Care Quality Commission

Leeds and York Partnership NHS Foundation Trust

Clifton House

Quality Report

Bluebeck Drive
Shipton Road
York
YO30 5RA
Tel:01904 294100
Website:www.leedsandyorkpft.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)
RGDT5	Clifton House	Rose Ward	YO30 5RA
RGDT5	Clifton House	Bluebell Ward	YO30 5RA
RGDT5	Clifton House	Westerdale Ward	YO30 5RA
RGDT5	Clifton House	Riverfields Ward	YO30 5RA

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Leeds and York Partnership Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership Foundation Trust.

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

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

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

Summary of findings

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

Summary of findings

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Summary of findings

Overall summary

We found the following issues that the trust needs to improve:

- During the inspection we found issues relating to safety on the inpatient forensic and secure wards. Maintenance issues were not always addressed in a timely manner which could impact on the safety of the environment. Also, we identified two incidents on Westerdale ward that had not been investigated relating to the use of a temporarily decommissioned seclusion room.
- The patient care records we reviewed did not have consistent risk assessment documentation that was fully completed. Blanket restrictions were identified, including the routine searches of patients and restrictions on mobile phone and internet use. These restrictions were not based on individual risk. In addition, the removal of cigarettes from patients until they were discharged appeared to be a disincentive for patients to hand over tobacco products and resulted in patients being searched in line with the trust policy. This procedure was disproportionate and was not person-centred.
- The trust was not fully compliant with the requirements of the Mental Health Act code of practice. The managers' hearings did not always occur in a timely manner, or in line with the trust's timescales and the requirements of the Mental Health Act code or practice. The seclusion room did not have a bed and the two-way communication between the inside and outside of the seclusion room was poor, which did not fully comply with the Mental Health Act code of practice. Also, the Mental Health Act information was not always recorded and maintained in line with the mental Health Act code of practice, and the mental health legislation audits completed by staff did not identify, or record any, appropriate actions. Finally, policies we reviewed were out of date and did not reflect the changes brought about by the Mental Health Act code of practice.
- Information provided by the trust demonstrated that training in both the Mental Health Act and the Mental Capacity Act was 62%.

However we also found:

- The wards were visibly clean, staff carried out comprehensive environmental ligature risk assessments and all the identified ligature risks had either been removed or mitigated. In addition, the clinic rooms in each ward were clean and tidy and daily checks were carried out on resuscitation equipment and fridge temperatures.
- Staff were committed to building the therapeutic relationship and using de-escalation and distraction techniques with patients, and used as a last resort. As a result, the use of restraint and rapid tranquilisation was low. This was in line with the Department of Health guidance positive and proactive care 2014 with regard to 'relational security. Also, staff could describe the types of abuse and could explain the safeguarding procedure and how to raise an alert.
- All care records we reviewed showed the patient had a routine physical examination on admission and ongoing physical health monitoring. Care plans were holistic and developed in collaboration with the patient and care involved the multidisciplinary team, including doctors, nurses, occupational therapists, activity coordinators, support workers and a psychologist. The staff we spoke with reported that they received regular supervision to fulfil their role in delivering care and treatment.

Summary of findings

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

Are services safe?

We found the following issues that the trust needs to improve:

- Blanket restrictions were identified, including the routine searches of patients and restrictions on mobile phone and internet use. These restrictions were not based on individual risk.
- There was not always a timely response to health and safety audit outcomes, including maintenance issues.
- The seclusion room did not fully comply with the Mental Health Act code of practice. There was no two-way communication between the inside and outside of the seclusion room was poor.
- The removal of cigarettes from patients until they were discharged appeared to be a disincentive for patients to hand over tobacco products and resulted in patients being searched in line with the trust policy. This procedure was disproportionate and was not person-centred.
- The patient care records we reviewed did not have consistent risk assessment documentation that was fully completed.
- We identified two incidents on Westerdale ward that had not been investigated relating to the use of a temporarily decommissioned seclusion room.

However, we also found:

- Wards were visibly clean.
- Staff carried out comprehensive environmental risk assessments
- Ligature risk assessments had been carried out on all wards. Identified ligature risks had either been removed or mitigated.
- The clinic rooms in each ward were clean and tidy and daily checks were carried out on resuscitation equipment and fridge temperatures.
- Staff could describe the types of abuse and could explain the safeguarding procedure and how to raise an alert.
- Staff were committed to building the therapeutic relationship and using de-escalation and distraction techniques with patients, and used as a last resort. As a result the use of restraint and rapid tranquilisation was low. This was in line with the department of health guidance positive and proactive care 2014 with regard to ‘relational security.

Summary of findings

Are services effective?

We found the following issues that the trust needs to improve:

- Policies we reviewed, including the 'Search of service users (detained and informal), visitors and their property procedure' was out of date and did not reflect the changes brought about by the Mental Health Act code of practice.
- The managers' hearings did not always occur in a timely manner, or in line with the trust's timescales and the requirements of the Mental Health Act code or practice.
- Mental Health Act information was not always recorded and maintained in line with the mental Health Act code of practice, and the mental health legislation audits completed by staff did not identify, or record any, appropriate actions.
- Staff mandatory training was below 62% for both the Mental Health Act and the Mental Capacity Act.

However, we also found:

- Care plans were holistic and developed in collaboration with the patient.
- All care records we reviewed showed the patient had a routine physical examination on admission and ongoing physical health monitoring.
- The multidisciplinary team included doctors, nurses, occupational therapists, activity coordinators, support workers and a psychologist.
- Staff we spoke with reported that they received regular supervision.

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust provides inpatient services for men and women aged 18 years and over with mental health conditions, who require management under conditions of low security.

Clifton House Hospital in York includes the following four low secure wards:

Westerdale ward a 13 bed male low secure ward for admissions, assessment and rehabilitation.

Riverfields ward a 14 bed male low secure ward for continuing care and rehabilitation.

Rose ward a 10 bed female low secure ward for women with a diagnosis of personality disorder to receive assessment, treatment and rehabilitation.

Bluebell ward a 12 bed female low secure ward for patients with functional mental disorders to receive assessment and treatment and rehabilitation.

We inspected Leeds and York Partnership Foundation Trust in October 2014 including this service. At the time of the inspection we found the provider to be in breach of regulation 19 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010. The systems for identifying, handling and responding to complaints made by service users were not effective. This regulation has now been met.

Our inspection team

Lead Inspector: Lisa Clayton.

The team that inspected this service comprised of:

- four CQC Inspectors
- two Mental Health Act reviewers
- one inspection manager
- one mental health nurse specialist advisor
- one expert by experience

Why we carried out this inspection

We completed this unannounced focussed inspection on the inpatient, forensic and secure wards at Clifton House, York. The inspection was in response to concerns raised in relation to their being insufficient numbers of regular staff on the wards and high use of bank or agency staff. It was also in response to reports of incidents that had occurred on the wards which had not been investigated. Finally, the inspection was in response to the application of the Mental Health Act.

How we carried out this inspection

We asked the following question(s) of the service:

- is it safe
- is it effective?

Before the inspection visit, we reviewed information that we held about these services, including previous CQC reports, complaints and whistleblowing concerns

During the inspection visit, the team:

- visited all four of the wards and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 12 patients who were using the service
- spoke with the managers or acting managers for each of the wards

- spoke with eight other staff members; including nurses and support workers
- interviewed the acting modern matron with responsibility for these services
- attended and observed two multi-disciplinary meetings
- looked at 28 treatment records of patients

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients told us that things had improved at the service more recently since the recruitment of additional staff and occupational therapists. This had improved access to ward activities, patients were able to go on more section 17 leave and staff had more time to talk with them.

Patients complained about the recent smoking ban introduced by the trust and felt that it should be their choice if they wanted to smoke. Patients reported that they were made to hand over their tobacco by staff and were not allowed it during leave. They explained that this meant they had to go to the shop during leave to buy tobacco; they then had to either throw it away or hide it in bushes, as they were not allowed to bring it onto the ward.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff are compliant with the mandatory training in the Mental Health Act.
- The provider must ensure that restrictive practices, when required, is planned, evidence based, lawful, in the patient’s best interest, proportionate and dignified, and is an individual response to the actual individual risk identified.
- The provider must ensure that their policies have been reviewed, are current, and reflect the changes brought about by the Mental Health Act code of practice.
- The provider must ensure that all serious incidents are investigated in a timely manner and that adequate and effective actions are taken to prevent further incidents.

Action the provider SHOULD take to improve

- The provider should ensure that there is a timely response to health and safety audit outcomes, including maintenance issues.
- The provider should ensure that their approach to a smoke-free environment is proportionate and person-centred.
- The provider should ensure that the seclusion room has two-way communication in line the Mental Health Code of Practice.
- The provider should ensure that all Mental Health Act information is recorded and maintained in line with the mental Health Act code of practice, and that the mental health legislation audits completed by staff identify appropriate actions, and that these are recorded.
- The provider should ensure that staff are compliant with the mandatory training in the Mental Capacity Act.

Care Quality Commission

Leeds and York Partnership NHS Foundation Trust

Clifton House

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rose Ward	Clifton House
Bluebell Ward	Clifton House
Westerdale Ward	Clifton House
Riverfieds Ward	Clifton House

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Mental Health Act training was introduced into the trust's mandatory training schedule in July 2015. Compliance rates were in line with the trust's proposed trajectory of 62% for the implementation of this training. This trajectory was confirmed in an email from the trust dated 4 August 2016.

We reviewed 17 detention records at Clifton House and we identified two records where the internal audit had not picked up issues.

We found delays in managers reviewing the renewal of detention. In one case the delay was eight months. The delays in the managers' hearings did not meet the trust's own timescales, or the requirements of the Mental Health Act code of practice.

We found some errors within detention , hospital managers and outcome records. These included staff recording the incorrect detention date, leaving parts blank, and not recording which written reports had been received or whether renewal was contested or not.

Patient records demonstrated attempts to provide patients with information on their legal status and rights under the Mental Health Act. Capacity to consent to treatment for mental disorder was recorded in care records.

There were clear records of leave with care plans incorporating contingency and crisis plans.

Independent mental health advocates were available. All patients we spoke with confirmed that they knew how to contact the independent mental health advocates should they require advocacy support.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was introduced into the trust's mandatory training schedule in July 2015. Compliance rates were in line with the trust's proposed trajectory of 62% for the implementation of this training. This trajectory was confirmed in an email from the trust dated 4 August 2016.

There were no Deprivation of Liberty safeguards applications made in the last six months.

Patients had their capacity assessed with regards to whether they could make decisions, for example about their finances or physical health.

Where patients had been deemed to lack the capacity, best interest decisions were documented in the care records

Are services safe?

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

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

Our findings

Safe and clean environment

Wards were visibly clean. The trust employed housekeeping staff for all wards and communal areas at Clifton House.

Staff carried out comprehensive environmental risk assessments. On Riverfields ward, the trust had completed a health and safety inspection which was carried out 15 February 2016. The health and safety inspection had identified that the portable appliance testing across the site was out of date. The portable appliance testing had been completed on 29 March 2016. There were other items identified that had been waiting for upgrading or repair for some considerable time. For example, there were several areas where the paint was flaking from the walls and skirting boards and required improving. However, we saw records demonstrating that the ward manager had made a number of attempts to ensure that these minor works were addressed from their identification at the health and safety inspection in February 2016.

Staff had also completed a health and safety inspection checklist in March, July and October 2015 and January 2016. On each occasion the checklist stated that not all fire exit signs were in clear view. The comments stated that one sign was awaiting repair in the day area. We spoke with the manager about this who told us the sign had actually been missing for nearly two years. This meant that patients, staff and visitors may not being able to identify the fire exit should an emergency occur.

Ligature risk assessments had been carried out on all four wards. The trust had replaced a number of fixture and fittings and where risks still remained these were mitigated by the use of observation and risk assessment.

The wards had access to outside space which had the appropriate level of fencing for a low secure facility.

The clinic rooms in each ward were clean and tidy. Daily checks were carried out on resuscitation equipment and fridge temperatures.

The seclusion room situated between Bluebell and Rose wards did not fully comply with the standards set out by the Mental Health Act code of practice. The room did not allow for two way communication to occur, and required both staff and patients to shout through the door so that they could hear each other.

There were no nurse call points in patient bedrooms. This meant patient could not summon assistance if needed. However, there had been no incidents reported at the service where having call points would have made a difference, or which would suggest these call points were required..

Safe staffing

Staffing establishments were maintained across the wards during the three months leading up to the inspection. Ward managers told us they were able to increase staffing numbers if they needed to due to enhanced observations or increased risk on the wards. Staff and managers explained that the use of bank and agency was high in order to meet the safer staffing requirement numbers identified by the trust.

Bank and agency staff were provided with a brief induction to familiarise them with trust procedures, the requirements of the ward, and the patients. We spoke with one agency support worker that had recently started working on the ward. The staff member was able to describe the induction process that included key management, risks relating to the environment and risks relating to individual patients.

Handovers between staff took place when shift changes occurred. There was a mixture of long day shifts, and early and late shifts. Ward managers reported that they always ensured there was a handover, even if it was just one member of staff joining the shift. Staff reported that they felt handovers were consistent and effective.

Mandatory training rates in most areas was over 75% with some training courses achieving 100% compliance such as training in the prevention and management of violence and aggression. However, Mental Health Act and Mental Capacity Act training were in line with the trust trajectory of 62% following its implementation as mandatory training in July 2015.

Are services safe?

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

Staff produced a monthly report that reviewed all activities, leave, and also monitored any cancelled leave. Since the recruitment of additional staff, the reports demonstrated there had been a significant reduction in the number of leaves cancelled.

Assessing and managing risk to patients and staff

The wards had systems to assess and monitor risks to individuals. We found that risk assessments were comprehensive and holistic. Staff carried out patient risk assessments on admission and staff updated these during multidisciplinary team meetings or if patients' needs changed. The trust used various methods of risk assessment, including the safety assessment and management plan, historical, clinical, risk management 20, which is a tool to assess the risk of violence. They also used the functional analysis of the care environment risk profile tool.

We reviewed the care records of five patients on Westerdale ward. All had safety assessment and management plans completed and there was evidence of regular reviews. The forensic clustering records had not been completed for two patients. All five patient care records had historical, clinical, risk management 20 assessments. However, only two were fully completed.

On all four wards patients were searched routinely following leave regardless of individual risk. We found the trust had not reviewed and updated the 'Search of service users (detained and informal), visitors and their property procedure' in line with the Mental Health Act code of practice. We saw the content did not meet current guidance. Access to mobile phones and the internet was also restricted. Patients could not have access to their mobile phones whilst they were on the wards, and access for all patients to the internet was allowed only under supervision on trust computers. These restrictions did not comply with the Mental Health Act code of practice which states "Restrictive practices, when required, should be planned, evidence based, lawful, in the patients' best interest, proportionate and dignified."

Staff could describe the types of abuse and could explain the safeguarding procedure and how to raise an alert. Safeguarding adults training was completed on all four wards. Safeguarding children had recently been added to the mandatory training programme and this was being rolled out across the service.

In addition to the mandatory training in the prevention and management of violence and aggression, staff were equipped with alarms and would use these to call for assistance from other team members in a patient emergency or if they felt threatened. Staff had also taken part in in-house relational security training. Some staff had been trained in search procedures and 'wand training'. A wand is a hand held metal detector.

There had been minimal use of restraint and rapid tranquilisation across the service during the three months prior to this inspection. Staff confirmed that this was due to their commitment to building the therapeutic relationship and using de-escalation and distraction techniques, with restraint used as a last resort. This was in line with the department of health guidance positive and proactive care 2014 with regard to 'relational security.' Staff also reported that having increased occupational therapy input on the ward, as well as the activities coordinator, was having a positive effect and contributing to the low levels of restraint.

There was no seclusion reported on the wards Bluebell and Rose wards had access to both a seclusion room and a de-escalation room and seclusion room. These were located off the ward area between the two wards. Staff explained how they used the de-escalation area for patients who were agitated to allow them the time and space to calm down in a lower stimulus environment. Staff explained that two or three members of staff would remain with the patient to support them.

At the time of the inspection, there was one person on the inpatient forensic and secure wards who had been in long-term segregation. We reviewed the records of this patient and found a segregation care plan and segregation management plan were in place.

The trust became a 'smoke-free' environment as of the 3 April 2016, which was the day before the responsive inspection. Patients reported that they had their tobacco taken from them on the 3 April 2016. The modern matron confirmed that patients who had cigarettes or tobacco products at the beginning of the trust going smoke-free were asked to give them to the nursing staff to be stored, and these were to be returned when the patients were discharged. The trust had a 'Nicotine management and smoke free procedure' which was effective from 4 April 2016.

Are services safe?

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

Patients told us that they could not access their tobacco products for their section 17 leave. They told us that they had to buy their cigarette or tobacco again whilst on leave and they either threw them away before they returned to the ward, or hid them in the bushes for the next time they went on leave.

The modern matron confirmed that any patient who brought these items on to the premises following leave, were asked to hand them in so that they could be returned on discharge. If a patient did not hand their tobacco products to the ward staff and it was suspected that a patient had “contraband items,” including tobacco products, the trust search policy would be followed. The modern matron told us that in this situation, the cigarettes or tobacco would be destroyed as drugs or alcohol would be. Each item destroyed was recorded on the electronic incident recording system. We were concerned that this procedure was disproportionate and not patient-centred. This was because cigarettes were only returned to patients when they were discharged. This appeared to be a disincentive to handing over tobacco products and resulted in patients being searched in line with the trust policy. However, we acknowledged that the smoke free environment had only just been introduced.

The pharmacist carried out medication reconciliation which is the process of creating the most accurate list possible of all the medication a patient is taking. We reviewed 11 medication cards on Westerdale ward. Staff had recorded the medication and prescription information correctly, with the name of the drug, date, time, route, and signature of the person administering the drug. Patients self-administrating their medication were clearly identified on their medication card, and there were monitoring progress forms for each patient. However, staff had not completed the Mental Health Act status on all 11 patient medication cards and only two cards reviewed had photographs of the patient.

Track record on safety

The trust told us that there were no serious incidents requiring investigation recorded on the forensic and secure inpatient wards in the last 12 months.

However, during the inspection we identified an incident where a patient had been placed in the seclusion room on Westerdale ward despite it being temporarily decommissioned. The seclusion room had been damaged by a patient and was in the process of being repaired. The investigation into this incident had not been completed. A further incident of seclusion occurred in this temporarily decommissioned seclusion room, was not investigated. We discussed this with the trust, and they confirmed that they would complete an investigation into these incidents.

Reporting incidents and learning from when things go wrong

All staff could tell us the procedure for reporting incidents and the types of incidents that needed to be reported. They would report these incidents on the electronic incident reporting system.

Nursing staff led weekly clinical meetings to review incident forms and ensure they identified trends and took action where required. This was then fed back to staff during supervision and team meetings. Following incidents staff told us that de-brief sessions took place for both patients and staff.

The trust had a policy on the duty of candour, and staff could explain the need to be open and transparent with patients when things went wrong. At the time of the inspection, the clinical service manager did not have any examples of when duty of candour response had been required.

Are services effective?

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

Our findings

Assessment of needs and planning of care

On admission to the wards a comprehensive assessment was completed. This included details of the patient's background, their physical health and mental health, any prescribed medication, any substance use, and the results of their physical examination. Records we reviewed confirmed this.

Care plans were holistic and developed in collaboration with the patient. The occupational therapist also contributed to the care plans demonstrating a multidisciplinary approach. Therefore, care plans were patient focused, personalised and recovery focused.

Every patient had an inpatient treatment plan and patients had a variety of care plans depending on their individual needs, including wellbeing, physical health, occupational needs, medication, moving on, important to me, where I live, money, safeguarding children and supporting parents, substance misuse, Mental Health Act, staying safe and a crisis plan. Each section had an intervention plan and identified who was doing what. The interventions were clear around strengths and goals for example 'to re-establish contact with family'. Other care plans included medical need, a nursing care plan, and a standard care plan for nicotine replacement. However, it was notable that that the patients' inpatient treatment plans were all very similar in wording in the intervention to meet current mental health presentation.

Care records demonstrated that comprehensive and timely physical health assessments took place. All care records we reviewed showed the patient had a routine physical examination on admission and ongoing physical health monitoring. This included height, weight and blood pressure along with health promotion reviews such as advice around smoking cessation. Care records were stored electronically and staff did not report any problems with access to records.

Best practice in treatment and care

We saw evidence in the medication and care records that we reviewed that the service delivered treatment and care in line with the National Institute of Health and Care Excellence guidance, with regard to promoting recovery, prescribing medication, delivering therapeutic interventions, and engaging patients in meaningful activities.

Staff were able to describe examples of best practice followed which included the National Institute for Health and Care Excellence guidance, for example on the treatment of schizophrenia and personality disorders.

All the forensic wards had a choice of psychological therapies and a range of recovery focused activities available. An occupational therapist ran gardening groups, community meetings and art therapy with the support from the ward staff.

Staff used recognised rating scales to measure, assess and record outcomes for patients. This included the health of the nation outcome scales for secure services.

Skilled staff to deliver care

Staff completed an induction programme. This included environmental, relational and operational security. This was to ensure that all staff had a sound understanding on the environment they worked in, the trust policies and procedures. Agency staff completed a brief induction to familiarise them with trust procedures, the requirements of the ward, and the patients.

Staff we spoke with reported that they received regular supervision. Supervision rates across the service were above 80% on all wards.

The clinical lead on Rose ward confirmed that training had been planned to support staff on that ward in working with female personality disorders.

Staff told us that they had completed qualifications and credit frameworks, formerly called national vocational qualifications, specific to their role. Other staff had also been supported in completing degrees and master's degrees.

Multidisciplinary and inter-agency team work

The multidisciplinary team included doctors, nurses, occupational therapists, activity coordinators, support workers and a psychologist. A pharmacist regularly visited the wards; staff said they could call on the pharmacist whenever they needed to.

Are services effective?

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

The consultant led the multidisciplinary team. The format included reviewing the nursing report for the week in relation to the patient's mental and physical health, any identified risk social situation and any requests from the patient. Discussion took place between the multidisciplinary team prior to the patient attending. Once the patient attended, points were re visited and the patient was able to discuss their thoughts on their care and their choices and plans for moving forward. We observed how the multidisciplinary team worked closely with patients with borderline personality disorder to develop their autonomy. Staff did this by encouraging patients to consider the different treatment options and life choices available to them, as well as the consequences of those choices.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training was introduced into the trust's mandatory training schedule in July 2015. Compliance rates were in line with the trust's proposed trajectory of 62% for the implementation of this training. This trajectory was confirmed in an email from the trust dated 4 August 2016.

Following the information received from the trust in relation to issues linked to the administration of the Mental Health Act, we reviewed detention records, which had previously been audited by the trust.

We reviewed 17 detention records at Clifton House and we identified two records where the internal audit had not picked up issues.

There were delays in managers reviewing the renewal of detention. In one case the delay was eight months. The delays in the managers' hearings did not meet the trust's own timescales, or the requirements of the Mental Health Act code of practice.

There were some errors within the detention, hospital managers and outcome records. These included staff recording the incorrect detention date, leaving parts blank, and not recording which written reports had been received or whether renewal was contested or not.

Requests for medical scrutiny were evident on patient files. However, staff did not always document whether this had occurred. We therefore could not be assured that medical scrutiny occurred for all records.

Patient records demonstrated attempts to provide patients with information on their legal status and rights under the Mental Health Act. Capacity to consent to treatment for mental disorder was recorded in care records.

On Westerdale and Rivierfields wards staff audited patient records by completing a 'Mental Health Act legislation monitoring form.' These legislation monitoring audit forms included consent to treatment monitoring, monitoring provision of information to the patient, and monitoring of leave of absence. We found on Riverfields ward staff had identified that there were errors on eight patients' records. For example on one patient's form it stated there was not an original section 17 leave form in the patient's medical notes. Another form stated there was no record of the responsible clinician feeding information relating to their detention and leave back to the patient. None of the forms stated what staff would do to rectify the situation. We raised this with the ward manager who said they thought that staff had ticked the wrong box but that they would look into it.

There were clear records of leave with care plans incorporating contingency and crisis plans.

Independent mental health advocates were available. All patients we spoke with confirmed that they knew how to contact the independent mental health advocates should they require advocacy support. However, we found there was no clear process for automatic referral to the independent mental health advocacy service.

We found the trust had not reviewed and updated the 'Search of service users (detained and informal), visitors and their property procedure' in line with the Mental Health Act code of practice. We saw the content did not meet current guidance.

We found this policy referenced within a new policy, the 'Nicotine management and smoke free procedure' which was effective from 4 April 2016, making the new policy also inaccurate and not in line with the code of practice.

Good practice in applying the MCA

Training in the Mental Capacity Act was introduced into the trust's mandatory training schedule in July 2015. Compliance rates were in line with the trust's proposed trajectory of 62% for the implementation of this training. This trajectory was confirmed in an email from the trust dated 4 August 2016.

Are services effective?

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

There were no Deprivation of Liberty Safeguards applications made in the last six months.

Staff understanding of the Mental Capacity Act and Deprivation of Liberty safeguards was variable. Care records included evidence of informed consent and assessment of capacity. We saw that patients had their capacity assessed with regards to whether they could make decisions. For example, about their finances or physical health. Where patients had been deemed to lack the capacity to make a decision then a decision had been made in their best interest. Best interest decisions were documented in the care records

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 17 HSCA (RA) Regulations 2014 Good governance Good Governance How the regulation was not being met: The trust had not investigated serious two incidents and did not have sufficient systems in place to ensure appropriate actions were taken and that lessons were learned. Policies relating to the Mental Health Act had not been updated to reflect the changes brought about by the Mental Health Act code of practice. This was a breach of regulation 17 (2) (a) (b) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Patients were subjected to blanket restrictions. These included restricted access to mobile phones and routine searching of all patients following periods of leave. This was a breach of regulation 13 (4) (b)

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: The trust had not ensured the forensic inpatient service staff members were adequately trained in the Mental Health Act.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 18 (2)(a)