University Hospitals of North Midlands NHS Trust

County Hospital

Inspection report

Weston Road
Stafford
ST16 3SA
Tel: 01782715444
www.uhnm.nhs.uk

Date of inspection visit: 4 October 2022
Date of publication: 23/12/2022

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at County Hospital

Requires Improvement 

We inspected the medicine core service on the 4 October 2022. This was a follow-up focused inspection in response to a warning notice issued in 2021 whereby we notified the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement.

Medical care (including older people's care)

Inadequate 

We inspected the medicine core service on the 4 October 2022. This was a follow-up focused inspection in response to a warning notice issued in 2021 whereby we notified the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement. At the 2021 inspection we found patients and staff were at risk of serious harm as there were no effective processes in place to assess, record and mitigate risks associated with people with acute mental health needs. A serious incident had occurred at County AMU in February 2021.

We visited the acute medical unit (AMU) and Ward 12 to gather evidence. We also visited ED to understand the patient pathway through to medical wards.

We spoke with 19 staff including site management, matrons, doctors, nurses, healthcare assistants, security staff and support staff. We reviewed 10 patient records and an additional 1 medicine records.

We rated it as inadequate because:

- The service did not have enough staff to care for patients and keep them safe. Not all staff had completed training in relation to mental health. Staff did not consistently assess risks to patients with acute mental health needs, dementia or other cognitive impairment. Lessons were not always learnt following serious case reviews or incidents. We issued a warning notice regarding this to ensure standards were urgently improved.
- Not all staff had access to good information when working with patients with mental health conditions or symptoms. Staff did not assess mental capacity or deprive patients of their liberty in line with the trust policies or legal frameworks. We issued a warning notice regarding this to ensure standards were urgently improved.
- Not all risks relating to mental health were captured on the risk register. Staff did not receive structured support following incidents of violence or aggression. Oversight of some aspects of managing patients with mental health conditions or symptoms was not in place.

However:

- The service had systems in place to mitigate the risks associated with acute mental health concerns.
- Staff worked well together for the benefit of patients. Key services were available seven days a week.
- A governance structure in relation to mental health, learning disabilities, autism and dementia was in place.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate

Mandatory Training

Not all staff were up to date with training around mental health.

Medical care (including older people's care)

Staff had access to training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff undertook training in mental health as part of their mandatory training package. Autism awareness training was offered to staff.

Not all nursing staff were up-to-date with their mandatory training in relation to mental health. Nurses were required to complete mental health training level 1. We saw overall compliance was 84.3%. The acute medical unit (AMU) had the lowest compliance at 69.2%. The highest level of compliance was on Ward 7 which had 100%. Wards 1, 12, 14, and 15, ranged between 89% and 94% compliance against a trust target of 95%.

Compliance for mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards was better on AMU at 97%. Compliance across other wards ranged from 77.2% on Ward 14 and 100% on Ward 12.

Staff undertook conflict resolution training as part of the mandatory training package.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Other training relating to patients with mental health conditions, cognitive impairment, neurological conditions, neuro diversity or learning disabilities was monitored through governance meetings such as the Trust Mental Health and Learning Disability Group. Meeting minutes showed, as of September 2022, 80.6% compliance within the medicine division for ligature knife training. Dementia awareness training was at 95% compliant. Learning disability awareness training was 78.4% compliant. These figures were for compliance within the medicine division within the trust.

Clinical education nurses sent emails and reminders when staff were required to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific to supporting patients who may lack capacity to consent to treatment or care. Compliance for mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards 97% on AMU. Compliance across other wards ranged from 77.2% on Ward 14 to 100% on Ward 12.

We requested Mental Capacity Act and Deprivation of Liberty Safeguards training data for medical staff which showed 3 out of 4 respiratory medical staff had completed this (75%), 10 out of 11 AMU medical staff had completed this (91%), 1 out of a total of 1 elderly care medical staff were complaint (100%) and the one medical staff member for general medicine had not yet completed this (0%).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we asked provided examples of referrals they had made to the local authority following the identification of concerns around the potential abuse of a patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we asked, including bank staff, knew how to make a safeguarding referral and where to seek support for this.

Medical care (including older people's care)

Environment and equipment

Ward environments were not designed specifically for patients with mental health conditions or symptoms as this was an acute hospital. However, staff worked within the environment to keep patients safe.

The design of the environment followed some national guidance; however, we acknowledged that an acute setting is not designed for patients with mental health conditions or symptoms. Within the emergency department, we saw a designated room for patients with mental health conditions or symptoms or patients at risk of violence and aggression had two entrances, an alarm and heavy furniture.

The rest of the ward was in line with standard acute hospital wards. This meant lines of sight could be compromised due to corners and cubicles. However, we saw that some patient spaces could be directly observed from the nursing station.

Assessing and responding to patient risk

Staff did not always complete or update risk assessments for each patient. Staff identified and quickly acted upon patients at risk of psychological or behavioural deterioration.

Staff did not always complete risk assessments for each patient on admission or review this regularly, including after any incident. Patients attending the hospital with acute mental illness, whether attending primarily due to their mental health or physical health, generally arrived through the emergency department (ED). However, in particular cases some patients could be admitted directly to an inpatient ward or if attending for a specific clinical test or procedure such as blood tests, could attend the medical receiving unit (MRU) which bypassed ED.

Patients attending the MRU was not a common occurrence and occurred on a structured basis for detained patients at the local mental health hospital. Staff from the mental health hospital attended with the patient and provided all risk assessments and necessary care from a mental health point of view.

Where patients arrived at ED, it was expected that a mental health proforma would be completed in triage if a patient presented with a primary mental health presentation such as intentional self-harm or attempted suicide. Where patients presented with a physical health condition that needed urgent attention, but also had ongoing psychiatric diagnoses or symptoms, triage nurses were expected to complete the mental health proforma. This proforma was separate to the general health triage tools and was devised specifically to gain a good understanding and assessment of the needs of patients experiencing acute mental health symptoms. Following our previous inspection and enforcement action the proforma had been developed to include a section for ED staff to hand over the information to ward staff and for ward-based staff to document that they had understood the handover and the risk assessment.

If a patient was admitted direct to a ward for example following a GP referral, it was expected that the ward staff would complete the mental health proforma.

During our inspection we reviewed 4 sets of records for patients who attended through ED and became inpatients who were eligible to have a mental health proforma initiated in ED. We found 3 out of 4 patients had the mental health proforma initiated. The service audited the completion of these proformas although the audits focused on assessments undertaken in ED rather than the continuation of the form on the wards.

In addition to the mental health proforma, nursing staff opened a ‘seven-day patient risk assessment booklet’ for every inpatient which included a range of risk assessments and screening tools for both physical health such as falls, and mental health, cognitive impairment, safeguarding and neurodiversity.

Medical care (including older people's care)

During our inspection, we checked 7 booklets and found whilst the assessments for physical health were routinely completed, assessments and screening cognitive impairment, safeguarding and neurodiversity were not.

Of the 7 booklets reviewed, 5 out of 7 patients did not have any cognitive screening completed despite some of these patients triggering an automatic screening due to their age. Data from the trust supported this finding. Four out of 6 relevant patients did not have this completed within a ward 'Care Excellence Framework' audit for AMU in February 2022. An action relating to this was set; specifically, 'All patients over 65 years should have a 6 CIT (Six Item Cognitive Impairment Test (6CIT)) assessment undertaken within 72 hours of admission'. For the same audit on ward 12 in December 2021; we saw 3 out of 5 relevant patients checked had received this assessment.

None of the patients had received a safeguarding screening or a neurodiversity screening.

There were also 2 sections for staff to complete for any patients diagnosed with dementia or a learning disability. Whilst there was no evidence that any of the 7 patients had been previously diagnosed with a learning disability, there was evidence that at least 2 patients had a confirmed diagnosis of a form of dementia. Despite this, the dementia checklist tool was not completed. The checklist was designed to prompt staff, upon completion, to make referrals to teams which could offer supportive individualised care.

This meant that staff could not be assured they had a full awareness of patients' risks and needs in relation to these areas. In addition, there were no care plans in place where required. We asked staff why the sections of the form were not completed and were told it was generally handed over to the next shift to complete. However, some patients reviewed had been in the hospital for at least a week at the time of the inspection.

Not all staff knew about and dealt with any specific risk issues. Staff on ward 12 were not aware of the mental health proforma and therefore were not aware one was not in place for a patient who presented at ED with physical health problems but also clear history of and presentation with mental health symptoms as described in general ED paperwork. There was no evidence ward staff had received a handover with regards to the patient's mental health from the emergency department.

If a patient who was not detained under the Mental Health Act or under the Deprivation of Liberty Safeguards wished to self-discharge against medical advice, staff told us they completed a form with them which had a flowchart and checklist to work through to ensure the patient was well informed as to the consequences of this. We did not identify any patient records at the time of our inspection where this had occurred. The service did not specifically audit this paperwork.

The service had 24-hour access to mental health liaison and specialist mental health support. The psychiatric liaison team was available on site from 8am through to 2am each day. Between 2am and 8am, cover was provided by the local mental health trust. However as this was a separate trust, staff at County Hospital could not access the patient notes overnight. No incidents or harm were identified as a result of this.

Staff completed, or arranged, risk assessments for patients thought to be at risk of self-harm or suicide. Three out of 3 records completed by the psychiatric liaison team showed compliance to the National Institute of Health and Care Excellence (NICE) standards of initial assessment within 1 hour and crisis assessment within 4 hours. However, we saw, and staff told us that there could be delays in getting assessments for a patient to be detained under the Mental Health Act.

Medical care (including older people's care)

Staff did not always share key information to keep patients safe when handing over their care to others. Staff handovers to AMU from ED enabled ward staff to understand patients with psychiatric support needs. However, we found on Ward 12, ward staff did not routinely receive handovers regarding psychiatric status from ED. We did not see any evidence of incidents as a direct result of this.

Staffing

The service did not have enough staff to undertake enhanced or therapeutic observations to keep patients safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix however this did not always result in increased staffing as needed.

The service did not have enough nursing and support staff to keep patients safe. The service did not have enough staff to adequately support patients who required enhanced supervision to protect themselves or others as related to acute mental illness. We saw evidence during our inspection of instances where one to one supervision was required overnight, but not provided. A patient caused themselves minor harm and compromised dignity. The trust confirmed that staff had not reported this as an incident. The trust did respond to the concerns regarding the monitoring of this patient following the inspection and stated the patient would receive appropriate therapeutic observations.

Data from the trust showed for AMU, from July to September 2022, a total of 26 shifts required one-to-one nursing. Of these shifts, 7 were filled. This equated to 36.8% of shifts where enhanced observations were required being staffed appropriately. Some of these occasions were reported as an incident. However not all were; staff told us they did not incident report all occasions as it was such a frequent occurrence.

In total 332 shifts were identified as requiring additional staffing for one-to-one nursing during this time. Of these, 219 were unable to be staffed which equated to 66% of shifts not having sufficient staff to provide one-to-one nursing as identified within patient care plans.

Where it was identified that patients required additional supervision, managers made effort to request additional staff including bank staff to cover this. However, this was not always possible. Where this was not possible, staff tried to cohort patients who required high levels of supervision in the same bay so that 1 member of staff may monitor the entire bay. Although this provided some oversight of patients, the staff member within the bay would not be able to consistently observe all patients at the same time, for example if they had to see a patient who had their curtains drawn. Staff told us that where possible they did try to mitigate this by asking a colleague to come into the bay to observe the other patients whilst they attended to one individual.

Staff from the psychiatric liaison team also supported with enhanced supervision if they were available. In some cases, where a patient was detained under the Mental Health Act and normally resided at a mental health hospital but was an inpatient at County Hospital for physical interventions, managers could request staff from the psychiatric hospital to attend to support with enhanced supervision. Staff also sought support from relatives to monitor patients when staffing was reduced. We saw evidence of this happening for 2 patients during our inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Shortages in staffing to cover enhanced supervision was escalated to the matron for the relevant area. In addition, the staff rostering system allowed managers to ‘red flag’ shifts as being low on staffing to the extent where full care plans were not able to be carried out. We saw

nurses also recorded within patient records when they had not been able to complete all of their tasks due to short staffing. Managers were aware of the impact of providing enhanced supervision, particularly constant supervision, on staff. Managers told us they tried to rotate staff during their shift to prevent fatigue. However, we saw on some wards staff were expected to fill this role throughout the entirety of their shift except for breaks.

We asked the trust if any incidents have been reported as a result of the lack of staffing for enhanced observations. The trust told us that there had been 3 incidents reported however patient harm had been avoided by using mitigating actions such as cohorting patients and moving patients to a more easily observed area.

The number of nurses and healthcare assistants did not always match the planned numbers.

Overall AMU staffing, from August to September 2022, saw the day shift fill rates for nursing staff ranged from 66.6% to 133.3%. The average fill rate was 94.2%. Nursing staffing at night was better with an average fill rate of 111.8%.

Healthcare assistant staffing for the same dates was an average of 69.8% filled shifts for day shifts and 120.9% filled shifts for night shifts.

The overall fill rate for all shifts for wards 1, 12, 14 and 15 was 90.4%.

The acute medical unit (AMU) had recruited a mental health nurse who was due to start the week after our inspection. This role was to provide additional support to ward staff when working with patients who presented with an acute mental health condition.

The senior clinical education nurse on AMU worked clinically to support staff as required.

Data from the trust showed staffing was impacted by high levels of sickness from August to September 2022 with almost 25% of all sickness being due to respiratory conditions including COVID.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. The service used bank staff to cover vacancies for nurses and healthcare assistants where possible. The use of agency nurses was minimal, however those used worked regularly.

Ward staff told us that, in the main, police stayed with patients detained under section 136 of the Mental Health Act (1983) who had been brought to the ward. Section 136 allows the police to take a person to a ‘place of safety’ if the person is suspected of having a mental disorder, is in a public place, and is identified as requiring immediate care or control. We did not identify any incidents of harm as a result of this and none were recorded in governance meeting minutes.

Records

Staff kept records of patients’ care and treatment. Records were stored securely and easily available to all staff providing care, however did not always contain information needed for staff to manage patients psychological or behavioural needs.

During our inspection we reviewed 10 sets of patient records.

Medical care (including older people's care)

When patients transferred to a new team, there were no delays in staff accessing their records. Staff on the acute medical unit told us the emergency department staff handed over mental health proformas and assessments in a timely way when the patient arrived on the ward. However, on Ward 12 staff were not aware of this form and did not receive a handover in relation to mental health.

As above, we found not all documentation was completed fully by ward staff which meant staff taking over patients' care may not be aware of all risk factors relating to mental health, cognitive impairment, safeguarding and neuro diversity.

When patients detained under the Mental Health Act (1983) were admitted to the acute medical unit as an inpatient, the discharge facilitator reviewed any accompanying paperwork detailing the detention. The discharge facilitator requested any missing paperwork or reviews to ensure patients were not being illegally detained for example if a detention period was due to expire.

Staff could access patients' full medical notes if they needed to review past health information, including mental health related contact with the NHS.

The psychiatric liaison team kept electronic records when they saw a patient. This was on a different system to that used by ward staff as they were employed by the local mental health trust. Ward staff told us they could not access these notes. This was confirmed by the trust who reported that this issue was being discussed to identify if trust staff could access the system used by the mental health trust. After the inspection, the trust told us the psychiatric liaison team did add information to the system used by County Hospital Staff.

When patients were identified as requiring enhanced supervision or observations to protect themselves or others, staff did not complete the required documentation to support this. Within the 'Therapeutic and Engagement Observation (Specialling) of Adult Patients' policy, a template was provided for staff to use for this purpose. This meant that staff were not able to evidence if they had supervised the patient as required in their care plan, for example if a patient needed constant supervision.

Records were stored securely. Paper-based records were kept in lockable storage cabinets on the ward when not in use. We saw the paper-based records on Ward 12 were outside of individual patient rooms however there was a staff member present at all times.

Medicines

Medicines used to manage patient behaviour was in line with national standards.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. During our inspection we reviewed 5 sets of medicine records to review the use of psychiatric medicine. We did not see any evidence of rapid tranquilisation being used, or of patients being over sedated to manage behaviour. Lorazepam was prescribed as required on an individual basis in line with the British National Formulary (BNF) for the management of acute symptoms of conditions such as anxiety.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents however we saw evidence that shared learning was not embedded.

Medical care (including older people's care)

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us, and we saw, they reported incidents relating to patients with cognitive impairment and/or a psychiatric history or presentation. Staff reported incidents when they could not get required staffing to provide enhanced observation for patients who required this. However, this was not consistent; staff told us they did not report every incident where there were not sufficient staff as it was such a frequent occurrence.

Staff reported serious incidents clearly and in line with trust policy. Managers shared learning about incidents with their staff. Data from the trust showed 44 incidents regarding patients with mental health conditions or cognitive impairment over the 12 months preceding the inspection. This information included learning where relevant to prevent incidents recurring.

There was evidence that changes had not been made as a result of feedback. Data from the trust showed an incident had been reviewed under section 42 safeguarding enquiry within the last 12 months. This is where the Local Authority has a duty to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. This incident had occurred at the Royal Stoke Hospital and related to a patient who was being deprived of their liberty with no capacity assessment or Deprivation of Liberty Safeguards (DOLS) in place. As reported under the 'effective' domain we saw evidence which showed learning had not been shared widely enough to ensure all staff understood their legal requirements under the Mental Capacity Act.

Data from the trust also showed that a Safeguarding Adults Review (SAR), which is a multi-agency review which seeks to determine what relevant agencies and individuals involved could have done differently, that could have prevented serious abuse or neglect or a death from taking place had taken place at the trust within the 12 months prior to the inspection in relation to capacity to consent. As we saw evidence that capacity assessments were not being completed during our inspection at County Hospital, this indicated that again, learning was not sufficiently shared or embedded to ensure a change in poor practice.

Local managers did not formally debrief or support staff after any serious incident. There was no specific process for debriefing or supporting staff following incidents involving violence and/or aggression; despite an increase in violence and aggression toward staff is documented within the May 2022 Trust Mental Health and Learning Disability Group meeting minutes. In the above-mentioned 44 reported incidents, we saw some of these did relate to staff being injured as a result of patient behaviour. Generalised support was available, for example staff could speak to the nurse in charge. Staff could attend Critical Incident Stress Management (CISM) sessions or access third party counselling as part of the trust's well-being provision. Data sent by the trust reported staff from this site had accessed the trust well being support options.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate.

Evidence-based care and treatment

The psychiatric liaison service provided care and treatment based on national guidance and evidence-based practice. However, this was not always monitored at ward level. Staff protected the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

Staff followed up-to-date policies where available to plan and deliver high quality care according to best practice and national guidance. Staff in the acute medical ward (AMU) had access to 2 folders both containing detailed information about working with patients with a mental health condition or symptoms including trust documentation policies and general information about providing support. Staff also had access to information about the Mental Capacity Act (2005), including how to assess a patient's capacity to consent to care or treatment and information about the Deprivation of Liberty Safeguards (DOLS).

Staff on other medical wards did not have immediate access to printed detailed information, although they could access this information on the trust intranet.

Staff had access to policies on specific patient pathways for example alcohol withdrawal.

We requested the trust policy or standard operating procedure on working with patients who had a lasting power of attorney (LPA). This information was within the trust consent policy and specified 'healthcare practitioners should read the LPA if it is available, in order to understand the extent of the attorney's power'.

Staff mostly protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The hospital completed several audits in relation to mental health across the trust. These included auditing the responsiveness of mental health services, auditing the Mental Health Act policy, auditing the mental health assessment tool in ED, auditing the Mental Health Act, auditing the deprivation of Liberty safeguards and auditing therapeutic observations.

We requested audit data for the completion of mental health assessments on medical wards. However, we did not receive this data; instead we received a full list of audits completed at County Hospital across all areas. We saw an in-depth audit around supporting patients with mental health conditions or symptoms had been completed within ED for June 2022 however audits had not yet been undertaken on the medical ward areas.

At handover, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers on one ward. Staff handovers to AMU from ED enabled ward staff to understand patients with psychiatric support needs. However, we found on Ward 12, ward staff did not routinely receive handovers regarding psychiatric status from ED.

Competent staff

The service mostly made sure staff were competent for their roles in relation to supporting patients with mental health conditions or symptoms or patients with reduced cognitive functioning. Managers held some supervision meetings with staff to provide support and development.

Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of patients with mental health conditions or symptoms or patients with additional needs as related to cognitive functioning. A senior clinical education nurse on AMU provided training on the mental health proforma and supporting documentation. Staff were required to sign to say they had received this training. We saw evidence that nurses and healthcare assistants working day shifts in the acute medical ward had undertaken this updated training. Night staff were yet to be trained at the time of the inspection however there were plans for the psychiatric liaison team to deliver this.

Medical care (including older people's care)

Staff on other medical wards were less knowledgeable about the mental health proforma, and support that could be accessed while caring for patients with psychiatric needs. However, data from the trust showed that staff had access to some information for each ward; however, this was not comprehensive on wards other than AMU. Information following incidents was emailed to all staff when learning was available. The mental health policy was also shared with all nursing staff from August 2022.

Some staff told us they would like more training around caring for patients with mental health diagnoses, and the Deprivation of Liberty Safeguards (DOLS).

Three nurses were trained on the acute medical ward (AMU) to restrain patients in line with national guidance as required and the list was maintained. Security staff were also trained to do this. Governance meeting minutes indicated this was being reviewed to be in line with national guidance around the Use of Force Act.

We saw within Trust Mental Health and Learning Disability Group meeting minutes; that the service held patient review panel meetings following cases involving patients with a learning disability, mental health diagnosis or other vulnerability. The purpose of these meetings was to encourage reflective practice and a shared learning. Three reflective practice sessions have been held over the 12 months prior to our inspection.

Managers made sure staff received any specialist training for their role. The discharge facilitators on the acute medical ward (AMU) were knowledgeable about areas relating to patients detained under the Mental Health Act (1983) or who required assessment under the Mental Capacity Act (2005).

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had a dedicated support for patients diagnosed with a psychiatric condition or experiencing symptoms of poor mental health. A site specific psychiatric liaison team was based at County Hospital from 8am to 2am 7 days a week. Staff could also refer to a dementia liaison team to support patients with a dementia diagnosis. These teams were delivered and managed by the local mental health trust covering the area.

Staff could contact psychiatric support at any time of day or night through the local mental health hospital based close by to County Hospital when the psychiatric liaison team were not available.

Staff told us that the psychiatric liaison team were very responsive to requests for support on the ward.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We saw records of patient referrals to specialist services were maintained; and all medical wards had made referrals, with the majority coming from AMU.

Feedback from staff and patient representatives showed good working relationships between the local mental health trust and County Hospital, particularly where patients were already registered as a patient at the mental health trust.

Staff could refer patients to drug and alcohol services within the community. The trust employed an alcohol liaison nurse however they were based at the Royal Stoke Hospital. Staff could access the alcohol team based at the Royal Stoke; who could update management plans via the electronic patient record. Although not employed in this role, a member of the psychiatric liaison team was a trained alcohol support nurse. Staff told us this member of staff was helpful for additional support with patients withdrawing from alcohol.

Not all medical staff completed mental capacity assessments in a timely way to support patients who may lack capacity to consent to care or treatment. See the 'consent, Mental Capacity Act and Deprivation of Liberty Safeguards' section below for more details.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from mental health services 24 hours a day, 7 days a week. The psychiatric liaison team worked seven days a week from 8amto 2am. Between these hours ward staff could contact the local mental health trust if they required advice or support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not support all patients to make informed decisions about their care and treatment. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always assess capacity to consent or deprive patients of their liberty within legal frameworks or the trust policy.

Nursing staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS); however, this training was not effectively used in practice. Compliance for mandatory training on the MCA and DOLS was 97% on AMU. Compliance across other wards ranged from 77.2% on Ward 14 and 100% on Ward 12.

We requested MCA and DOLS training data for medical staff which showed 3 out of 4 respiratory medical staff had completed this (75%), 10 out of 11 AMU medical staff had completed this (91%), 1 out of a total of 1 elderly care medical staff were complaint (100%) and the one medical staff member for general medicine had not yet completed this (0%).

We requested data about compliance to consent training modules for both nursing and medical staff across the medicine core service. We received data for medical staff. The data for medical staff showed that 14 out of 17 staff had completed this (82%). Nursing staff completed consent training as part of their MCA and DOLS training referenced above.

Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff did not ensure that legal frameworks were followed as per the MCA. During our inspection staff told us that doctors were responsible for completing mental capacity assessments where it was suspected a patient may not have capacity to consent to care and/or treatment.

We reviewed 3 patient records within which there was evidence to suggest the patient required a mental capacity assessment to confirm if these patients were able to consent to their treatment or not. Within all 3 records, there was no evidence that any capacity assessment had been undertaken as per the MCA. We asked staff about all 3 patients; staff confirmed there had been no capacity assessment recorded.

Following the inspection; the trust told us they had completed capacity assessments for 2 of these patients as we had raised specific concerns. However, we were not assured this would be generalised to other patients who required MCA assessments or that these would be completed in a timely way as per the MCA legal framework.

Staff did not work in line with the trust policy when working with patients who could not consent. We reviewed the trust policy entitled 'Consent to Treatment (incorporating Mental Capacity Act)' which clearly stated that consent should be sought for starting treatment or physical investigation, or providing personal care, for a person. Where it was likely a patient may lack capacity to give consent; the trust mental capacity assessment form and best interest checklist (appendix 5 of the policy) must be completed.

Staff did not implement DOLS in line with approved documentation or legal requirements. Staff did not work in line with the trust policy when depriving patients of their liberty. We saw 2 of 3 patients described above had been deprived of their liberty as defined under the DOLS within the MCA. This included the use of medication to calm 1 patient down, close supervision of both patients and the use of bed rails for both patients. The MCA clearly states that in order to deprive someone of their liberty who may not be able to consent to this, a mental capacity assessment must be undertaken which identifies a lack of capacity to consent at that time; and an application to deprive someone of their liberty must be made to the local authority.

Staff had not made a DOLS application for either patient at the time of our inspection. We acknowledged that an application had been prepared for 1 patient on AMU and was waiting to be sent off as soon as medical staff had completed a mental capacity assessment to confirm the patient did not have capacity to consent. However, by this point that patient had been subject to restrictions for over 48 hours. We asked staff about this patient and were told the reason the patient had not yet received a capacity assessment was because the patient did not speak English. Staff had not sought to arrange an interpreter to undertake a mental capacity assessment, nor any other assessment relating to the patient's health care, since arrival to the hospital. Instead staff relied upon a family member to interpret which was not in line with best practice guidance; and was also outside of the trust policy entitled 'interpreters' which stated 'when gaining formal consent, explaining management plans or delivering bad news that the patient can understand the information given, and request the use of an interpreter if this will improve understanding. In these circumstances the patient's family or friends should not be routinely used'. This meant the patient was not given an opportunity to provide an input into their own healthcare, to consent to any treatment, or to be assessed for a lack of capacity to consent to any care or treatment. Following the inspection, the trust told us they had provided an interpreter, completed a MCA assessment and made a DOLS application in response to us raising our concerns for this patient. However, we were not assured actions were in place at this stage to ensure all patients who required timely interpretation services would receive this; particularly in relation to complying with the MCA.

The second patient, located on Ward 12, also had neither an MCA assessment nor DOLS documented at the time of the inspection. This patient's relatives had lasting power of attorney for health and welfare which meant they could make healthcare related decisions on behalf of the patient if they deemed the patient no longer held the capacity to make their own decisions. However, we saw no evidence within the patient file that staff checked the lasting power of attorney (POA) for health and welfare was in place and were valid at the time of the inspection. We asked the trust for their process on ensuring staff check the legal status of individuals stating they have POA for patients. This was recorded within the trust consent policy.

Discharge facilitators on AMU were aware of the need to confirm any power of attorney for welfare and health before enabling individuals with this power of attorney to make decisions on behalf of a patient who lacked capacity to consent themselves.

Medical care (including older people's care)

Staff had access to information about gaining consent for patients with mental health conditions or symptoms. The trust policy entitled 'Consent to Treatment (incorporating Mental Capacity Act)' provided guidance to staff about working with patients with mental health diagnoses who were or were not detained under the Mental Health Act. The policy also provided guidance for working with patients who were self-harming or who had suicidal ideation or behaviour.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Meeting people's individual needs

The service was not always inclusive and did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff could not always make sure patients living with mental health problems and/ or dementia, received the necessary care to meet all their needs. See the 'staffing' heading in the 'safe' domain for more details.

When patients were assessed as having a lack of capacity to consent to care or treatment, if the patient had no family, friends or carers to support them in decision-making, Independent Mental Capacity Advocates (IMCAs) should be instructed to represent and support people to make a best interest decision. The trust had access to system based IMCAs; staff had access to information on the trust intranet which told them how to request this service.

Staff accompanied patients who smoked cigarettes outside the hospital building to provide support and supervision. This enabled staff to reduce the risk of distress or conflict that may arise if patients were prevented from smoking.

Staff supported some patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to communication aids when working with patients who communicated non-verbally.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they could access appropriate interpretation services such as British Sign Language interpreters if required.

During our inspection we saw 1 instance where staff had not provided an interpreter for a patient, instead relying on the patient's family. General Medical Council (GMC) guidance states that all possible efforts must be made to ensure effective communication with patients. This includes arrangements to meet patients' communication needs in languages other than English. We acknowledged that an interpreter was being booked for the day of our inspection, however by this point the patient had already been on the ward for over 48 hours. As in 'effective', after the inspection the trust told us they had obtained an interpreter in order to undertake a capacity assessment with this patient.

Is the service well-led?

Requires Improvement 

Medical care (including older people's care)

Our rating of well-led stayed the same. We rated it as requires improvement.

Culture

Staff did not always feel supported to care for patients with mental health conditions or symptoms or patients who required enhanced observations. However, staff were focused on the needs of patients receiving care. Staff were able to report incidents involving violence, aggression and short staffing; although did not always do so.

Local managers did not formally support staff after any serious incident. There was no specific process for debriefing or supporting staff following incidents involving violence and/or aggression; despite an increase in violence and aggression toward staff as documented within the May 2022 Trust Mental Health and Learning Disability Group meeting minutes. Generalised support was available, for example staff could speak to the nurse in charge. We saw posters for staff well-being services displayed on the walls.

The service held sporadic patient review panel meetings following cases involving patients with a learning disability, mental health diagnosis or other vulnerability. The purpose of these meetings was to encourage reflective practice and a shared learning. Three reflective practice sessions had been held over the 12 months prior to our inspection.

Staff could attend Critical Incident Stress Management (CISM) sessions or access third party counselling as part of the trust's well-being provision. Data sent by the trust reported staff from this site had accessed the trust well being support options.

Staff told us they worked well as a team and were able to support each other. Staff told us they received support from the psychiatric liaison team and could ask for advice or guidance at any time.

As part of ward 'Care Excellence Framework (CEF) audits on ward 12 in December 2022, and AMU in February 2022, staff identified they felt listened to and supported on the ward; however management had limited capacity to act on concerns and feedback raised.

Staff told us they did not always report incidents when staff numbers were below what was required for a shift as this was a regular occurrence.

Governance

Leaders operated governance processes, throughout the service and with partner organisations in relation to working with patients with mental health conditions or symptoms and patients with a disability relating to cognitive functioning. However, auditing on the ward in relation to mental health was limited and staff did not always follow policies and processes.

A governance structure was in place. A matron oversaw the provision of mental health and learning disability services within the trust. They were part of a mental health operational group which held regular governance meetings. Relevant aspects from these meetings were escalated to the mental health and learning disability group.

We saw meeting minutes from the trust wide mental health and learning disability group, the trust wide learning disabilities and autism working group and the trust wide mental health working group meetings. Meeting minutes demonstrated that information was shared between these groups for fuller oversight. The psychiatric liaison team attended the mental health working group meetings, the child and adolescent mental health services (CAMHS) working group meetings and the overarching mental health and learning disability group.

There was not a medical ward specific audit programme. The trust had a programme of audits in relation to supporting patients with acute mental health needs. These included auditing the responsiveness of mental health services, auditing the mental health policy, auditing the mental health assessment tool in ED, auditing the Mental Health Act, auditing the deprivation of Liberty safeguards and auditing therapeutic observations. However, the majority of these did not extend to medical wards. In particular, we found evidence of staff not following trust policies around therapeutic observations. The lack of auditing meant that there was no recognition, oversight or action plan in relation to this to keep patients safe from harm.

Where audits were undertaken on medical wards; we saw evidence that improvement had not been made. For example, within a ward 'Care Excellence Framework' audit for AMU in February 2022 an action was set; specifically, 'All patients over 65 years should have a 6 CIT (Six Item Cognitive Impairment Test (6CIT)) assessment undertaken within 72 hours of admission'. However, during our inspection, we found no evidence of improvement since this audit indicating the action plan and learning points were not embedded.

The service had access to a psychiatric liaison team which was provided by the local mental health trust and was funded through the local Integrated Care Board (ICB). A draft service level agreement was in place for April 2022 to March 2024. A review date was set for March 2023. This service level agreement set out the expectations of the trust for the psychiatric liaison team provision. This was aligned to current national guidance and the local need of County Hospital. The trust, at the time of inspection, was in discussion with the local mental health trust to design a standard operating procedure to support this service level agreement; and to finalise the service level agreement.

In the acute medical unit, a 'focus of the month' board was used to share updates and information about supporting patients with mental health conditions and symptoms.

Staff had access to a closed social media group the acute medical unit where updates and information was shared. Regular bank and agency staff were included within this group to ensure they were also informed of any necessary information.

When patients were identified as requiring enhanced supervision or observations to protect themselves or others, staff did not complete the required documentation to support this. We saw this was not highlighted within governance meetings nor was this monitored.

Staff told us that matron visibility was not high across all medical wards, although the matron covering AMU did attend this area. Data from the trust told us of staff sickness at this grade; which resulted in temporary matron support being implemented.

Management of risk, issues and performance

Leaders and teams mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. However, some actions were not sufficient to keep patients safe.

The service had a risk register in place which incorporated risks relating to patients with mental health diagnoses or symptoms. We reviewed the risk register for the medicine core service at County Hospital. The risk register was reviewed and updated regularly. We saw that nurse staffing was on the risk register for overall vacancies. We saw a gap in mental health provision had been identified as a risk in October 2021. There were clear actions which had now been completed including the extended psychiatric liaison team working hours which mitigated this risk.

We saw evidence of these positive changes to working with patients presenting with acute mental illness since our last inspection. The psychiatric liaison team had extended their operating hours since our last inspection and from January 2021 were based at the hospital between 8am and 2am.

Previously the psychiatric liaison team did not work with patients unless they were identified as medically fit. This meant often patients with mental health conditions or symptoms would have to wait until they have received physical interventions before receiving a psychiatric assessment. At this inspection we found this had changed. The psychiatric liaison team would see patients as soon as possible which meant risk factors were identified and care plans could be created to keep the patient, other patients and staff safe.

We saw not all risks were captured on the risk register although leaders in this area were aware of concerns. A risk that had been captured was ligature risks with regards to environment, staff knowledge, and staff response in emergency situations was discussed consistently within the mental health and learning disability group. It was clear that an audit had taken place, had been reviewed and resulted in the removal of this item from the risk register across minutes from March 2022 to September 2022.

Risks that were not captured included the lack of supervision for patients who required this as part of their care plan (therapeutic observation). We saw within meeting minutes for March 2022 that therapeutic observation was due to be added to the risk register, however when we reviewed the risk register as part of our post inspection data review, we did not identify this entry. Although staffing was on the risk register, there was no reference to the specific concerns about not always staffing enhanced observations where required. In addition, the use of physical restraint was discussed within governance meetings with regards to inconsistent reporting of this by staff, and not working within current guidance when working with patients with mental health conditions or symptoms. However, this was not registered as a risk.

Where physical restraint was used with patients, staff were expected to submit an incident to the trust incident reporting system. We also saw that some staff were trained in clinical holding rather than restraint which was specific for patients with mental health conditions or symptoms. Clinical holding is generally used for patients requiring physical health interventions and is defined as the proactive holding of part of the body to allow a procedure to be carried out; for example, holding an arm in order to take a blood sample. This was discussed within a mental health working group meeting in September 2022 whereby it was highlighted that due to the large number of patients attending acute hospitals primarily for mental health reasons, national recommendations had been to bring the Use of Force Acts in place in acute settings. We saw within the Mental Health and Learning Disability Group meeting minutes held later in September 2022; the Use of Force Act was introduced to the attendees. The trust's legal team were considering the application of this Act in an acute trust.

Leadership of AMU described local risks as caring for patients with psychiatric care needs. These included staff coverage for enhanced supervision and a potential future risk that when the new mental health nurse had commenced in role, they may not get fully utilised in the way intended due to staff shortages. Another area of potential concern was identified that the local geographical 'place of safety' to place patients detained under a section 136 (Section 136 is part of the Mental Health Act that gives police emergency powers. Police can use these powers if they think a person has a mental disorder, are in a public place and need immediate help. Section 136 says police must think the person needs immediate 'care or control') was within the local mental health hospital. However, if the spaces were already in use police would bring patients to AMU which meant they would then be under the care of AMU ward staff rather than

trained mental health staff. An additional concern was a delay in assessing patients with mental health conditions or symptoms out of hours (between 2am and 8am). The delays presented as other patients in the community were prioritised for assessment. Ward staff felt inpatients within the trust were seen as being in a safer setting by external mental health teams therefore not always prioritised.

During our inspection, staff on AMU demonstrated a good level of knowledge and awareness of working with patients with acute mental illness. They were familiar with the mental health proforma initiated in the emergency department and spoke positively of the psychiatric liaison team. However, staff on Ward 12 did not display the same level of knowledge. Some staff on AMU told us that other medical wards did not have the same level of knowledge and support regarding patients with mental illness as AMU. This indicated that although significant improvements had been made on AMU, within ED and within the psychiatric liaison team, this had not extended to other medical wards. Whilst other medical wards may not see the same number of patients with acute mental illness as AMU, as we saw on inspection, patients experiencing acute mental health symptoms were on these wards and therefore required the same level of intervention and support.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Data from the trust showed the psychiatric liaison team had received feedback demonstrating excellence in practice and excellent communication. This was reflected in what staff told us during the inspection.

Areas for improvement

Action the trust must take to improve:

MUSTS:

- The trust must ensure that where required, mental capacity assessments and Deprivation of Liberty Safeguards applications are made in line with the trust policy and legal frameworks. **(Regulation 11 Need for Consent)**
- The trust must ensure that all required assessments including the mental health proforma and within 'seven-day patient risk assessment booklet' are completed as per trust processes. **(Regulation 12 Safe Care and Treatment)**
- The trust must ensure that where enhanced or therapeutic observations have been identified as necessary within patient care plans, staff are sourced to cover these. **(Regulation 18 Staffing)**
- The trust must ensure they maintain oversight of performance and risks in relation to the medicine core service when supporting patients with acute mental health needs or cognitive impairment. In particular, the trust must ensure that all risks relating to the care of patients with mental health conditions or symptoms are captured on the risk register for the service and staff follow trust policies and processes. The service must also ensure that learning from serious case reviews, audits and incidents is shared and embedded across the trust. **(Regulation 17 Good Governance.)**

Action the trust should take to improve:

SHOULDS:

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Medical care (including older people's care)

- The service should ensure that staff stay up-to-date with mandatory and supplementary training around mental health, neuro diversity, cognitive impairment and the Mental Capacity Act.
- The trust should ensure they consistently check and record where a person has a power of attorney for health and welfare on behalf of the patient if that patient lacks capacity to consent for their own care and treatment.
- The trust should ensure that all patients requiring an interpreter are provided with one as soon as is reasonably practical prior to undertaking care and treatment.
- The trust should ensure staff are consistently supported following incidents of violence and/or aggression.
- The trust should consider that they work within the Use of Force Act as appropriate for acute settings.

Our inspection team

The team that inspected the service comprised of a CQC inspector and specialist advisors with expertise in medicine care and mental health.

The inspection was overseen by Sarah Dunnett, Head of Hospital Inspection.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment