Kent and Medway NHS and Social Care Partnership Trust

Frank Lloyd Unit

Quality Report

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Locations inspected

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

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Kent and Medway NHS and Social Care Partnership Trust. and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust..

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

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

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

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

Following our inspection of the Frank Lloyd unit, we issued the trust with a warning notice on 8 February 2016 having found them to be in breach of the following Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 12 (1) (2) Safe care and treatment.

Regulation 13 (1) Safeguarding service users from abuse and improper treatment.

Regulation 18(1) Staffing.

Regulation 11(1), (2), (3) Need for consent

We found the following problems that the trust needed to improve:

We identified serious concerns regarding the care and welfare of patients. There were a number of issues relating to compliance and practice regarding use of the Mental Capacity Act 2005 (MCA) Code of Practice and Deprivation of Liberty Safeguards (DoLS). Staff had made standard and urgent DoLS applications for all 39 patients. Staff had completed thirty six applications prior to assessing the patient's capacity and only five had been authorised. Principle one of The MCA 2005 Code of Practice (CoP) states 'A person must be assumed to have capacity unless it is established that he lacks capacity.' Section 6.50 of the MCA states 'Sometimes there is no alternative way to provide care or treatment other than depriving the person of their liberty. In this situation, some people may be detained in hospital under the Mental Health Act 1983– but this only applies to people who require hospital treatment for a mental disorder. Otherwise, actions that amount to a deprivation of liberty will not be lawful unless formal authorisation is obtained'. None of the patients on the ward had been detained under the Mental Health Act.

Staff told us that they would stop a patient who did not have an authorised DoLS from leaving the ward and complete a new DoLS application. This contravened the MCA, which states that a deprivation of liberty will not be lawful unless formal authorisation is obtained.

Staff did not manage medicines safely. There were missing signatures on medicine administration records (MARs), transcribing of medicines and missing information concerning allergies. A medication trolley was left unattended and unattached to a wall in the staff office between 10.10am and 11.25am during our inspection.

The MAR charts were mostly computer generated by the pharmacy. We saw that staff had handwritten some MAR charts, which had not been signed by a doctor. Staff had photocopied MAR charts, which meant that the boxes were very faint and it was unclear whether medicine was given and signed for.

Staff were restricting patients in their movements and using restraints for personal care, for which there was no record or assessment in the patients care plans.

Pull cords in the en suite toilets had been cut out of reach of patients and call bells next the patient beds had been disabled. Staff told us this was a precautionary measure to stop patients from deliberately harming themselves.

There were inconsistent thresholds and timeliness of reporting of safeguarding incidents. Risk assessments and risk management plans were variable in their detail and did not reflect patients' risks in some areas.

There was insufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they could meet patients care and treatment needs. The quality of care provided on each ward was inconsistent. Staff on Woodstock ward demonstrated care that was compassionate and engaged well with patients. Staff on Hearts Delight ward spoke of having little time to engage with patients and often being unable to provide personal care required by patients due to lack of staff. Staff told us that there was often insufficient staff available to ensure the safety and wellbeing of the patients. We observed that staff were unable to give patients sufficient time and attention. For instance, we saw that there was little interaction between staff and patients during a mealtime because there was too few staff. One staff member reported feeling stressed and fearful of the potential consequences of insufficient staff on Hearts Delight ward.

All patient bedrooms were furnished with appropriate beds and mobility armchairs where required. However, the trust had not replaced chairs for two patients that

Summary of findings

had been removed several months prior to the inspection because of damage. This meant that these patients remained in bed with little or no interaction with staff and other patients.

However, we also found:

All bedrooms had an e-suite toilet and basin. Rooms were spacious and patients were able to personalise their bedrooms. There were covered display boards in each bedroom which contained information including the patient's named nurse, moving and handling information, personal care information, photographs and activities enjoyed.

On Woodstock ward, we were shown a care planning booklet, which contained information regarding the individual patient's physical needs, diet, mental health, medication, mobility, personal care, religious and cultural needs, communication skills and relationships. However, we were told that these may not be in every patient's room due to being removed or 'lost' by the patient.

Dedicated rooms had been created to create a non-institutionalised environment. Rooms included a parlour, pampering room, barbers, a gentleman's club and a pub. Staff had created life story boxes to stimulate memories such as school days or transport. The trust had recently purchased two therapy dolls to promote comfort and calming for patients. There was a variety of activities available for patients including pet therapy, music therapy, a you and me group delivered by the chaplain, music and memories and a weekly church service. The 'daily sparkle' newspaper was available which included 'this day in history', 'do you remember', history and quizzes.

Corridors had been decorated to suggest that the entrance to bedrooms was through the patient's own colour coded front door with a photograph of the patient's younger self next to the door handle to encourage recognition of their room. Staff told us that the use of the photograph also encouraged staff to see the 'person behind the patient'.

Summary of findings

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

Are services safe?

We found the following problems that the trust needed to improve:

There was insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs. We reviewed staff rotas covering 42 days from the 17 December 2015 to 1 February 2016 inclusive, which showed a high use of bank and agency staff and shifts were sometimes not filled at all.

Pull cords and call buttons were inaccessible for patients to use and patients had to shout to gain attention.

Staff were not safely managing medicines. Three MAR charts reviewed did not always record allergies, which staff had documented in the patients care plans. Staff did not complete start and stop dates on MAR charts. There was evidence of staff transcribing medicines with no prescriber review completed. There were missing signatures on MAR charts, which raised further concern that medicines were not being given as directed. There was only one qualified member of staff to administer medication to 20 patients on the ward.

Eight out of 39 patients were receiving some of their medicines covertly. Staff filed covert medicines agreement forms in the MAR charts, which had been signed by the consultant psychiatrist, the named nurse for the patient and the next of kin. However, the pharmacist signature space was blank. The KMPT pharmacist informed us that she was aware of this and was going to be spending some time in the near future to resolve this. Staff told us that where they did not have consent to give medicines covertly, staff gave patients the medicine in food or drink and told them that it was in their best interests. However, staff had not documented best interest meetings in patient records.

Processes did not ensure that patients received adequate food and drink. Staff had documented food and drink on two of the seven food and fluid charts reviewed, for one day of our inspection.

Staff's lack of awareness of the Mental Capacity Act affected patients freedom to leave the unit, which included two patients on Hearts Delight ward who had been assessed as having capacity.

We observed staff using mechanical restraint for patients, which had not been recorded in any care plans reviewed.

Staff had not raised safeguarding alerts, despite recording them as safeguarding incidents.

Summary of findings

Risk assessments and risk management plans were inconsistent and not reflective of some known patient risks.

However, we also found that:

Most staff were up to date with their mandatory training.

The wards were clean and well maintained.

Bedrooms were large with appropriate furniture and an en-suite toilet and basin.

Are services effective?

We found the following problems that the trust needed to improve:

There was a blanket instruction for staff to complete DoLS applications for all patients admitted to both wards. Staff had completed 36 out of 39 DoLS applications, before assessing the patients capacity. Of 39 DoLS applications, only five had been authorised. Patients were assessed on admission to the wards. However, a mental capacity assessment often took place sometime after admission and after staff had made a DoLS application, which is contrary to the MCA Code of Practice (CoP). Staff had denied one patient's request to visit her son, despite being assessed as having capacity on 28 December 2015.

There was no Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Act (IMHA) Advocacy information displayed on the wards.

Patients physical health needs were not being managed safely and effectively. For example, there was no evidence of care plans or risk management plans regarding the safe use of pressure relieving mattresses.

We reviewed bathing charts and found that patients personal care needs were not being met. Bathing charts documented some patients not having had a bath for 12 months or more.

The consultant psychiatrist attended the unit every Tuesday afternoon for Care Programme Approach (CPA) meetings only.

However, we also found that:

Efforts had been made to create a familiar and non-institutional environment for patients.

Are services caring?

We observed limited interaction between staff and patients during meal times on Hearts Delight ward because there was too few staff to enable them to engage with patients.

Summary of findings

However:

We observed some positive, caring and compassionate interactions between staff and patients.

Efforts had been made to make the wards a welcoming and non-institutional environment.

Photographs of patients when younger were placed at door handle height to promote recognition for patients and encourage staff to see the 'person behind the patient'.

Both wards displayed a 'You Said We Did' board.

Summary of findings

Information about the service

The Frank Lloyd Unit is a 40 bedded continuing care unit for people with a diagnosis of dementia and associated needs. The unit consists of two 20 bed wards arranged on two floors. Hearts Delight ward is on the ground floor and admits both male and female patients. Woodstock ward is on the first floor and is for male patients only. All patients on the unit had been assessed as meeting NHS continuing health care criteria. The unit is fully accessible to those with mobility difficulties and all bedrooms have an en-suite toilet and basin.

The Frank Lloyd Unit had no patients detained under the Mental Health Act (1983) at the time of our visit. It is a GP led service, which is reassessed every six months by the clinical commissioning group (CCG). At the time of our inspection, there were 20 patients on Hearts Delight mixed gender ward, consisting of 16 female and four male patients. There were 19 male patients on Woodstock ward at the time of our inspection. Access to the unit and both wards was via key pad entry and the door is locked at all times.

The Frank Lloyd Unit was last inspected in March 2015 as part of the comprehensive Kent & Medway Trust inspection. A Mental Health Act Reviewer visited the unit on 25 November 2015.

Our inspection team

The lead inspector was Hannah Cohen-Whittle, with two CQC inspectors, two Mental Health Act Reviewers and a CQC pharmacist.

Why we carried out this inspection

This was an unannounced focussed inspection after a Mental Health Act Reviewer (MHAR) raised concerns following a visit on 25 November 2015. The MHAR found that staff did not understand the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Information received from the service showed that there were inconsistencies regarding the threshold and process for reporting safeguarding incidents.

Following this inspection, we issued a warning notice to the trust on 8 February 2016 and received no challenges from Kent and Medway NHS and Social Care Partnership Trust (KMPT).

CQC had previously undertaken a comprehensive inspection of KMPT in March 2015. At that time, we inspected seven wards for older people with mental health problems. We published a report of that inspection in July 2015. At that inspection, we rated the core service of wards for older people with mental health problems as requires improvement for Safe, Effective, Responsive and Well-led.

How we carried out this inspection

During this inspection we considered the following questions:

Is it safe?

Is it effective?

Is it caring?

Before the inspection visit, we reviewed a Mental Health Act reviewer report and information requested from the service.

During the inspection visit, the inspection team:

Summary of findings

Visited Hearts Delight and Woodstock wards on the unit, looked at the quality of the ward environment, and observed how staff were caring for patients.

Spoke to two patients.

Spoke with two family members.

Spoke with the manager for Woodstock ward. We were unable to speak with a manager on Hearts Delight ward due to sickness absence.

Spoke with nine members of staff, including a consultant psychiatrist, ward manager, band five nurse, a pharmacist and a health care assistant.

Attended and observed hand-over meetings, multidisciplinary meetings and activity groups, which included music therapy and a pampering session for patients.

Looked at 39 patient care records.

Carried out a specific check of the medicine management on both wards and looked at 30 out of 39 medicine administration records (MAR) charts.

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

Carried out two short observational framework inspection tool (SOFI) to observe the interaction between staff and patients.

Reviewed DATIX incidents and analysed serious incident reporting data for the previous six months.

Reviewed safeguarding reporting for the previous six months.

Reviewed restraint information.

Reviewed records relating to mental capacity and DoLS applications.

Reviewed staffing levels for the previous three months.

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

We spoke with two patients who said that they were happy and that the staff were nice.

We spoke with two family members of patients. One next of kin stated being happy with the care their family member was receiving and found staff caring. Another next of kin said staff did not consult with them and they felt unhappy with the personal care that their family member was receiving.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that the Mental Capacity Act 2005 Code of Practice and the trust's policies are adhered to in relation to Mental Capacity Act and Deprivation of Liberty Safeguards applications.

The trust must ensure compliance with the Nursing & Midwifery Council (NMC) Standards for Medicines Management.

The trust must take an immediate review focussing on risk assessments for all patients with safety plans being put in place to mitigate the risks to those patients presenting the highest risk.

The trust must review the safe management of medications on Hearts Delight and Woodstock ward.

The trust must ensure that there is an effective system to allow patients to call for assistance when required.

The trust must review the timeliness and consistency of reporting and recording of safeguarding incidents.

The trust must complete a comprehensive review of assessment and care planning for patients.

The trust must complete a comprehensive review of staffing levels and skill mix to ensure that patients care needs are responded to and to ensure the delivery of safe and effective care for patients.

Summary of findings

The governance arrangements in place failed to address areas for improvement on care plan audits. The trust must ensure that it has systems in place to act on information recorded on audits.

Action the provider SHOULD take to improve

The trust should ensure that risk to patients is identified and appropriate management plans are put in place to manage those risks, which are reviewed regularly.

The trust should ensure that nursing chairs are available for patients.

The trust should ensure effective management plans are in place concerning the use of pressure relieving mattresses to monitor and reduce the risk of patients experiencing bed sores.

The trust should continue to actively recruit to vacant posts.

The trust should ensure that staff Hearts Delight and Woodstock wards provide patients and their carers with information concerning advocacy services.

The trust should ensure that regular reviews regarding the use of mechanical restraints with patients are in place to ensure that they are appropriate and still necessary

Kent and Medway NHS and Social Care Partnership Trust

Frank Lloyd Unit

Detailed findings

Locations inspected

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

Mental Health Act responsibilities

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

A Mental Health Act reviewer visited the Frank Lloyd Unit on 25 November 2015 and identified concerns regarding the process and understanding of the Mental Health Act (MHA) 1983, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff did not make use of the MHA 1983 despite being a registered service for 'assessment or medical treatment for persons detained under the Mental Health Act 1983'.

Staff told us that they would not consider using the MHA, despite two patients on Hearts Delight ward having a mental health diagnosis. Staff could not explain how they would manage these patients to ensure that they were not unlawfully deprived of their liberty, whilst maintaining their health, safety and wellbeing

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff on the Frank Lloyd Unit did not have effective systems or processes in place to manage the use of the Mental Capacity Act (MCA) 2005 or Deprivation of Liberty Safeguards (DoLS). Staff did not understand the correct use of the MCA and DoLS to ensure appropriate care for patients. Standard and Urgent DoLS applications were made for all 39 patients of whom 36 were completed prior to assessing capacity. This contravenes the Mental Capacity Act 2005 Code of Practice, which states: 'Anybody who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, on the balance of probabilities, that the individual lacks capacity to make a particular decision, at the time it needs to be made (section 2(4)). This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question'.

Detailed findings

With regard to presuming capacity, the Mental Capacity Act 2005 Code of Practice states: 'The starting assumption must always be that a person has the capacity to make a decision, unless it can be established that they lack capacity'. Guidance to treat everyone equally states: 'A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour'.

There was a lack of evidence of best interests meetings taking place or being recorded in case notes. For example, where patients lacked capacity and mechanical restraint was being used, there was no evidence that a best interest meeting had taken place to consider its use and the effect on the health, safety and wellbeing of the patient. Furthermore, staff did not regularly complete reviews to consider the ongoing need and use of these restraints.

There was evidence of staff submitting a DoLS application before they had completed a capacity assessment with patients. There was no evidence that a best interest meeting had taken place before submitting the DoLS application. There were no systems or processes in place to manage patients or mitigate risks when an application had been submitted.

There were no systems or processes in place to manage patients or mitigate risk for patients that staff had submitted a DoLS application but had not yet been authorised. We spoke to staff and the service manager who told us that when staff had made the DoLS applications, the local authority had triaged them as a low priority. However, the service had not reported changes in a patient's presentation or a decline in their mental health to the local authority to allow them to review the application.

We spoke with staff whose knowledge and understanding of the Mental Capacity Act was limited. For example, staff told us that they completed DoLS applications for all patients due to the patient's diagnosis of dementia and being on a locked ward. However, two patients had a mental health diagnosis. Staff were unaware of the need to complete a capacity assessment prior to submitting the DoLS application. This was further evidenced when we reviewed the mental capacity assessments concerning place of residence, some of which were completed a significant period after the DoLS applications had been submitted.

Staff did not routinely complete capacity assessments effectively and in a timely manner prior to decisions being made. For example, staff completed a capacity assessment for one patient on 9 May 2015 however; staff submitted the DoLS application on 4 November 2014. The capacity assessment only considered the place to reside but stated that the patient lacked capacity for all decisions.

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

Summary of findings

We found the following problems that the trust needed to improve:

There was insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs. We reviewed staff rotas covering 42 days from the 17 December 2015 to 1 February 2016 inclusive, which showed a high use of bank and agency staff and shifts were sometimes not filled at all.

Pull cords and call buttons were inaccessible for patients to use and patients had to shout to gain attention.

Staff were not safely managing medicines. Three MAR charts reviewed did not always record allergies, which staff had documented in the patients care plans. Staff did not complete start and stop dates on MAR charts. There was evidence of staff transcribing medicines with no prescriber review completed. There were missing signatures on MAR charts, which raised further concern that medicines were not being given as directed. There was only one qualified member of staff to administer medication to 20 patients on the ward.

Eight out of 39 patients were receiving some of their medicines covertly. Staff filed covert medicines agreement forms in the MAR charts, which had been signed by the consultant psychiatrist, the named nurse for the patient and the next of kin. However, the pharmacist signature space was blank. The KMPT pharmacist informed us that she was aware of this and was going to be spending some time in the near future to resolve this. Staff told us that where they did not have consent to give medicines covertly, staff gave patients the medicine in food or drink and told them that it was in their best interests. However, staff had not documented best interest meetings in patient records.

Processes did not ensure that patients received adequate food and drink. Staff had documented food and drink on two of the seven food and fluid charts reviewed, for one day of our inspection.

Staff's lack of awareness of the Mental Capacity Act affected patients freedom to leave the unit, which included two patients on Hearts Delight ward who had been assessed as having capacity.

We observed staff using mechanical restraint for patients, which had not been recorded in any care plans reviewed.

Staff had not raised safeguarding alerts, despite recording them as safeguarding incidents.

Risk assessments and risk management plans were inconsistent and not reflective of some known patient risks.

However, we also found that:

Most staff were up to date with their mandatory training.

The wards were clean and well maintained.

Bedrooms were large with appropriate furniture and an en-suite toilet and basin.

Our findings

Safe and clean environment

The entrance to both Hearts Delight and Woodstock ward was via keypad entry directly into the foyer area of the ward. Each ward was a mirror image of the other consisting of two 10-bedded corridors, one to the right of the entrance foyer and the other facing the entrance door.

Woodstock ward was for male patients only and there were 19 patients at the time of our inspection. Hearts Delight ward was a mixed ward and there were 16 women and four men at the time of our inspection. Hearts Delight ward had separate sleeping and bathing areas for men and women that were compliant with Department of Health guidance on same sex accommodation.

The layout of the wards provided limited observation for staff. There was a rota in place for two staff on each ward to be responsible for general observations, which included regular checks on patients who were on 10 and 15 minute observations.

Are services safe?

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

The ward manager had completed a ligature audit, which had led to the light pull cords in the patient bedrooms en-suite being cut short and out of reach to patients. The trust used the electronic incident reporting tool, Datix to report incidents. Staff had recorded several incidences of patients found on the floor in their bedrooms or en-suites with minor injuries. Nurse call bells had been disabled to mitigate risk as the cables from the units were considered a ligature risk. A ligature point can be used by a patient to harm themselves. However, ligature risks remained in the form of electric plugs and cables in many of the call bell units.

Medicines were stored securely in designated cupboards in the clinical treatment rooms on both wards or on locked medicines trolleys. The medicines trolley on Woodstock ward was locked, secured to the wall and stored in the locked clinical treatment room when it was not being used. However, the medicines trolley on Hearts delight ward was not secured to the wall when not in use. We also saw that the clinical treatment room door was not always locked when it was not being used. This was despite staff being asked to lock the door on a number of occasions during the inspection. Controlled drugs (CDs) were stored and managed appropriately. CDs were checked at least once a day by two registered nurses.

The ambient temperatures of the clinical rooms and the fridge temperatures were monitored daily and were found to be satisfactory, therefore, we were assured that medicines were being stored at the correct temperatures and were fit for use. When there had been a problem with the temperature readings of the fridge, the nurses had sought advice appropriately. Numerous oxygen cylinders were being stored in the clinical treatment room. Staff completed daily checks on resuscitation equipment. One of the sharps bins we saw during the inspection had been opened since June 2015. The deputy ward manager was advised to discard it as per Department of Health guidelines on the use of sharps bins.

Medicines were dispensed into original boxes and were supplied on a monthly basis by the local community pharmacy. If medicines were needed urgently, the nurses were able to access supplies from any community pharmacy in the local area. Liquid medicines had the date of opening written on them. We saw evidence that a bottle of morphine sulphate 10mg/5mL solution had been returned to the pharmacy when it had been opened for more than three months. This was in line with expiry date guidance for medicines that have been opened.

The ward areas were clean and well maintained and the furnishings on Hearts Delight and Woodstock ward were appropriate and well maintained. The shower on Hearts Delight ward was not working and we were told that it had not worked for several weeks. The deputy ward manager told us that this was related to the water pressure and had been reported for repair. The ladies toilet on Hearts Delight ward was locked as it was out of order. However, this was repaired during our inspection. Although not cold, the temperature on the wards was not particularly warm. We were told that the heating system was faulty and was awaiting repair.

Safe staffing

Hearts Delight and Woodstock ward were a GP led service and patients were registered with a local onsite practice. The GP services could be contacted out of hours. There was also a minor injuries unit a short walk away from the unit, which patients had access to and some had previously attended. In the event of a medical emergency, staff called the emergency services rather than using the trusts emergency cover.

KMPT used the Hurst Tool to determine the number of nursing and Health Care Assistant (HCA) staff required for particular settings, based on the number of patients and their level of dependency. The trust used the tool to measure this over a set period and the average taken to identify appropriate level of staffing.

We reviewed staff rotas covering a 42 day period from 17 December 2015 to 1 February 2016 inclusive. The shifts were operated over an early, late and night system. We were informed by staff, the service manager and the trust that the staffing numbers were based on clinical need for patients on Hearts Delight and Woodstock ward. We were told that clinical need for the early and late shift was seven members of staff made up of two qualified staff and five HCAs. Clinical need for the night shift had been assessed as five members of staff, made up of one qualified member of staff and four HCAs. However, the clinical need on Woodstock ward and Hearts Delight was different, with

patients on Hearts Delight ward experiencing needs that were more complex. The service manager was unable to explain why staffing numbers were the same on both wards.

Patient care and treatment needs were not being met due to insufficient staff numbers and skill mix. On reviewing records for the above period over 42 early shifts, 24 only had one registered nurse on duty. Of the 42 late shifts, 25 had only one registered nurse on duty. There was only one registered nurse to administer medicines for up to 20 patients, which was insufficient. However, ward managers and qualified occupational therapy staff could provide support during the day when they were available. Staff on Hearts Delight ward told us that there were up to eight patients requiring assisted feeding and personal care at any one time. This meant that even when there was a full complement of staff, there was insufficient staff available to ensure the safety and wellbeing of the patients. Nursing staff told us that they did not have sufficient time to spend with patients or complete care plans and risk assessments. We spoke with staff who told us that the use of agency staff affected negatively on patients care and treatment needs. Staff told us that care needs including bathing and monitoring food and drink for patients was often unmet due to demands on staffing and lack of agency staff knowledge. We were unable to determine how often patients incontinence pads were changed as this was not recorded.

There was a disproportionate number of agency staff used. Over the 42 day period of rotas reviewed, there were over three or more agency staff for 11 early shifts, three or more agency staff for 17 late shifts and three or more agency staff for four night shifts on any given day. Staff told us that the use of agency staff affected negatively on patients care and treatment needs. Patients care needs, including bathing and monitoring of nutritional and fluid for patients, were often unmet due to demands on staff time and lack of agency staff knowledge.

The Manager of Woodstock ward told us that regular agency staff were used wherever possible using the National Health Service Professionals (NHSP) process, which included permanent members of staff. The trust told staff on 18 January that they were able to work overtime rather than being requested through the NHSP process. Overtime for staff had previously been unavailable, as staff had been required to register with NHSP in order to be considered to work unfulfilled shifts.

Five vacancies for HCAs had been recruited to and start dates were waiting to be agreed. Two vacancies for band five nurses were being advertised. Because of the new therapeutic nursing initiative one band five OT had been appointed and was waiting for a start date. One band five OT vacancy and two band four associate practitioners was being advertised. Two band four assistant psychologist's and two band four associate practitioner's had been appointed and were waiting a start date. Two deputy ward manager vacancies were being advertised.

A GP visited the unit twice a week on Mondays and Thursdays. Staff had access to an Out of hours GP service.

Mandatory training was monitored centrally by the trust and locally by ward managers. There was a training list for each staff role, which documented training required and how often it should be completed. Training included management of violence and aggression, basic life support, Deprivation of Liberty Safeguards (DoLS), infection control, health and safety, equality, moving and handling, complaints and medication calculation. The trust sent ward managers a matrix each month, which highlighted the training that had been completed and training due or overdue. Most staff had completed most of their mandatory training, or were booked into future sessions. Staff told us that they had to complete e-learning training at home, as there was no time to do so on the ward.

Assessing and managing risk to patients and staff

Staff had not regularly completed or reviewed risk assessments for any of the 29 care records we reviewed. There was minimal evidence of falls risk assessments or risk management plans being completed or updated following an incident.

There was limited or no evidence of risk assessments or care plans in place for the use of restraints such as lap belts, bed rails, cot bumpers and restraint for personal care. For example, on Hearts Delight ward there were seven bed rails, seven cot bumpers and four floor mats being used for patients. However, there were no care plans or risk

management plans in place for any of these patients. Staff was unable to state with confidence whether the restraints were in place to safeguard the patients or to control their movements.

We reviewed a patient's risk assessment, which documented a history of them entering other patients bedrooms at night. Staff had documented several incidents of physical aggression. However, there was no detailed risk management plan in place to manage the patient's behaviour to ensure the health, safety and wellbeing of other patients. Case notes did not detail potential triggers for an antecedent in order to prevent incidents of aggression for the patient.

There were no systems or processes in place to manage patients or mitigate risk for patients where staff had submitted a DoLS application, which had not been authorised. We spoke to staff and the service manager who told us that when applications were made, the local authority had triaged these as a low priority. However, the service had not reported changes to a patients mental health to the local authority to allow the application to be reviewed.

Two staff on each shift were allocated the responsibility for observation of patients, general observation of the ward and patients bedrooms. Staff were advised during the handover meetings, which patients were on a higher level of observation, for example every 10-15 minutes. However, patients told us that they could often be calling for help for long periods of time before receiving a response from staff.

We saw evidence that physical observations were completed on a regular basis.However, they were not necessarily completed after patients were given medicines to reduce anxiety / aggression e.g. lorazepam.

Staff told us that physical restraint never went any further than gently holding onto a patient's arm to stop a patient being hit or scratched, and a good therapeutic relationship with the patient prevented restraint. Staff told us that if a patient required physical intervention which had been care planned, this was not considered an incident so a Datix form was not completed.

The mandatory promoting safe and therapeutic services training had expired for some staff. However, staff had been booked onto the next available training.

All staff completed mandatory e-learning training which included safeguarding, manual handling, fire safety and health and safety.

Nursing staff had to complete an annual online medicines assessment which included a drugs calculation quiz with a required pass mark of 100%. There was a practical element to the annual assessment and staff had to complete further competencies with a senior nurse before they were able to administer medicines.

There were inconsistencies in the timeliness and reporting of safeguarding incidents. The Datix and safeguarding spreadsheet documented an incident dated 9 January 2016 where staff had found a patient with unexplained injuries of cuts and bruises. However, staff had not completed a safeguarding alert or reported the incident to the safeguarding team until 21 January 2016, after advice from our inspectors. Staff had recorded two separate incidents dated 22 November 2015 as one incident. However, the events were unrelated and involved isolated incidents of patient on patient assault. These were not reported or recorded as safeguarding incidents until 21 January 2016, after advice from our inspectors. This did not comply with the trust's Safeguarding policy 6.4 which stated: 'The alert must be completed within 24 hours of the abuse being alleged and a safeguarding plan put in place for the adult at risk within 48 hours of the alert being raised'.

Ward staff did not always follow the correct procedures for the management and administration of medicines. MAR charts were not always completed, reviewed or in line with trust policy and national guidance. There was evidence of transcribing of medications with no review by a prescriber. There were missing signatures on MAR charts, which meant that staff might not be giving medicines as directed. Allergy information and start and stop dates for medicines were not completed. Staff told us that they did not always administer medicines as prescribed on the MAR charts, which they believed to be incorrect. Staff told us that the general practitioner or consultant psychiatrist should amend the MAR charts to reflect changes. However, this was not always done. We were told that MAR charts received from the pharmacy department were not always updated with changes due to a lack of communication from the general practitioner or consultant psychiatrist. Discrepancies were noted between what the dispensing label dictated and what had been entered onto the MAR

chart. A number of nurses explained that the MAR charts often came from the pharmacy with errors, and they occasionally amended the charts to fit the correct medicines regime for the patients.

The transcribing of medicines did not comply with The NMC Standards for Medicines Management Section 2(3.2) which states 'This should only be undertaken in exceptional circumstances and should not be routine practice …' and 'any medication that you have transcribed must be signed off by a registered prescriber'. Standard 2.4 specifies … 'start and finish dates'. Standard 2.5 'Is signed and dated by the authorised prescriber'.

The trust Medicines Management Policy 20.8 stated: 'Each prescription must be validated by the full signature of the prescriber. The signature must be legible or the printed name of the prescriber should be written next to the signature. Initials or abbreviated signatures are not an adequate means of authorisation. If the prescriber is a non-medical prescriber the signature should be followed by the letters NMP-for non-medical prescriber'.

KMPT were not contracted to provide pharmacy services to the Frank Lloyd Unit. The contract was given to local GPs to provide, and they contracted the medicines management to a local pharmacy. The pharmacist told us that issues had been identified by the KMPT medicines management team. The pharmacist told us that there was a plan in place to get a better understanding of these issues in order that they could be rectified. The trust pharmacist visited the unit once every two months.

We found no evidence of care plans or risk management plans regarding the safe use of pressure relieving mattresses. There were four patients on pressure relieving mattresses due to the risk of pressure sores. Staff told us that they did not routinely turn, record or monitor patients and they would do this 'as and when' due to the type of mattress being used. We found no evidence documented to show that the health, safety and welfare of patients was being safely delivered in respect of patient care and treatment regarding the use of pressure relieving mattresses. We reviewed care plans regarding pressure sores, which were generic and contained no information regarding how this was being monitored.

We observed two patients who were care planned for bed rest. Staff told us that these patients had previously been supported in a chair for short periods. However, the chairs had been removed several months prior to the inspection due to damage to the chair covering, which resulted in concerns regarding infection control. The trust had not ordered replacement chairs, which meant that the patients had to remain on bed rest and were unable to interact with other patients and staff.

Children were not allowed on the ward although rooms such as the parlour could be used by visiting families if available. Visitors had to walk through the ward area in order to access the parlour.

Track record on safety

The trust used the electronic incident reporting tool Datix, to record and manage risks. However, there were inconsistencies concerning incidents referred to the safeguarding team. There had been 160 Datix incidents reported at the Frank Lloyd Unit over the previous six months. 10 of these incidents had safeguarding alerts raised for both Hearts Delight and Woodstock ward.

We found Datix incident WEB5178 raised on 9 January 2016 had been identified as a safeguarding alert due to a patient being found with a cut, bruising and dried blood under the left eye. However, staff had not completed an alert until requested by the inspection team on 19 January. Despite this request, staff did not raise the alert until 21 January 2016, after several requests for confirmation by the inspecting team. Other similar examples of inconsistent safeguarding alerts included WEB5049 dated 23 November 2015 involving patient to patient assault and WEB6119 dated 9 January 2015, which involved a patient who had fallen from her bed. Again, staff did not raise alerts for these incidents until after our inspection on 21 January 2016, following a request by the inspection team. Staff told us that if a patient were found on the floor where no cause can be ascertained, it would be recorded as an unwitnessed fall, often without further investigation.

The trust maintained a number of risk registers which included a local risk register, a nursing governance risk register, an older adults risk register and a trust risk register. The aim of this system was to operate a multi-tier management of risk register. We reviewed the local and trust wide risk registers and noted that a risk had been identified on 20 March 2015 for 'Inappropriate recording/ documentation and storage of medication (FLU)'.. 'Controls in place' documented: 'Audits have begun being completed

Are services safe?

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

on a weekly basis to ensure staff are correctly signing medication charts'. However, audits were not being completed and there were several concerns about the management and recording of medicine.

Reporting incidents and learning from when things go wrong

We found inconsistencies in the threshold and timeliness for reporting incidents, which had been referred to the local authority safeguarding team. For example, staff completed a safeguarding alert for some incidents where a patient was found with cuts or bruising but not others. There had been 160 Datix incidents reported at the Frank Lloyd Unit over the last six months Staff had completed safeguarding alerts for 10 of these incidents.

There were three incidents between 22 November 2015 and 5 January 2016 which met the threshold for raising a safeguarding alert. However, none of these incidents was raised as a safeguarding concern until numerous requests from the inspection team. Staff routinely reported incidents where patients were found with unexplained injuries as an unwitnessed fall, without investigating. For example, records in the handover notes on 1 February 2016 recorded that at 0230, night staff had found a patient on the floor of their room documenting she had missed the bed. However, the uploaded electronic progress notes recorded that the patient was "sat on the floor" at 2.30am. We found two separate incidents that took place on 22 November 2015 which involved a patient staff had assessed as a risk to other patients, recorded as one incident. The incidents were unrelated and included patient to patient assault.

The ward manager told us that there had been an increase in staff reporting incidents since being identified as an area requiring improvement at the last CQC inspection. However, we found variations in the timeliness and threshold for staff raising safeguarding alerts which did not comply with the trust's Safeguarding policy.

Staff told us that incidents were discussed during handover meetings. We saw copies of team meeting minutes from July 2015 to January 2016 (minutes from November and December 2015 for Woodstock ward and August and September 2015 for Hearts Delight were missing). Minutes reviewed included Serious incidents (closures / learning/ reviews and RCA updates) and Safeguarding (adult / children / update/feedback) as agenda items to discuss. However, there was often no entries documented or recorded staff discussing the same two patients only.

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.

Summary of findings

We found the following problems that the trust needed to improve:

There was a blanket instruction for staff to complete DoLS applications for all patients admitted to both wards. Staff had completed 36 out of 39 DoLS applications, before assessing the patients capacity. Of 39 DoLS applications, only five had been authorised. Patients were assessed on admission to the wards. However, a mental capacity assessment often took place sometime after admission and after staff had made a DoLS application, which is contrary to the MCA CoP. Staff had denied one patient's request to visit her son, despite being assessed as having capacity on 28 December 2015.

There was no Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Act (IMHA) Advocacy information displayed on the wards.

Patients physical health needs were not being managed safely and effectively. For example, there was no evidence of care plans or risk management plans regarding the safe use of pressure relieving mattresses.

We reviewed bathing charts and found that patients personal care needs were not being met. Bathing charts documented some patients not having had a bath for 12 months or more.

The consultant psychiatrist attended the unit every Tuesday afternoon for Care Programme Approach (CPA) meetings only.

However, we also found that:

Efforts had been made to create a familiar and non-institutional environment for patients.

Our findings

Assessment of needs and planning of care

Patients were not receiving care and treatment that was based on an assessment of their needs. Risk assessments and care plans were not always being completed or reviewed. We found limited or no evidence of risk assessments or care plans in place for the use of restraints such as lap belts, bed rails, cot bumpers and restraint for personal care. For example on Hearts Delight ward, there were seven bed rails and seven cot bumpers used for patients. However, there were no care plans or risk management plans in place for these for any of these patients.

There was a blanket restriction of staff completing a DoLS application for all patients. Staff had completed 36 of 39 DoLS applications before they had assessed the patients' capacity. Two patients on Hearts Delight ward had been assessed as having capacity. One patient had been assessed as having capacity on 28 December 2015 and had previously asked and attempted to leave the ward using the memorised the key code. The trust had instructed staff to prevent the patient from leaving and changed the key code. Staff had been told to make an urgent DoLS application in the event of a patient attempting to leave the ward, without considering if this was appropriate. There were five authorisations for 39 patients meaning that the remaining patients were 'de-facto' detained.

We reviewed nine patients bathing charts which documented staff not giving one patient any baths over a 12 month period, another patient having had one bath over a period of 25 months and another patient having no baths recorded for a period of 13 months. The service manager and staff confirmed that bathing charts were accurate. The shower had not been working for some time on Hearts Delight ward and patients' personal care primarily consisted of bed baths. Staff confirmed that all of the patients on Hearts Delight ward required two members of staff to use a hoist to bathe patients. Agency staff were not permitted to operate the hoist and at least one regular member of staff had to be present at all times. Staff confirmed that this, along with insufficient availability of staff due to patient's clinical needs, meant that patients were not able to have a bath as regularly as they should or would like. We spoke to relatives who raised concerns about the lack of personal care staff provided for their relative.

Staff were not monitoring patients weight and nutrition. We reviewed seven food and fluid balance charts which recorded various levels of food and fluid intake. Staff had not recorded what actions were being taken with patients who were refusing food and drink to ensure patient safety and wellbeing. Patients were left calling out for staff assistance for long periods of time and were not receiving

adequate food and drink. Staff initially told us that all patients were on food and fluid charts. However, we were later told that staff only completed charts for patients who had been assessed as appropriate. We reviewed seven food and fluid charts on Hearts Delight ward and found that only two documented patients having had anything to eat or drink. Staff had recorded a patient having a poor appetite which required staff support with food and fluid intake. The patient was bed bound and had no means of calling for staff assistance other than shouting. Throughout the inspection, we observed the patient repeatedly call for staff assistance. This was brought to the attention of a member of staff who said that they could not help the patient as they were with other patients and were unable to leave them.

During the inspection, we observed staff feeding lunch to a patient. The patient had been asleep and staff immediately began to feed the patient after waking them. The member of staff did not engage with the patient and left the room whilst the patient was still eating, which increased the risk of choking. The patient was not on a food or fluid chart and was unable to drink without assistance. The patient was therefore reliant on staff to provide necessary fluids that had been recorded in the care plan.

We observed a bed bound and constricted patient whose room was at the end of a corridor, shouting and screaming undistinguishable words. Staff told us that the patient could not be moved closer to nursing staff because the patients bed could not fit through the door. Staff had documented that the patient had been refusing food. However, staff had not recorded if the patient had been offered a drink and the patient did not have a food and fluid diary. The handover notes stated that staff had given the patient food and drink had and personal care had been attended. We could find no record of this.

One patients care plan documented "patient to be encouraged to participate in activities, to be transferred to their nursing chair at frequent intervals". However, the patients nursing chair had been damaged and was not in use. This meant that the patient was being deprived of participating in a change of environment, which had not been reflected in the patient's care plans.

Staff recorded patient information on the trust's electronic records system (RIO) and uploaded completed paper work onto the patients care record. However, some documents had not been uploaded to patient records.

Best practice in treatment and care

We reviewed 29 care plans and 30 MAR charts. MAR charts were not always completed, reviewed or in line with trust policy and national guidance. We found evidence of staff transcribing medicines, with no review completed by the prescriber. There were missing signatures on prescription charts, which meant that staff might not be giving medicines as directed. Staff had not recorded allergies and start and stop dates for medicines. There were 74 missing signatures on one prescription chart, ten on another and nine missing on another making it impossible to ascertain if medication had been given or not. Staff were not dispensing medicines as directed on the prescription. Staff told us that they gave medication at a time they felt to be correct where they believed the prescription was inaccurate.

The regular and routine transcribing of medications does not comply with The Nursing & Midwifery Council (NMC) Standards for Medicines Management Section 2(3.2) which states 'This should only be undertaken in exceptional circumstances and should not be routine practice …' and 'any medication that you have transcribed must be signed off by a registered prescriber'. Standard 2.4 specifies … 'start and finish dates'. Standard 2.5 'Is signed and dated by the authorised prescriber'.

Staff did not follow the trust medicines management policy 20.8 which stated: 'Each prescription must be validated by the full signature of the prescriber. The signature must be legible or the printed name of the prescriber should be written next to the signature. Initials or abbreviated signatures are not an adequate means of authorisation. If the prescriber is a non-medical prescriber the signature should be followed by the letters NMP-for non-medical prescriber'. 20.9 states .'…A prescription for a drug that has been discontinued should be cancelled by drawing a straight line through the drug and the cancellation signed and dated.

During the inspection we reviewed 29 care plans and risk assessments. Patients were not receiving care and treatment that was based on an assessment of their needs. Staff did not complete or review risk assessments and care plans. There was evidence of care plans being written from a staff's perspective which included 'patient must be compliant with their medication'. One member of staff had the primary responsibility of entering information onto

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.

patient's records because of restricted duties due to a shoulder injury. The member of staff documented notes despite not being present or involved in many of the interventions recorded.

Staff did not record management plans to support the turning of patients and monitoring of pressure sores for patients using pressure relieving mattresses.

One patient's risk assessment documented that they had a history and several incidents of physical aggression which included entering other patients bedrooms at night . However, staff had not completed a detailed risk management plan to manage the patient's behaviour to ensure the health, safety and wellbeing of other patients.

We reviewed care planning audit review paperwork provided by the trust about Hearts Delight and Woodstock wards for the period 30 June to 27 December 2015. Four audits had taken place on Hearts Delight ward between 27 August 2015 to 29 November 2015. The audits consistently showed a red RAG rating for question 8: 'Are all clinical risks, risk management and crisis relapse and contingency plans clearly identified and completed'? Data for audits completed on 27 August 2015 and 26 September 2015 recorded 37% compliance. On 30 October 2015, compliance was recorded at 12% and on 29 November 2015 25%. Data for question 8 for Woodstock ward for 31 August 2015 showed 12% compliance. No data was collected for September and October. Compliance on 1 November was 37% and 12% on 27 December 2015. Despite the audits demonstrating a clear breach of trust targets and significant areas for improvement, there was no evidence of detailed action plans with accountability and timeframes to address these issues.

Skilled staff to deliver care

There was a range of disciplines providing input on both Hearts Delight and Woodstock wards which included qualified nurses, health care assistants, consultant psychiatrist and occupational therapy. Occupational Therapy assistants supported shifts where required to ensure a full complement of staff. Woodstock and Hearts Delight ward were moving towards more therapeutic staffing for patients. Staff told us that this meant an occupational therapist would provide personal care for patients and were concerned how this would affect the patients' needs being met.

We reviewed team meeting minutes from July 2015 to January 2016 (minutes from November and December 2015 for Woodstock ward and August and September 2015 for Hearts Delight were missing). The minutes included agenda items such as health and safety, mandatory training, serious incidents, safeguarding, pharmacy and MHA. However, on several occasions no information had been recorded for agenda items.

However we found that:

A range of psychological interventions was used on both wards. Interventions included a memory box, the recent introduction of two therapy dolls and a life story box.

Staff received an induction and had to complete mandatory training relevant to their role. Training was monitored centrally within the trust and ward managers were sent an email flagging up when training was due or overdue.

The manager on Woodstock ward reported all staff being up to date with appraisals and staff receiving regular one to one supervision. The manager for Hearts Delight ward was on long term sick during our visit and staff were uncertain who would be providing supervision for them in the manager's absence.

Multi-disciplinary and inter-agency team work

There was a handover at the end of each shift where staff from the previous shift discussed issues or concerns. We attended a handover meeting on Hearts Delight and Woodstock ward where staff discussed patients to be resuscitated, staffing issues, patient diet, continence and presentation and issues experienced during the previous shift.

We observed a Care Programme Approach (CPA) meeting attended by the consultant psychiatrist, named nurse, occupational therapist and patient. Families and carers were invited to CPA meetings. We saw evidence that during a CPA meeting a family had asked to take their relative out for the day. Staff had told them that a best interest meeting would have to be arranged to discuss. However, staff could have discussed this with the family during this meeting, which could have been considered a best interest meeting.

The service is GP led, who visited the ward twice weekly. Any changes in medication for mental health were primarily at the discretion of the consultant psychiatrist, although could be started by the GP. However, the GP did

not have access to the trust's electronic records. If the GP made changes to patients medication, they recorded it on their database and the consultant psychiatrist would update the trust's electronic records when he attended the unit weekly.

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

All staff completed mandatory Mental Health Act e-learning training as part of their induction.During the inspection staff told us that Hearts Delight and Woodstock ward would not consider using the Mental Health Act as there 'was insufficient consultant psychiatrist cover'. Staff reported being unaware that the ward was registered to make use of this legislation.

We spoke with the consultant psychiatrist, staff nurse, health care assistant and student nurse regarding a patient assessed as having capacity on 28 December 2015. Staff told us that plans were in place to prevent the patient from leaving should they wish to do so. We advised staff that they had no authority to prevent the patient from leaving the unit. Staff agreed that the Mental Health Act might be more appropriate to meet the needs of the patient whose diagnosis was one of mental health rather than mental capacity.

We saw no Independent Mental Health Advocacy or Independent Mental Capacity Advocacy information displayed on Hearts Delight or Woodstock ward.

Good practice in applying the Mental Capacity Act

We reviewed 39 patients case notes and found that staff had completed capacity assessments for 36 patients, after they had submitted a DoLS application for place of abode. There was no evidence that a best interest meeting had taken place in any of the 39 records reviewed.

We spoke with nine staff whose knowledge and understanding of the MCA was limited. For example, staff told us that they made DoLS applications for all patients due to the patients diagnosis of dementia and being on a locked ward. Staff told us they were unaware of the need to complete a capacity assessment before submitting the DoLS application.

There were no systems or processes in place to manage patients or mitigate risk for patients for whom an application had been submitted but had not yet been authorised. Best Interests meetings were not recorded in case notes. There was no system for ensuring patients subject to DoLS had been provided with information about their rights. Staff had not recorded if a best interest meeting had taken place if mechanical restraint was being used and if this was the least restrictive option for the patient. Staff did not complete regular reviews for the ongoing need and use of these restraints.

We were told that all staff completed mandatory Mental Capacity Act e-learning training as part of their induction.

Are services caring?

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

Summary of findings

We observed limited interaction between staff and patients during meal times on Hearts Delight ward because there was too few staff to enable them to engage with patients.

However:

We observed some positive, caring and compassionate interactions between staff and patients.

Efforts had been made to make the wards a welcoming and non-institutional environment.

Photographs of patients when younger were placed at door handle height to promote recognition for patients and encourage staff to see the 'person behind the patient'.

Both wards displayed a 'You Said We Did' board.

Our findings

Kindness, dignity, respect and support

We observed some positive staff interactions with patients treating them with care, compassion and communicating effectively. However, we observed patients personal care needs being unmet and staff on Hearts Delight ward told us that patient's personal care was compromised due to staffing levels.

Through the use of short observational framework for inspection tool (SOFI) we saw limited interaction between staff and patients during lunch, with staff undertaking several tasks during the period of observation.

We spoke with two patients, who said that they were happy and that staff were nice. We spoke with four families and carers of patients. Three told us that they were happy with the care their relative was receiving and felt involved in their relative's care planning. One told us that they were unaware staff had made a DoLS application for their relative. We were told that staff were good at informing them of incidents including a recent fall.

Another carer told us they were unhappy with the care that their relative was receiving and that they did not feel consulted.

The involvement of people in the care that they receive

We saw little evidence of patient involvement in their care plans and risk assessments. Care plans had been written from a staff perspective with no evidence or consideration given to patient involvement. We saw evidence of notes recorded in the 'clients view' section of the care plan completed from the staff perspective. For example, 'For patient to be compliant with prescribed medication …'

We saw information from a relative on a patients care plan telling the service the activities that their relative enjoyed. However, we found no evidence that staff used this information to benefit the patient's care.

We saw evidence of advanced decisions documented in patients electronic care records.

We observed two CPA meetings attended by the patient, psychiatrist and named nurse. We saw evidence of staff inviting relatives and carers to CPA meetings.

There was no information regarding advocacy on either Hearts Delight or Woodstock ward.

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.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Kent and Medway NHS and Social Care Partnership Trust did not always provide care and treatment for patients in a safe way and risks to the health and safety of patients were not mitigated. The trust did not have effective systems and processes in place which enabled staff to report on and manage any allegation or evidence of abuse of patients. The trust did not take measures against inappropriate or unsafe care and treatment by failing to identify, assess and manage risks relating to the health and welfare and safety of patients and inconsistency in failing to raise safeguarding alerts. The trust had ineffective governance systems in place to assess, monitor, and improve the quality and safety of the health care provided.

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 Kent and Medway NHS and Social Care Partnership Trust did not have effective systems and processes in place which enabled staff to report on and manage any allegation or evidence of abuse of patients. We found several records of safeguarding incidents that had not been completed as safeguarding alerts.

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

This section is primarily information for the provider

Enforcement actions

Kent and Medway NHS and Social Care Partnership Trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that patients care and treatment needs could be met.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Kent and Medway NHS and Social Care Partnership Trust did not have effective systems or processes in place to manage the use of the Mental Capacity Act or Deprivation of Liberty safeguards applications.