being at high risk of falls. Their risk assessment had not been reviewed for 13 days. Another patient was assessed as at high risk of developing pressure ulcers. Their risk assessment had not been reviewed for 12 days.

Community inpatient services

Staff told us that increased levels of observations were not always responded to with increased staffing levels. Staff reported that high observations levels meant that sometimes there were no staff free to take patients to the toilet. Staff said that staffing levels at night were not always adequate, depending on levels of observation required. At the time of our unannounced visit there were four staff to cover the night shift on one ward and two patients needing level two observations. This meant that these patients required a member of staff within arm's length to ensure their safety or the safety of others. This left two staff to provide care for 14 patients, some of them with poor sleep patterns and likely to be awake during the night.

Anticipation and planning

The provider's Mental Health Act Committee met regularly to discuss all services within the Trust where there may be patients detained under the Mental Health Act 1983. The committee looked at possible safety issues, such as complaints and reports of significant incidents. Any recommendations for action were followed up at the next meeting.

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

The provider's policies were available electronically via the intranet and some in paper format so all staff had access to them. The policies reflected national guidance with appropriate evidence and references. For example, the observation policy was based on national guidance on patient observation, issued by the National Institute for Health and Care Excellence. The policy noted the evidence base, and references included the Department of Health National Dementia Strategy and guidance from the Nursing and Midwifery Council.

Staff told us about a recent Trust initiative to provide all staff with training in current good practice in caring for people with dementia. This had been well received by staff.

Monitoring and improvement of outcomes

Staff told us they could bring their views, ideas or concerns to regular team meetings or to supervision or informally to the ward managers. Staff said the ward managers were approachable and willing to listen to them.

Staffing arrangements

Patients told us that staff were usually available when they were needed. They said, "They respond pretty quickly if I need the bathroom." and, "If I pull the switch in my room staff come quickly." Two relatives said that staff were usually around when they visited.

Staffing on the wards was usually adequate during the day, though often stretched. Staffing at night was not always adequate. Staff on one ward felt that night staffing levels did not take into account the observation levels required or the poor sleep patterns of many patients with dementia. Staff told us that the planned staffing level of five staff in total at night was not always maintained. We saw that there were four staff on duty for the night following our unannounced visit. This had also happened on the previous night.

Staff told us that there were currently nine staff vacancies in total for both wards. The provider was recruiting to fill the vacancies and bank and agency staff were being used to cover the shifts. Staff said that they could select preferred bank staff to maintain some continuity and to ensure staff with relevant training, such as staff that were trained in managing challenging behaviour.

Staff felt there was a good skill mix on the wards as there were general nurses as well as mental health nurses. The nurses all had a chance to be in charge of a shift. There were 'band 6' nurses on each ward: staff nurses with additional responsibilities. They had undertaken leadership training that had helped with their role.

We saw white boards informing the public how many staff should be on duty and how many were, and which staff were in charge. Electronic rostering was being introduced. Some staff were positive about the new system, though others told us they found the e-rostering time consuming and not efficient.

Staff told us they had an annual appraisal which included discussion of their personal development and training needs. Staff told us they had clinical supervision and also used the 'Brief and Boundaried' model that had been introduced alongside the existing clinical supervision. Staff said they did not have supervision sessions planned in advance; they would arrange supervision when they felt it was needed. Staff said that providing evidence of

supervision was a requirement at their annual appraisal. However, staff used the term 'supervision' for both the planned clinical supervision and the opportunistic 'Brief and Boundaried'.

The provider's information for staff described a 'Brief and Boundaried' model that captures opportunities for brief supportive discussions with colleagues to complement rather than replace time protected Clinical Supervision. Clinical supervision was described as protected time for staff to reflect on their practice in order to learn from experience, develop and maintain competence.

Multidisciplinary working and support

We spoke with occupational therapy staff and a physiotherapist who worked with patients on both wards. The occupational therapy staff told us that they would like to be more involved in shift handovers on the wards. They said this would save time spent chasing information about patients and would ensure that information could be shared in a more timely and effective way. Occupational therapy staff told us there were not always enough of them to provide the service required. The physiotherapist was based at another community hospital site and saw patients at Walton Hospital on a referral basis. This was more of a 'good will' agreement rather than a formal arrangement and ward staff said it was not always easy to access the physiotherapist. Therapy and ward staff felt that patients would benefit from having a physiotherapist based at Walton Hospital.

Ward staff told us they had good links with the therapy staff based at Walton Hospital and also with the community team. There was a weekly multidisciplinary team meeting that included the community staff.

Are community inpatient services caring?

Compassion, dignity and empathy

Patients told us that staff were kind and caring and treated them with respect. Patients said, "Excellent care from dedicated staff.", "People let you know what is happening." One relative said, "They're so calm and patient with her." We saw that patients were mostly treated with kindness and compassion by staff caring for them. However, we also saw some less positive interactions between staff and patients. We observed staff speaking to patients in a directive manner, rather than engaging in a more friendly and respectful way. We saw that staff did not respond honestly to a patient's question, causing the patient to become agitated.

Patients were accommodated in single rooms with ensuite toilets to help uphold their privacy. We saw that staff ensured toilet doors were closed when in use. Signs used on the wards, such as on toilet and bathroom doors, were designed to be easily understood by patients with dementia.

The ward environment did not always promote the wellbeing of patients. During our unannounced visit the main lounge on one of the wards was very noisy. There was a television and music playing in the same area. There was a hard laminate floor causing the noise levels to increase. We noted that one patient was sitting in the lounge although their care plan said that they did not cope well with a noisy environment. A member of staff said they felt patients could be, "Over stimulated in the lounge as too much is taking place – medicines, food and so on. Patients would benefit if we could spread them out a bit more (around the ward)."

There was a change in the colour of the floor covering from one area to another which was confusing and a possible falls risk for patients with altered perception. We saw one patient try to step across the area where the two floor coverings joined, even though there was no change in floor level. We noticed a strong and unpleasant smell of bleach on one ward during our unannounced visit

Involvement in care

Patients and/or their relatives were usually involved in making decisions about their care and treatment. Patients told us they were involved in discussions about their care and treatment. One patient said that assessments were explained before and afterwards so they could understand. They said that staff sometimes explained things to them several times to ensure the patient was clear on what was being said. Relatives told us they understood why the patient had been admitted to hospital and they had been involved in multidisciplinary team meetings to discuss the patient's care and treatment. We saw good examples of staff working together with patients and relatives to achieve the best outcomes.

However, we found that some of the patients' records we looked at did not show how the patient or their relatives /

carers had been involved in making decisions about their care and treatment. Staff told us that patients were not always informed about the observations being carried out. The provider's observation policy says that patients should be informed of the reasons for observation and should be involved in the decision making process. If the patient is judged to lack capacity to understand reasons why observation is required, then this capacity decision must be recorded along with best interest decision that demonstrates that observation is in the patient's best interest. We did not see this information in patients' records.

Trust and respect

Patients' dietary needs and preferences were in their records and on laminated cards used by staff serving meals and drinks. It was noted for a patient recently admitted that they preferred food from their native country, although staff were not sure yet whether this could actually be provided.

A member of staff told us that ward routines did not always reflect patients' individual preferences. They said that patients all had to be up and dressed ready for breakfast by 8.30 to 9am. They felt that routines should be more flexible.

Emotional support

A patient and their relative told us they enjoyed sitting together in a quiet area of the ward during the relative's visits. The relative said the staff encouraged this as the patient was calmed and reassured by the relative's presence. Another relative told us this was the first time the patient had been admitted to a hospital for treatment of their mental health condition. The relative said they were surprised and pleased by the calm and supportive attitude of the staff.

Staff told us that emotional support for relatives was important as they were often distressed by the effects of the patient's ill health. Staff said they took time to explain to relatives and provide reassurance about the treatment of patients.

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

Meeting people's needs

There were medical staff available to assess and treat patients' physical healthcare needs. Staff said the medical cover worked well and they were able to access an out of hours service as necessary. Patients' physical healthcare needs were not always documented in their care plans. This meant that staff may not have sufficient guidance about how to meet those needs. One patient's medical history showed they had several health conditions, including asthma and diabetes, but there were no care plans about how these conditions were to be monitored and managed. Two patients were noted to have wounds or pressure ulcers but did not have plans about how these should be treated and monitored.

Patients' care plans lacked detail about what may trigger challenging behaviour or what action staff should take if the patient became agitated or aggressive. An example was a patient who was noted to have a history of being physically aggressive to family members. There was no plan in their records about how any physical aggression could be avoided or managed. Other patients had standard care plans about managing challenging behaviour. This meant the care plans did not have guidance for staff that was specific to the individual patient, such as how the patient preferred to be supported to manage their behaviour, or what might trigger the patient to become agitated or aggressive.

Access to services

Patients were referred to Linacre and Melbourne wards through consultant psychiatrists as acute or emergency admissions. Patients were usually living locally.

Both of the wards were purpose built and all at ground floor level. There was access throughout for people with reduced mobility and people using wheelchairs. The hospital was located on a bus route and there was free car parking available on site.

Vulnerable patients and capacity

Staff did not always understand or apply the requirements of the Mental Capacity Act 2005 (MCA) when delivering care. The MCA provides the legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Where people have the mental capacity to make their own decisions, their consent must be obtained and acted in accordance with. The Deprivation of Liberty Safeguards (DoLS) are part of the MCA. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Community inpatient services

The safeguards should ensure that people are only deprived of their liberty in a safe and correct way and only when it is in the person's best interests and there is no other way to look after them.

The provider required that all staff should receive mandatory training in consent, the MCA and DoLS. The provider told us that 72% of staff on Linacre and Melbourne wards had received this training. The provider said that this training was mandatory for qualified nurses, but not compulsory for health care support workers.

We saw that a patient had a 'Do not attempt resuscitation' (DNACPR) form completed and signed by the patient's relative and a doctor. Another patient's records noted they had consented to the administration of suppositories. Staff told us the patient was unable to give consent to care and treatment because they had dementia. Neither patient had an assessment of their capacity to make the decision or any record of how the decision had been made in their best interests.

On one ward we saw that applications for DoLS authorisation had been made appropriately for two patients. However, nurses on the other ward were not aware whether any DoLS authorisations were in place when we asked for this information. The nurses lacked awareness of what could constitute deprivation of liberty and did not know who to contact to apply for a DoLS authorisation. One patient was often physically restrained when having personal care. The nurses were not aware whether any formal process had been followed to assess the patient's capacity, to make a decision in their best interest, or to apply for a DoLS authorisation.

Leaving hospital

We saw that planning for the patient leaving hospital started on the day of admission. Multidisciplinary team meetings (MDT) were held every week where patient discharges were discussed and provisional dates agreed. We saw evidence of discussions around discharge in patients' records. The discussions and preparation for discharge involved the patient and their families. One relative told us they attended meetings where discharge plans were discussed, "She is a bit better but we know it might be another five or six months before she can come out." Another relative of a recently admitted patient said that staff had already discussed possible discharge plans with them, "They've kept me informed. I know she could be here at least three weeks."

Learning from experiences, concerns and complaints

The provider's Board meetings included feedback from patients through the Patient Experience and Engagement Group and patient's story, and also looked at trends in complaints and incidents.

Information was available for patients and their families about how to make a complaint or raise concerns. Patients and relatives told us they would go to the ward staff if they were unhappy about anything.

Are community inpatient services well-led?

Vision, strategy and risks

Information about the provider's vision and values was prominently displayed in the hospital. Most staff we spoke with were aware of the provider's approach to delivering quality services: 'The DCHS Way'.

Quality, performance and problems

Staff were able to share ideas and raise concerns through team meetings, supervision, shift handovers, and informally with their managers. Staff told us they were asked for their opinions on new ideas being trialled, such as changes to documentation.

Leadership and culture

Most staff we spoke with were aware of the basic structure of the organisation and knew the name of the Chief Executive. Staff told us that senior managers had visited the wards and had an informal approach when talking to staff. Staff said they had good support from their line managers. They told us, "The ward matrons are very visible on the wards." and, "We know that the information we get from the matrons is direct from board level."

Patient experiences and staff involvement and engagement

Communication about changes in the Trust was cascaded to staff through several routes. The Trust issued a monthly bulletin, 'The Voice', and the Chief Executive wrote a weekly email to staff. Updates were discussed at ward team meetings. Staff told us they enjoyed working for the Trust and were proud of the standard of care they provided to patients.

Community inpatient services

Patients, relatives and carers we spoke with were mostly positive about the service provided at Walton Hospital. Patients and their families were provided with opportunities to raise concerns or complaints. Patients told us they would speak to staff if they were unhappy.

Learning, improvement, innovation and sustainability

Staff had a five day induction when first employed, followed by a probationary period of three to six months.

During the probationary period, staff performance and behaviour was monitored through supervision and appraisal. Staff told us that learning and personal development were encouraged and supported by their managers.

Mental health act responsibilities

Information about the service

The Mental Health Act 1983 allows a person to be admitted to hospital for assessment and treatment of their mental health. This imposes restrictions upon their liberty, for example, they may not be able to leave hospital without permission and they may be given treatment against their consent. This means important safe guards must be in place to make sure patients know their rights to appeal against detention. Systems must be in place to ensure correct procedures are being followed in detaining and treating patients. The Mental Health Act Code of Practice gives guidance to hospitals on how to do this. We monitor the Mental Health Act and Code of Practice to ensure it is being adhered to.

Linacre and Melbourne wards are purpose built one storey buildings opened in 2010 at Walton Hospital. Both wards provide acute admission services for up to older people with mental health problems. There are 24 beds on each ward. On the day of the inspection there were 18 patients on Linacre ward, five of whom were subject to detention under the Mental Health Act (the Act) and two of whom were on overnight leave from the ward. There were 24 patients on Melbourne ward, five of whom were subject to detention under the Act and there were no patients on overnight leave.

The wards provide accommodation for both male and female patients in single occupancy ensuite rooms. Shared dining and lounge areas are provided along with access to an enclose courtyard and garden area. All patients have access to their own rooms throughout the day and although rooms are not normally locked patients can request that they are locked by staff. Male and female patients are accommodated on separate but adjoining wings of the ward and each has a small quiet area. There is a separate wing with occupational therapy rooms, sensory room, pamper area and hairdressing facilities.

Lea Hurst is one of two community day hospitals in the area and also provides the base for the community outreach team. The team provides a 'Living well with dementia programme' and a 'life styles' programme with onward referral of the specialist services in the day hospital if required. At the time of the inspection there were no patients using Lea Hurst as services alternate between the two locations. None of the patients attending either of the two sites are currently subject to legislative compulsion.

We last undertook an unannounced visit to Melbourne and Linacre Wards on 22 July 2011 and found a number of concerns to which the Trust responded with an action plan.

Mental health act responsibilities

Summary of findings

During the inspection we reviewed the records of eight of the detained patients and scrutinised the detention documents. We spoke with detained and informal patients, interviewed staff at all levels and met both formally and informally with patients' relatives / carers.

We found that there were effective systems and processes in place to manage the admission of detained patients under the Mental Health Act. The detention documents were available and contained all the required information including the views of the patients and the nearest relative as appropriate. Although for one patient no nearest relative had been identified by the Approved Mental Health Professional (AMHP) at the point of admission. There was no evidence of any further attempts to rectify the situation. This is important in ensuring the least restrictive option was considered and the views of the patient and nearest relative were considered. All detentions appeared to be lawful.

We found evidence that the hospital managers discharge their duties to review the detention of patients. This included holding full panel meetings when patients appealed against their detention and also when the responsible clinician renewed the detention, whether or not the patient contested the renewal.

We found that the lead pharmacist and technicians visited the wards every two weeks to monitor stock levels, undertake general medication audits and provide advice on the use of covert medication. They referred to the mental health trust, (Derbyshire Healthcare NHS Foundation Trust), pharmacist for specialist advice relating to medicines used in the treatment of mental illness. The monitoring and audit against the National Institute for Clinical Excellence (NICE) guidelines relating to anti-psychotic medication prescribed by the responsible clinician was undertaken by Derbyshire Healthcare NHS Foundation Trust.

In respect of the operation of Part IV of the Mental Health Act, we found inconsistency in the recording of discussions between the patients and responsible clinicians regarding their capacity to consent to medication at initial administration or prior to the end of the first three months. There was no system in place to ensure that the start of the three month period included medication given prior to commencement of compulsion.

Responsible clinicians are employed by Derbyshire Healthcare NHS Foundation Trust and operate in Derbyshire Community Health Services NHS Trust under a service level agreement. We found a lack of clarity over which organisation's policies and procedure medical staff are working to when on the wards. There was duplication of information as a result of patients' notes from two organisations being used. Staff had access to clinical and managerial supervision, but there were no formal monitoring arrangements.

We found that detained patients were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in compliance with the Mental Health Act Code of Practice. Patients' capacity to understand their rights was assessed and recorded by nursing staff. We found that information about patients' rights was not provided in alternative formats other than the standard rights leaflet.

We found that the mental health care plans were rudimentary, formulaic, and process focused, rather than person centred. Patients' views of their care were not always recorded or taken into consideration.

Information on the role of the Independent Mental Health Advocacy service was provided. We found automatic referrals to the Independent Mental Health Advocacy (IMHA) service in place for all new patients, though staff also made referrals when necessary for individuals who lacked capacity. IMHA and Independent Mental Capacity Advocate (IMCA) supported patients at ward rounds, multi-disciplinary team and discharge planning meetings.

We found evidence of consideration of the least restrictive treatment option. This included documented discussion of the use of the Deprivation of Liberty safeguards (DoLS).

Mental health act responsibilities

Are other services safe?

Governance

A service level agreement was in place with Derbyshire Healthcare Foundation NHS Trust, (a mental health trust), who provided the responsible clinicians for the older people's mental health services at Walton Hospital. People who are detained under the Act or discharged onto supervised community treatment must be under the care of a 'responsible clinician'. He or she has overall responsibility for an individual's care. All responsible clinicians have applied for, and been given, 'approved clinician' status. An approved clinician is a doctor, a psychologist, a mental health nurse, an occupational therapist or a social worker who has been trained and approved (for five years at a time) to carry out certain duties under the Act.

There had been discussion over the past year to develop a detailed new service level agreement to cover governance arrangements, audits, policies and procedures. The absence of finalised service level agreements meant there were clinical risks that were not being addressed. For example, we found that there were separate patient medical notes and separate files for nursing and other professions. We found that some but not all information from the nursing and professions allied to medicine were copied to medical files. This lack of integration of notes meant there was a danger of a patient's history and plans not being seen in sequence and therefore subject to misunderstanding leading to errors. Staff informed us that they did not agree with the separate patient files. However, they had been told that because the medical staff were employed by another trust, the files had to be kept for clinical governance purposes. Staff were not clear what audits or governance processes the patient's files were subject to.

Whilst the responsible clinicians were employed by another trust, staff told us they worked very flexibly and were easily accessible and responded to emails quickly. Access to local GP services was provided on-site. The GPs visited regularly and were readily available. An out of hours service was provided by Derbyshire Health United.

We were told that patients did not always come with their notes if admitted from another trust. This was a risk as it potentially caused delays in treatment.

Staffing

Staff raised the issue that increased levels of observations were not always responded to with increased staffing levels. Staff reported that high observations levels meant that sometimes there were no staff free to take patients to the toilet.

The occupational therapy team reported they felt under resourced and not engaged with the nursing and medical teams, raising issues of communication and response to patient need.

Detention

There were effective systems and processes in place to manage the admission of patients detained under the Act. The detention documents were available for inspection and included all the relevant criteria for detention and treatment. The patients' views of the detention process had been taken into consideration at the point of application and the nearest relative had been consulted as appropriate. The nearest relative is defined under the Act and has rights that can be exercised to provide additional safeguards. However, we found there was no system in place to ensure that where no nearest relative was identified this was followed up.

Copies of the approved mental health professional's report detailing the circumstances of the detention were available in all but one case. An approved mental health professional (AMHP) is a social worker, mental health nurse, occupational therapist or psychologist who has received special training to help decide whether people need to be admitted to hospital. They are 'approved' by a local social services authority for five years at a time. Most AMHPs are social workers. The detentions of all eight patients appeared to be lawful.

Consent to Treatment

All treatment appeared to be given under the relevant legal authority. However, there was inconsistent recording of patients' capacity to consent to medication at initial administration and prior to the expiry of the three months in which the responsible clinician may prescribe treatment without the individuals consent. There was no assurance that the three month period for treatment given under the consent of the responsible clinician started when the patient was first prescribed medication, even if they were not subject to detention at the time. This meant that some non-consenting detained people could be receiving treatment for longer than the three month period. Second

Mental health act responsibilities

Opinion Appointed Doctor (SOAD) provide an essential safeguard for detained patients who do not consent to their treatment. We saw that SOADs were requested as appropriate to review patients' medication treatment plans.

Patient rights

Hospital managers had a system in place to ensure patients were provided with information on their rights under the Act, (both verbally and in writing), at first admission and on subsequent occasions in adherence with the Mental Health Act Code of Practice. Under the Act, the term 'hospital managers' describes the organisation that is in charge of the hospital – the Trust in this case. Hospital managers are ultimately responsible for what happens to people who are detained and treated under the Act within that particular hospital; for making sure the law is used properly within the hospital; and for ensuring that patients who are detained and treated under the Act are fully informed of their rights.

Patients' capacity to understand their rights was assessed each time their rights were reviewed and recorded by nursing staff.

Information on the role of the Independent Mental Health Advocate (IMHA) service was provided and eligible patients were referred to the Independent Mental Capacity Advocate (IMCA) service.

We found there was no system in place for ensuring detained patients who lacked capacity to exercise their right of appeal to the Mental Health Tribunal were brought to the attention of the hospital managers. This must be done within the appropriate time frame to ensure an appeal is made on the patient's behalf if required.

Section 17 Leave of Absence

Section 17 leave under the Act means that people cannot leave the hospital without authorisation from the responsible clinician and with clearly defined conditions being set, such as geographical boundaries and whether the leave is escorted or not. Where section 17 leave was in place, we found this was authorised appropriately and had conditions specified following risk assessments.

The section 17 leave forms were not routinely copied to patients or their families / carers, only when they actually went on leave. Nor was the risk assessment on the day of leave and the evaluation of the leave formally recorded. We found that there was no section 17 leave authorised for emergency medical treatment, staff said this would be done in retrospect. Most patients on the wards had physical healthcare needs in addition to their mental health needs and so were quite likely to require admission to an acute hospital.

Use of seclusion and longer term segregation

Neither ward had formal seclusion facilities; however, the seclusion of patients in individual bedrooms was reported by staff. Staff were not clear about seclusion or about the Trust's policy on its use. We found no evidence of the use of longer term segregation.

Are other services effective?
(for example, treatment is effective)

Are Mental Health Act Responsibilities effective

Governance

There was a service level agreement in place with Derbyshire Healthcare NHS Foundation Trust, who provided the three Responsible clinicians for the Old Age Mental Health Psychiatry services. This was under review and had not been finalised. This meant that there was little monitoring of the effectiveness of mental health care and treatment. The Responsible clinicians had carried out a review of anti-psychotic medication, focussing on reducing the use of this. However, no other examples were given to us from the staff we spoke to.

Junior medical staff were not directly employed by the Trust. They reported that they were unsure whose policies and procedures they were to follow, those of the Trust or of the organisation that employed them. Senior managers of the Trust and the lead consultant psychiatrist for older people were clear that staff who were delivering a service to the Trust were expected to follow Trust procedures. All staff in a team should be following the same policies and procedures in order to avoid misunderstandings and errors.

Junior medical staff were familiar with National Institute for Health and Care Excellence (NICE) guidance in relation to physical healthcare. However, they were not so familiar with mental health NICE guidance and were not aware of any audits of NICE guidance or audits of mental health care. Senior managers said that NICE guidance was cascaded to staff. However, there was no evidence of monitoring implementation and identifying outcomes related to mental health care and treatment.

Mental health act responsibilities

Junior medical staff told us communication could be improved, particularly when new patients were to be admitted. They said that patients did not always come with information or notes from the previous trust which could cause delays in treatment.

Hospital managers hearings

We found evidence that the hospital managers discharged their duties to review the detention of patients. This included holding full panel meetings when patients appealed against their detention and also when the Responsible clinician renewed the detention, whether or not the patient contested the renewal. However, we found that the knowledge of other duties of the hospital managers was rudimentary, such as their duties in relation to the admission and transfer of patients, assignment of responsible clinicians, referral to the Mental Health Tribunal. We found there was no explicit training programme for hospital managers or those with delegated responsibility. We were informed legal updates, risk assessment and role specific training were not provided.

Medication Management

Pharmacists visited the wards to provide general information and advice to staff. For example, they provided advice on covert medication for patients who required this and we saw the advice reflected in covert medication care plans. The pharmacists did not provide direct advice to patients and their families / carers. Pharmacists carried out audits of medicines in stock, controlled drugs and medication charts. However, they did not carry out audits of the forms used for authorisation of medication for detained patients, (form T2 for consenting detained patients and T3 for non-consenting detained patients). Specialist advice relating to medication used in the treatment of mental illness was sought from the Derbyshire Healthcare Foundation Trust pharmacists. It was not clear whether these pharmacists checked that medication was being given according to the requirements of the Act and the Code of Practice.

The pharmacists were working on a rapid tranquilisation policy with Derbyshire Healthcare Foundation Trust. Rapid tranquilization is medication used to manage the disturbed or violent behaviour of a patient. It is used when immediate management of such patients is necessary to ensure the safety of other patients and staff and to reduce the patient's level of distress.

Monitoring and audit against the NICE guidelines for anti-psychotic medication had been carried out by the Responsible clinicians from Derbyshire Healthcare Foundation Trust.

Staffing

We found there was a mix of general and mental health nurses so that the physical and mental health needs of patients could be met.

We spoke with occupational therapy staff and a physiotherapist who worked with patients on both wards. The occupational therapy staff told us that they would like to be more involved in shift handovers on the wards. They said this would save time spent chasing information about patients and would ensure that information could be shared in a more timely and effective way. Occupational therapy staff told us there were not always enough of them to provide the service required. The physiotherapist was based at another community hospital site and saw patients at Walton Hospital on a referral basis. This was more of a 'goodwill' agreement rather than a formal arrangement and ward staff said it was not always easy to access the physiotherapist. Therapy and ward staff felt that patients would benefit from having a physiotherapist based at Walton Hospital.

Ward staff told us they had good links with the therapy staff based at Walton Hospital and also with the community team. There was a weekly multidisciplinary team meeting that included the community staff

Restraint and Seclusion

Staff informed us that restraint was used when necessary using approved techniques. When restraint was used this was documented in the patient's notes and reported as an incident on an electronic incident reporting system. The patterns of incidents were fed back to the matron and shared with the team.

Seclusion was used in patients' bedrooms and documented in their notes. There was a lack of clarity regarding the seclusion policy. This did not comply with the Code of Practice.

Mental Health Act Monitoring

There were four associate hospital managers who carried out an annual audit of the detention paper work. This was

Mental health act responsibilities

last completed in September 2013. The consultants were provided with a list of patients who were detained under the Act and were prompted regarding specific dates, such as for renewal of the detention and for appeals.

We found that although the Mental Health Act Committee reviewed organisational policies, there was little sense of ownership by the hospital managers of the policies as listed in the Code of Practice. The relevant NICE guidance was not considered in a comprehensive and structured manner by the Mental Health Act Committee.

The Trust did not directly employ approved clinicians as these were provided through a service level agreement with Derbyshire Healthcare Foundation Trust. However, the hospital managers had responsibility for ensuring the appropriate allocation of patients' responsible clinicians from the approved clinicians. The hospital managers had not been involved in the review of the service level agreement.

We were provided with evidence of a scheme of delegation protocol which detailed the allocation of some key functions and responsibilities of the hospital managers to identified staff members. However, this did not include the delegation of the role of responsible clinician under the service level agreement.

Risk Assessments and Care Plans

The mental health care plans we saw were rudimentary, formulaic towards the section the patient was on and their rights, and were not explicit about the mental health treatment being provided. The mental health care plans were not written in a person centred manner.

Are other services caring?

Are Mental Health Act Responsibilities caring

Patients and their families / carers told us they were treated with dignity and respect by staff. They described the service as responsive and caring with everything explained to them on admission and their families being involved. One patient said, "It's lovely here isn't it? The staff are so friendly, they always make an effort and even come and let you know when they are going home." A relative told us they felt well informed, involved and able to participate in the patient's care plan.

We observed high levels of staff patient engagement during our visit. This included the use of de-escalation techniques where one patient was becoming increasingly distressed and another was upsetting their relative by persistently trying to get into bed with another patient. Staff handled both situations in a calm and professional manner.

Patients reported feeling safe on the wards and able to participate in decisions concerning their care. They said that they felt able to approach staff with any issues. Patients told us they had regular access to their responsible clinician and that the care and treatment provided was of a good standard.

Independent advocacy was provided by Derbyshire MIND and patients were able to easily access the service.

The wards did not hold formal meetings for patients to comment on the service provided. Staff said this was because some patients had dementia. There was a weekly informal 'Café' meeting for patients, families and carers and also adhoc events, such as social days, cake sales and pamper days. Families and carers were able to drop in and ask for advice from staff.

Are other services responsive to people's needs?

(for example, to feedback?)

Are Mental Health Act Responsibilities responsive to people's needs

Detained patients views

We received positive comments from patients and their families / carers about the service provided. One patient said that everything was explained to them on admission and their family were involved. They said that staff treated them with respect and the environment met their needs. They said, "If I want a drink I go to the kitchen and they sort out whatever I want. They are pretty good with me" and "I'm very satisfied with the service."

Seclusion

We were told that the use of seclusion and the operational policy relating to the use of seclusion had been reviewed since the last Care Quality Commission visit. The current policy referred only to learning disabilities services as this was the only inpatient area where seclusion was used within the Trust. However, this conflicted with reports from staff on Melbourne ward that patients were sometimes secluded in their bedrooms.

Mental health act responsibilities

Rights

Detained patients were informed of their rights as required under the Act so that they knew how to appeal against their detention. Copies of patients' rights were given to their families / carers as required. The Code of Practice requires that patients are given information about their rights in a format that they can understand. We found that information was not provided in alternative formats other than the standard rights leaflet. There was no evidence of formats such as pictorial, easy read or audio being used to enable people to understand.

Information was available to patients about their rights to an Independent Mental Health Advocate or Independent (IMHA) Mental Capacity Advocate (IMHCA) to support them. Staff said there was an auto referral process in place for both IMHA and IMCA who were both involved in the multi-disciplinary team (MDT) ward rounds. IMHA were involved in discharge planning for detained patients and tribunal hearings.

Hospital managers

We were informed that the hospital managers on the Mental Health Act Committee were not consulted over the recent closure of a ward at Walton Hospital and the move of detained patients to another site. This meant they were not able to ensure it was an appropriate place to meet the mental health treatment of detained patients.

There were systems in place to organise hospital managers' hearings and Independent Mental Health Review Tribunals. We found there was no system in place for ensuring detained patients who lacked capacity to exercise their right of appeal were brought to the attention of the hospital managers.

Discharge

Discharge planning starts from the time a patient was admitted. The average length of stay on the wards was 111 days. Discussion about discharges took place at weekly MDT meetings and also with social services. Staff reported that delayed discharges were due to care home placements being unavailable or the costs of placement.

Patient participation

The wards did not hold formal patient community meetings for patients to express their views on matters relating to the operation of the service. There were informal events and other opportunities to gain the views of patients, their families and carers, such as the weekly 'Café' and social events.

Are other services well-led?

Are Mental Health Act Responsibilities well-led

Leadership and culture

Some staff reported that more positive feedback from management would be welcome as they felt they often had only negative feedback. However, other staff reported that they felt well supported and well led. They felt there was good visibility of senior managers and board members, giving examples of people at senior levels in the Trust visiting the wards. Staff said they had regular updates from the chief executive and they felt consulted about change. Staff said they were proud to work for the Trust, stating they were proud of the compassionate individualised care they gave to patients and their relatives.

Supervision

Staff reported that they have access to clinical and managerial supervision. However, there were no formal arrangements for monitoring the uptake of supervision.

There was an appraisal system in place and staff reported they had received an appraisal in the last year. The staff continuous professional development plans were based on appraisal.

Training

Staff had received training in line with the provider's mandatory programme. Staff reported they had received training about the Mental Health Act and DoLS from Derbyshire Healthcare Foundation Trust. We saw that staff had access to the Mental Health Act and the Code of Practice.

Mental Health Act Monitoring

There was a recognised governance structure in place for the operation and oversight of the Act. There was a policy in place which clearly described the reporting structure within the organisation. The Mental Health Act Committee was chaired by a non-executive director and met six times a year. This committee was a sub group of the Quality and

Mental health act responsibilities

Safety Committee which in turn was a sub group of the Trust Board. The Mental health Act Committee was able to raise issues directly with the board through the non-executive director.

We found that hospital managers did not fully appreciate the scope of their explicit duties and implicit responsibilities under the Act and as described in the Mental Health Act Code of Practice. The Trust Board, however, was aware of this issue and had plans in place to audit the role and redress this matter

There was a new lead trainer for mental health in post who had a focus on dementia care in practice and developing links with general wards. They were also providing a fundamentals of care course for all new support workers. The trainer was undertaking an audit of the use of DoLS on mental health wards with a view to establishing training needs.

Partnership Working

The Trust staff reported good partnership working with the local authority, the local acute trust and the mental health trust. Members of the Mental Health Legislative Committee were unsure if they were part of the Mental Health Act Partnership Working Group that monitored the implementation of the Mental Health Act across the local health economy. This meant the Trust's role in Mental Health Act partnership working arrangements were not clear

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 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: Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe because their care was not planned to meet their individual needs or ensure their safety and welfare. Regulation 9(1)(b)(i)(ii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: Suitable arrangements were not in place for obtaining patients' consent to care and treatment or for acting in their best interests. Regulation 18(1)(a)(b) & (2)