

Requires improvement 

Leicestershire Partnership NHS Trust

Long stay/rehabilitation mental health wards for working age adults

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)
RT5KE	Stewart House (Narborough)	Stewart House Skye Wing	LE19 4SL
RT5FK	The Willows	Acacia Bungalow	LE5 OLE
RT5FK	The Willows	Cedars Bungalow	LE5 OLE
RT5FK	The Willows	Sycamore Bungalow	LE5 OLE
RT5FK	The Willows	Maple Bungalow	LE5 OLE

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

Summary of findings

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 Leicestershire Partnership NHS Trust and these are brought together to inform our overall judgement of Leicestershire Partnership NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Leicestershire Partnership NHS Trust long stay / rehabilitation mental health wards for working age adults as **requires improvement** because:

- Arrangements for medication management did not keep all patients safe which meant that some patients did not receive the follow-up care they should have received and some patients received medication that was not covered by consent documents
- The systems that manage patient information (electronic and paper files) did not support staff to deliver effective care and treatment in line with the Mental Health Act
- The granting of Section 17 leave for patients detained under the Mental Health Act at Stewart House did not follow the Trust's documented procedure (dated September 2014) and also contravened the Mental Health Act Code of Practice (2008 and 2015)

- Consent to Treatment could not be easily established for a number of patients because the documentation could not be located by staff

However:

- Patients told us that they were satisfied with the care they received and we observed warm, positive interactions between staff and patients
- The Willows had good systems in place to collect, monitor and act upon patient feedback
- Managers were able to demonstrate that they took poor staff performance seriously and they were actively dealing with this
- Morale amongst staff we spoke with was generally good and staff were clear about their roles and responsibilities

Summary of findings

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

Are services safe?

We rated Safe as **Requires Improvement** because:

- Some patients did not receive the medical tests requested by their doctor
- Some patients were not monitored following medication administration as was recommended by the British National Formulary (BNF)
- There were delays for new staff to undertake mandatory training in management of aggression

However:

- Staff had a good understanding of incident reporting and most felt able to raise concerns internally and externally
- Clear systems were in place to learn lessons when things had gone wrong
- Mandatory training was routinely undertaken and staff attendance was monitored
- All ward environments were clean and well maintained

Requires improvement



Are services effective?

We rated Effective as **Requires Improvement** because:

- The systems that manage patient information (electronic and paper files) did not support staff to deliver effective care and treatment in line with the Mental Health Act.
- Patient consent to treatment was not routinely stored effectively and could not be found

However:

- Patients were effectively supported to move on from the service, when appropriate in their care pathway
- We saw good practice around assessing, supporting and monitoring patients nutritional needs
- In line with the Mental Health Act Code of Practice (2015) and NICE guidelines, patients received thorough physical health checks and medical support to promote their well-being and they had access to other health services when they needed them
- Care Programme Approach (CPA) reviews were held routinely in order to collect and monitor patient outcomes
- Occupational therapy, medical and nursing staff worked together to plan and deliver patient care

Requires improvement



Summary of findings

Are services caring?

We rated Caring as **good** because:

- Patients told us that staff were lovely and provided them with good care; staff were willing to provide help when they needed it and they were treated with kindness
- Patients told us that their individual needs were catered for and staff showed them respect
- During the inspection visit we observed considerate and positive interactions between staff and patients. Patients were treated with kindness, dignity and respect. We observed appropriate use of humour and witnessed warm interactions between staff and patients. Staff took time to interact with patients and delivered information in a way which the patient was able to understand
- Staff said that when there had been an incident of a staff member behaving inappropriately toward a patient. This had been reported and managers had dealt with the issue effectively so that the worker was no longer employed at the unit
- Most patients knew that they had a care plan and had been involved in developing it
- Most patients had privacy to see visitors in their bedrooms if they wished and they could make telephone calls in private if they wanted to

However:

- Most patients told us that they were not involved in the running of the service and we saw little evidence of patient views in care plans

Good



Are services responsive to people's needs?

We rated Responsive as **good** because:

- The facilities and premises were appropriate for the services that were being delivered
- Equipment such as hoists and pressure relieving mattresses were readily available to meet the needs of patients with additional needs, as required
- Locations were accessible by public transport and close to local community facilities enabling patients to become part of their wider community as part of their rehabilitation programme
- Patients using the service told us that they felt listened to and were confident that if they had a complaint it would be acted upon
- We saw evidence of the staff and the service being willing to change in order to meet the needs of patients

Good



Summary of findings

- We saw notices informing patients how to complain and how to access an advocate

However:

- Patients and staff told us that planned leave was almost never cancelled but was sometimes delayed due to staff shortages

Are services well-led?

We rated Well-led as **good** because:

- Staff told us that they were clear about their role in delivering the strategy of the service
- Some staff were aware of the wider vision of the trust
- Most staff were familiar with members of the trust executive and could give examples of board members visiting their wards
- There were recording and monitoring measures in place to deal with staff absence
- Managers were visible on the wards and demonstrated skill, knowledge and experience to lead their service effectively
- Managers said they had autonomy to do their jobs effectively and were confident they could raise issues of concern with senior colleagues
- Managers proactively attempted to engage staff in regular briefings and meetings
- The Willows had a well-developed system in place to regularly obtain patient feedback
- Most staff said they felt confident to raise concerns to senior colleagues or to use the whistleblowing procedure; and felt their concerns would be taken seriously

However:

- There were gaps in systematic programmes of clinical and internal audit to monitor quality in areas such as the recording, storing and retrieving of consent to treatment paperwork (T2 forms) and the follow up of medical tests requested by doctors
- When opening Maple bungalow, effective measures had not been put in place to assess and monitor the impact on quality and sustainability of the service. Consequently, a number of staff reported that there had been shortages of qualified staff since Maple bungalow was opened.

Good



Summary of findings

Information about the service

Leicestershire Partnership NHS Trust Long stay / rehabilitation mental health wards for working age adults provides inpatient rehabilitation, care and treatment for patients with enduring mental health problems.

The service is provided across two hospital sites, the Willows in Leicester and Stewart House in Narborough

The service has 68 beds which are located at:

- Stewart House Skye Wing – 30 beds – mixed gender
- The Willows Acacia bungalow - ten beds – mixed gender

- The Willows Sycamores bungalow – ten beds - male
- The Willows Maple bungalow – eight beds - male
- The Willows Cedars bungalow – ten beds – mixed gender

With the exception of Maple bungalow at The Willows which is a locked rehabilitation ward, all other wards in the service are open access.

This is the first CQC inspection at The Willows. Stewart House was last inspected in April 2013 when it was found to be compliant.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The inspection team inspecting this service comprised of two CQC inspectors and a variety of specialists:

- two nurses
- a consultant psychiatrist
- two Mental Health Act reviewers
- an occupational therapist

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information we held about the service.

During the inspection visit, the team:

- visited all five of the wards at the two hospital sites
- looked at the quality of the ward environments looked at clinic rooms, emergency equipment and ward facilities

Summary of findings

- spoke with seven patients who were using the service
- spoke with two team managers
- spoke with six nurses, one doctor, a panel of Mental Health Act hospital managers and nine other staff from a range of backgrounds

We also:

- looked at 29 medication records and carried out a check of the medication management on all five wards
- looked at the legal records of 25 patients who were detained under the Mental Health Act
- looked at 27 care records, including risk assessments and care plans
- looked at a range of policies, procedures and other documents relating to the running of the service including the staff training records
- observed interactions between patients and staff and between staff
- observed a therapy session
- attended two Care Programme Approach (CPA) reviews and three patient centred meetings (ward rounds)

What people who use the provider's services say

Patients told us that they were satisfied with the care and treatment they received from the service. Staff listened to them and treated them with kindness, dignity and respect. Patients knew how to make a complaint and felt confident that if they did complain, it would be taken seriously.

The Willows carried out regular quarterly patient feedback surveys. We saw the results of the surveys for June and December 2014 and these showed that overall, patients were satisfied with the care they received. Eighty per cent of patients in June 2014 and 85% in December 2014 felt they had been welcomed by the ward and that staff were kind and caring. There was also an improvement from 62% to 85% in patients reporting that they were involved in their care.

The number of patients likely or extremely likely to recommend the ward to friends / family increased from 77% in June to 88% in December.

Ninety-three per cent of patients in June and 91% in December reported that the ward was clean. Patients at Stewart House told us that their unit was very clean and that cleaning was carried out several times a day.

We looked at complaints data provided by Leicestershire Partnership NHS Trust and found that from January to December 2014 there was one complaint received about the service at The Willows and this had had been upheld. There were no complaints registered for Stewart House.

Areas for improvement

Action the provider MUST take to improve

Leicestershire Partnership NHS Trust long stay / rehabilitation mental health wards for working age adults **MUST** improve in the following areas:

- The trust MUST improve the recording and storing of T2 and T3 documents
- The trust MUST demonstrate that they have effective systems in place for safe management of medication.
- The trust MUST demonstrate that they have effective systems in place to ensure that medical tests are carried out in line with the doctor's recommendation.
- The trust MUST ensure that they adhere to the Mental Health Act Code of Practice and their own guidance notes and record this properly.

Leicestershire Partnership NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Maple Bungalow	The Willows
Sycamore Bungalow	The Willows
Acacia Bungalow	The Willows
Cedar Bungalow	The Willows
Stewart House Skye Wing	Stewart House (Narborough)

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.

- The use of the MHA was not consistently good across the service. The documentation we reviewed in detained patients files was not always up to date and paperwork was missing.
- Three approved mental health professional reports were missing from both the paper and electronic files. There were incomplete photocopies of MHA documents in patient files. There were some sequential renewal papers initially stored in paper files and then on the electronic system but some were missing. One patient had no detention in hospital (H3) form on file.
- Ministry of Justice approval for Section 17 leave was missing for two patients. Section 37/41 original documentation was missing from both the paper and electronic files for one patient.
- Completed consent to treatment forms were not routinely available to inspect. Some were stored in

Detailed findings

paper files, some were stored electronically and some could not be found at all (six out of eight were missing at The Willows). Some were out of date. Some patients were administered medication not covered by the T2 or T3s.

- The granting of Section 17 leave was not completed by the responsible clinician but delegated to a specialist registrar at Stewart House. A patient at The Willows was recorded as having escorted leave but the authorisation and leave history indicated that the patient should have unescorted leave. Section 17 leave authorisation for one patient at The Willows stipulated escorted leave but did not specify the number of escorts. The electronic recording showed that the patient had actually taken unescorted leave. Some files at Stewart House did not record if the granted leave had been taken. We saw evidence of leave forms being completed for six – twelve months in advance for leave of 30 minutes once a day, indicating a lack of regular review. Patients were not given copies of their leave forms but were given slips of paper which detailed the leave. A number of obsolete Section 17 forms were present in files but not clearly marked as obsolete. One patient had a Section 17 leave form detailing leave which was granted beyond the expiry of the detention period and the patient had actually been discharged from the Section.
- We talked to a panel of hospital managers who were present for a hearing at Stewart House. They expressed concern at the number of temporary staff and the turnover of staff, noting that the nurse present at the hearing that day did not know the patient. However the trust told us that there is a regular group of bank staff used who were familiar with the ward.
- Covert medication plans were agreed involving all relevant parties, such as the pharmacist, medic, nurse and relative and in one case with the police. These had good rationales and were well recorded with review dates.
- Information on the rights of people who were detained was displayed in wards and independent advocacy services were readily available to support patients, both Independent mental health advocates and generic advocates. Staff and patients were aware of how to request an advocate. Staff were aware of the need to explain people's rights to them and attempts to do this were generally recorded. However, we found that there were some gaps in the recording of attempts to explain people's rights to them.
- Staff knew how to contact the MHA office for advice when needed.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) by explaining it to us. They were aware of recent legal decisions relating to the MCA and the impact of this on the service and patients.
- Staff knew who to contact for further advice and guidance about issues relating to the MCA.
- Deprivation of Liberty Safeguards (DoLS) authorisations were applied for when relevant and records showed the status of the authorisation. One patient at The Willows was referred for a DoLS assessment but did not meet the criteria and was sectioned under the Mental Health Act soon after.
- Contact details for the county council and city DoLS teams were displayed on the units.
- Staff demonstrated a good understanding of assessing capacity and decisions were recorded.

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 rated Safe as **Requires Improvement** because:

- Some patients did not receive the medical tests requested by their doctor
- Some patients were not monitored following medication administration as was recommended by the British National Formulary (BNF)
- There were delays for new staff to undertake mandatory training in management aggression

However:

- Staff had a good understanding of incident reporting and most felt able to raise concerns internally and externally
- Clear systems were in place to learn lessons when things had gone wrong
- Mandatory training was routinely undertaken and staff attendance was monitored
- All ward environments were clean and well maintained

Our findings

- The ward layouts enabled staff to observe most parts of the ward. Maple bungalow was a locked rehab unit for men. Access to non-patient areas was by staff operated keys. There was a locked entrance area (airlock) to that ward. All doors on Maple bungalow were “anti-barricade” so could be removed by staff if required. There were CCTV cameras covering communal patient areas, exits and the seclusion room.
- Patients said repairs were always carried out in a timely manner. However, staff told us that there could be delays which they had to follow up in order to get the work done.
- Most bedrooms were not ensuite. There were designated male / female areas on the mixed gender wards with shared toilet and shower rooms toilets in these designated areas. These were only shared by patients of the same gender. Maple Bungalow had an assisted shower room and bathroom with one ensuite bedroom.
- Ward staff carried out assessments of ligature risks. There were a number of ligature risks at Stewart House. Staff said they managed this by refusing admission to anyone who might be at risk of harming themselves. They gave an example of recently refusing admission based upon this. Staff felt that individual patient risk assessments kept patients safe from harming themselves. There had been no recent incidents of self harming behaviour. Staff areas at Stewart House presented additional ligature risks and staff felt that because these were designated staff areas, such as offices, with no unsupervised patient access, there was no risk to patients.
- The wards were well-maintained and the corridors were clear and clutter free. Patients told us standards of cleanliness were good. There was a plentiful supply of cleaning material in designated locked areas. Hand washing procedure signs were visible. Hand gel was available. Staff conducted regular audits of infection control and prevention to ensure that patients and staff were protected against the risks of infection. Staff disposed of sharp objects, such as used needles and syringes, appropriately in yellow bins. These bins were not over-filled. However, the number of staff who had attended training for infection control at The Willows was 68%.
- Active cleaning was take place on the wards when we visited. Cleaning labels were dated and attached to equipment that might be used by a variety of people in clinic rooms. Toilets appeared clean and all wards had full toilet paper, soap and hand drying facilities.
- Equipment was maintained and serviced appropriately. Dates of servicing were clearly visible. Emergency equipment, including defibrillators and oxygen, was in place. It was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Check and service dates were up to date. Medical

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devices and emergency medication were also checked regularly. The checklist logs in clinic rooms were seen. There were several gaps in the resuscitation trolley check log for Maple bungalow of which staff were aware.

- Staff carried personal alarms. Stewart House reported they had to wait for 19 hours before the alarm system was repaired last year. Staff said that when the alarms were used, staff responded very quickly. We witnessed alarms being responded to quickly and effectively.

Safe staffing

- The trust had a safe staffing team. The wards submitted staffing levels (planned and actual) on a monthly basis to the safe staffing team who publish these on the trust website. The trust's "UNIFY fill rate submission" documents for December 2014, January 2015 and February 2015 were calculated by dividing the planned staff hours by the actual worked staff hours. These figures showed an average for the last three months as 125% for day nurse shifts and 144% for day health care assistant shifts at Stewart House. The figures showed 102% for night nurse shifts and 155% for night health care assistant shifts at Stewart House. The average for the same period at The Willows showed 141% day nurse shifts and 169% for day health care assistant shift.
- Some staff reported that there were enough staff on duty most of the time. However, other staff said that there had been staffing problems at The Willows following the opening of Maple Bungalow and that there had been occasions in the last month when there had been no qualified nurses working in some of the bungalows. However the trust provided information that stated that there had always been qualified staff on shift.
- We talked to a panel of hospital managers who were present for a hearing at Stewart House. They expressed concern at the number of temporary staff and the turnover of staff and noted that the nurse at the hearing was new and did not know the patient.
- Staff told us they could get additional staff when required and did not need senior manager approval. Staffing was increased in relation to individual patient need for additional observations when required to keep patients safe.

- There were staff vacancies which were being actively recruited to. Stewart House had 4.1 whole time equivalent (WTE) nurse vacancies, whilst the Willows had 3.8 (WTE) nurse vacancies. Regular bank staff were used when possible, to maintain continuity of patient care. Staff reported that they rarely used agency staff. The Trust data seen confirmed this. For December 2014, January 2015 and February 2015 Stewart House used an average of 44% temporary staff, all of which were bank staff rather than agency. For the same period, The Willows used an average of 20% temporary staff. Ward managers told us that they experienced some difficulty recruiting qualified staff. They had locally agreed with another unit to share the recruitment process and have multiple roles advertised together. They hoped this would save time and provide support to each other.
- Temporary staff, who had not worked on a ward before, were given an induction to the ward. Handovers included information about which staff were identified to respond to alarms on the units, individual patient observation levels, which patients had Section 17 leave planned, scheduled mental health review tribunals, escorts, ligature checks and environmental checks as well as patient health and wellbeing.
- Staff and patients told us that planned escorted leave from the wards was almost never cancelled. However, they said that there may be a delay at times due to staffing problems.
- Staff told us that there was adequate medical staff available day and night to attend the ward quickly in an emergency.

Assessing and managing risk to patients and staff

- All patients and staff we spoke with told us they felt safe on the wards. However, a member of staff was physically assaulted during the inspection visit and went home as a result. We observed that the assault was responded to and de-escalated effectively although there were no staff to offer a debriefing to those involved or witness to the incident.
- Individual risk assessments had been carried out for all patients on the wards. Staff told us how they managed individual risks.
- Risk assessments were routinely and regularly updated. However, prior to detained patients taking Section 17 leave, no risks assessments were recorded. A

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description of what the patient was wearing was not recorded. Staff told us that they check that patients are okay before they take their leave and record this but we saw no evidence of this.

- For patients detained under the Mental Health Act, the Approved Mental Health Act Professional's (AMHP's) paperwork was not always available so staff could not easily see what, from the patient's history and risks, had led to the patient's admission.
- The handover process included discussion of individual patient risk.
- All patients could leave the ward environment apart from Maple bungalow,. All doors were open access. Each unit had a reception area that was usually staffed during office hours. Main doors were locked at midnight.
- Staff had received training in safeguarding vulnerable adults and children. All staff we spoke to showed a good understanding of how to identify and deal with potential safeguarding concerns. Staff told us that they could get advice from senior colleagues and the safeguarding team if they felt they needed to. Staff could give us examples of safeguarding issues and what had been done to mitigate them in the past. Managers said there were very few safeguarding incidents on the wards.
- The Willows had a seclusion unit situated on Maple Bungalow. Staff and patients said it was seldom used; the last time was in September 2014. The seclusion unit had CCTV cameras installed, a secure window for ventilation, toilet and washing facilities, a bed, blanket, a viewing hatch and access to view a clock. A control panel outside of the unit controlled temperature. The toilet and wash facility could be closed for privacy but there was a viewing hatch should staff require it. There were no ligature points and all areas of the unit could be safely viewed by staff from outside and inside the unit.
- Staff at Stewart House said they very rarely used restraint techniques but were aware of one instance in the last six months where it had been used. Staff felt confident that their de-escalation techniques were generally sufficient to prevent incidents from escalating. Staff said that if one of the patients needed seclusion, they would need to get the police to transport the patient to The Willows. During the period between June and December 2014 there were a total of 13 episodes of restraint of which 1, at Stewart House, was in the prone position. There was only 1 seclusion throughout that time. This was at Acacia bungalow.
- Management of actual and potential aggression (MAPA) training was mandatory for all staff on the wards. New staff did this as part of their induction. However, there was a delay for new staff to attend this training. Staff who started in March told us that they were scheduled to do the MAPA training in July. Other new staff reported similar time delays in being scheduled to do the MAPA training.
- We reviewed the medicine administration records of 29 patients in total across the wards. We found a few reported errors in administration of medication. Two patients at Stewart House were receiving medication that was not covered by the T2 or T3 paperwork. One patient was recommended by the doctor to receive an ECG each month but the paperwork did not make it clear if this was done and staff were not aware that it should be done regularly. Another patient was prescribed a long-acting injectable antipsychotic medication but guidelines were not followed so the patient did not receive the monitoring of physical health that is recommended. There were no records of patient lithium levels where we would have expected to find them for two patients.
- Staff were not able to locate six out of eight T3 forms at The Willows. Capacity to consent to treatment was not completed by the current responsible clinician for one patient. There were out of date T2 forms in the clinic room at Stewart House though some more up to date forms were found on the electronic recording system. We concluded that the service could not demonstrate that they had effective systems in place to record and store evidence of patient consent to treatment (T2 forms) or of second opinion appointed doctor forms (T3 forms). Consequently, nurses that administered medication could not be certain that medication administration was accurate
- People using the service were provided with information about their medicines. The pharmacist could meet with individual patients if requested to.

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- Staff said they were aware of child visiting policies. To facilitate child visits, both units had suitable rooms available. The room for Maple bungalow was situated outside of the locked ward area.

Track record on safety

- Data from the trust showed no serious untoward incidents for this service in the previous six months. However, the incident that happened on the day of the visit was reported as an incident, but was not accounted for in these records as it had been more recent than the timeframe we looked at. In April 2014 a detained patient from Stewart House died of natural causes when on unescorted Section 17 leave. Lessons learned considered the sharing of good practice from the case which enabled individualised care for the patient and showed that on-going records were well maintained. The investigation found that there was no single root cause for the incident and the unit could not have predicted nor prevented it. Staff were aware of the incident. Learning from the incident had been shared amongst the service and wider Trust.
- Staff were currently investigating the incident of a patient carrying a knife at The Willows that had occurred that day.

Reporting incidents and learning from when things go wrong

- Staff we spoke to knew how to recognise and report incidents. They were confident that they could report incidents without fear of recrimination. The trust used an electronic incident report form (EIRF) to record incidents. Local and senior managers had access to monitor this. Staff told us they felt confident using this form and new staff felt confident of support from colleagues to complete it if required. All recorded incidents were reviewed by the ward team manager to determine the next course of action. Staff were made aware of incidents in team meetings and handovers. Staff were confident that they could access support and “de-briefs” if they were involved in an incident. A member of staff was assaulted by a patient during the inspection visit. Support was given but no debrief was provided at the time.
- Staff showed an awareness of the trust’s “Whistleblowing” procedures and most felt confident they would use the use procedure if they felt it was necessary.

Are services effective?

Requires improvement 

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

Summary of findings

We rated Effective as **Requires Improvement** because:

- The systems that manage patient information (electronic and paper files) did not support staff to deliver effective care and treatment in line with the Mental Health Act
- Patient consent to treatment was not routinely stored effectively and could not be found

However:

- Patients were effectively supported to move on from the service, when appropriate in their care pathway
- We saw good practice around assessing, supporting and monitoring patients nutritional needs
- In line with the Mental Health Act Code of Practice (2015) and NICE guidelines, patients received thorough physical health checks and medical support to promote their well-being and they had access to other health services when they needed them
- Care Programme Approach (CPA) reviews were held routinely in order to collect and monitor patient outcomes
- Occupational therapy, medical and nursing staff worked together to plan and deliver patient care

Our findings

Assessment of needs and planning of care

- Patients needs were assessed and care was delivered in line with their individual care plans. Records showed that risks to physical health were identified and managed effectively.
- Occupational Therapy staff supported patients with ward based activity therapies. Nurses worked to these plans when occupational therapy staff were not available. Therapy assistants and nurses were available to support patients with their therapeutic activity. An occupational therapist was trained in assessment of motor and process skills which is a recognised tool used to evaluate a person's quality of performance of their personal or instrumental activities of daily living skills.

- Care plans were in place that addressed patients assessed needs. We saw that these were reviewed and updated. Patients gave us examples of how their individual needs were met but care plans did not reflect patient views.

Best practice in treatment and care

- Patients could access psychological therapies as part of their treatment and psychologists were part of the ward team.
- Stewart House held specialist pressure relieving equipment such as mattresses, which reduced delays for patients who were assessed as needing it. Both units displayed their number of "free from pressure ulcer days" but these covered only one month.
- The Willows collected patient feedback every quarter to monitor the quality and effectiveness of the service provided. Managers from across the service met and discussed issues and learning needs at monthly clinical governance meetings.

Skilled staff to deliver care

- Staff working in the service came from a range of professional backgrounds including nursing, medical, occupational therapy, chaplaincy, support time recovery, housekeeping, pharmacy and psychology. Social work / care manager support was provided by the local authority. Other staff were drawn upon for specialist assessments such as learning disability, speech and language therapy, and nutrition, when required. All patients at Stewart House were registered with a local GP surgery, a doctor from which visited the unit twice a week. Patients at The Willows received physical healthcare from a local surgery and had a GP visiting the unit once a week. Both units had a nurse led clinic on site once a month.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including: safeguarding children and adults; fire safety; health and safety; basic life support; moving and handling; infection control; information governance; and management of actual or potential violence. New staff were scheduled to undertake this training. This was verified when we looked at records at The Willows and was 94% for

Are services effective?

Requires improvement 

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

mandatory training, 91% for information governance, 68% for infection control, 78% for medicines management, 72% appraisals completed and 78% for record keeping.

- Records showed that most staff were up-to-date with their mandatory training. Records we checked showed that managers could easily determine which staff had completed their training and which may need to be re-scheduled, for example if sickness absence prevented them from attending. Data available on The Willows showed staff numbers attending mandatory training was 94% at the time of the inspection visit.
- Staff told us they received clinical and managerial supervision, usually every month. This time was used to address performance issues, to reflect on their practice and development needs and to consider incidents that had occurred on the ward. The service used a "supervision tree" where each grade of staff supervised someone in a grade below them.
- There were regular team meetings and sub team meetings. Staff told us they felt valued and supported by their managers, colleagues and senior managers. Staff told us they liked their jobs and enjoyed their work. Most staff reported good morale within their areas.
- Ward team managers gave examples of how they dealt with issues of staff performance and sickness absence. Managers said they were confident in the support they could receive from their managers and the human resources department. A new sickness protocol had been introduced and managers reported that this was a fair system.

Multi-disciplinary and inter-agency team work

- Assessments on wards were multidisciplinary in approach. People's records showed that there was effective multidisciplinary team (MDT) working taking place. Staff gave examples of having involved external professionals when the patient needed this. There was evidence of families being invited to care programme approach meetings, some of whom attended.
- Staff told us that the handover, MDT and patient centred meetings were effective in sharing information about patients and to review progress. A care manager from the local authority would be present leading to discharge planning and any other relevant professionals

involved in the patients care could be invited. Different professionals were seen to be working together effectively to assess and plan patients care, treatment and discharge.

- Staff said referrals to other services such as speech and language therapy were accepted and dealt with in a timely manner.

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

- The use of the MHA was not consistently good across the service. The documentation we reviewed in detained patients files was not always up to date and there was missing paperwork.
- Three approved mental health professional reports were missing from both the paper and electronic files. We saw incomplete photocopies of MHA documents in patient files. We saw some sequential renewal papers initially stored in paper files and then on the electronic system but some were missing. One patient had no Detention in hospital H3 form on file.
- Ministry of Justice approval for Section 17 leave was missing for two patients. Section 37/41 original documentation was missing from both the paper and electronic files for one patient.
- Completed consent to treatment forms were not routinely available to inspect. Some were stored in paper files, some were stored electronically and some could not be found at all (six out of eight were missing at The Willows). Some were out of date. Some patients were administered medication not covered by the T2 or T3s.
- The granting of Section 17 leave was not completed by the responsible clinician but delegated to a specialist registrar at Stewart House. A patient at The Willows was recorded as having escorted leave but the authorisation and leave history indicated that the patient should have unescorted leave. A patient at The Willows Section 17 leave authorisation stipulated escorted leave but did not specify the number of escorts. The electronic recording showed that the patient had actually taken unescorted leave. Some files at Stewart House did not record if the granted leave had been taken. We saw evidence of leave forms being completed for between six and twelve months in advance for leave of 30

Are services effective?

Requires improvement 

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minutes once a day, indicating a lack of regular review. Patients were not given copies of their leave forms but were given slips of paper which detailed the leave. A number of obsolete Section 17 forms were present in files but not clearly marked as obsolete. One patient had a Section 17 leave form detailing leave which was granted beyond the expiry of the detention period and the patient had actually been discharged from the Section.

- Covert medication plans were agreed involving all relevant parties, such as the pharmacist, doctor, nurse and relative and in one case with the police. These had good rationales and were well recorded with review dates.
- Information on the rights of people who were detained was displayed in wards and independent advocacy services were readily available to support patients, both independent mental health advocates and generic advocates. Staff and patients were aware of how to request an advocate. Staff were aware of the need to explain people's rights to them and attempts to do this were generally recorded. However, we found that there were some gaps in the recording of attempts.

- Patients had access to mental health review tribunals and managers hearings.
- Staff knew how to contact the MHA office for advice when needed.

Good practice in applying the Mental Capacity Act

- Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They were aware of recent legal decisions relating to the MCA and the impact of this on the service and patients.
- Staff knew who to contact for further advice and guidance about issues relating to the MCA.
- Deprivation of Liberty Safeguards (DoLS) authorisations were applied for when relevant and records showed the status of the authorisation. One patient at The Willows was referred for a DoLS assessment but did not meet the criteria and was sectioned under the Mental Health Act soon after.
- Contact details for the county council and city DoLS teams were displayed on the units.

Are services caring?

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

Summary of findings

We rated Caring as **good** because:

- Patients told us that staff were lovely and provided them with good care; staff were willing to provide help when they needed it and they were treated with kindness
- Patients told us that their individual needs were catered for and staff showed them respect
- During the inspection visit we observed considerate and positive interactions between staff and patients. Patients were treated with kindness, dignity and respect. We observed appropriate use of humour and witnessed warm interactions between staff and patients. Staff took time to interact with patients and delivered information in a way which the patient was able to understand
- Staff said that when there had been an incident of a staff member behaving inappropriately toward a patient. This had been reported and managers had dealt with the issue effectively so that the worker was no longer employed at the unit
- Most patients knew that they had a care plan and had been involved in developing it
- Most patients had privacy to see visitors in their bedrooms if they wished and they could make telephone calls in private if they wanted to

However:

- Most patients told us that they were not involved in the running of the service and we saw little evidence of patient views in care plans

- We saw staff engaging in positive interactions with patients and showing appropriate levels of humour.
- We talked to staff about patients and they discussed them in a respectful manner and showed a good understanding of their individual needs. Staff could give examples of the type of person centred support that individual patients needed to help them to feel safe and comfortable, for example opening the door to the courtyard garden after midnight if it would help a patient to feel settled.

The involvement of people in the care that they receive

- When patients arrived on the ward they were shown around and introduced to the building. There was a “welcome pack” giving them information about the service but not all patients remembered getting this information. Staff said patients could visit the units before moving there.
- Patients, who wanted to, could actively engage in developing their care plans and knew what the care plan was. They were satisfied with the care plans. Some patients said they did not want to be involved in their care plans. Patients could have their relative present in CPA meetings but some chose not to. Patients were invited to attend their patient centred meeting but not all of them did.
- For the patients less able to engage in their care planning advocates could be appointed. Referrals to the advocacy service were made by staff when patients could not make this decision themselves. Details of the local advocacy service were displayed in all the wards. Patients told us they were supported to access an advocate if they wished.
- There were also patient telephones available on the units and staff allowed patients to use the ward telephones if they needed to.
- Staff said that patient “community meetings” were regularly held, usually on a weekend at Stewart House. Carers groups were advertised on the units.
- Staff said they paid attention to the feedback from patients. They planned to get a clothes drying machine for male patients to use at Stewart House as a result of

Our findings

Kindness, dignity, respect and support

- Patients told us that staff treated them with respect.
- We observed staff interacting with patients in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner. They de-escalated situations by listening to and speaking quietly to people who were frustrated, upset or angry and offering medication. Staff appeared interested and engaged in providing good quality care to patients.

Are services caring?

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

patient feedback (female patients already had one). The views of patients were gathered quarterly regularly at The Willows and results analysed by the team manager. There were comment boxes available at Stewart House.

- There was one complaint in the service during 2014. Stewart House staff said that issues were dealt with quickly, patients and relatives listened to and issues discussed openly so this was probably why no complaints were registered.

Are services responsive to people's needs?

Good 

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

Summary of findings

We rated Responsive as **good** because:

- The facilities and premises were appropriate for the services that were being delivered
- Equipment such as hoists and pressure relieving mattresses were readily available to meet the needs of patients with additional needs, as required
- Locations were accessible by public transport and close to local community facilities enabling patients to become part of their wider community as part of their rehabilitation programme
- Patients using the service told us that they felt listened to and were confident that if they had a complaint it would be acted upon
- We saw evidence of the staff and the service being willing to change in order to meet the needs of patients
- We saw notices informing patients how to complain and how to access an advocate

However:

- Patients and staff told us that planned leave was almost never cancelled but was sometimes delayed due to staff shortages

- Staff at Stewart House said they did not have a current problem with delayed patient discharges but if a patient needed to move directly to a care home from the ward, there may be delays around funding. The Willows had one patient whose discharge was delayed but this was due to physical health problems.
- We saw no evidence of patients having to move wards because of non-clinical reasons. Staff said that patients with complex behaviour were generally managed on the units and not moved. One patient at Stewart House presented particular management problems but the multi-disciplinary team decided not to move the patient because that would be a negative step in the patient's care pathway.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had a full range of rooms and equipment. This included space for therapeutic activities, relaxation and treatment.
- There were rooms for patients to meet relatives, who could also spend time with patients in their bedrooms on most wards if it was safe to do so.
- Each ward had access to a patient telephone and staff helped patients to make calls if they needed it. Staff allowed patients to use the unit telephone if needed.
- All the wards offered access to an outside space, which included a smoking area. The Willows had a courtyard garden and the building was set in grounds with green space. The Willows had a therapeutic garden funded by the Kings Fund as well as a secure garden for Maple bungalow and garden areas for smoking attached to the other bungalows. All garden areas had seating and plants. As Maple Bungalow was new, the garden was tastefully landscaped but not yet planted, though staff said this was being considered.
- Snacks and drinks were available when patients wanted them. Hot meals were provided which were delivered and reheated on the units. Patients had a choice of meals and told us there was plenty of food and it was generally very good. Foods that complied with specific religious, cultural and dietary needs were available for patients.
- Weekly and monthly activity programmes were advertised on all wards, though when we enquired they

Our findings

Access and discharge

- Ward team managers told us that there was currently a waiting list for the service. There were no bed vacancies at the time of the inspection visit. The Willows had recently started to take patients from outside of their geographic area.
- The Willows said they see inpatients referrals within ten days and community referrals within one month.
- A discharge planning nurse was part of the team at Stewart House. Eight patients had recently been discharged to care homes because there had been plans to close the unit. Plans had been recently revised and the unit is no longer to close. A new build will be attached to it and it will continue to run in conjunction with the new service on the site. Patient discharge was a multi-disciplinary process.

Are services responsive to people's needs?

Good 

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

were not accurate as the activities planned were not taking place and staff did not know why. There was a range of low level activities for patients from walking to weekly cinema trips that were paid for by the ward. We observed knitting, colouring and music sessions taking place which some patients appeared to be engaged in and enjoying. There were activity rooms on both units with access to art materials, games, books, computers and crafts. Staff at Stewart House said that the occupational therapists did home visits related to patient discharge and carried out assessments of activities of daily living. We saw no evidence of patients involved in education or high level therapeutic and rehabilitation activities.

- Wards had dedicated occupational therapy staff who developed individual therapy plans for patients. At evenings and weekends, ward staff said they led activities. Some patients told us they did not want to engage in activities.
- Patients and staff told us that activity and therapy sessions were almost never cancelled due to a lack of staff but sometimes they were delayed.
- Patients could manage their own laundry if they wanted to and were able to. Staff managed the laundering of linen.
- Patients did not routinely have keys to their rooms and but we saw staff responding quickly to open or lock patient rooms when asked to do so. Patients had safe lockable spaces in their rooms to store important items and those that wanted to could store their sweets and biscuits in a room that only staff could access at Stewart House.

Meeting the needs of all people who use the service

- Staff respected patients' diversity and human rights. Meaningful attempts were made to meet patients' individual needs including cultural, language and religious needs.

- There was a chaplaincy service to support patients with a diverse range of spiritual and religious needs.
- Interpreters were available to staff to help assess patients needs and explain their rights, as well as their care and treatment if required. There was evidence of interpreters having been used. Some staff spoke other languages in addition to English.
- A choice of meals was available to suit patients religious, cultural and personal choices. Patients could access snack outside of meal times if they wanted to and healthy eating guidance was available to patients.
- All units were equipped to support patients with physical health and mobility needs. The ensuite room on Maple bungalow had a level access shower facility. Showers and baths were also available if patients wished to use them. Stewart House had a supply of hoists and equipment but staff said they were not used because patients were independently mobile.

Listening to and learning from concerns and complaints

- Information about how to make a complaint was displayed on the wards, as well as information about the independent advocacy service, a culturally specific advocacy service, a generic mental health advocacy service, CQC and the patient advice and liaison service.
- Patients could also raise concerns and complaints in the community meetings, by using a comment card or patient feedback form as well as directly with staff.
- Patients told us they knew how to make complaints and were confident they would be listened to and their views would be taken seriously.
- Staff told us they were open to receiving both positive and negative feedback and considered all feedback in team meetings.

Are services well-led?

Good 

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

Summary of findings

We rated Well-led as **good** because:

- Staff told us that they were clear about their role in delivering the strategy of the service
- Some staff were aware of the wider vision of the trust
- Most staff were familiar with members of the trust executive and could give examples of board members visiting their wards
- There were recording and monitoring measures in place to deal with staff absence
- Managers were visible on the wards and demonstrated skill, knowledge and experience to lead their service effectively
- Managers said they had autonomy to do their jobs effectively and were confident they could raise issues of concern with senior colleagues
- Managers proactively attempted to engage staff in regular briefings and meetings
- The Willows had a well-developed system in place to regularly obtain patient feedback
- Most staff said they felt confident to raise concerns to senior colleagues or to use the whistleblowing procedure; and felt their concerns would be taken seriously

However:

- There were gaps in systematic programmes of clinical and internal audit to monitor quality in areas such as the recording, storing and retrieving of consent to treatment paperwork (T2 forms) and the follow up of medical tests requested by doctors
- Managers were relatively new in post (around one year) and organisational changes at the time of the inspection visit meant that one of the managers was leaving to take a promotion within the service
- When opening Maple bungalow, effective measures had not been put in place to assess and monitor the impact on quality and sustainability of the service. Consequently, a number of staff reported that there had been shortages of qualified staff since Maple bungalow was opened.

Our findings

Vision and values

- Some staff showed a clear understanding of the trust's vision and values. Staff told us that quality care was their aim.
- Most staff told us that they felt valued by the trust and believed that they could express their views without recrimination.
- Ward managers had regular contact with their managers and senior colleagues and felt supported by them.
- Most staff could describe a visit to their unit by the chief executive or a member of the board. Some staff recalled a board member working a shift at The Willows.

Good governance

- The service had systems of governance in place such as the EIRF reporting system which assisted staff to manage and monitor risk on the ward environment. These systems also provided information to senior managers in the trust in an open and transparent way. Trust-wide teams such as safe staffing and safeguarding were available for individual and ward support when required.
- Performance data was captured and used to address quality and staff performance issues.
- The ward managers told us they had enough time and autonomy to manage the wards effectively. They also said that, where they had concerns, they could raise them with senior managers. When necessary, concerns could be escalated.
- Staff had regular appraisals and most were up to date. However, staff reported that a confusing message from the trust meant that there were delays in completing some appraisals due to the introduction of new online paperwork. The Willows data showed a target of 80% and they were achieving 72% at the time of the inspection visit.
- Managers said they supported their staff to manage performance issues of their supervisees and had dealt with some complex staffing issues directly, because they had more experience in the area.

Are services well-led?

Good 

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

- Systems for auditing MHA compliance and documentation were not effectively dealing with the problems of recording, storing and retrieving accurate, up to date records.
- Systems for monitoring the effective management of medication were not effectively identifying or rectifying problems.

Leadership, morale and staff engagement

- There was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day-to-day provision of care and treatment, they were accessible to staff. The culture on the wards was generally open and managers felt they had seen positive change since they started working in the service.
- Staff we spoke with were enthusiastic and engaged with their roles. They told us they felt able to report incidents and raise concerns. They were mostly confident they would be listened to by their line managers.
- Staff were kept up to date about developments in the trust through regular emails and team meetings.
- Staff were aware of the Whistleblowing process and most of them told us they felt confident to use it.
- Most ward managers told us they had access to leadership training and development opportunities. They told us they felt supported and valued by their immediate line manager.

- Staff had access to laptop computers so they could work away from the ward area if they needed to.
- Staff on Maple bungalow said they had been involved in the design of the ward.

Commitment to quality improvement and innovation

- The Willows had received funding from the Kings Fund and redesigned the unit's central entrance area and attached therapeutic garden. They had also applied for money to redevelop the entrance stairs and landing area in light of recent risk assessments (planners were onsite during the inspection visit).
- New staff felt engaged and enthusiastic and one reported that their ideas for developing healthy activities for patients had been well received by other staff and managers at Stewart House.
- The Willows were introducing "my shared pathway" a national initiative to reduce length of stay and focus on a recovery and outcomes based approach for patients. The team manager aimed to increase staff awareness of outcome focused interventions with staff at the Willows and had secured funding for a temporary post to support with this.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

The trust did not make appropriate arrangements to ensure the consent to care and treatment of all services users.

- Not all patients had recorded assessments of capacity.
- Procedures required under the Mental Capacity Act were not always followed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

The provider did not protect patients against the risks associated with the unsafe management of medicines.

- At the rehabilitation service we found two patients where necessary medical checks had not been undertaken following administration of high dose anti-psychotic medication.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment due to a lack of accurate records being made and held securely.

- Procedures were not always followed for detention under the Mental Health Act and records relating to patient's detention were not always in order.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care in a way that ensures the welfare and safety of the patient.

- Arrangements for patients taking section 17 leave were not clear and in line with the Mental Health Act.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment through availability of accurate information and documents in relation to the care and treatment provided.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.