John Munroe Hospital – Rudyard

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

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

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

Summary of findings

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

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

Overall summary

We rated John Munroe hospital as requires improvement because:

- We saw that provider had made improvements since our last inspection. The provider had resolved some of the issues that we had identified or had started to make improvements but there was further work to complete. However, there were still improvements that the provider needed to make in other areas.
- We saw there was still a blanket restriction in place. On Kipling ward patients did not have free access to a toilet without asking staff permission. This general restriction was not justified although it may have been in the interests of a few patients on the ward.
- The hospital did not always follow best practice in relation to gender separation requirements; there was not a female only area on Rudyard ward.
- Staff did not have consistent access to supervision and appraisals. There had been an improvement in appraisal completion, but supervision and appraisal completion were still an issue on Rudyard; approximately 10% of staff had received regular supervision in the year prior to our inspection and 45% of staff had an appraisal.
- The ligature risk policy was out of date and an environmental ligature risk assessment for Kipling ward was out of date. Staff did not always update ligature risk assessments where individual patient's risk was recorded and were not assessing risks in line with policy.
- We did not find evidence that learning from incidents; patient feedback or complaints took place at team meetings. Team meetings took place regularly on only three of the five wards. The hospital had introduced a lessons learnt bulletin in December 2017 to share learning more regularly but most staff were not familiar with this.
- Most staff did not understand what duty of candour was and could not describe why it was important.
- All patients had a care plan but these did not always demonstrate a recovery focus or personalisation. Active involvement in care planning was not always evident; it was not always clear whether patients had received a copy of their care plan.
- The provider did not maintain comprehensive records of the activities offered to and taken up by patients. Individual therapists maintained records but there was no overall summary of the provider offering support to engage patients in activities that aimed to assist them to gain skills for their rehabilitation.
- Staff did not know the values of the organisation. Staff described a 'disconnect' between the most senior management on the board and the hospital staff. There had been a low level of feedback from the staff survey.

However:

- There were effective processes in place to ensure staff implemented the Mental Health Act properly. The Mental Health Act manager supported the wards and ensured that mental health act processes were regularly audited and that staff were supported in relation to the act.
- Staff had a good understanding of safeguarding, staff had completed training and there were effective processes in place for safeguarding. Overall, mandatory training figures had improved since our last inspection. Staff compliance was at 92%. There were effective processes to monitor and implement training.
- Staff said they felt comfortable to raise concerns and knew how to whistle-blow and said they would do if needed. The provider had a 'freedom to speak up guardian' who staff could raise concerns with directly. Staff were positive about the support they received from managers throughout the hospital including the hospital manager.

Summary of findings

- Staff demonstrated that they knew and understood patients' needs, preferences and risks. Staff ensured risk assessments were up to date, thorough and reviewed regularly. Clinical items and areas were clean, the integrity of mattresses was audited and staff completed checks of emergency equipment.
- Staff managed patients' often chronic and complex physical health problems well. The service had a GP who saw patients regularly. Staff promoted healthy lifestyles and supported patients to make healthy choices
- Staff treated patients kindly and respectfully. We saw staff had a good rapport and were kind and sensitive to patients' needs. Carers and family members were positive about the care of their loved ones, they felt appropriately involved with care and were happy with the way staff communicated with them about patients. Overall patients and carers were satisfied that patients' belongings were safe.

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Summary of this inspection

Background to John Munroe Hospital – Rudyard

John Munroe Hospital is an independent mental health hospital that provides care, treatment and rehabilitation services for up to 57 adults, aged 18 or over, with long-term mental health needs. Patients may be informal or detained under the Mental Health Act 1983.

John Munroe Hospital is one of two hospitals run by the John Munroe Group Limited. The Edith Shaw Hospital is located nearby and both hospitals share the same registered manager.

John Munroe Hospital is registered to carry out the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury, and
- diagnostic and screening procedures.

John Munroe Hospital has five wards located on a secure site. Three wards (Horton, Kipling and Rudyard) are located in the main hospital building. Larches and High Ash wards are located in self-contained bungalows.

- Horton ward is a male ward that supports up to 16 patients with chronic or complex mental health needs. Prior to our inspection, Horton ward changed from being a mixed-gender ward to a male-only ward.
- Kipling ward is female-only ward for up to 13 patients with chronic or complex mental health needs.
- Rudyard ward is a mixed-gender ward that supports up to 15 patients with organic conditions such as dementia.
- High Ash is a female-only ward for up to seven patients and provides locked rehabilitation.
- Larches is a male-only ward for up to six patients and provides locked rehabilitation.

Rudyard ward is an older adult's inpatient ward and we have inspected this as a separate core service. We had previously inspected this ward as a rehabilitation service but following the last CQC inspection, the provider had decided to develop the unit as a specialist service for people with dementia.

Our inspection team

Team leader: Liz Millet

The team that inspected the two core services comprised of three inspectors, an inspection manager, two specialist professional advisors (an occupational therapist and mental health nurse) and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who has used mental health services.

Why we carried out this inspection

We inspected the two core services as part of our on-going comprehensive mental health inspection programme.

We last inspected the service in November 2016. Following this inspection we told the provider that it must:

- The provider must ensure that clinic equipment is kept clean.
- The provider must ensure timely replacements of mattresses that are unfit for purpose.
- The provider must ensure that all staff receive mandatory and appropriate specialist training for their roles.
- The provider must ensure that care is person-centred and meets the specific needs of the different patient groups.
- The provider must ensure that patients have access to a range of therapeutic, rehabilitative and social activities specific to their needs.

Summary of this inspection

- The provider must ensure that Rudyard ward environment is dementia-friendly and all wards contain the appropriate facilities.

We also told the provider that it should:

- The provider should ensure that staff fully comply with checks on resuscitation and other equipment.
- The provider should ensure that staff on High Ash ward and Larches ward can contact the nurse immediately in an emergency.
- The provider should ensure that blanket restrictions are in place only where these are the least restrictive means of managing specific risks.
- The provider should update its rapid tranquillisation policy to reflect the national institute for health and care excellence (NICE) guidelines (May 2015).
- The provider should ensure there is guidance for all medication prescribed for PRN (pro re nata – as needed) purposes.
- The provider should continue to address staffing recruitment and retention issues.
- The provider should ensure that staff receive their annual appraisals.
- The provider should ensure that patients are offered a choice of good quality food, and that menus are displayed for information.
- The provider should ensure that all staff have a good understanding of capacity to consent and that it is applied appropriately.
- The provider should ensure that patients' belongings are kept safe.

We issued four requirement notices at the last inspection in November 2016 for breaches of:

- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

At our most recent inspection, we checked whether the provider had addressed the issues that we said it must improve. We found that the provider had started to make, or made improvements in the following areas:

The provider ensured that clinical equipment was clean, and that the integrity of mattresses was monitored and that mattresses were replaced when required. Staff compliance with mandatory training had improved and some staff had received the specialist training they required for their roles. There were staff that had not completed dementia training; however, the provider had an action plan for this.

We saw evidence of an improvement in person centred care although this was not always recorded in care plans to evidence that it was person centred. It was difficult for us to assess whether patients had enough access to a range of activities specific to their needs because of the way that the provider recorded this. We did however see and hear about different activities. There had been an improvement in the facilities on the wards and some improvement to Rudyard to make it more dementia-friendly; there were plans to further improve this ward further by relocating it to another area of the hospital.

We found that provider had started to make or made improvements in the following areas that we said it should improve:

We saw that there was guidance for all medication prescribed for PRN (pro re nata – as needed) purposes. The provider had a rapid tranquilisation policy that was in line the national institute for health and care excellence (NICE) guidelines (May 2015). Staff completed checks on resuscitation and other equipment and nurses could be contacted if staff needed them in an emergency. Staff understood capacity to consent and applied this properly.

There was an on-going programme of staff recruitment and retention. There had been an improvement in staff receiving their annual appraisals; however, this was still an on-going issue on Rudyard ward where appraisal compliance was still low.

Overall patients and carers were happy that their belongings were safe. Most patients were happy with the quality of food. However, there were still no menus on display. The provider had had reduced blanket restrictions but there was still one in place on Kipling ward.

We also undertook a Mental Health Act monitoring visit to Rudyard ward in May 2017.

Summary of this inspection

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 that we held about the location, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited each of the five wards in the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 12 patients who were using the service
- spoke with eight carers
- spoke with the managing director, Human Resources manager, Mental Health Act administrator, hospital manager, deputy hospital manager and nurses in charge
- spoke with 30 other staff members; including doctors, qualified nurses, health care assistants, occupational therapists, activity lead, psychologist and assistant psychologist
- attended and observed a multi-disciplinary meeting and care plan approach meeting
- attended two activity groups
- spoke to the GP and pharmacist who worked closely with the service
- looked at 24 care and treatment records of patients
- carried out a specific check of the medication management on all the wards
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke to 12 patients who used the service. We conducted nine short observational frameworks for inspection (SOFI) observations on Rudyard ward. A SOFI involves close observation of staff and patient interactions for short periods of time. We used SOFIs because we were unable to speak with some patients because of the severity of their dementia

Overall, patients were positive about how staff treated them. Three patients said that staff turnover was high and this could affect the quality of the care they received. One patient identified several problems with the service including; they felt that care was not person centred and staff were not respectful. This patient also said that there was no choice of food and that there was only one hot meal a day.

Patients said the service was clean and some patients described the wards as "homely." Two patients said they did not have a key to their room or a safe. One of these patients said some of their belongings had been lost.

Overall, patients said the hospital was clean and tidy and that staff treated them well. Patients were particularly happy with how they were supported with their physical health. They told us about how they had access to treatment for day to day health issues and appointments, and for long term and significant health problems.

Patients were generally satisfied with the quality of food and felt they could make a complaint. The patients also said there was access to spiritual support if they wanted it.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We saw evidence of a blanket restriction in place on Kipling ward. The toilets were locked and patients were unable to access them without asking staff. There had been risks identified for three patients using the toilet freely but the restriction had been applied to all patients.
- Rudyard ward was a mixed gender ward, but there was no female only lounge or communal area. There were two women on the ward at the time of our inspection. On mixed wards good practice requires a day lounge for use by women only. However, the provider changed this shortly after our inspection and Rudyard ward is now a male only ward.
- We observed dirty wheelchairs on the Rudyard ward and different patients used these. A member of staff told us there was no clear process for cleaning wheel chairs. This was an infection control issue.
- On Larches, the emergency adrenaline was not stored where it should have been, this would have made it difficult to find if staff had needed to use.
- Not all portable electrical equipment had been tested to check that it was safe to use. We saw that this was not in line with the provider's maintenance policy.

However:

- Staff ensured individual patients' risk assessments were up to date and reviewed regularly. Risk assessments were thorough, individualised, and covered relevant risks.
- Clinic rooms were well equipped and clean and staff checked emergency resuscitation equipment and recorded when they had done this.
- The wards were visibly clean and tidy. Cleaning took place and staff recorded when this had been completed. Staff audited mattresses and took action to replace mattresses when necessary.
- There were enough trained staff to carry out physical interventions and all staff including bank and agency staff were trained in carrying out restraint.

Are services effective?

Requires improvement

We rated effective as requires improvement:

Summary of this inspection

- Supervision and appraisals did not always take place. There had been an improvement in appraisal compliance. However, on Rudyard ward only two members of staff had been supervised, the provider said they thought this was approximately 10% of staff and only 45% of staff had received an
- All patients had a care plan but on High Ash and Horton these did not always demonstrate a recovery focus or that they were person centred. Staff had not consistently evidenced that evident that the patients' preferences had been considered.
- Staff meetings should have taken place once every three months in each clinical area to meet the local standard. However, this had not happened. On Horton, team meetings had not taken place in the last six months and on High Ash, there had been one team meeting take place in the last six months. The other three wards had held regular meetings. Team meetings did not have a set agenda to ensure specific issues were communicated hospital wide and there were no action points from these meetings.
- At our last inspection, we identified that staff had not completed dementia training; on Rudyard, the majority of patients had dementia. Since our last inspection, 37% of staff had completed this training.

However:

- Staff managed patients' physical health well. Many patients at the hospital had complex physical health needs. There was a GP that the provider commissioned who regularly reviewed and monitored patients' health. Patients saw specialists when required and staff supported patients to live healthier lives.
- Mental Health Act paperwork was stored correctly and regularly audited. The Mental Health Act manager supported staff with implementation of the Mental Health Act and provided the wards with up to date policies concerning the Mental Health Act.
- Clinical staff completed audits these included medicines and prescribing audits and audits of the environment and infection control.
- Staff received a thorough induction. All staff received mandatory training on induction and had time to shadow staff on the ward before they started to work. Health care assistants completed training in line with the care certificate standards.

Are services caring?

We rated caring as good because:

Good

Summary of this inspection

- We saw positive interactions from staff towards patients. We saw staff having a good rapport and being kind and sensitive to patients' needs. Patients told us staff were respectful and maintained their privacy.
- Staff had a good understanding of patients' needs and preferences and were focused on positive outcomes for patients.
- Patients had access to advocacy and the Independent Mental Health Advocates told us that staff made regular referrals to them.
- Carers and family members were positive about the care of their loved ones. There was evidence that carers were involved in treatment decisions and invited to meetings. Carers told us that staff communicated about their loved one's progress.

However:

- Active involvement in care planning was not always evident. There was not always evidence that patients received a copy of their care plan.
- There were patient meetings where patients could give feedback about the service, but these did not always take place regularly and there were no action points from these meetings.

Are services responsive?

Good

We rated responsive as good because:

- Patients were able to personalise their bedrooms and the staff actively supported this. Patients were able to store their belongings securely and if appropriate could have access to a safe in their rooms. Overall patients and carers were happy that belongings were safe.
- Patients had access to outside space. John Munroe hospital was set in large and well looked after grounds.
- The hospital worked closely with a local church, patients could attend church services at the hospital or if appropriate at the local church. Staff ensured that they met patients' spiritual and cultural needs.
- There had been a low level of complaints to the hospital, staff understood the complaints process and supported patients if they wanted to complain. Patients and carers knew how to make a complaint and felt confident to do so.

Summary of this inspection

- The hospital catered adequately for patients with dietary needs. The catering staff catered to patients' religious, cultural or personal food choices. We saw examples of this during our inspection. Most patients were happy with food choices.

However:

- Staff did not think there was enough access to activities for patients. We did not consistently see activity taking place on all wards. We did see some good examples of patients engaging in activities. However, it was not possible for us to assess whether there was enough activity for patients to aid their recovery and rehabilitation because the provider did not keep accessible and comprehensive records of activity levels for individual patients.
- Information displayed for patients was limited. It was not always in an accessible format suitable for patients to easily read and understand. Menus were not displayed on the wards, we had identified this as an issue at our last inspection.
- Rudyard ward was not an ideal environment for patients with dementia. Some improvements had been made since our last inspection however, corridors were narrow and there were limited aids for patients with mobility problems. The lounge was small and could be noisy and this could potentially increase patients' levels of distress. However, the provider did have plans in place to move the ward to a different area of the hospital.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The hospital did not ensure that staff received feedback from incidents, complaints and service user feedback. There was little evidence that learning was shared directly with staff at individual supervision or at team meetings or handovers. Where the hospital had tried to improve this with a learning lessons folder introduced in December 2017, the ward staff were unaware of this. This initiative was not well known among staff. Staff did not always share information about incidents with patient's family or carers.
- The ligature risk reduction policy for the hospital was out of date and staff were not assessing environmental risks in line with policy.
- Most staff did not understand the duty of candour and could not describe to us why it was important.

Summary of this inspection

- Staff did not know the values of the organisation or understand how they were reflected in their team objectives. Staff described a 'disconnect' between the most senior management on the board and the hospital staff.
- The hospital did not provide us with feedback from their most recent staff survey when we requested this. This had been the case at our last inspection. The provider told us that they discounted the feedback from this as only 28% of staff had responded and they did not feel the feedback demonstrated the views of staff from across the organisation.

However:

- Safeguarding procedures were clearly set out and staff understood these. Staff compliance levels for safeguarding training were high at 92%. There was a thorough monitoring and auditing system for both Mental Health Act and Mental Capacity Act procedures.
- Staff mandatory training figures had improved since our last inspection. Staff compliance levels across the hospital was at 92%. Training was well organised and efficiently monitored.
- Staff knew how to whistle blow and said they would do if needed. The provider had appointed to the role of a 'freedom to speak up guardian'. Staff could now raise concerns directly with the guardian.
- Staff were complimentary about how their teams worked together and supported each other. They were positive about the support they received from both the hospital manager and the deputy service manager.

Detailed findings from this inspection

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.

- We reviewed Mental Health Act paperwork and saw staff completed this correctly.
- There was a clear process for monitoring that staff followed to check Mental Health paperwork and the Mental Health Act manager oversaw this.
- There had been an improvement in staff completing Mental Health Act training since out last inspection, 76% of staff had completed this.
- Overall staff had a good understanding of the Mental Health Act and the Code of Practice.
- The Mental Health Act manager carried out thorough and regular audits of Mental Health act paperwork.
- The Mental Health Act manager supported in relation to the Act and ensured staff had access to a full set of up to date policies regarding the Mental Health Act.
- Staff informed patients of their rights regularly and the Mental Health Act monitored this process.
- Staff made regular referrals to the Independent Mental Health Act advocacy service Assist.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There had been an improvement in staff completing Mental Capacity Act training since out last inspection 76% of staff had completed this.
- Staff showed a good understanding of the Mental Capacity Act 2005 and gave examples of how they applied this in their work.
- The provider had an up to date policy on Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff assessed patients' capacity and recorded this appropriately.
- The Mental Health Act manager carried out regular audits of Mental Capacity Act paperwork.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

- The design and layout of Horton ward and Kipling ward meant that there were blind spots and some narrow corridors. Kipling ward was on two levels with bedrooms upstairs. Horton ward had some bedrooms on a lower floor. The provider mitigated blind spots with the use of mirrors and staff positioned themselves in specific areas of the ward. When required, staff increased observations. Larches had clear lines of sight and it was easier for staff to observe the ward. High Ash ward was split between three floors so staff positioned themselves in such a way that they could observe the ward effectively.
- Wards had ligature anchor points and whilst there had been improvement work carried out there were still identified risks. These included taps, showers and window and door handles. A ligature point is anything that patients could attach a cord, rope or other material for the purpose of hanging or strangulation. Staff told us they assessed each patient individually for risk in relation to ligatures and assessed the most suitable environment and level of observation for patients who were at increased risk. All wards had accessible ligature cutters for staff to use.
- The provider had a ligature risk reduction policy. This went out of date in September 2017 and had not yet been updated. The hospital manager said that the clinical governance team were in the process of reviewing this and ligature risk assessments were carried out annually. The policy stated that staff should complete ligature risk assessments quarterly. We observed that staff had not completed a ligature risk assessment on Kipling ward since November 2016. This was now out of date. A patient on Kipling ward had tied a ligature in the last year. We also found that where staff had recorded individual patient risks these were not always up to date. For example, when a patient had been discharged from a ward or a new patient had come onto the ward the information about the patient's individual risk had not always updated on the ligature risk assessment. The ligature risk assessment was a working document but we did not find an up to date copy on High Ash ward. When we asked to see this, we found it was in the main hospital, this meant staff could not easily refer to it. On Horton ward, we observed that a shower room that should have been locked due to ligature risk had been left open.
- On Horton ward we saw that the external door to the staff area outside the ward did not close properly. Staff told us this was an on-going issue. Later in the day, we observed that both this door and the door to the ward were open. This meant that patients could have easily left the ward area. The hospital manager dealt with this immediately and contacted maintenance about the doors not closing properly, who resolved the issue.
- High Ash and Kipling were female wards; Larches and Horton were male wards. On Kipling ward, there were three bedrooms where there was not a toilet in the room and the patients in these rooms had to go onto Rudyard ward to use the toilet. In order to do this

females passed a male patient's rom at the end of a corridor. However, because the door to this ward was locked, a staff member was always with the female patient when they were escorted through.

- Horton and Kipling wards had well equipped clinic rooms. High Ash and Larches did not have clinic rooms. On these two wards, patients' medication and emergency equipment was kept in the nursing office and staff and patients could use the clinic rooms in the main hospital if needed. The clinic rooms were clean and well organised. There was a defibrillator in the main hospital and a second defibrillator shared between High Ash and Larches. The provider had not carried out a drill to establish how long it would take to access a defibrillator for the different wards; however, our inspection team was satisfied that this could be done quickly.
- The wards did not have seclusion rooms. Staff did not practice seclusion.
- All wards were visibly clean. We observed that there had been improvements made to the environment on Horton ward and that painting had taken place throughout the hospital. On Horton ward there was still some woodwork that was scratched and needed painting. Overall, the provider ensured the wards were well maintained although we did observe that on Kipling ward there was some old furniture that was visibly torn.
- There were hand sanitisers throughout the wards and in addition to this staff could carry alcohol gel. There were hand washing guidance posters in areas where patients and staff washed their hands. Staff completed infection control audits; managers reviewed these in clinical governance meetings.
- Clinical equipment was clean and well maintained; this had improved since our last inspection. The wards had access to emergency resuscitation equipment. This was checked regularly on all wards to ensure that equipment was safe to use. Staff checked this equipment three times per week and recorded that they had done this. This had been improved since our last inspection. Wards had access to calibrated equipment, this was working properly and included blood pressure monitors and weighing scales.
- Electrical equipment had not always had a portable appliances test (PAT). We observed several items that had not been PAT tested including radios, a television and electric radiators on Kipling ward. This was not in line with the provider's maintenance policy.
- We reviewed cleaning schedules. Cleaning staff updated these daily and they indicated that cleaning had taken place. The cleaning supervisor reviewed these records.
- The infection control leads for each ward audited mattresses. We reviewed mattress audits and saw that these took place monthly and that staff had identified relevant actions, including replacing mattresses and that these had been completed. This had improved since our last inspection
- Environmental risk assessments took place including health and safety risk assessments.
- All bedrooms had a nurse call system. We observed that all staff wore an alarm; staff also used radios so that they could speak to staff if they needed assistance.

Safe staffing

- Day shifts started at 7.15am, and night shifts started at 7.45pm.
- Vacancy levels had been high in the four months prior to our inspection. Kipling ward had a total vacancy rate of 20%, High Ash 17%, Larches 17% and Horton 15%.
- Establishment levels were for 1.9 whole time equivalent nurses (WTE) and 10.5 WTE health care assistants on Kipling ward during the daytime. There were 0.6 WTE nursing vacancies and five health care assistant vacancies. In addition to this, Kipling ward shared staff with Rudyard ward at night. The two wards shared 2.5 WTE nurses and 19 health care assistants. There were no nursing vacancies and 2.6 WTE health care assistant vacancies at the time of inspection.
- Establishment levels were 4.75 WTE nurses and twenty-eight whole time equivalent health care assistants on Horton ward to work across day-time and night-time shifts. There were vacancies of 0.75 WTE for nurses and 3.2 WTE for health care assistants at the time of inspection.
- Establishment levels were 4.85 WTE nurses and 21 WTE health care assistants at High Ash and Larches. There were 0.15 WTE nursing vacancies and 5.4 WTE health care assistants at the time of inspection.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Sickness levels were at 3.27% on average across the wards since November 2016. Sickness levels were low; however, staff said the impact of any sickness was significant as there were a number of bank and agency staff working on the wards.
- Staff turnover was high; there had been 34 staff leave, the wards throughout the year prior to inspection. The highest number of staff had left Horton ward. The reasons for a high level of staff turnover varied. Staff told us that people moved on to develop their careers, some staff had gone to do their nurse training. However, whilst nurses had seen their terms and conditions improve, health care assistants had not and some staff told us that people left for improved salaries.
- Bank and agency staff had worked on 324 daytime shifts on Kipling ward in the last three months, there had been a further 735 night time shifts covered by bank and agency staff on both Rudyard and Kipling ward. On Horton ward, 813 shifts had been covered by bank and agency, both daytime and night time On High Ash and Larches 778 shifts had been covered both daytime and night time.
- The provider followed the Telford model in applying professional judgement to assess how many staff and what grades were required on the wards. The Telford model is a recognised model for assessing safe staffing levels. There was a minimum ratio of one member of staff for three patients on day shifts and one member of staff for four patients on night shifts. There were more staff on the ward than this as additional staff were requested for enhanced observations and one to one care.
- The provider had recently recruited nurses. In the interim bank and agency nurses had been used, although the hospital favoured using bank staff for consistency. Nurses completed an induction and mandatory training that included training in the management of actual or potential aggression (MAPA.) There was a good supply of bank and agency nurses. When there were shortages of 'in house' trained bank and agency staff the hospital did on occasion use external agency nurses.
- The use of bank and agency staff over the three months prior to our inspection was high. The hospital were working to recruit staff and had recently made significant improvements to the terms and conditions that they could offer nurses. The hospital planned to recruit non-qualified staff from other countries in Europe to reduce their vacancies. There was a plan to implement a performance related pay programme for all staff. The provider hoped this would serve as an incentive to improve recruitment and retention.
- Bank and agency staff were familiar with the ward. There were several examples of staff that changed from permanent roles to bank and agency who knew the job and wards well.
- The nurses in charge, managers and qualified nurses told us that they could bring in extra staff when required if there was additional clinical need on the ward.
- There was one registered nurse on both Horton and Kipling ward in the daytime although at night one registered nurse was shared across Kipling and Rudyard. At Larches and High Ash there was one registered nurse who worked across both wards. Now that the provider had completed recruitment, the hospital manager explained that there would be more support available for the nurse in charge so that they could have more time way from ward duties to carry out other tasks such as facilitating team meetings, supervision and appraisals.
- Nurses told us that they tried hard to ensure patients had one to one time with their named nurse but that this was sometimes difficult as until recently there had been less staff.
- There were enhanced one to one levels in place for several patients; however, we did not always see staff offering meaningful activity and engagement when this was taking place.
- Staff and patients consistently told us that activities and leave from the ward were rarely cancelled due to staff shortages. We observed patients going off the ward for leave. Leave records indicated that patients regularly took part in recreational leave.
- There were sufficient staff to carry out physical interventions and all staff including bank and agency staff had completed training in restraint using MAPA (management of actual or potential aggression.)
- There was effective medical cover. Three doctors worked across the wards throughout the week between 9am and 5pm. In addition, these doctors had a rota system that provided emergency cover out of hours. Doctors could access patient electronic care records from home and could respond within 45 minutes if staff contacted them out of hours.
- Mandatory training compliance levels had improved since our last inspection. The provider had a dedicated

training lead who worked to ensure that the provider met staff training needs. There was a comprehensive training planning calendar for the service. Across the whole hospital, 97% of staff had completed MAPA training, 83.3% of staff had completed personal safety training and 93.9% had completed in house training, this included infection control, basic life support, manual handling, health and safety, equality and diversity, risk assessing and fire awareness. In total 81.5% of staff had competed their food safety training. Food safety training was lower High Ash; 52.9% and Kipling; 72.7%. There was a plan in place for the provider to offer food safety training monthly so that staff could complete this.

Assessing and managing risk to patients and staff

- The service did not use seclusion. There was no seclusion room. There had been no recent cases of long-term segregation.
- In the six months prior to our inspection there had been 29 incidents of restraint on Horton for seven patients, 53 on Kipling for nine patients, 10 on High Ash for two patients and none on Larches.
- There had been no incidents of prone restraint used on the wards.
- We looked at 25 care records in the course of our inspection. We looked at risk assessments and risk management plans. We saw that staff undertook a risk assessment of every patient at admission and that these were updated regularly, following incidents and at reviews. Of the 25 risk assessments we looked at 23 were up to date. Staff ensured they completed detailed risk assessments and management plans and we saw good practice, for example; including carer's opinions and patient views. Risk assessments were individualised and covered risk to self and others, physical health risk, risk of self-neglect, vulnerability and quality of life.
- We saw that staff had removed some blanket restrictions we had observed on our last inspection. Patients were able to keep food in their room unless there was a specific reason that had been care planned for them not to. Patients could make their own drinks and snacks although staff locked risky items to do this away and patients had to ask staff to unlock cupboards to access these.
- We saw that a blanket restriction was in operation on Kipling ward. The staff kept the ward toilet locked. There were no toilets that patients could access without asking staff for permission to unlock doors. Staff explained this was because there were three patients on the ward who had specific physical health or behavioural reasons that meant they could not access the toilet freely. However, this adversely affected the other eight patients who were also unable to access the toilet. Individual care plans did not describe why this was required for all patients. We observed a patient waiting for the door to be unlocked who was in discomfort. We also saw team meeting minutes from the ward that stated that some staff had refused patients access to the toilet if they had just been to the toilet. In this team meeting, the nurse in charge had reminded staff that patients could request to go to the toilet again even if they had just been recently.
- Informal patients could leave the wards at will. There were signs on the wards explaining the rights of informal patients and that they should ask staff if they wished to leave the ward.
- There were policies and procedures for the use of observation and we saw staff carrying out enhanced observations on the wards throughout our inspection. The rota for carrying out observations meant staff were changed over regularly. Although some staff on Horton ward said that two hours was too long for them to carry out observations and they wanted this time to be reduced. There was a search policy; staff only completed searches when there were specific concerns identified in relation to individual patients.
- Staff only used restraint as a last resort. Staff were trained in MAPA (Management of Actual or Potential Aggression) however they did not use this unless they had attempted less restrictive interventions including de-escalation or redirection. Positive behaviour support plans were in place. Staff demonstrated a good understanding of patients and care records demonstrated understanding of triggers for potential aggression and management strategies. We saw team meeting minutes from Kipling ward were there was an example of incorrect MAPA techniques discussed by the team, staff had been asked to correct this, as the practice used was restrictive.
- The provider had a rapid tranquilisation policy and this reflected the most recent National Institute for Health

and Care Excellence guideline set out in May 2015. This provider had updated this since our last inspection. There had been no use of rapid tranquillisation in the six months before our inspection.

- Staff were able to describe how they would identify safeguarding issues and were able to explain the process they would follow, giving examples in some cases of when this had been done. At the time of our inspection, 91% of staff had completed adult safeguarding training. The deputy hospital manager offered this training; the training had been approved by the local authority as a level one training course. The deputy manager was the hospital safeguarding lead. The safeguarding lead reviewed all safeguarding incidents and referred safeguarding concerns to the local authority. There were 19 safeguarding alerts raised between January 2017 and January 2018. The provider notified the CQC of safeguarding incidents.
- We saw some evidence of good medicines management practice. A commissioned pharmacist came to monitor and audit medicines related activity on each ward. We saw correct protocols for the administration and reviews of pro re nata (PRN) medication. Overall medicines were well organised and stored safely. However, we saw on High Ash that on occasion, the room temperature had gone above the recommended temperature for safe storage of medication and no action was taken following this. There was no guidance for staff on High Ash to say what staff should do they should do if temperatures went outside of the recommended temperature, this was however in place on the other three wards. On Larches ward, we observed there was a sign indicating where the emergency adrenaline was stored but it was not where it should have been and the nurse was unsure where to find it.
- Staff carried out falls assessments and assessed pressure ulcer risks using the Waterlow pressure ulcer risk calculator. We saw evidence of staff using this in care records.
- Children were able to access a visitors' room in the reception area and this was individually risk assessed for suitability.

Track record on safety

- There had been one serious incident in the last 12 months. This had taken place on Kipling ward. This was an unexpected death. The provider notified the CQC of the event and followed correct procedures after the event.
- We reviewed the last six sets of clinical governance minutes and saw that managers and senior clinicians discussed serious incidents at these meetings and incidents were a standing agenda item.

Reporting incidents and learning from when things go wrong

- Staff told us that they reported incidents; they knew how to do this and what they should report. We checked the incident-reporting book on Horton ward for incidents staff had told us about and staff had reported these. There was an internal database where staff logged incidents. The clinical governance group monitored this to ensure that they identified any themes or trends.
- The incident log for the hospital demonstrated that staff had reported 85 incidents across the four wards, between August 2017 and January 2017. The three most common incidents reported were for physical aggression, verbal abuse and assaults.
- There was a duty of candour policy. However, most staff did not understand what the duty of candour was.
- Staff told us that they did not consistently receive feedback from incidents. There was a learning lessons file on each ward. However, managers had introduced in December 2017 so it had not yet become a tool to share learning. We asked eleven members of staff specifically about feedback from incidents. Seven staff said that they did not receive feedback; four said this did take place sometimes.
- Where staff did receive feedback this took place in handovers, but staff said this did not consistently take place. Staff did not take minutes at handover meetings; therefore, it was not possible to evidence that learning or feedback had taken place. However, on Horton ward, we saw that the staff nurse had spoken to the ward staff about recent medicine errors. One member of staff said incidents that took place on other wards were heard about informally, another member of staff said that if they did bank shifts then sometimes they heard about

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

incidents that had taken place on other wards. We reviewed team meeting minutes; learning from incidents was not discussed and it was not a standing agenda item.

- We spoke to the pharmacist who was commissioned by the service who told us that he had not been made aware of two recent medicine errors. Staff had not discussed these errors with the patients concerned as they lacked capacity to understand. However, the service had not contacted their families to inform them either.
- Staff could not provide examples of how changes had been made in a response to feedback from incidents.
- Staff said they received a debrief after incidents took place and sometimes patients did. Overall staff spoke highly of the support they had received from their managers and gave examples of when this had happened.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Care records indicated that staff completed comprehensive and timely assessments for all patients. Staff started this process after referral and before patients came on to the ward to assess whether their needs could be met by the hospital. Staff completed this process after admission.
- Care records demonstrated that a physical assessment took place on admission. The service worked closely with the local GP who attended the service on a weekly basis. A practice nurse also supported the GP. The GP saw patients when required, but at a minimum of every 12 weeks if there were no specific health issues. Staff completed and recorded physical health monitoring. We saw evidence of this in patients' care records. Staff used Modified Early Warning scores (MEWS) to monitor patients' vital signs.
- We reviewed 25 care plans. All patients had a care plan in place and all but one of these was up to date. Care plans were detailed, thorough, and holistic. Staff updated these regularly. We saw 16 care plans that were person centred. Of the other care plans staff did not always ensure that the patients' views were clearly recorded. We saw examples of care plans where progress was demonstrated and we saw care plans that reflected all the needs identified in assessments. Not all care plans however were recovery focused. We saw eight care plans where staff had not recorded patients' strengths and goals.
- There were both paper records and electronic records. Records were well organised and accessible. However, there was information stored in several places. Staff recorded daily care records on an electronic system, some activity records were kept on an electronic shared drive. A paper file contained archived information and another paper file 'working folder' contained care plans, risk assessments, physical health plans, information about activities, therapies, Mental Health Act, and Mental Capacity Act documentation. All health care assistants could access all records, although only the senior health care assistants, clinical practitioners and nurses could make records. In addition to these records, each ward had a folder with an information summary sheet with a photo of each patient and a summary of their needs and care. This meant temporary staff had quick access to information and patients could carry these with them if they went to hospital for physical health care.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication in relation to psychosis and schizophrenia: prevention and management of in adults (clinical guidance 178).There was evidence that doctors ensured that nearly all patients were prescribed within British National Formulary limits for anti-psychotic medication. Where this did not take place there was clear rationale for this in a high dose antipsychotic treatment plan.
- The psychologist offered psychological interventions to support patient's recovery. There was one 0.8 whole time equivalent psychologist and a whole time assistant who worked across John Munroe hospital and Edith Shaw hospital; there were 71 patients over the two hospitals. There had been an art therapist in post at the time of our last inspection but there had been a decision not to recruit to this post. However, a music

therapist was at the hospital one day a week. Nine patients in the hospital were involved in individual psychological therapy, the psychologist was assessing four patients and four were waiting for treatment. At the time of our inspection, the majority of patients were not engaged in psychological therapies.

- Staff said there was a shortage of appropriate space for therapy and there was a plan to change the sensory room into a staff room, however. The hospital manager told us that the sensory room needed to be relocated from its current site to the main hospital building.
- The psychology staff provided psychological assessment, formulation and interventions. They used standardised rating scales. The psychology staff did not currently offer a group programme at present. They were able to offer cognitive behaviour therapy (CBT), schema focused therapy, acceptance and commitment therapy (ACT) and eye movement desensitisation and reprocessing therapy (EMDR). Psychology staff supported other hospital staff in their communication with and approach to patients.
- Patients had access to physical health care through the GP who attended the service. Patients who were more independent went to the local surgery if they preferred. We saw staff responding to the needs of diabetic patients in a safe and responsive way and there were many examples of complex and chronic health problems being well cared for. Patients saw specialists such as oncologists and diabetic nurses when required. The GP ensured screening for breast, bowel and prostate cancer was carried out for appropriate patients. All patients had annual blood tests. Staff ensured that patients prescribed anti-psychotics were monitored effectively. Staff offered patients advice and support in relation to healthy life styles including weight loss and smoking cessation. Care notes demonstrated that patients had access to dental care.
- Staff assessed and met patient's nutrition and hydration needs using a recognised tool, the Malnutrition Universal Screening Tool (MUST).
- Staff used recognised rating scales to assess and monitor outcomes including the Health of the Nation Outcome Scales (HONOS) to identify suitable care pathways and assess progress.
- A range of audits took place and clinical staff took part in these. There were audits of infection control. The visiting pharmacist carried out monthly audits of medication. A doctor had audited the use of rapid tranquilisation.

Skilled staff to deliver care

- There was a range of disciplines working with patients in the core service. There were doctors, nurses, health care assistants, clinical practitioners, a psychologist and assistant, two activities workers, a music therapist, who worked one day a week and occupational therapist and occupational technicians. In addition to this, the service commissioned a GP and a local pharmacist.
- Registered nurses held a mental health or learning disabilities nursing qualification. There were two nurses who held a general nursing qualification. The psychiatrists' special interests included complex female patients and older adults. However, staff did not receive specific training about rehabilitation and recovery.
- Staff received an appropriate induction. Induction was two weeks long; it included mandatory training comprising of understanding your role, food safety, fire, infection control, positive behaviour support, values, privacy and dignity, basic mental, equality and diversity health problems, risk assessment, Mental Health Act and Mental Capacity Act. All staff competed five days MAPA training. We spoke to staff who had recently completed an induction and they said they were given time to shadow staff on the ward before they started in their new role. Health care assistants completed training in line with the care certificate standards.
- We spoke to staff about their experience of supervision. We asked eight staff specifically about the supervision that they received. Six staff told us that they did not receive supervision in line with policy. They told us supervision was infrequent. Two staff said they were supervised every six months. We reviewed the supervision policy and supervision records. The policy stated that staff should receive supervision every three months. We looked at 14 records from across the service and saw that 50% of staff had received regular supervision. Prior to the inspection, the provider gave us supervision data that indicated that clinical supervision compliance was at 85% across the service for the previous 12 months. Our inspection finding did not reflect this figure and so we asked the provider to check

this. The final data suggested that overall supervision was at 86%. Data demonstrated that supervision was highest on Kipling ward. During our inspection, we also noted this to be the case.

- Some staff told us in addition to supervision that they had attended reflective practice sessions and the psychologist facilitated these. The psychologist was keen to ensure that these happened regularly in the future but currently these did not take place regularly. The provider included reflective practice sessions as supervision when collating data for High Ash.
- Staff told us that team meetings did not happen regularly and this was because it there had not been enough nursing staff to facilitate these meetings. A member of staff said that they were required to attend meetings after their shift, in their own time, even when this was not convenient. We checked with the hospital manager who said team meetings should happen on a quarterly basis and that this was taking place. We requested minutes from team meetings for each of the wards for the last six months. We saw that team meetings had taken place on Kipling ward for day staff in October 2017 and January 2018. Night staff meetings had taken place in October 2017 and December 2017, no meetings had taken place on Horton ward for day staff and on High Ash, there had been one team meeting that had taken place in a six-month period. At team meetings, staff discussed concerns about the ward. There was no standard agenda, no minutes were reviewed from the previous meeting and there were no clear action points.
- The hospital provided us with information about staff appraisals prior to our inspection. On Horton ward, 31.9 % of staff had received an appraisal; on Kipling ward 86%, High Ash ward 61.5% and Larches ward 88.8%. This was an overall figure of 67%. We had identified this as an issue at our last inspection, but this compliance rate had increased by only 7%. The hospital refreshed this data and this suggested that appraisal compliance improved after we had announced our inspection. The overall figure was 90%
- Staff completed training for their role in the mandatory training programme. In addition to this, the provider had made dementia-training part of their mandatory training. This was an in-depth distance-learning course. Some staff had already completed dementia training.
- There was an opportunity for staff to complete leadership training. The psychologist provided training in eating disorders, personality disorders and dissociative disorder. The provider supported staff with learning needs to help them to complete training. The Mental Health Act manager had completed training in mental health law.
- Managers gave us examples of how they had managed poor staff performance both formally and informally. There were no formal performance management issues at the time of our inspection. Issues with staff behaviour were recorded as having being discussed in minutes from a team meeting on Kipling ward. There had been seven staff suspended across the whole of the hospital between November 2016 and October 2017. The reasons for suspensions involved inappropriate conduct by staff towards patients and managers and staff falling asleep on duty.

Multidisciplinary and inter-agency team work

- There were regular multidisciplinary meetings (MDT), these were open for all staff to attend and they took place regularly, patients were encouraged to attend these meetings. We observed an MDT on Kipling ward and we saw that a doctor, occupational therapist, activities worker and psychologist attended the meeting. We observed a holistic discussion covering the patient's family relationships, observations, fluid and food intake, achievement, their physical and mental health including triggers. The discussion was sensitive to the patient's needs and explored all options before the group made clinical decisions.
- There were effective handovers that took place twice a day and staff discussed the presentation of each patient. The nurse in charge led staff handovers and all staff on shift attended these. There were handover files on the wards in which staff recorded details of the patients' presentation.
- The staff had good relationships with the GP that the hospital commissioned. The managers had good relationships with the local safeguarding board and advocacy service. Care Plan Approach meetings took place and care coordinators and external professionals attended these.

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- There was a clear process for monitoring and checking Mental Health Act paperwork. Qualified staff received and checked all Mental Health Act paperwork. The Mental Health Act manager then reviewed these documents.
- Staff knew that that they could contact the Mental Health Act administrator. The administrator provided support with all elements of the Mental Health act including renewals and tribunals. The ward staff knew when important dates were for patients concerning their detention.
- Each ward had a folder that contained documentation relating to patients' leave from the ward. Staff followed a clear process in relation to leave and patients received a copy of their leave paperwork.
- Mental Health Act training took place and across the hospital, 76% of staff had completed this. This had improved since our last inspection in November 2016 by 25%.
- Overall staff demonstrated understanding of the Mental Health Act and the Mental Health Act code of practice.
- Staff attached consent to treatment and capacity forms to medication charts of detained patients. This meant staff could check that the medicines that nurses administered were authorised.
- The Mental Health Act manager gave support and advice to staff when they required this. There was also a folder with all relevant up to date policies concerning the Mental Health Act.
- Care records showed that patients had their rights given to them regularly. This happened on a monthly basis and there was a file kept detailing that this had taken place.
- We reviewed Mental Health Act paperwork and saw that staff completed this correctly. Copies of paperwork were stored in patients' files. Original copies were stored securely in at the hospital headquarters.
- The Mental Health Act manager carried out regular audits of Mental Health Act paperwork including patients' leave paperwork. The Mental Health Act manager created action plans where issues had been identified through audits.
- Patients had access to the Independent Mental Health Act advocacy service. This service was provided by Assist advocacy. We spoke to Assist who told us that they regularly supported patients from the hospital. The advocacy service visited the hospital when patients required their support.

Good practice in applying the Mental Capacity Act

- Staff completed Mental Capacity Act and Deprivation of Liberty Safeguarding training, 76% of staff had completed this across the hospital.
- There had been two Deprivation of Liberty Safeguarding applications made in the last six months.
- Staff showed a good understanding of the Mental Capacity Act (2005) and the five guiding principles. Staff could give examples of how they applied the act to their work. Staff assumed capacity unless there was a specific reason not to and demonstrated they understood capacity to consent.
- The provider had an up to date policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew where to get advice regarding the Act.
- We saw evidence of patients' capacity assessments in patient files and this related to specific decisions. Staff gave us examples of how they supported patients to make their own decisions wherever possible Staff worked with families and other professionals to ensure that where the patent lacked capacity decisions were made that took into account the patient's wishes, feelings, culture and interests.
- Staff demonstrated that they understood the Mental Capacity Act definition of restraint
- The Mental Health Act manager provided staff with support regarding the Mental Capacity Act
- The Mental Health Act manager carried out regular audits of Mental Capacity Act paperwork and suggested relevant actions from these.

Assessment of needs and planning of care

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Long stay/rehabilitation mental health wards for working age adults

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Long stay/rehabilitation mental health wards for working age adults

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- Staff completed training for their role in the mandatory training programme. In addition to this, the provider had made dementia-training part of their mandatory training. This was an in-depth distance-learning course. Some staff had already completed dementia training.
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- There were effective handovers that took place twice a day and staff discussed the presentation of each patient. The nurse in charge led staff handovers and all staff on shift attended these. There were handover files on the wards in which staff recorded details of the patients' presentation.
- The staff had good relationships with the GP that the hospital commissioned. The managers had good relationships with the local safeguarding board and advocacy service. Care Plan Approach meetings took place and care coordinators and external professionals attended these.

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

- There was a clear process for monitoring and checking Mental Health Act paperwork. Qualified staff received and checked all Mental Health Act paperwork. The Mental Health Act manager then reviewed these documents.
- Staff knew that that they could contact the Mental Health Act administrator. The administrator provided support with all elements of the Mental Health act including renewals and tribunals. The ward staff knew when important dates were for patients concerning their detention.
- Each ward had a folder that contained documentation relating to patients' leave from the ward. Staff followed a clear process in relation to leave and patients received a copy of their leave paperwork.
- Mental Health Act training took place and across the hospital, 76% of staff had completed this. This had improved since our last inspection in November 2016 by 25%.
- Overall staff demonstrated understanding of the Mental Health Act and the Mental Health Act code of practice.
- Staff attached consent to treatment and capacity forms to medication charts of detained patients. This meant staff could check that the medicines that nurses administered were authorised.
- The Mental Health Act manager gave support and advice to staff when they required this. There was also a folder with all relevant up to date policies concerning the Mental Health Act.
- Care records showed that patients had their rights given to them regularly. This happened on a monthly basis and there was a file kept detailing that this had taken place.
- We reviewed Mental Health Act paperwork and saw that staff completed this correctly. Copies of paperwork were stored in patients' files. Original copies were stored securely in at the hospital headquarters.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The Mental Health Act manager carried out regular audits of Mental Health Act paperwork including patients' leave paperwork. The Mental Health Act manager created action plans where issues had been identified through audits.
- Patients had access to the Independent Mental Health Act advocacy service. This service was provided by Assist advocacy. We spoke to Assist who told us that they regularly supported patients from the hospital. The advocacy service visited the hospital when patients required their support.

Good practice in applying the Mental Capacity Act

- Staff completed Mental Capacity Act and Deprivation of Liberty Safeguarding training, 76% of staff had completed this across the hospital.
- There had been two Deprivation of Liberty Safeguarding applications made in the last six months.
- Staff showed a good understanding of the Mental Capacity Act (2005) and the five guiding principles. Staff could give examples of how they applied the act to their work. Staff assumed capacity unless there was a specific reason not to and demonstrated they understood capacity to consent.
- The provider had an up to date policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew where to get advice regarding the Act.
- We saw evidence of patients' capacity assessments in patient files and this related to specific decisions. Staff gave us examples of how they supported patients to make their own decisions wherever possible Staff worked with families and other professionals to ensure that where the patent lacked capacity decisions were made that took into account the patient's wishes, feelings, culture and interests.
- Staff demonstrated that they understood the Mental Capacity Act definition of restraint
- The Mental Health Act manager provided staff with support regarding the Mental Capacity Act
- The Mental Health Act manager carried out regular audits of Mental Capacity Act paperwork and suggested relevant actions from these.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

- We observed positive interactions between patients and staff. We saw that staff interacted with patients in a kind and respectful way. On all wards we observed staff having a good rapport with patients whilst being sensitive to their needs. We observed that staff on Kipling ward supported patients to maintain independence.
- Patients overall were positive about staff. They told us that staff were supportive and kind and that they respected their privacy; knocking on their door before they entered their room. Patients said staff were respectful, polite and supportive. Some patients said that they felt that there were too many staff changes and this could affect the quality of their care.
- When we spoke to staff, they demonstrated that they understood individual patient's needs, and were motivated to see good outcomes for patients. Staff were knowledgeable about the specific health needs of their patients, what kind of activities they liked to partake in and their likes and dislikes.

The involvement of people in the care they receive

- Each ward had an information pack that they gave to patients when they were admitted to the ward. This information pack included information about making a complaint, patient's rights and advocacy as well as information about the care and treatment provided at the hospital.
- Active involvement in care planning was seen in some cases, in that the patients' voice could clearly be heard in some care plans. It was not clear however that patients always received a copy of their care plan. Five of the ten patients we spoke to could remember being offered a copy of their care plan.
- Patients had access to advocacy. An independent mental health advocate (IMHA) who was based in the local area supported patients. We spoke to the advocacy service who told us that they received regular referrals from the hospital.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- We spoke to carers and family members who were all positive about the care of their loved ones. They told us staff invited them to meetings about their family member's care plan and that staff communicated with them about their progress. Carers overall were happy with how staff interacted with them and said that they were able to give feedback about the service. Some carers told us that they had been involved in care planning and had a copy of their family members care plan. Two carers told us that there was no carers group. The provider explained they had tried to start a carers group in the past but that because patients came from a large geographical area this was not successful due to low levels of attendance.
- There were patient meetings where patients could give feedback about the service. These took place on the ward; staff told us that they should take place monthly. However, when we looked at minutes from patient meetings we saw that they did not always take place frequently. For example, the last meeting on Larches took place in October 2017 and on Horton ward in September 2017. However, they were well attended by patients and there was a set agenda including aspects of care that affected patients including activities menus and environment. The minutes from the meeting lacked detail and did not highlight any action points.
- We saw that some patients had advance decisions in place. Some patients had a 'do not attempt to resuscitate' (DNAR) decision recorded.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The hospital did not have a formal recovery focused and rehabilitative model of care. However, the medical director presented a new model that the hospital wanted to implement. The model focused on individual patient's needs with an emphasis on patient's recovery, attachment and meaning.
- Average bed occupancy was 100% throughout the hospital.
- Most patients came from outside of the local area.
- Staff told us that patients' always had a bed when they returned from leave.
- Staff only moved patients between wards and rooms for clinical reasons. For example, patients were sometimes stepped down to Larches and High Ash from wards in the main hospital.
- The hospital did not report any delayed discharges. The average length of stay for Kipling was 185 days Horton was 137 days, High Ash was 368 days and Larches was 199 days. Most patients moved to community placements and we saw examples of this taking place. There were occasional transfers to acute hospital beds or psychiatric intensive care units. Some patients stepped down from the main hospital wards to Larches ward and High Ash wards.
- Discharges took place in normal working hours. When staff discharged patients, they planned this well and in advance and discharged patients at an appropriate time of day.
- At the time of our inspection there were four patients waiting for psychological therapies.

The facilities promote recovery, comfort, dignity and confidentiality

- Kipling ward was located in the main hospital and was a single sex ward with a lounge, dining room and clinic room. Kipling had 13 bedrooms and some of these were ensuite. Horton ward had 16 bedrooms, it was also in the main hospital and had a lounge and dining area and some bedrooms were ensuite. The self-contained bungalows at High Ash for seven female patents and Larches for six male patients had communal lounge, dinning and kitchen areas had enough rooms to support the care and treatment of patients. There were no clinic rooms but staff could see patients in their own rooms if required. Staff told us that there was a shortage of rooms for activities and therapies across the hospital.
- There were no quiet areas on Kipling or Horton. Both these wards had a lounge and dining room. If patients wanted quiet time, they could go their room. There was a quiet room available for patients on High Ash and Larches. Here patients could meet with visitors in communal areas on the ward or use the visitors' room in reception. On Horton, patients were able to see family in

the visitors' room; the provider did not allow visitors on the ward. On Kipling, patients could have visitors in their bedrooms once this had been risk assessed, visitors were not allowed on the ward.

- Patients were able to use their own mobile phones unless there was a specific reason for them not to. Staff told us that patients could use the office phone if they needed to.
- Patients had access to outside space. John Munroe hospital was set in large and well-maintained grounds.
- Most patients were happy with the quality and variety of food offered to them. Two patients complained about food, one said portions were too small and that there was not enough choice. A patient at High Ash said there was only one hot meal a day that the food budget limited choice. At High Ash and Larches wards patients and staff planned, prepared and cooked patients' meals. There were no menus displayed on Kipling and Horton wards so patients had to ask staff what was for dinner. We had identified this as an issue at our last inspection and staff had not improved this.
- Patients had access to drinks and snacks. We observed on Horton ward that items considered to be of risk to patients were locked away, including the kettle. Patients could ask staff if they wanted to access these.
- We saw bedrooms that were personalised and had possessions and photos displayed. On Horton ward, a patient used their walls to draw and paint. The provider supported this and the room was regularly re-painted so that the patient had new space to illustrate.
- Patients were able to lock their rooms and were able to have a safe in their bedroom for their belongings if they wished to. However, one carer said her family member's belongings had gone missing. Overall patients were happy that their belongings were safe.
- The hospital had an activity lead and an activities worker who worked with patients at both John Munro Hospital and Edith Shaw Hospital. The activity workers carried out specific activities with patients in addition to activities that took place on the ward. This included activities at weekends. The hospital had a pet as therapy (PAT) dog who visited for patients. Staff told us that patients valued this.
- On Kipling and Horton wards, we did not see patients involved in activities. On the ward, patients were sat or watching television. On Larches and High Ash wards, patients were involved in activities. On Horton, staff had planned a quiz but this had been postponed. Staff said they would like to see more activities for patients on Horton ward. They explained that there had been some improvements. For example, patients had complained that staff did not have funds to have a drink when they took patients out. Since then the hospital board had agreed for each ward to have a small budget, so that staff could pay for a drink when they took patients out.
- Staff said there was not enough capacity for activity workers and occupational therapists to achieve what they wanted to with patients. We reviewed data that demonstrated that patients had access to activities on the ward, with occupational therapists and with activity workers. However, staff told us that there was no accessible way of monitoring in total how much activity each patient was involved in, as staff did not collectively monitor the different records of activity. This made it difficult for us to assess whether patients could access sufficient activities to aid their recovery and rehabilitation.

Meeting the needs of all people who use the service

- The wards were accessible to patients with disabilities and wheelchair users. There were accessible lifts, toilets and bathrooms throughout the wards.
- There was limited information displayed for patients. On Larches and High Ash wards there was a range of information accessible for patients. However, we did not see information about treatments available. On Horton and Kipling wards, we saw limited information on the wards about advocacy, making a complaint and how to contact the CQC. We did not see leaflets in different languages. However, at the time of inspection there all patients spoke English. The information displayed was not always accessible, for example, the activity schedules were in small type that may have been difficult for patients to read. There were plans for picture boards to be used to describe activities in a more accessible way, but no firm date for this to happen.
- On Kipling ward, we saw a 'memory board'; staff had just introduced this the week before our inspection.
- There was no current need for interpreters or signers; however, there was one member of staff that was trained in British Sign Language level 1 and staff gave examples of how they had accessed interpreters in the past.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- We observed that patients with dietary needs were catered for adequately. We saw patients being offered a vegetarian options and another patient had almond milk for their diet.
- The hospital worked closely with a local church and patients could attend a regular church service held at John Munroe. There were also opportunities for patients to attend the local church. Staff could give examples of how they would support patients with other spiritual beliefs or requirements.

Listening to and learning from concerns and complaints

- The hospital received 11 complaints in the 12 months prior to our inspection. Two of these complaints were upheld and none were referred to the Parliamentary and Health Service Ombudsman. Both of the complaints were in relation to carers and families being able to access the hospital out of hours. In response to this, the hospital had fitted a new buzzer system.
- Overall patients and carers knew how to make a complaint and were confident and comfortable to do so. We reviewed a complaint and saw that feedback had been given to a patient.
- Staff knew how to handle complaints and supported patients to do this if required.
- Staff told us they did not receive feedback from complaints. We reviewed team meeting minutes and did not see that there was an agenda item for complaints or findings to be fed back to staff.

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Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Vision and values

- Staff were unable to tell us the organisational values. Some staff said that they had only been introduced in the last few weeks.
- We spoke to the managing director of the hospital who said he thought that staff understood the values of the organisation and that this came through in the care that staff delivered. Staff however, were unable to tell us how the team objectives reflected the organisational values and objectives.
- Staff knew who the most senior members of the organisation were. Staff talked about a 'disconnect' between the most senior managers on the board and the staff who worked at and managed the hospital. Staff gave mixed responses about whether the board members came regularly to spend time on the wards. The board had introduced board to ward meetings to improve communication with staff. Staff could attend these meetings and we saw that one had taken place in January. We saw that there were completed actions relating to the issues that staff had highlighted.

Good governance

- Staff mandatory training figures had improved since our last inspection. There was a training lead that monitored training and we saw a clear timetable of training for the year ahead. Staff appraisal compliance had improved since we announced our inspection. Managers told us that a low level of permanent nursing staff had impacted negatively on this last year but now that recruitment had taken place improved compliance had been easier to achieve.
- Shifts were covered by enough staff. The wards used bank and agency staff when they needed to and these staff were usually familiar with the ward. Staff told us that there were too many bank and agency staff.
- We observed staff maximised their time completing direct care activities, but there was a lack of meaningful activity on some wards.
- Staff participated in clinical audit, including infection control audits.
- The provider did not have an up to date policy for assessing environmental ligature risks. This was due to be ratified; but had not been at the time of our inspection. Staff did not assess ligature risk in line with policy.
- Most staff told us that they did not receive feedback and therefore learn from incidents and complaints. The consultant psychiatrist reviewed incidents every three months. Incidents, complaints and service user feedback were discussed at clinical governance meetings where managers, doctors and senior managers met. However, these were not systematically

discussed with staff. Also staff did not always share incidents with family and carers. In December 2017 a lessons files had been introduced to the wards, but not all staff were aware of this.

- Safeguarding procedures were clearly set out and followed by staff. Staff compliance levels for safeguarding training were high at 91%. There was a thorough monitoring and auditing system for both Mental Health Act and Mental Capacity Act processes.
- The provider used key performance indicator data to assess the performance of the wards. Ward activity, staffing and daily feedback was reviewed by the managing director. This took place daily.
- The hospital manager had sufficient authority and administrative support for their role.
- The provider had a risk register, this set out risks to the business including external, clinical and reputational risks, and it included contingency plans to maintain the continuity of business. The hospital manager could submit items to the risk register when required.

Leadership, morale and staff engagement

- There had been a staff survey carried out in July 2017. Feedback from staff had been poor. Only 28% of staff completed the survey. The provider said that they did not think that the opinions expressed were a true overall representation of staff opinions. At our last inspection in 2016 feedback from staff for the staff survey was also poor.
- Sickness and absence rates were low at 3.27% however, staff told us sickness was an issue due to already high levels of bank and agency staff.
- Staff told us that there were no bullying and harassment cases.
- Staff told us they knew how to whistle blow and would feel comfortable to do so. Staff knew where to find the whistle blowing policy. Staff had contacted the CQC in the past with concerns. The provider had of a 'freedom to speak up guardian'. Staff could raise concerns directly with the guardian both confidentially and informally. The provider was developing this role at the time of our inspection.
- Staff said they could raise concerns without feeling that they would be victimised.
- There was evidence of low morale on Kipling and Horton wards. We saw that issues on Kipling ward had been discussed at a team meeting. Staff told us this was improving and that now nurses had been recruited staff hoped this would continue to improve.
- Staff had been offered the opportunity to complete leadership training. The provider had offered this to nurses and health care assistants in a clinical practitioner role.
- Overall staff spoke highly of their teams and said that they worked well with other staff who were mutually supportive. Staff were very complimentary about the hospital manager and deputy manager and said that they were supportive.
- Staff did not demonstrate that they understood duty of candour.
- Staff were able to give feedback at team meetings and board to ward meetings, although some staff said they did not feel listened to. Team meeting minutes did not demonstrate what happened after staff had given feedback as there were no action points

Requires improvement

Wards for older people with mental health problems

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are wards for older people with mental health problems safe?

Good

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Safe and clean environment

- The design of Rudyard ward meant that there were blind spots and narrow corridors. The ward was on two floors with bedrooms upstairs. Staff positioned themselves in specific areas of the ward to mitigate blind spots. When required, staff increased their observations of patients to ensure their safety.
- Wards had ligature anchor points and whilst there had been improvement work carried out there were still identified risks. These included taps, showers and window and door handles. A ligature point is anything that patients could attach a cord, rope or other material to for the purpose of hanging or strangulation. Staff told us they assessed each patient individually for risk in relation to ligatures and reviewed the most suitable environment and level of observation for patients who were at increased risk. The ward had accessible ligature cutters for staff to use if required.
- The provider had a ligature risk reduction policy. This was due for renewal in September 2017 but the provider had not updated this. The hospital manager said that the clinical governance team were in the process of reviewing this and staff completed ligature risk assessments annually. The policy stated that staff should complete ligature risk assessments quarterly. Staff had completed a ligature risk assessment for Rudyard recently, in December 2017.
- Rudyard ward was a mixed gender ward. On mixed wards good practice suggests there should be a day lounge for use by women only. At the time of our inspection, there were two females present on the ward; both of these females were cared for on a one to one basis and staff constantly observed these patients. The ward normally had a higher level of male patients. We spoke to the hospital manager about the plans to move the ward to another area of the hospital. This move was completed shortly after our inspection and Rudyard has now been made a male only ward, the female two female patients were moved to Kipling ward.
- Rudyard ward had a well-equipped clinic room. The clinic room was clean and well organised. There was a defibrillator in the hospital that was shared between Rudyard and two other wards. Staff could access this quickly if there was an emergency. Staff checked emergency resuscitation equipment to make sure it was safe to use. Staff completed checks of this equipment and recorded when they had done this, this was an improvement since our last inspection.
- The ward did not have a seclusion room. Staff did not practice seclusion.
- The ward was clean but required some decoration and whilst some of the ward had been re-painted, there were areas where paint was peeling on a wall in the lounge area.
- There were hand sanitisers accessible to staff but these had been removed from some communal areas as there was a risk of a patient accessing and ingesting it. Staff carried alcohol gel. There were hand washing guidance posters in areas where patients and staff washed their hands. Staff carried out infection control audits. These were discussed in clinical governance meetings attended by senior managers.

- Clinical equipment was clean and well maintained; this had improved since our last inspection. The ward had access to other equipment that had been calibrated to ensure it was working properly including blood pressure monitors and weighing scales.
- Electrical equipment had not always had a portable appliances test (PAT). We observed items that had not been PAT tested. This was not in line with the provider's maintenance policy.
- We reviewed cleaning schedules. Staff updated these daily and indicated that cleaning had taken place. A supervisor reviewed these.
- The infection control leads for each ward audited mattresses. We reviewed mattress audits and saw that these took place monthly, staff had identified relevant actions and that these had been marked as completed, this had improved since our last inspection.
- A member of staff told us that they were concerned about dirty wheelchairs that different patients used on the ward. They said there was no system for cleaning wheel chairs and that managers had not responded to a request for wipes to clean them, rather than using spray. We observed wheelchairs had not been cleaned and that they were dirty.
- Environmental risk assessments took place including health and safety risk assessments.
- All bedrooms had a nurse call system. We observed that all but one member of staff wore an alarm; they said they had forgotten to use it. Staff also used radios to communicate.

Safe staffing

- Day shifts started at 7.15 am, the night shift started at 7.45pm.
- Establishment staff levels were 1.75 whole time equivalent nurses (WTE) and 17.5 WTE health care assistants at Rudyard ward during the daytime. There were 0.75 nursing vacancies and one health care assistant vacancy at the time of our inspection. In addition, Rudyard ward shared staff with Kipling at night-time. The two wards shared 2.5 WTE nurses and 19 health care assistants. There were no nursing vacancies and 2.6 WTE health care assistant vacancies at the time of our inspection. However, four health care assistants on Rudyard ward had recently handed in their notice and therefore there will be more vacancies.
- Sickness levels were at 3.3% in the year before our inspection. Sickness levels were low.
- There had been ten staff leave the ward in the twelve months before our inspection. The reasons for staff turnover given were varied. Staff told us that people moved on to develop their careers, some staff had gone on to do their nurse training. However, whilst nurses had seen their terms and conditions improve health care assistants had not and some staff told us that people left for improved salaries.
- Bank and agency staff had worked on 385 shifts on daytime shifts on Rudyard ward in the last three months. There had been a further 735 night time shifts covered by bank and agency staff on both Rudyard and Kipling ward.
- The provider used the Telford model following their professional judgement to assess how many staff and of what grade was required on each ward. The Telford model is a recognised model for assessing safe staffing levels.
- The provider had recently recruited nurses. In the interim bank and agency nurses were used, although the hospital favoured using bank staff for consistency. The hospital also had developed their own agency so that they could ensure that temporary nurses were suitably trained. They completed an induction and mandatory training that included training in the management of actual or potential aggression (MAPA.) There was a good supply of bank and agency nurses. When there were shortages of 'in house' trained bank and agency staff the hospital did on occasion use external agency nurses.
- The use of bank and agency staff over the three months prior to our inspection was high. The hospital were working to recruit staff and had recently made significant improvements to the terms and conditions that they could offer nurses. The hospital was starting to recruit non-qualified staff from other countries in Europe to try to reduce their vacancies. There was a plan to implement a performance related pay programme for all staff that the hospital hoped would serve as an incentive and improve recruitment.
- Bank and agency staff used were usually familiar with the ward. There were several examples of staff who changed from permanent roles to bank and agency and who knew the job well.

Requires improvement

Wards for older people with mental health problems

- The nurse in charge and nurses told us that they could bring in extra staff when there was additional clinical need on the ward. We observed this to be the case.
- There was one registered nurse on Rudyard ward in the daytime although at night, one nurse was shared across Kipling and Rudyard wards. Now that the provider had completed recruitment, the hospital manager explained that there would be more support for the nurse in charge so that they could have more time away from ward duties to carry out other tasks such as facilitating team meetings, supervision and appraisals.
- Nurses told us that they tried hard to ensure patients had one to one time with their named nurse but that this was sometimes difficult as until recently there had been a lower level of nurses. There was a high level of one to one care on the ward but we observed a low level of meaningful activity taking place.
- Staff consistently told us that activities and leave from the ward was rarely cancelled due to staff shortages. We observed a patient going off the ward for leave. The hospitals kept records of patients' leave and these demonstrated that patients had leave.
- There were sufficient staff to carry out physical interventions and all staff, including bank and agency staff were trained in carrying out restraint using MAPA (management of actual or potential aggression.)
- There was effective medical cover. A consultant psychiatrist worked on the ward and was on site between 9am and 5pm Monday to Friday. In addition, hospital doctors had a rota system that provided emergency cover out of hours. Doctors could access patient electronic care records from home and could respond within 45 minutes if staff contacted them out of hours.
- Mandatory training compliance levels had improved since our last inspection. The provider had a dedicated training lead who worked to ensure they met the training needs of staff. There was a comprehensive training planning calendar for the service. There were 97% of staff who had completed and were up to date with MAPA training, 97% had completed in house training, this included infection control, basic life support, manual handling, health and safety, equality and diversity, risk assessing and fire awareness. Food safety training was lower, 75% of staff had completed this. There was a plan in place for food safety training to be offered monthly so that staff could complete this.

Assessing and managing risk to patients and staff

- The service did not use seclusion. There was no seclusion room. There had been no cases of long-term segregation used in the six months prior to our inspection.
- In the six months prior to our inspection, there had been 71 incidents of restraint used on 12 patients. On two of these occasions, staff had used prone restraint.
- We looked at five care records in the course of our inspection. We looked at risk assessments and management plans for each of these records and saw that staff undertook a risk assessment of every patient at admission and updated these regularly, following incidents and at reviews. All of the five risk assessments were up to date. Staff completed detailed assessments and management plans. They were individualised and covered risk areas including risk to self and others, physical health risk, risk of self-neglect, vulnerability and quality of life.
- We saw that some blanket restrictions that we had observed across the hospital on our last inspection had been reduced. Patients were able to keep food in their room unless there was a specific reason that had been care planned for them not to. Patients were when supported and appropriate were able to make drinks. Although because of patients' high level of needs and potential risk staff often did this for them.
- Patients who were not subject to Deprivation of Liberty safeguarding or detained under the Mental Health Act could leave the wards at will. There were signs on the wards explaining the right of informal patients and that they could ask staff if they wished to leave the ward.
- There were policies and procedures for the use of observation and we saw enhanced staff carrying out enhanced observations on the ward. The rota for carrying out observations meant staff normally changed over every hour. The hospital had a search policy that staff referred to.
- Staff used restraint as a last resort. Staff were trained in MAPA (Management of Actual and Potential Aggression) however they did not use this unless they had attempted less restrictive interventions including de-escalation or redirection. Positive behaviour support

plans were in place, staff demonstrated a good understanding of their patients, and care records demonstrated detailed understanding of triggers for potential aggression and management strategies.

- The provider had a rapid tranquilisation policy and this reflected the most recent National Institute for Health and Care Excellence guideline set out in May 2015. This provider had updated this since our last inspection. There had been no occasions of rapid tranquilisation used in the six months prior to our inspection.
- Staff were able to describe how they would identify safeguarding issues and were able to explain the process they would follow, staff gave examples of safeguarding concerns that had been caused by peer on peer aggression. At the time of our inspection, 92% of staff had completed adult safeguarding training. The deputy service manager offered training in safeguarding and this had been approved by the local authority as a level one training course. The deputy manager was the hospital safeguarding lead, and she reviewed all safeguarding incidents, and referred safeguarding concerns to the local authority. There were 19 safeguarding alerts raised across the whole hospital between January 2017 and January 2018. The provider notified the CQC of safeguarding incidents.
- We saw some evidence of effective medicines management practice. A commissioned pharmacist came to monitor and audit medicines related activity on the ward. Overall medicines were well organised, monitored and reviewed effectively and stored safely. Staff monitored and recorded fridge and room temperatures daily.
- Staff carried out falls assessments and used sensor mats for patients at high risk of falls. Staff assessed pressure ulcer risk using the Waterlow pressure ulcer risk calculator. Staff completed used bowel movement charts to monitor patients who required this.
- Children were able to access a visitors room in the reception area, this was individually risk assessed for suitability.

Track record on safety

- There had been no serious incidents on the ward in the last 12 months.
- We reviewed the last six sets of clinical governance minutes and observed that serious incidents relating to the whole hospital were consistently discussed at these meetings and were a standing agenda item.

Reporting incidents and learning from when things go wrong

- Staff told us that they reported incidents and that they knew how to do this and what they should report. We checked the incident-reporting book and saw that this was completed. There was an internal database where staff recorded incidents; the clinical governance group monitored this to identify themes or trends.
- The incident log for the hospital demonstrated that there had been 49 incidents reported by the ward. The three most common incidents reported were for physical aggression, verbal abuse, falls and assaults.
- The provider had a duty of candour policy. However, most staff did not understand what this was**.**
- Staff told us that they did not consistently receive feedback from incidents. There was a learning lessons file on each ward. The provider had introduced this in December 2017 but it had not yet become a tool for sharing learning. Where staff did receive feedback this took place in handovers, but staff said this was inconsistent. Staff did not take minutes at handover meetings; therefore, it was not possible to evidence that learning had taken place. We reviewed team meetings, staff did not discuss learning from incidents and there was not a standing agenda item for incidents.
- Staff could not provide examples of how changes had been made in response to feedback from incidents.
- Staff said they received a debrief after incidents took place and sometimes patients did. Overall staff spoke highly of the support they had received from their managers and gave examples of when this had happened.

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Requires improvement

Wards for older people with mental health problems

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Care records indicated that comprehensive and timely assessments were completed for patients. Staff started this process before patients came on to the ward after referral. They assessed whether patients' needs could be met by the hospital and this was completed after admission.
- Care records demonstrated that a physical assessment took place on admission. The service worked closely with the local GP who attended the service on a weekly basis. A practice nurse supported the GP. The GP saw patients when required; this happened at a minimum of every 12 weeks if there were no specific health issues. Staff completed and recorded physical health monitoring and we saw evidence of this in patients' care records. Staff used Modified Early Warning scores (MEWS) to monitor patients' vital signs.
- We reviewed five care plans. All patients had a care plan in place and all were up to date. Three care plans were detailed and holistic. Care plans did not always clearly demonstrate patients' views or their preferences. We did not see consistent evidence of patients' or carer's involvement.
- There were both paper and electronic records. Records were well organised and accessible. However, there was information stored in several places. Staff recorded daily care records on an electronic system, activity records were kept on an electronic shared drive. A paper file contained archived information and another paper file 'working folder' contained care plans, risk assessments, physical health plans, information about activities, therapies, Metal Health Act, and Mental Capacity Act documentation. Health care assistants could access all records, although only the senior health care assistants and nurses could record information. In addition, each ward had a folder with an information summary sheet with a photo of each patients and a summary of their needs and care. This mean temporary staff had quick access to information about patients and patients could carry these with them if they were being treated in hospital or elsewhere.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication in relation to dementia.
- At the time of our inspection, the psychology team was assessing two patients from Rudyard ward. The psychology staff were planning to start a group for patients with dementia, this was to be jointly run with occupational therapy staff.
- Patients had access to physical health care through the GP who attended the service. We saw examples of complex and chronic health problems being well cared for. Patients saw specialists such as oncologists, podiatrists and diabetic nurses when required. The GP ensured that screening for breast, bowel and prostate cancer was carried out when required. All patients had annual blood tests. Patients prescribed anti-psychotics were monitored effectively. Staff offered advice and support to patients in relation to healthy life styles. Care notes demonstrated that patients had access to dentists, podiatrists and other specialists.
- Staff assessed and met patients' nutrition and hydration needs using a recognised tool, the Malnutrition Universal Screening Tool (MUST). Some patients required help and support with eating, there were patients who had a soft food or thickened liquid diet. The ward used speech and language therapists to carry out dysphasia assessments.
- Staff used recognised rating scales to assess and monitor outcomes including the Health of the Nation Outcomes Scale (HONOS) to identify suitable care pathways and assess progress.
- A range of audits took place and clinical staff took part in these. There were audits of infection control. The visiting pharmacist carried out monthly audits of medication. A doctor had audited the use of rapid tranquilisation.

Skilled staff to deliver care

- There was a range of disciplines working with patients in the older people's ward. There were doctors, nurses, health care assistants, clinical practitioners, a

psychologist and assistant psychologist, two activities workers, a music therapist, who worked one day a week and occupational therapist and occupational therapy technicians. In addition to this, the service commissioned a GP and a local pharmacist.

- Registered nurses held a mental health or learning disabilities nursing qualification. There were two nurses who held a general nursing qualification. The psychiatrists' special interests included complex female patients and older age psychiatry.
- Staff received an appropriate induction. Induction was two weeks long; it included mandatory training comprising of understanding of role, food safety, fire, infection control, positive behaviour support, values, privacy and dignity, basic mental health training, equality and diversity health problems, risk assessment, Mental Health Act and Mental Capacity Act. All staff competed five days MAPA training. Health care assistants completed training in line with the care certificate standards.
- The provider gave us data that indicated that 80% of staff on the ward had received supervision every three months in line with policy. When we asked the provider some more questions about supervision, they told us that they had counted team meetings as supervision in their data. They told us that only two members of staff on the ward had received regular supervision and they thought this would account for approximately 10% of all the staff.
- Some staff told us that in addition to their supervision that they had attended reflective practice sessions and the psychologist had facilitated these. The psychologist and staff were keen to ensure that these happened more in the future but currently these did not take place regularly.
- The hospital manager and nurse in charge told us that team meetings took place every three months. We reviewed minutes for these meetings and saw that they took place in November 2017 and January 2018. At these meetings staff and nurse in charge to discuss concerns about the ward. They had also discussed a piece of writing created by the nurse in charge, which was about the imagined experiences of a patient on the ward. The aim of this piece of writing was to support staff to change their ward culture and improve care. The nurse in charge said it was difficult for staff to attend meetings because of their work on the ward. She had run the team meeting in January there times to ensure that as many staff as possible had the opportunity to attend. The team meeting did not have a standard agenda, staff did not review minutes from the previous meeting and there were no clear action points.
- The hospital provided us with information about staff appraisals prior to our inspection. Compliance was at 31.9%. We had identified this as an issue at our last inspection. The hospital refreshed this data and improved appraisal compliance after we had announced our inspection and compliance was at 45%. One member of staff told us that they had not had an appraisal for three years. The nurse in charge said that due to the lack of nursing staff it had been difficult to complete appraisals. The nurse in charge said she was concerned about this, as the hospital planned to relate pay to performance and she would need to review this at appraisal meetings. The nurse in charge hoped that the recent recruitment of nurses would mean that she could focus more time on her management role.
- Staff completed training for their role in the mandatory training programme. In addition to this, the provider had recently made dementia-training part of their mandatory training plan. At our last inspection, over a year ago we identified that staff had not completed training in dementia. This did not reflect the needs of the patients on the ward. At the time of our most recent inspection, 37% of staff had completed this. There was a plan in place for all staff to complete this training, and this was due to start in the month following our inspection. The hospital was developing a dementia strategy and an occupational therapist (OT) was taking the lead for this. The activities coordinator and occupational therapist were in the process of developing more activities for patients with dementia.
- The ward nurse in charge gave us examples of how they had managed poor staff performance both formally and informally. There were on-going issues of performance management at the time of our inspection. The nurse in charge explained that she was working to improve standards of care on the ward.
- There had been seven staff suspended across the whole of the hospital between November 2016 and October 2017. The reasons for this involved inappropriate conduct towards patients and managers and staff falling asleep on duty.

Multi-disciplinary and inter-agency team work

Requires improvement

Wards for older people with mental health problems

- There were regular multi-disciplinary meetings (MDT), these were open for all staff to attend and they took place regularly, patients were encouraged to attend these meetings.
- There were effective handovers that took place twice a day and staff discussed the presentation of each patient. All staff due on shift attended handovers; the nurse in charge usually led these. There were handover files on the wards where staff recorded details of the patients' presentation.
- The staff had good relationships with the GP that the hospital commissioned. The managers had good relationships with the local safeguarding board and advocacy service. CPA meetings took place and care coordinators and external professionals attended these.

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

- There was a clear process for monitoring and checking Mental Health paperwork. Qualified staff received and checked all Mental Health Act paperwork. The Mental Health Act manager then reviewed these documents.
- Staff knew that that they could contact the Mental Health Act administrator. The administrator provided support with all elements of the Mental Health act including renewals and tribunals. The ward staff knew when important dates were for patients concerning their detention.
- Each ward had a folder, which contained documentation relating to patients' leave from the ward. Staff followed a clear process in relation to leave and patients had a copy of their leave paperwork.
- Mental Health Act training took place and 89% of staff had completed this. This had improved since our last inspection in November 2016.
- Overall staff demonstrated understanding of the Mental Health Act and the Mental Health Act code of practice.
- Staff attached consent to treatment and capacity forms to medication charts of detained patients. This meant staff could check the medicines that nurses administered were authorised.
- The Mental Health Act manager gave support and advice to staff when they required this. There was also a folder with all relevant up to date policies concerning the Act.
- Care records showed that patients had their rights given to them regularly. This happened on a monthly basis and there was a file kept detailing that this had taken place.
- We reviewed Mental Health Act paperwork and saw that staff completed this correctly. Copies of paperwork were stored in patients' files. Original copies were stored securely at the hospital headquarters.
- The Mental Health Act manager carried out regular audits of Mental Health Act paperwork including patients' leave paperwork. The Mental Health Act manager created action plans where issues had been identified through audits.
- Patients had access to the Independent Mental Health Act advocacy service. by Assist advocacy provided this service. We spoke to Assist, who told us that they regularly supported patients from the hospital. The advocacy service visited the hospital when patients required their support.

Good practice in applying the Mental Capacity Act

- Staff completed Mental Capacity Act and Deprivation of Liberty safeguarding training, 89% of staff had completed this.
- There had been two Deprivation of Liberty Safeguarding applications made in the last six months.
- Staff showed a good understanding of the Mental Capacity Act 2005 and the five guiding principles. Staff could give examples of how they applied the act to their work. Staff assumed capacity unless there was a specific reason not to an demonstrated they understood capacity to consent.
- There had been a recent Deprivation of Liberty Safeguard application made for a patient on Rudyard ward. During our inspection a best interests assessment took place for this patient.
- The provider had an up to date policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew where to get advice regarding the Act.
- We saw evidence of patients' capacity assessments in patient files and this related to specific decisions. Staff gave us examples of how they supported patients to make their own decisions wherever possible Staff worked with families and other professionals to ensure that, where the patent lacked capacity, decisions were made that took into account the patient's wishes, feelings, culture and interests.

Requires improvement

Wards for older people with mental health problems

- Staff demonstrated that they understood the Mental Capacity Act definition of restraint.
- The Mental Health Act manager also provided staff with support regarding the Mental Capacity Act.
- The Mental Health Act manager carried out audits of Mental Capacity Act paperwork and suggested relevant actions from these.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

- We conducted one short observational framework for inspection (SOFI) observation on the ward that included six patients. A SOFI involves close observation of patient and their interactions with staff over short time periods. We saw that there was some positive interaction with patients but that there were also quite a lot of neutral interactions. A neutral interaction is when there are no observable signs of positive mood but no signs of negative mood either. We did not record any negative interactions. We recorded staff interacting with patients in a kind and respectful way and offering supported with their basic needs such as food and drink and mobility. However, we saw staff change over in their care of a patient but there was no introduction made by the new member of staff. We also observed a patient trying to communicate with staff but staff did not respond.
- We spoke to two patients they were both were positive about staff behaviour. They told us they were well cared for and that they felt safe on the ward. They said staff were respectful and polite.
- When we spoke to staff they demonstrated a person centred approach, they understood individual patient's needs and were motivated to see good outcomes for patients. Staff were knowledgeable about the specific health and nutrition needs of patients.

The involvement of people in the care they receive

- Each ward had an information pack that they gave to patients when they were admitted to the ward. This information pack included information about making a complaint, patients' rights and advocacy as well as information about the care and treatment provided at the hospital. Staff talked through this with patients and their families to aid understanding. In addition to this staff spent time with patients supporting them to get to know the ward and find their way around.
- Active involvement in care planning was not always possible for the patients on the ward. However, we did not always clearly hear the patient's voice in care plans or see the involvement of family and carers' to support the patients' wishes.
- Patients had access to advocacy. An independent mental health advocate (IMHA) who was based in the local area supported patients. We spoke to the advocacy service who told us that they received regular referrals from the hospital.
- We spoke to two carers and family members who were positive about the care of their loved ones. Both carers said they were involved with their loved one's care and one of the carers attended six monthly meetings. They both said they received feedback from staff and that staff were kind and respectful.
- Patient feedback meetings did not take place on Rudyard.
- We saw that some patients had advance decisions in place. Some patients had a 'do not attempt to resuscitate' (DNAR) decision recorded.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The hospital did not have a formal model of dementia care in place.. However, the medical director presented a new model of care focused on individual patient's needs to inform values based care throughout the hospital. This new model also had a strong focus on the care and treatment of patients with dementia and would be implemented as part of the development of Rudyard as a specialist dementia ward.

Requires improvement

Wards for older people with mental health problems

- Average bed occupancy was 100% throughout the hospital.
- Most patients came from outside of the local area.
- Staff told us that patients always had a bed when they returned from leave.
- Staff usually only moved patients between wards and rooms for clinical reasons
- The average length of stay for Rudyard ward was 160 days.
- The hospital had not identified any delayed discharges. When staff discharged patients they planned for this and patients were discharged at an appropriate time of day.

The facilities promote recovery, comfort, dignity and confidentiality

- Rudyard ward was located in the main hospital. There were patient bedrooms on a different floor to the main ward and there was a lounge and dining room. The corridors were narrow and the environment was not ideal for patients with dementia, however plans were in place to move the ward to a more suitable environment. We did not see dementia friendly items on the ward such as rummage boxes or nostalgia items and pictures. Since our last inspection, the provider had installed some easy read signage so that patients with dementia could more easily navigate around the ward and corridors had been colour coded to help patients orientate themselves more easily.
- There were no quiet areas on Rudyard ward. There was a small lounge and a dining room. At points during our inspection, the ward became noisy when patients were distressed or particularly vocal. This could be potentially distressing or confusing for other patients. Families could see patients in their room if this was assessed as suitable, they could not see patients on the ward. Staff said this was due to potential risks from other patients.
- As part of the programme of service development managers planned to move Rudyard to the Kipling ward area following refurbishment. This would improve the ward environment and provide more room for social activity and updated clinical facilities. The move was planned to take place in April 2018.
- Patients were able to use their own mobile phones unless there was a specific reason for them not to. Staff told us that patients could use the office phone in private if they needed to.
- Patients had access to outside space. John Munroe hospital was set in large and well looked after grounds.
- Patients had access to drinks and snacks and could make their own drinks with the support of staff if they were able to.
- We saw bedrooms that were personalised; some bedrooms had possessions and photos displayed.
- Staff ensued that they locked patients' rooms if patients were unable to do this for themselves and wanted their room locked. They could access a safe for their belongings if they were able to remember a code.
- The hospital had an activity lead and an activities worker, two occupations therapists (OT) and an occupational therapy technician who worked with patients at both John Munro hospital and Edith Shaw hospital. Activity workers carried out specific activities with patients in addition to activities that took place on the ward. This included activities at weekends. Activities included music related activities, exploring antique objects and jigsaws. The activities coordinator had started to send out interest lists to family members so that activities could align with patients' interests and planned to start life books with families and patients. The occupational therapy staff offered activities including activities of daily living and reminiscence groups. The hospital had a pet as therapy (PAT) dog who visited patients. Staff told us that patients really valued this. Staff told us that both the activities department and occupational therapy department had experienced reduced staffing. Staff told us that there was not enough capacity for the patients that needed support and meaningful activity.
- We saw an activity worker exploring an antique object with a patient on Rudyard ward, and a member of staff playing cards with a patient. We observed a reminiscence group taking place that patients from the ward attended, this was a well-run group where patients engaged well.
- We requested data for the ward regarding how many patients were involved with activities provided by the activity workers and OT. We requested data from the hospital about activity levels on the ward, from the data we saw from different departments these appeared to be low. Staff told us there was no combined monitoring of all activities that an individual patient completed. Staff did not combine and collectively monitor records

Requires improvement

Wards for older people with mental health problems

of activity from occupational therapy, the ward and activity workers. This made it difficult for us to assess whether patients could access sufficient activities to stimulate and engage them.

Meeting the needs of all people who use the service

- The wards were accessible to patients with disabilities and wheel chair users. There was an accessible lift, one shower and toilet with a handrail and an adapted bathroom. The other toilet did not have a handrail.
- There was limited information displayed for patients on the ward. There was information about advocacy, making a complaint and how to contact the CQC. The activities timetable was written on a small piece of paper that was difficult to read. There was some easy read information on a board about the staff on duty and the day of the week and the weather. There was no easy read information about activities and no information about menus or treatments. At our last inspection in 2015, we had said the provider should display menus.
- There was no current need for interpreters or signers; however, one member of staff had completed training in British Sign Language level one. Staff gave examples of how they had accessed interpreters in the past.
- Patients with dietary needs were catered for adequately. The catering staff catered to patients' religious, cultural or personal food choices.
- The hospital worked closely with a local church and patients could attend a regular church service held at John Munroe. There were also opportunities for patients to attend the local church. Staff could give examples of how they would support patients with other spiritual beliefs or requirements.

Listening to and learning from concerns and complaints

- During the year prior to our inspection there were no complaints made about the ward.
- Patients told us that they knew how to complain. Carers told they knew how to make complaints.
- Staff knew how to handle complaints and supported patients to do this if required.
- Staff told us they did not receive feedback from complaints, however there had been no recent complaints made about the ward.

Are wards for older people with mental health problems well-led?

Requires improvement

Vision and values

- Staff were unable to tell us the organisational values. Some staff said that these had only been introduced in the last few weeks.
- Staff, were unable to tell us how the team objectives reflected the organisational values and objectives.
- Staff knew who the most senior members of the organisation were. Staff talked about a 'disconnect' between the most senior managers on the board and the staff who worked at and managed the hospital. Staff gave mixed responses about whether the board members came regularly to spend time on the wards. The board had introduced board to ward meetings to improve communication with staff. Staff could attend these meetings and we saw that one had taken place in January; we also saw that there were completed actions related to the issues that staff had highlighted.

Good governance

- Staff mandatory training figures had improved since our last inspection. There was a training lead that monitored training and a clear timetable of training for the year ahead. However, at our last inspection, we identified the need for staff to complete dementia training and not all staff had completed this. However, there was a plan now for all staff to do this.
- Staff appraisal compliance was still an issue since our last inspection and less than half the staff had an appraisal in place. Managers told us that a low level of nursing staff had affected this. Staff did not receive regular supervision, the provider gave us data that was incorrect as this had included team meetings and counted these as supervision.
- Shifts were covered by enough staff. The wards used bank and agency staff when they needed to and these staff were usually familiar with the ward. Staff told us that the hospital used too many bank and agency staff.
- We observed staff maximising their time completing direct care activities.

Requires improvement

Wards for older people with mental health problems

- Staff participated in clinical audit, including infection control audits.
- Most staff told us that they did not receive feedback about incidents and complaints and that learning did not take place in relation to this. The consultant psychiatrist reviewed incidents every three months. Incidents complaints and service user feedback were discussed at clinical governance meetings where mangers, doctors and senior managers met. There was no system in place to ensure that these were systematically discussed with staff. In December 2017 a learning lessons files had been introduced to the ward, but not all staff were aware of this.
- The provider did not have an up to date policy for assessing environmental ligature risks. This was due to be ratified; but had not been at the time of our inspection. Staff did not assess ligature risk in line with policy.
- Safeguarding procedures were clearly set out and followed by staff. Staff compliance levels for safeguarding training were high at 92%. There was a thorough monitoring and auditing system for both Mental Health Act and Mental Capacity Act procedures.
- The provider used key performance indicator data to assess the performance of the wards. Ward activity, staffing and daily feedback was reviewed by the managing director on a daily basis.
- The hospital manager had sufficient authority and administrative support for her role.
- The provider had a risk register. This sets out risks to the business including external, clinical and reputational risks. It also included contingency plans. The hospital manager could submit items to the risk register when required.

Leadership, morale and staff engagement

- There had been a staff survey carried out in July 2017. Feedback from this had been poor. Only 28% of staff completed the survey. The provider did not think did not think that this feedback represented opinions expressed were a true overall representation of wider staff group opinions. At our last inspection in 2016, feedback from staff for the staff survey was also poor.
- Sickness and absence rates were low at 3.3%.
- Staff told us that there were no bullying and harassment cases.
- Staff told us they knew how to whistle blow and would feel comfortable to do so. Staff knew where to find the whistle blowing policy. Staff had contacted the CQC in the past with concerns. The provider had appointed the role of a 'freedom to speak up guardian' to one of the doctors. Staff could raise concerns directly with the guardian both confidentially and informally. The provider was developing this role at the time of our inspection.
- Staff said they could raise concerns without feeling that they would be victimised.
- There was evidence of low morale and some team cohesion issues on the ward. We saw that this had been discussed at a team meeting in November. Staff told us this was improving and that now nurses had been recruited staff hoped this would continue to improve.
- Staff had recently been offered the opportunity to complete leadership training. The provider had offered this to nurses and health care assistants in a clinical practitioner role.
- Staff overall spoke highly of their teams and said that they worked well with other staff who were mutually supportive. They were very complimentary about the hospital manager and deputy manager and said that they were there to support them.
- Staff did not demonstrate that they understood duty of candour; this meant staff did not understand the need to act transparently with patients and relatives when incidents had taken place.
- Staff were able to give feedback at team meetings and board to ward meetings. At team meetings, it was unclear what happened after staff had given feedback, as there were no action points.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure staff individually risk assess patients rather than applying blanket restrictions.
- The provider must ensure that there is an up to date policy regarding the management of environmental ligature risks.
- The provider must ensure that all staff receive regular supervision in line with policy and that they complete an annual appraisal.
- The provider must ensure that there is a system to ensure that learning is embedded and that managers share findings and learning from incidents consistently with staff.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure there is a clear process for cleaning wheel chairs and that this is completed.
- The provider should ensure that staff know where equipment to respond to anaphylaxis is stored.
- The provider should ensure that all staff complete the mandatory training programme in dementia.
- The provider should ensure that all electrical items are PAT tested in line with the maintenance policy.
- The provider should ensure that all care plans are recovery focused and that staff offer patients a copy of their care plan and record this.
- The provider should ensure that team meetings take place regularly and that there is a clear agenda and action points identified.
- Staff should share incidents that affect patients with their family and carers where appropriate.
- The provider should ensure that patient meetings take place regularly and that staff record action points from meetings.
- The provider should ensure there are accessible records indicating how much activity individual patients complete.
- The provider should ensure that there is a range of accessible information for patients that takes into consideration patients' understanding and needs. This information should include menus.
- The provider should ensure that all staff understand and are able to describe duty of candour.
- The provider should look at ways to improve feedback from staff through staff surveys.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care** The provider did not ensure that decisions about restrictions that affected patients were individually care planned. **This was a breach of regulation 9 (3) (a) (b) (c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good Governance** The provider did not ensure that learning from incidents was consistently shared with staff. **This was a breach of regulation 17 2 (a)** The provider did not have an up to date policy regarding the management of environmental ligature risks. **This was a breach 17 2 (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing**

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Not all staff received clinical supervision and appraisals on a regular basis. **This was a breach of regulation 18(2)(a)**

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.