Good

Rotherham Doncaster and South Humber NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Woodfield House,
Tickhill Road Site,
Weston Road,
Balby
Doncaster
DN4 8QN
Tel:01302 796000
Website:www.rdash.nhs.uk

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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)
RXE92	Great Oaks	Laurel Ward	DN16 2JX
RXE00	Trust Headquarters - Doncaster	Coniston Lodge	DN4 8QN
RXE00	Trust Headquarters - Doncaster	Windermere Lodge	DN4 8QN
RXE07	Woodlands Unit	The Brambles	S60 2UD
RXE07	Woodlands Unit	The Glades	S60 2UD

This report describes our judgement of the quality of care provided within this core service by Rotherham Doncaster and South Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We have rated wards for older people with mental health problems as **good** overall because:

- Following our inspection in September 2015, we rated the services as 'good' for Safe, Caring, Responsive and Well led. Since that inspection, we have received no information that would cause us to re-inspect these key questions or change the ratings.

However

- Our rating of the Effective key question remains 'requires improvement.'This was because improvements were required in the use and application of the Mental Capacity Act. Not all staff received supervision at the required frequency and in accordance with trust policy. Some had received no formal supervisions for several months. Staff did not receive training to help them acquire skills and knowledge in the conditions of the patients they supported, such as dementia and mental illnesses. Only 43% of eligible staff had completed the required Mental Health Act training for their role.

Summary of findings

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

Are services safe?

Good

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

Are services effective?

Requires improvement

We rated wards for older people with mental health problems as 'requires improvement' because:

- Staff did not apply the Mental Capacity Act consistently where patients may not have had capacity to make decisions.
- Capacity assessments did not always evidence that staff had consulted with or discussed other relevant persons in relation to the decision to be made.
- Not all staff received supervision at the required frequency and in accordance with trust policy. At the time of our inspection in September 2016, some staff had received no formal supervisions within that year.
- Only 43% of eligible staff had completed the required Mental Health Act training for their role.
- Staff did not receive training to help them acquire skills and knowledge in the mental health conditions of the patients they supported.
- The service was undergoinga transition process of making all patient records electronic. This had caused some issues for staff with time taken to find and access information.

However:

- Staff undertook comprehensive assessments of patients on admission to the service and family members were involved in this process.
- There was effective multidisciplinary team working. Patients and relatives had opportunities to attend regular multidisciplinary meetings and they could contribute their views where they could not attend.
- Patients and relatives were positive about the service and the competence of staff providing care.
- Patients had access to occupational therapy, psychology and specialist services. Staff supported patients to maintain their physical health.

Are services caring?

Good

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

Summary of findings

Are services responsive to people's needs? At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating	Good 
Are services well-led? At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating	Good 

Summary of findings

Information about the service

Rotherham Doncaster and South Humber NHS Foundation Trust has five wards for older people with mental health problems across three locations. At our last inspection there were six older people's wards. However, the Ferns ward at The Woodlands was not in operation at the time of this inspection as the trust was undertaking a restructure of this ward. The wards provide care for patients who are aged over 65 who require hospital admission for care and treatment of mental health problems.

Coniston Lodge is a 20 bed ward at Tickhill Road Hospital for both male and female patients. It is an assessment and treatment ward for patients with functional mental health problems such as, depression and psychosis. There were 19 patients using the service at the time of our inspection. Eight patients were detained under the Mental Health Act, one was subject to a Deprivation of liberty safeguard authorisation and ten were informal which meant they consented to stay on the ward and receive care and treatment.

Windermere Lodge is a 20 bed ward at Tickhill Road Hospital for both male and female patients. It is an assessment and treatment ward for patients with memory difficulties or dementia. There were 12 patients using the service at the time of our inspection. Eight patients were detained under the Mental Health Act and four were subject to Deprivation of liberty safeguard authorisations.

The Brambles is a 15 bed in the Woodlands Unit for male and female patients. It is an assessment and treatment ward for patients with functional mental health problems such as depression and psychosis. There were 13 patients using the service at the time of our inspection. Nine patients were detained under the Mental Health Act and four were informal patients.

The Glades is a 15 bed in the Woodlands Unit for male and female patients. It is an assessment and treatment ward for patients with memory difficulties or dementia. There were 12 patients using the service at the time of our inspection. All patients were detained under the Mental Health Act

Laurel ward is a 13 bed ward at Great Oaks for both male and female patients. It is an acute ward designed for patients who require a short stay in hospital to recover from a significant period of mental illness. It supports patients with functional mental health problems and also patients living with dementia. There were seven patients using the service at the time of our inspection. All were detained under the Mental Health Act.

Our inspection team

The team that inspected the services provided by Rotherham, Doncaster and South Humber NHS Foundation Trust was led by Jenny Wilkes, Head of Hospital Inspection (North East), Care Quality Commission.

The team that inspected wards for older people with mental health problems consisted of one Care Quality Commission mental health hospital inspector and two specialist advisors who had previous experience as mental health nurses including in the specialism of care for older people

Why we carried out this inspection

We undertook this inspection to find out whether Rotherham Doncaster and South Humber NHS Foundation Trust had made improvements to their wards for older people with mental health problems since our last comprehensive inspection of the trust in September 2015. This was an unannounced inspection which meant the service was not aware before our visit that we would be attending.

Summary of findings

When we last inspected the trust in September 2015, we rated wards for older people with mental health problems as good overall. We rated the core service as good for safe, caring, responsive and well-led and requires improvement for effective.

Following that inspection we told the trust that it must take the following actions to improve wards for older people with mental health problems:

- The service must take action to ensure staff have detailed comprehensive knowledge of the Mental Capacity Act and its application to ensure patients are cared for in accordance with the correct legal framework.
- The service must ensure daily nursing notes reflect the care and treatment of patients to ensure care is being delivered in accordance with the care plans and risk assessments in place.

We also told the trust that it should take the following actions to improve:

- The provider should ensure that all members of the multidisciplinary team work in an integrated effective way.
- The provider should ensure patients' are cared for in the least restrictive way.

We issued the trust with two requirement notices in relation to long stay/rehabilitation mental health wards for working age adults. These related to:

- Regulation 11 Health and Social Care Act (Regulated Activity) Regulations 2014 Need for Consent
- Regulation 17 Health and Social Care Act (Regulated Activity) Regulations 2014 Good governance

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the most recent inspection, we reviewed information that we held about wards for older people with mental health problems. This information suggested that the ratings of 'good' for safe, caring, responsive and well led, that we made following our September 2015 inspection, were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for effective.

This inspection was unannounced, which meant the service did not know that we would be visiting. During the inspection visit, the inspection team:

- visited all five wards at the hospital sites and looked at the ward environments
- observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with eight family members of patients who were using the service
- spoke with two modern matrons and the ward managers for five wards
- spoke with 15 other staff members individually; including nurses, nursing assistants, occupational therapists, pharmacist and a doctor
- spoke with an independent mental health advocate who attended the wards
- looked at 18 patients' care and treatment records.
- observed two staff handovers and two multidisciplinary meetings.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

Some people using the service were not able to speak with us due to their cognitive impairment. We observed that people appeared to be calm and comfortable in their environment and in the presence of staff. Two patients we spoke with were content with how staff cared for them and felt this met their needs.

All relatives we spoke with were positive about the care their family members received. All thought staff were knowledgeable about their family member's needs and said staff were competent and effective in their delivery of care. Relatives told us staff kept them up to date with any changes to their family member's care and treatment needs and supported them with any physical health needs. They were able to attend regular multidisciplinary reviews of their family member's care.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff are consistent in their use of the Mental Capacity Act to assess patient's capacity and support decision making. This must be in accordance with the legislation set out in the Act and must ensure that any decisions are made in patient's best interests. The provider must be able to evidence adherence to the principles of the Act.
- The provider must ensure all staff receive supervision at the required frequency and in line with trust policy and must be able to evidence that these have taken place.
- The provider must ensure that all eligible staff complete the requisite training in relation to The Mental Health Act in order to achieve compliance with trust targets.

Action the provider SHOULD take to improve

- The provider should consider the provision of further staff training where necessary to help enable all staff to understand the conditions of the patients they support. The provider should consider whether staff would benefit from this extra training within their roles.
- The provider should continue to monitor and review the transition of care records onto the electronic system so that this occurs with minimal disruption.

Rotherham Doncaster and South Humber NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Laurel Ward	Great Oaks
Coniston Lodge	Tickhill Road
Windermere Lodge	Tickhill Road
The Brambles	Woodlands Unit
The Glades	Woodlands Unit

Good

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

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Staff completed assessments of patients' needs when they were admitted to the service. These took account of key needs within the patient group of older people, for example, assessing patients for falls risks, pain levels, nutrition, dysphagia; which is difficulty or discomfort in swallowing, and skin integrity. A nurse then compiled an initial interim care plan and undertook a period of assessment from which they would produce more comprehensive care plans. We saw evidence of these in patients' records. However, on Glade ward, one patient had been admitted three days previously and although some specific assessments had been completed, staff had not yet completed an initial care plan. This meant there was no guidance about what overall support the patient required. The manager and staff said that this should have been completed and this had been an oversight. They started to compile this care plan during our inspection. Patients received a physical examination as part of the admission process and we saw evidence of these in patients' care records.

Care records contained personalised information about patients that was holistic and recovery oriented. Patients and relatives felt that the care and support was appropriate to the patients' needs. Relatives told us that staff involved them at assessment stage and throughout the care planning process.

The trust was in the process of making the transition to a new electronic system to store patient records. All wards were at different stages with this and therefore patient information was held differently across the wards. Some wards had input all patients' care plans onto the system and some were running two systems simultaneously with several patients records held electronically and the remainder on paper. Some records across all wards, such as risk assessments and physical health checks, were held in paper format and some scanned these in electronically. Mental Health Act documentation was stored in separate folders for patients on all wards. We found that whilst in the midst of this transition, some information was not straightforward to locate due to not all being stored in one central record. The aim was that in future all records would be stored on one system.

Staff told us they saw both benefits and disadvantages with the new system. The main advantage was that they had access to patient information prior to admission if the patient was already known to services. Some staff felt that the system design, and assessments that staff had to complete on it were not tailored to the patient group. They also said information could take time to access due to how and where it was stored. Staff told us the system went down for periods of time, sometimes days, which meant there were instances where staff had not been able to update records contemporaneously or access information. The trust had identified risks relating to the transition of patient records and recorded this on the trust risk register which stated 'there is a risk to the quality of care provided if the inpatient service does not adequately implement the transition to electronic patient records'. This was under regular review and staff on the wards told us they could, and did, escalate concerns where these arose. Staff completed training in the use of the new system.

At our last inspection, we identified that daily nursing notes did not always reflect patients' care plans. This meant we could not evidence that care and treatment was being delivered in accordance with patients' needs. At this inspection, we found that daily notes linked in with plans of care. On Laurel ward, staff had numbered sections of their daily notes to easily correspond with the relevant care plan number. Staff said that they were aware of the need to ensure information was person centred and reflective of patients' needs.

Best practice in treatment and care

Discussions with staff, and review of records, demonstrated that medicines were prescribed in accordance with best practice. For example, staff reviewed the use of antipsychotic drugs within patients' multidisciplinary meetings and during medication reviews. Staff used the Glasgow anti-psychotic monitoring scale to to detect the side effects of second generation antipsychotics. Consultants and doctors attended personal development sessions to ensure they kept up to date with best practice and were aware of any changes to relevant guidance. Staff used a number of evidence based assessments in order to monitor progression and outcomes for patients.

Staff were able to refer patients for psychology input and support if required. Psychologists could help construct behavioural plans to assist staff to identity and support patients with challenging behaviour. Two managers said

Are services effective?

Requires improvement

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

they felt more psychology input for patients would be beneficial. Some staff were trained to be able to offer one to one counselling. Occupational therapy input was available on the wards. We spoke with three occupational therapists and observed therapists engaging with patients on the wards. The therapist told us about groups and therapies, such as cognitive behavioural therapy, they were able to offer. They spoke about various functional assessments that they completed with patients to aid and promote independence. They cited use of evidence based best practice tools such as the model of human occupation screening tool.

Staff undertook regular health checks and monitoring of patients' physical health. Records showed evidence of specialist input, for example, tissue viability nurses where patients may need specialist care for skin integrity. Relatives confirmed staff supported their family members with any physical health care needs. They also gave examples of staff supporting patients to maintain their health and access eye tests and hearing tests. The consultant we spoke with told us they referred patients for various health checks and tests as necessary.

Staff assessed patients' nutritional needs using the malnutrition universal screening tool. They made referrals to dieticians and speech and language therapists where required and we saw evidence of their input. There were systems in place to ensure staff accommodated patients' dietary needs, such as where patients may be diabetic or require a specialist diet.

Wards that accommodated patients living with dementia were designed in accordance with good practice for dementia friendly environments. Colour schemes, design and lighting reflected guidance in place for such environments. Relatives said the environments were suitable for their family members.

Staff completed clinical audits which included checks of equipment, medicines and care documentation .Pharmacists completed separate audits and checks of medicines and prescription charts. Following our last inspection, the trust had implemented a system of regular care plan audits. These involved managers reviewing care plans and records to ensure they were person centred and had evidence of patient and carer input. We saw a sample of these audits for each ward. The audits picked up themes such as omissions, incomplete and incorrectly completed documentation. Managers then fedback findings for staff to rectify and produced information about any recurring themes so they were aware of any systemic shortfalls and could target these as necessary.

Skilled staff to deliver care

The staff team was made up of a range of professionals. This included mental health nurses, nursing assistants, consultant psychiatrists, junior doctors, and various allied health professionals who had input into the services. There was regular input from a pharmacy team based on site.

New staff completed an induction program on commencement of their employment. This consisted of a corporate induction at trust level then a local induction at service level in addition to completion of necessary mandatory training. A buddying system enabled new staff to work with a more experienced staff member for a period of time so they gained a practical understanding of their role.

There was various specialist training that staff could undertake outside of mandatory training. This included venepuncture, clinical skills, sepsis monitoring and delirium training amongst other subjects. If staff identified specific training that would be beneficial to their role, they could request this via their personal development reviews. However, there was no requirement for staff to undertake any role specific training. For example, support staff did not routinely receive training in the conditions of the patients they supported such as dementia awareness or mental health conditions. The manager of Laurel ward had arranged for staff to complete online dementia training. Windermere Lodge were looking into possibly sourcing such training for their staff in future. Two staff members said they had completed dementia training some years ago and one had picked up useful skills in this area in another role outside of their work. Some managers and staff said they felt such training would be beneficial, especially as practice changed over time.

Managers described ways informal learning and information sharing took place. Wards had nominated staff as 'champions' where they took the lead in specific areas such as diabetes, infection control and moving and handling. Staff could gain extra skills in these roles, one manager gave an example of staff attending conferences, where they could then share information with the whole team. Another said it helped empower staff by giving them

Are services effective?

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extra responsibilities and ownership. Ward managers told us they had recently begun meeting as a team to share best practice and learning which could be disseminated amongst each of their wards. Relatives we talked with all spoke highly of the staff on all wards and felt they were very competent and able to meet the needs of their family members.

The trust's policies for staff supervision stated that the frequency of supervision should be no less than every two months. Managerial and clinical supervisions were not held separately although staff could access specific clinical supervision themselves if they chose to.

Each ward manager had a system where they recorded staff supervisions however these had not been effective to ensure all staff received supervision at the required frequency. For example, on Windermere Lodge, four out of 27 staff were showing as not having had any supervision between January and September 2016. On Coniston Lodge, five staff had received only one supervision in the same period. On Brambles, eleven staff were shown to have received no formal supervision between January and September 2016 and ten staff received only one. The manager acknowledged that formal staff supervision needed to improve. Glade and Laurel wards matrixes showed the majority of staff received supervisions at more regular intervals, however still not always within the timeframes set out by the trust as there were gaps of over four months between supervisions on some occasions.

Most of the staff we spoke with told us they received regular supervisions. We checked the matrix which confirmed these staff had received fairly regular supervisions. Two staff said they did not have regular supervisions which was also reflected when we looked at their details on the supervision matrixes.

The trust target for appraisals was 90%. Coniston Lodge had achieved lowest compliance towards this target as 72% of staff had received appraisal. Ninety five percent of Windermere Lodge staff had received an appraisal. Laurel ward and Glade ward were both at 80% against the target and Brambles had exceeded this with 92% of staff recorded as having had an appraisal.

Staff told us they had regular team meetings which helped to keep them updated about key information across the wards. They said that information was also shared in other more informal ways such as verbally, and via emails from managers.

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings took place regularly and consisted of a range of staff including consultants, doctors, nursing staff and allied health professionals. Further staff disciplines attended as and when required. We observed two multidisciplinary meetings, one on Coniston Lodge and one on Brambles ward. The professionals within both meetings included the consultant, doctors and nursing staff from the ward, occupational therapist, a staff member from a community mental health team and a representative from a nursing home that a patient was moving to. Patients were invited to attend the meetings where they were able to and one patient did attend. Relatives told us they were able to attend these meetings where they chose to and to contribute their views. All said they received feedback where they did not attend and were kept up to date with any developments. During the meetings, all attendees contributed, and we saw that staff sought extra input if required, for example, the team made a decision to consult a specialist psychiatrist for further advice in one instance. Staff updated patients records with details of the discussion and actions that the multidisciplinary team had agreed.

Staff handovers took place at each shift change. We observed two handovers, one on the Brambles and one on Coniston Lodge. All staff were engaged in the handover process and all patients were discussed in relation to their physical, mental health and psychosocial needs as well as any risks. A new patient had been admitted to Coniston Lodge and their needs were discussed in detail. The handovers demonstrated a person centred approach and they imparted information to ensure staff were able to deliver continuity of care. Wards had handover files for staff which included key information about each patient including recent care notes so that staff could easily access current important information about patients.

Staff said they had good working relationships with the multidisciplinary team and other professionals. A pharmacist who supported two wards reported good mutual relationships and said staff contacted them for advice and input. They attended multidisciplinary

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meetings where their input was requested or they felt it was necessary. The service had effective links with other services such as care home liaison teams and community mental health teams. The independent mental health advocate we spoke with said they were always welcomed on to the wards and had positive relationships with staff.

The nature of the service meant many patients moved on to other placements such as nursing homes. Staff reported variable relationships, with some homes being more proactive at joint working than others. Staff at the trust said they would hand over all care plans and information and discuss patients with staff at placements they may be moving onto. They felt it was imperative to be open, realistic and impart as much information as possible in order to try to achieve successful placement for patients.

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

Qualified staff were required to complete Mental Health Act training every three years. Records showed that only 43% of required staff across all of the wards had completed, or were current with, this training. The lowest compliance rate of the wards was Brambles ward where only 16% of staff had completed the training. Managers and staff we spoke with said that staff Mental Health Act training sessions booked in and that this would also incorporate the changes to the Code of Practice from which was updated in April 2015

Non-qualified staff were not required to complete any formal training in the Mental Health Act. The trust advised that they were developing a leaflet in Mental Health Awareness which new starters into the organisation would receive during their induction. All staff were expected to have to have this core understanding.

Nursing staff informed patients of their rights in accordance with section 132 of the Mental Health Act. Records showed staff did this on a regular basis. Relatives we spoke with told us they had observed staff explaining their family member's rights to them even though their family member may not have been able to understand these rights on all occasions.

The trust had a central Mental Health Act office that provided administrative support and there was a Mental Health Act lead in place. Staff were able to contact the lead person and staff in the Mental Health Act office for legal advice and guidance. Managers and staff from the Mental Health Act office completed regular audits of Mental Health Act documentation.

Detention paperwork that we saw in patient records was in good order, clearly set out and correctly completed. We checked patients' section 17 leave records across all wards where they had this in place. Staff had crossed through expired forms to evidence that these were not in use and reduce the potential for errors. On Glade ward, one patient still had expired forms that had not been crossed through. A staff member told us they would ensure these were marked through.

There was an independent mental health advocacy service available to patients which was advertised on all of the wards. We spoke with the advocate who attended the wards at Rotherham and Doncaster. They visited the wards on a regular basis and often turned up announced. The advocate said staff had a sound knowledge of the Act and were very patient focussed. They confirmed that the Mental Health Act office automatically referred all detained patients to the advocacy service. There was also advocacy provision available for informal patients.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themselves. The Act applies to situations where people may be unable to make a particular decision at a particular time. At our last inspection, we found shortfalls in the application of the Act and some staff members' understanding.

All staff were required to read a Mental Capacity Act and Deprivation of liberty safeguards basic awareness leaflet. This was a one time only requirement and ninety eight percent of staff at the service had completed this. The trust had reviewed their learning framework and compiled a new corporate learning and development programme for 2016 and 2017. This included further training courses in the Mental Capacity Act that clinical and non clinical staff were required to complete. As these had not yet begun, there were no figures for this additional training. Training was scheduled to start in the future with course dates advertised from late September 2016 through until 2017.

Since our last inspection the trust had created a role for a Mental Capacity Act lead person. Staff were able to access

Are services effective?

Requires improvement

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the lead for advice and support about the Act. Managers told us they attended the wards to deliver informal training sessions for staff. There were Mental Capacity Act resources available on the trust intranet as well as trust policies and documentation to record decisions.

Most staff were able to speak about the principles of the Act. However, two had limited understanding about how it applied in practice. There was inconsistency across the wards about how the Act was implemented. One manager said that at a recent meeting, managers had found that each ward had differing thresholds of when staff undertook capacity assessments and subsequent best interest decisions if needed. We found evidence of this within records we reviewed. For example, staff had completed capacity assessments to determine whether patients could consent to admission. Where patients lacked capacity, Laurel ward had evidence of best interest discussions and decisions to accompany these whereas other wards did not. Staff on Laurel ward competed capacity assessments and best interest decisions in relation to patients understanding of their rights and other wards did not. This demonstrated variation in staff practice about use of the Act.

On Glade ward, notes from one patient's ward round stated that the doctor had assessed them as not having capacity to consent to admission. However, the Mental Capacity Act assessment for this decision was dated a week later to the ward round notes which suggested it had been completed retrospectively. On Coniston Lodge, one patient's records included a mental capacity assessment dated May 2016 for administration of covert medicines. There was no evidence of any best interests meeting that had taken place in relation to this decision. Staff told us the patient never received their medicines covertly and did not know why this was present. The same patient had a do not attempt resuscitation order in place which was ticked to say the patient did not have capacity to discuss. There were notes in the patient's records from their previous placement which said it appeared the order had not been discussed with the patient or her family. Staff were unaware of this and confirmed that they had not discussed this decision with the patient or family. The modern matron assured us this would be addressed.

We also saw examples of good practice in relation to capacity assessments and best interest decisions which showed staff had involved patients and their family members in discussions. Records showed that staff had considered and discussed benefits and disadvantages of available options. Relevant professionals were involved dependent on the decision to be made. Patients' capacity was discussed within multidisciplinary meetings. Pharmacists told us staff consulted them and involved them in discussions around any decisions relating to medicines, for example if staff needed to administer these covertly in a patient's best interests.

Inconsistent recording of mental capacity in patient records was an entry on the trust risk register. Managers had recently begun joint meetings to share information about how they applied the Mental Capacity Act and look at ways of ensuring consistent practice. Some acknowledged there were still improvements to make. Our findings did not demonstrate that suitable and sufficient improvements had been made across the whole service to a level which would meet the requirements of the relevant regulation.

Five patients had a Deprivation of Liberty Safeguard authorisation in place at the time of our inspection. The majority of patients were subject to the Mental Health Act as they had been assessed as meeting the criteria for detention. During one multidisciplinary meeting we observed clinicians having a detailed discussion about one patient who was due to be admitted to the service. They gave consideration to both the provisions of the Mental Health Act and Deprivation of Liberty safeguards when discussing what legislation they may need to use to accommodate the patient. The discussion showed that staff had an understanding about the safeguards and in what circumstances these could be used. Staff we spoke with could also explain the use of these safeguards.

Good

Are services caring?

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

Our findings

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

Are services responsive to people's needs?

Good

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

Our findings

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

Are services well-led?

Good

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

Our findings

At the last inspection in September 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

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 **How the regulation was not being met:** Care and treatment was not always provided in accordance with the provisions of the Mental Capacity Act. There was inconsistency amongst staff on all wards about when they undertook assessments of patient's capacity to consent. On Glade ward, a capacity assessment had been completed at a later time than when the person had been assessed for their ability to make a specific decision. On Glade, Bramble and Coniston Lodge, capacity assessments did not always evidence what considerations staff had made to show that decisions made were in the patient's best interest. On Coniston Lodge one patient had a capacity assessment with no evidence of any best interests discussion. Staff were unaware of this assessment. One patient had a do not attempt resuscitation order with no evidence this had been discussed with the patient and/or their family or advocate. Regulation 11 (1) (3)

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 (RA) Regulations 2014 Staffing **How the regulation was not being met:** Staff did not receive the appropriate support and training for their role. Not all staff received supervision at the required frequency and in accordance with trust policy.

This section is primarily information for the provider

Requirement notices

Four staff on Windermere Lodge and eleven staff on Bramble ward had received no formal supervision in 2016. Five staff on Coniston Lodge and ten on Brambles had received only one supervision in this same period.

Glade and Laurel wards supervision matrixes showed gaps of over four months between staff supervisions on some occasions.

Only 43% of eligible staff across the service had completed the required Mental Health Act training for their role.

Regulation 18 (2) (a)