# South West Yorkshire Partnership NHS Foundation Trust

# Forensic inpatient or secure wards

## Inspection report

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## Ratings

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

# Our findings

## Forensic inpatient or secure wards

**Requires Improvement** 

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services.

We rated the service inspected as requires improvement. Overall, we rated safe, effective, responsive, and well-led as requires improvement and caring as good.

We visited 9 of the forensics wards provided by the trust at the following locations:

**Fieldhead**

Newhaven ward, a 16 bedded low secure/ learning disability ward.

**Bretton Centre**:

Sandal Ward, a 16 bedded low secure ward.

Thornhill ward a 15 bedded low secure ward.

Ryburn Ward, a 7 bedded low secure ward.

**Newton Lodge:**

Priestley ward, a 17 bedded medium secure ward

Johnson ward, a 15 bedded medium secure ward

Chippendale ward, a 12 bedded medium secure ward

Appleton ward, an 8 bedded medium secure/ learning disability ward

Hepworth ward, a 15 bedded medium secure ward

We also carried out a Mental Health Act monitoring review visit on Bronte ward, at the same time as the inspection. This will follow the normal process for these reviews.

Our rating of services went down. We rated them as requires improvement because:

- Some aspects of ward environments were not safe. Up to date ligature risk assessment were not always accessible to staff. Equipment was not always checked to ensure it was in date and safe to use in an emergency. Records showed the temperatures in some clinic room fridges were not always kept within the required range.

# Our findings

- Staffing pressures meant there were high levels of bank and agency staff on some wards which impacted on the quality of care patients were receiving. Staffing pressures also meant that patient's leave was sometimes cancelled.
- Staff did not always use least restrictive practices. On one ward, we found high levels of restraint, including prone restraint being used.
- Staff did not always consider individual circumstances when applying restrictions.
- Positive behavioural support plans were of variable quality, not always informed by psychological formulation and were not always used effectively to reduce incidences of prone restraint on wards.
- Supervision levels varied across wards. Staff on some wards did not receive regular supervision and it was not clear if staff had received the required level of supervision as set out by the trust. Staff did not always attend regular team meetings.
- Not all staff had received training on meeting the needs of patients with a learning disability or autistic people. This training was not mandatory for all staff and although training for staff on learning disability wards had been introduced in April 2023, it had not been completed by all staff.
- Staff did not always respect patients' privacy and dignity. Staff sometimes accompanied patients on leave in scrubs which identified them as a patient of the hospital. The therapy room on one ward was not sound proofed and private conversations could be heard on the ward.
- Governance processes did not always ensure managers had full oversight of quality or ensure that ward procedure ran smoothly. We found significant variations between wards which included the completion and recording of staff supervisions and mandatory training. On some wards meaningful activities were not always available to patients. Prone restraint was not monitored and managed effectively.
- Staff did not fully implement the trust's duty of candour policy. A written letter of apology was not always sent to people as required and senior staff were not clear about this requirement.

However:

- The service mainly provided safe care. The ward environments were mostly clean. The wards mostly had enough nurses and doctors to ensure the wards were safe. Staff mostly assessed and managed risk to individual patients well. Staff managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams mostly included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers mostly ensured these staff received training and appraisals. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

# Our findings

**How we carried out the inspection**

During our inspection we visited 9 wards which were based on 3 sites at Newton Lodge, the Bretton Centre and Newhaven.

During our visit we:

- conducted 9 ward tours.
- spoke with 31 members of staff.
- spoke with 25 patients.
- spoke with 9 carers.
- checked 22 records and reviewed a range of seclusion and restraint records.
- observed a handover and a multi-disciplinary team meeting.
- conducted an evening visit.
- carried out medication checks.
- reviewed a range of policy and documentation.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Is the service safe?

**Requires Improvement** 

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

### Safe and clean care environments

**Most but not all wards were clean, well furnished, and fit for purpose. Not all wards were well maintained. Aspects of the ward environment were not safe because ligature risk assessment were not up to date on most wards and equipment had not always been checked to ensure it was safe to use.**

#### Safety of the ward layout

Staff did not always complete and regularly update thorough risk assessments of all ward areas. We found the ligature risk assessments for most wards were out of date. New ligature risk assessments had been carried out but were in draft, had not been approved by managers and were not available for staff to view. The process between staff conducting a ligature risk assessment and this being approved was lengthy, taking up to 6 months to complete. Ligature risk assessments were not easily accessible, and several managers found them difficult to locate. We highlighted this to the trust following our inspection and they took measures to ensure ligature risk assessments were more easily available to staff. Fire risk assessments were in place for all wards and were up to date.

# Our findings

There were potential ligature anchor points in the service. Staff knew about some but not all potential ligature anchor points. Staff had received an induction which included information about the location of these. Staff mitigated ligature anchor points through locking rooms, staff awareness and individual care planning. The trust were undertaking a programme of door replacements which involved installing door alarms which would alert staff if a patient attempted to use a ligature from a door. This work was ongoing at the time of our inspection.

There was no mixed sex accommodation.

Staff had easy access to alarms. Most patients had easy access to nurse call systems, however a nurse call alarm in one patient's bedroom and a nurse call alarm in a visitor's room had been turned off and this had not always been regularly monitored.

### Maintenance, cleanliness and infection control

Most ward areas were clean, well-furnished and fit for purpose. However, we found some wards had areas that were not well maintained. For example, Johnson ward had areas of poor décor, the seclusion room shower had gaps in the panelling that presented a risk because they could be used to self-harm and the communal bathrooms required maintenance. There were stains on the carpet and floors of several wards. Ryburn ward had some furniture that was stained and needed replacing. The trust had an estates and facilities team who carried out maintenance on site.

There was an issue with the drains on Chippendale ward, one patient told us sewage sometimes came out of the drains. Staff told us that this occurred when maintenance staff unblocked toilets. Maintenance records showed there had been an issue with the drains in March 2023 and this had been fixed.

Staff cleaned wards but we found gaps in some cleaning records where recording had not taken place. The trust told us these related to occassions when patients had not wanted staff to access their bedrooms. Following our inspection, the trust put a process in place to escalate to ward managers, repeated refusals for rooms to be cleaned. Rooms were then identified to be deep cleaned to ensure patient safety.

Staff followed infection control policy, including handwashing. All staff were wearing surgical face masks in clinical areas. This was in accordance with the trust policy at the time of our visit.

### Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

### Clinic room and equipment

Most clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly, cleaned, and maintained. However, staff on Johnson ward had not checked the red bag, containing resuscitation equipment and emergency drugs, since March 2023. This check was meant to occur weekly. We raised this during our inspection and staff took action to address this issue.

Some of the equipment on Johnson ward was out of date. This included syringes and a first aid kit. We also found staff were not using the soft close lids for boxes containing used needles, which meant these were not securely stored.

Daily clinical fridge temperatures had not always been recorded on Priestley ward and the maximum fridge temperature recording for Priestley ward exceeded the recommended temperature on a regular basis. It was not clear whether staff had taken any action in response to this. We found staff were not recording minimum and maximum clinical fridge temperatures on Johnson ward and there was no space on the form to do this.

# Our findings

## Safe staffing

**The service had enough nursing and medical staff who had received basic training to keep people safe from avoidable harm. However, not all staff knew the patients well because there were high levels of bank and agency staff on most wards.**

### Nursing staff

The service had enough nursing and support staff to keep patients safe.

Overall, the service had reducing vacancy rates. Vacancy rates on some wards were quite high, particularly in relation to nursing vacancies. For example, Johnson ward had a nursing vacancy rate of 3.1 full time equivalent and a nursing support vacancy rate of 5.8 full time equivalent, and Sandal ward had a nursing vacancy rate of 4.3 full time equivalent and a nursing support vacancy rate of 2.5 full time equivalent. Other wards had much lower vacancy rates. The trust had taken on extra staff in other roles to support wards with vacancies.

The service had high rates of bank and agency staff. Managers requested staff familiar with the service and some agency and bank staff were familiar with patients. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates, although these varied between wards. The turnover rate for the year was 14.6 % across all wards that we visited. This was above the trust target for 10-12%, however registered nursing vacancies had reduced from 35 whole time equivalent to 12 whole time equivalent during the financial year.

Levels of sickness varied across wards. For example, Priestley ward had high levels of sickness at 17% in April and Hepworth ward had low sickness levels with no sickness for April. The average sickness across the year for all wards was 8%. Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. However, we were told that not all shifts were filled. Ward managers could adjust staffing levels according to the needs of the patients, for example extra staff were requested when patients required one to one observations.

The trust moved staff between wards to ensure high risk areas were covered. This meant wards where patients had less complex needs, often had poor staffing levels which impacted on patients' leave and activities.

There had been 7 incidents where a lone preceptee, who is a newly qualified nurse, was left in charge of a ward for part or the whole of a shift. When this occurred, it was reported and investigated as an amber incident. The nurse could access support from senior staff on another ward during these times.

It was not clear patients were receiving regular one to one sessions with their named nurse. Records did not always demonstrate evidence of this. However, patients told us that permanent staff found time for them. The trust told us, the named nurse on duty engaged with service users and spent some time in conversation with them during each shift. Managers had recently implemented a strategy which involved blocking out days for nurses to carry out one to one sessions with patients.

Patients sometimes had their escorted leave and activities cancelled across most wards, this included the occasional cancellation of medical appointments, although these were prioritised. An average of 14% of escorted leave was cancelled in the year prior to our inspection. This was partly due to staffing pressures The trust had a recruitment plan in place to reduce vacancies and the impact of staffing vacancies on patients and staff numbers were increasing.

# Our findings

Staff shared key information to keep patients safe when handing over their care to others. Staff held handovers between each shift and ensured key information was shared to help keep patients safe.

### Medical staff

The service had medical cover at all times. A doctor was available to attend the ward quickly in an emergency. **Staff told us they could get hold of a doctor when they needed one. There was an on-call system operated by managers and this included an on-call consultant and access to acute doctors.**

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

## Mandatory training

Most staff had completed and kept up to date with their mandatory training. However, some staff's training was out of date. Food safety compliance was low across most wards, for example, 63% of additional clinical staff and 50% of nursing staff on Newhaven and 58% of additional clinical staff and 64% of nursing staff on Priestley ward had completed this course. 72% of staff had completed this course across all wards we visited. Cardiopulmonary training compliance also varied across wards. For example, 67% of additional clinical staff on Priestley ward and on Ryburn ward had completed this course. However, overall compliance for this course across the wards was 80%. Overall compliance for all wards and staff groups was at 90%. The trust told us there was a focus on ensuring staff had completed reducing restrictive practice and cardiopulmonary resuscitation training.

The mandatory training programme met the needs of most patients and staff. However, learning disability and autism training was not mandatory across the service and had only been mandated for Newhaven ward in April 2023.

The Health and Care Act 2022 introduced a new legal requirement for all registered health and social care providers to ensure that their staff receive training in learning disability and autism, at a level appropriate to their role. This requirement has been in place since 1 July 2022. Newhaven ward employed learning disability nurses and a learning disability psychiatrist alongside mental health nurses to support patient need and the trust had started to roll out the Oliver McGowan training. However, this training was still being developed. 67% of staff had completed the tier 1 programme of this training. Previous to this, the trust were unaware of how many staff had completed learning disability and autism training because the training was available but not mandatory or monitored. This was concerning because staff were supporting patients with learning disabilities and with autistic spectrum disorder who had complex needs.

Managers monitored mandatory training and alerted staff when they needed to update their training.

## Assessing and managing risk to patients and staff

**Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. However, staff did not consistently develop and implement good positive behaviour support plans or follow best practice in anticipating, de-escalating and managing challenging behaviour.**

### Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised assessment tool, and reviewed this regularly, including after any incident. The trust used the Formulation Informed Risk Management tool across the service. Most risk assessments were up to date, however we found 2 risk assessments on Johnson ward that were out of date. These were updated following our inspection.

# Our findings

### Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff mostly updated risk assessments and care plans following incidents.

Staff could not always observe patients in all parts of the wards. Some wards had mirrors which enabled staff to observe areas of the ward that were outside of a line of sight, but we found other wards did not have mirrors. For example, Appleton ward had a number of blind spots which were not covered by mirrors. Staff told us CCTV was used to cover the blind spots, however following our inspection, the trust clarified this was not the case. Following our inspection, the trust told us they were adding additional mirrors to support the safety of staff and patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

### Use of restrictive interventions

Restrictive interventions were in place. Some of the restrictive interventions were in response to identified risks. However, there were some blanket restrictions that were applied widely, for example all the courtyards were supervised for all patients except for patients on Ryburn ward. This was because a patient had absconded from one of the wards. Patients were also only provided with decaffeinated drinks, despite the trust telling us that there was patient choice between caffeinated and non-caffeinated drinks. There were also restrictions around cutlery which was managed according to levels of patient need and risk on each ward. Wards had a blanket restriction risk register which was reviewed monthly.

It was not clear staff always made every attempt to avoid using restraint by using effective de-escalation techniques. Although restraint levels were quite low on most wards, restraint levels on Newhaven were high. 155 restraints had been carried out in 6 months prior to our inspection.

Staff sometimes carried out prone restraint which is a type of physical restraint which involves holding a person chest down. This was rarely used on most wards, however the level of prone restraint on Newhaven ward was high. This was concerning because prone restraint can impact on patient's breathing. There had been 17 prone restraints in the 6 months prior to our inspection. This had involved 4 different patients with 1 patient being involved in 12 episodes of prone restraint.

We reviewed 5 prone restraints on Newhaven ward and found staff were not always carrying out observations following a prone restraint. Staff had not carried out observations following a prone restraint in 3 out of the 5 restraints reviewed and it was unclear whether they had carried out observations following 1 other restraint.

We also found that on two occasions the patient was in prone restraint on more than one occasion during restraint.

However, prone restraints were mostly short in duration. One prone restraint lasted 4 to 5 minutes all other prone restraints lasted less than 2 minutes. Staff took patients out of prone restraint as soon as possible. Where staff restrained patients, this could occasionally result in prone restraint being used unintentionally. For example, if a patient

manoeuvred into prone restraint. It also included very short periods of prone restraint where a patient required being placed in seclusion under restraint and was resisting to enable staff to withdraw safely. The trust had invested in safety pods and were working towards alternative strategies for restraining patients. Since our inspection the trust provided additional training for staff on Newhaven ward.

We were not assured that positive behavioural plans were used to help reduce instances of restraint. For example, we reviewed 7 incident reports for prone restraint and 4 of these stated that the positive behavioural support plan or staying well plan had not been initiated or reviewed.

We reviewed 4 positive behavioural support plans for patients who had experienced prone restraint. Positive behavioural support plans were of varying quality and were not always informed by psychological formulation. One positive behavioural support plan had an accompanying psychological formulation and key issues identified in the formulation which may have helped support the patient however, these were not present in the positive behavioural support plan. Plans did not always contain information that were helpful to staff understanding the patient and some plans contained information that focused on the negative behaviour of patients with less information relating to how staff could support them.

Although the trust had reviewed each individual prone restraint episode, there had been no longitudinal review of individual patients subject to prone restraint to identify patterns of behaviour and how prone restraint could be avoided. There was also no evidence that staff had carried out any recent meaningful or regular functional analysis of behaviour for each patient subject to prone restraint.

Occasionally the incident reporting wording did not accord with people receiving person-centred care as they used phrases such as ‘care seeking behaviour’. This was concerning because the language used was not reflective of a person centred response to the patient’s distress.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed 4 seclusion records and found these were completed accurately and appropriate reviews had taken place. We found one record did not contain an exit plan, which is a plan to help a patient understand what needed to be achieved for them to leave seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was placed in long-term segregation. There had been one episode of long-term segregation in the last 6 months across the wards we visited.

### Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff had received mandatory safeguarding training for adults and children at an appropriate level.

# Our findings

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had up to date safeguarding policies for adults and children which provided staff with clear guidance about safeguarding procedures. The trust also had a safeguarding team and staff told us they could obtain advice and support about safeguarding concerns from this team.

Staff followed clear procedures to keep children visiting the ward safe. There were family rooms which provided appropriate facilities for visits with children and the service had procedures in place for assessing and supervising these visits.

### Staff access to essential information

**Staff did not always have easy access to clinical information. Most care records were comprehensive though and stored securely.**

Patient notes were comprehensive and most risk assessments were up to date. However, 2 out of 3 records we looked at on Johnson ward did not have an up to date risk assessment. Staff had identified this and work was ongoing to address this.

Staff told us there could be problems accessing the computer system as it did not always work.

Most records were kept electronically and these were stored securely. Some patients had files containing basic information that could be accessed easily. We found 2 of the 3 paper files on Newhaven did not contain this information. This meant staff who did not know patients well did not always have quick access to information about them.

### Medicines management

**The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.**

Staff followed systems and processes to prescribe and administer medicines safely. The trust used an electronic medicines management system which supported the administration of medication. Staff completed medicines records accurately and kept them up-to-date.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Leaflets could be printed off to provide information for patients about their medicines.

Staff stored and managed all medicines and prescribing documents safely. Pharmacy staff attended the wards weekly to audit medication and were available to support staff with medication queries.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The primary care team carried out physical health monitoring and liaised with staff on the ward regarding any concerns that related to their medication.

### Track record on safety

**The service had a good track record on safety.**

# Our findings

There had been no never events in the 12 months prior to our inspection.

The trust monitored and categorised incidents according to severity with red and amber incidents being the most serious. There was 33 of these incidents between October 2022 and April 2023. These included 3 incidents of violence and aggression, 1 incidence of absconding from a low secure courtyard and 7 incidences of a lone preceptee left in charge of a ward for part or the whole of a shift.

There were clear responses to these incidents to reduce the likelihood of recurrence.

### Reporting incidents and learning from when things go wrong

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff were not following the duty of candour correctly.**

Staff knew what incidents to report and how to report them. Staff accessed the trust's reporting system to report incidents and there was a system in place to ensure this was escalated to the appropriate manager to review.

Staff raised concerns and reported incidents including serious incidents and near misses in line with trust policy.

Staff including some senior staff did not fully understand the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. However, staff did not always provide patients with a written apology. This is a requirement of the duty of candour. The trust policy states that all verbal apologies should be followed by a written apology, however staff understanding was that a written duty of candour letter was to be offered rather than sent as standard practice.

Managers debriefed and supported staff after any serious incident. Managers told us psychologists were often involved in debriefs and that sometimes other teams such as the resuscitation team would provide debriefs following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were monitored by the trust to identify any trends and themes.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were sent emails with learning from investigations. The trust also offered learning lessons events meetings where incidents would be reviewed and learning shared.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, a physical weight monitoring pathway had been developed in response to a serious untoward incident.

## Is the service effective?

**Requires Improvement** 

# Our findings

Our rating of effective went down. We rated it as requires improvement.

### Assessment of needs and planning of care

**Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements. However, positive behavioural support plans varied in quality, and we were not assured these always supported staff to understand patients effectively.**

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. The trust had an assessment ward where each patient received a thorough assessment.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. The service completed a range of care plans for each patient, which focused on different areas of care. Not all patients had a one page profile or other documentation which staff could refer to quickly for key information.

Staff regularly reviewed and updated care plans when patients' needs changed.

Most care plans were personalised, holistic and recovery-orientated. However, some were written in a professional tone and did not reflect the patient's voice. The trust told us they had an improvement group who were addressing this and taking actions to improve the voice of the patient in care plans and risk assessments.

Positive behavioural support plans varied in quality and did not provide clear guidance to enable staff to provide patients with consistent care or manage their distress. Psychological formulations were not always completed or used effectively to inform the positive behavioural support plans. We saw one plan had an accompanying psychological formulation, but key information identified in the formulation was not included in the positive behavioural support plan.

Different templates were used to create positive behavioural support plans which caused inconsistencies in quality, for example, 2 patients had an easy read template with a care plan template which provided some basic positive behavioural support information, 1 patient had a positive behavioural support plan which included details of a traffic light system to help staff identify how to support the patient when presenting with different levels of agitation, but no easy read plan. One patient had a positive behaviour support plan which was formulated on a template designed to support staff create a positive behavioural support plan with relevant prompts and an easy read plan. Following our inspection, the trust put plans in place to improve the quality of positive behaviour support plans.

### Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.**

Staff provided a range of care and treatment suitable for the patients in the service. Patients on all wards had access to a psychologist, who carried out a range of interventions with patients including cognitive behavioural therapy; dialectical

behaviour therapy; eye movement desensitisation and reprocessing therapy; trauma self-management and mental health awareness. Wards also had occupational therapists, who provided one to one and group sessions across wards. This provision was impacted by staffing challenges at the time of our inspection. Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. Staff supported patients with a variety of physical health concerns including patients with diabetes and cancer. Care plans were in place to ensure patients were supported with these concerns. Staff completed National Early Warning Score (NEWS2) with patients. This is an assessment for monitoring patient's physical health. However, we were told there was an issue with the system which meant a patient's air/oxygen intake could not be recorded properly which affected the accuracy of the score.This issue was resolved following our inspection.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, patients received a choking assessment and were referred to a dietician for support where this was identified as an issue.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There was a range of activities across wards to support patients to lead healthier lives. These included walking groups, access to the gym, sports groups including badminton and football and a healthy eating group. This was ward led and some wards offered a range of activities, whilst other wards had limited access to healthy activities.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Technology was sometimes used to support patients. For example, wards had a tablet they could use for feedback and patients could access computers, where this was risk assessed as being safe to do so.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers carried out a clinical records review which assessed compliance with a range of information including reviewing the quality of care plans and risk assessments, whether these were up to date, whether consent to share had been updated and completion of nutritional screening tools. Managers identified gaps and put plans in place to address these.

### Skilled staff to deliver care

**The service had access to a range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided appraisals and an induction programme for new staff. However, they did not always support staff with supervision and opportunities to update and further develop their skills.**

The service mostly had access to a range of specialists to meet the needs of the patients on the ward. This included occupational therapists, speech and language therapists, dieticians and psychologists. Medium secure wards also had access to social workers.

Managers mostly ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, we were concerned staff had not all received relevant learning disability and autism training.

# Our findings

Managers gave each new member of staff a full induction to the service before they started work. Bank and agency staff also received inductions.

Managers supported staff through regular, constructive appraisals of their work. Overall appraisals were at 83%, although Priestley ward had a low compliance rate at 62.5%.

Staff did not always receive regular supervision. Staff supervision levels varied between wards. Staff were expected to receive 6 hours clinical supervision and 6 hours management supervision a year. It was unclear how this compliance was being monitored and the trust told us there were some issues with monitoring supervision which they were in the process of addressing. Staff were not receiving monthly supervision on most wards, for example an average of 37% of staff received supervision monthly on Johnson ward, whereas 89% of staff were receiving supervision each month on Thornhill. Most staff received supervision quarterly. The trust also offered group supervision from psychology and the trust told us these were well attended.

Managers did not always make sure staff attended regular team meetings. This varied between wards but we were told that some wards had not had regular team meetings due to the difficulties with getting staff together. Minutes from team meetings were shared with all staff.

Managers mostly identified any training needs staff had and gave them the time and opportunity to develop their skills and knowledge. For example, staff undertook trauma informed training and Mary Seacole training where this related to their role.

Managers recognised poor performance, could identify the reasons and dealt with these promptly.

### Multi-disciplinary and interagency team work

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular multi-disciplinary team meetings to discuss patients and improve their care. Patients met with the multi-disciplinary team once a week. There was a range of professionals at multi-disciplinary meetings including psychiatrists, nurses and occupational therapists and psychologists. Carers could attend multi-disciplinary meetings if they wished, however carers fed back that this was not something they did regularly.

Ward teams had effective working relationships with other teams in the organisation. Staff regularly liaised with other teams such as speech and language therapists, dieticians and the physical health team in order to support patients.

Ward teams had effective working relationships with external teams and organisations. For example, staff regularly liaised with the Ministry of Justice, the police, housing and advocacy organisations about patient's care and treatment.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.**

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice's guiding principles.

# Our findings

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Where appropriate, staff used easy read rights to help patients understand their rights. Advocates were sometimes used to support patients with understanding their rights.

Staff were not always able to make sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. This was partly due to insufficient staff to facilitate this.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and could access them when needed. Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Staff had regular contact with the Mental Health Act office who carried out regular audits. The Mental Health Act office sent regular reminders about tribunals and patients' rights being read to staff on the ward.

### Good practice in applying the Mental Capacity Act

**Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of the five principles. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff understood and knew how to access.

There were no deprivations of liberty safeguards applications made in the last 12 months.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff gave us examples of when they had carried out capacity assessments with patients, when they had concerns about a patient's ability to make a specific decision.

# Our findings

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

## Is the service caring?

**Good** 

Our rating of caring stayed the same. We rated it as good.

### Kindness, privacy, dignity, respect, compassion and support

**Staff treated patients with compassion and kindness. They mostly respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

Staff were mainly discreet, respectful, and responsive when caring for patients on wards. We saw positive and responsive interactions between staff and patients on most wards. Staff mainly responded to patients' individual needs.

Patients said most staff treated them well and behaved kindly. Patients told us permanent staff were kind, respectful and good at listening.

Most staff gave patients help, emotional support and advice when they needed it. Patients told us staff were lovely and that they felt listened to. Patients told us about staff who they felt they could go to for support. For example, some patients told us they felt they could speak to the ward manager if they had any concerns and other patients told us the ward psychologist was really helpful.

However, some patients told us that bank and agency staff were less responsive than regular staff and some bank and agency were judgemental and were less caring than permanent staff. Patients also told us they felt unhappy about staff wearing scrubs when they were out in the community because this meant they could be identified as a patient when they were on escorted leave.

Staff directed patients to other services and supported them to access those services if they needed help. Patients were referred to services to support them with a range of issues such as housing, healthcare needs, and legal issues.

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

### Involvement in care

**Staff involved patients in most care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.**

#### Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

# Our findings

Staff involved most patients in their care and gave them access to their care plans and risk assessments. However, we found some care plans were written using nursing terminology and were clinical in tone. Following our inspection, the trust told us they were undertaking work to improve the patient's voice in care plans.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, staff discussed patients' medication with them and helped them understand the effects of this. Staff used easy read information and additional explanations to support their communication with patients.

Patients were involved in decisions about the service, when appropriate. Staff held regular community meetings with patients to share information and listen to patient feedback about the service. Patients were also supported to take part in local service user involvement forums within the wider area. Patient representatives would attend these meetings and feedback to other patients on the ward. Patients, who had leave, had the opportunity to attend service user involvement activity off the ward.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff held community meetings to provide patients with the opportunity to provide suggestions and discuss concerns about the ward. Patient representatives were also invited into monthly managers meetings to give feedback about patient concerns on the ward. Staff also carried out patient surveys to obtain feedback from patients about their experience on the ward.

Staff made sure patients could access advocacy services. Advocacy services regularly attended the ward and patients had access to independent mental health advocates where required.

### Involvement of families and carers

**Staff did not always inform and involve families and carers appropriately.**

Staff did not always inform and involve families or carers. Staff told us carer involvement had reduced during Covid 19 and that involvement in activities were starting to be reintroduced. The trust had a carers project officer and carers champions who identified and supported carers within the service.

Carers provided us with a mixed response regarding their involvement. Some carers told us that staff kept them informed and other carers told us communication was poor, and staff did not always get back to their queries regarding their loved ones. Most carers told us that they were not involved in their loved one's care plan.

Staff helped families to give feedback on the service. Feedback forms were available for families to give feedback to the service. Staff gave carers information on how to find the carer's assessment.

## Is the service responsive?

**Requires Improvement** 

Our rating of responsive went down. We rated it as requires improvement.

# Our findings

## Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

### Bed management

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning. Discharges were carefully planned to help patients prepare for discharge.

### Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. At the time of our inspection there were no delayed discharges on the wards

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

## Facilities that promote comfort, dignity and privacy

**The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe, however not all bedrooms had an en-suite bathroom. There were quiet areas for privacy. The food was not of good quality and patients could not always make hot drinks and snacks at any time.**

Each patient had their own bedroom, which they could personalise. Most bedrooms had an en-suite bathroom, however the bedrooms on Sandal ward and Thornhill did not have en-suite bathrooms.

Patients had a secure place to store personal possessions.

Not all wards had a full range of rooms and equipment to support treatment and care. Wards varied in the space they had available for patients. Priestley ward lacked one to one space. One of the quiet rooms had been turned into a hydration station during the Covid 19 pandemic and this still remained. The other one to one room lacked privacy. Conversations held in the room could be heard in communal areas. The trust told us that action had been taken following our inspection to improve the privacy of the room.

Work had been undertaken on some wards to update and improve the ward environment, for example Appleton ward had a sensory/relaxation room that had been equipped in consultation with patients. The service had also refreshed its visitors' rooms including providing a range of toys and resources for children.

Patient kitchens, although present, were mainly unused. Due to ongoing Covid 19 restrictions, patients were only allowed to use them during 1-1 assessment sessions with occupational therapy staff. This impacted on patient activities, particularly in relation to patients who did not have section 17 leave and therefore had to remain on the ward. Following our inspection, these restrictions were reviewed and the use of the kitchens was returned to pre-pandemic use.

# Our findings

Patients could make phone calls in private. Some wards had a telephone room and there were arrangements on some wards for patients to have a basic mobile phone that they could make calls from. This was individually risk assessed.

All wards had outdoor space. Patients on all wards except for Ryburn ward could access this space under supervision. Patients on Ryburn ward had unsupervised access to outside space, due to this being a rehabilitation ward.

Patients could not always make their own hot drinks and snacks and were dependent on staff to do this for them. However, this was based on the needs and risks on the ward. We observed staff making patients hot drinks on request and patients told us they could generally get a hot drink fairly quickly.

The service offered a variety food. However, most patients we spoke to told us the food was unpleasant because it was reheated on the ward which affected the texture. This had been raised at community meetings and the catering manager was invited to some of these meetings to discuss concerns about food with patients.

### Patients' engagement with the wider community

**Staff supported patients with activities outside the service, such as work, education and family relationships.**

Patients had some access to opportunities for education and work. There were some opportunities for patients to access education on the ward, for example patients could study English and maths and we were told some patients accessed college. Some of the patients also had jobs on the wards and were financially rewarded for these.

Staff were not always able to help patients to stay in contact with families and carers. Families told us contact with their loved ones had sometimes been difficult, particularly during the Covid-19 pandemic and that escorted visits were often cancelled.

### Meeting the needs of all people who use the service

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service could access information leaflets available in languages spoken by the patients and local community. The service had an online animated induction to the ward, and this was also available in a variety of languages.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Wards had access to multi faith rooms and there were arrangements for spiritual leaders to visit wards.

Following incidents at the service, staff and patients worked together to create a cultural events calendar to promote positive education and a greater understanding of diversity in all its forms. This involved the ward hosting events throughout the year, that helped staff and patients improve their understanding of different religions and cultures.

# Our findings

### Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers did not always know how to complain or raise concerns. However most felt as though they could if they needed to, and most patients and carers felt they would be able to raise issues with staff and these would be taken seriously.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, changes had been made to security systems as result of a complaint that had been made to the service, which meant these systems were more robust.

The service used compliments to learn, celebrate success and improve the quality of care.

## Is the service well-led?

**Requires Improvement** ↓

Our rating of well-led went down. We rated it as requires improvement.

### Leadership

**Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.**

The ward had a clear management structure to support the service. This included a general manager, a medical clinical lead, a quality and governance lead and an inpatient clinical manager for medium secure services and low secure services.

Staff told us that ward managers and inpatient clinical managers were visible on the wards. Managers were supportive and staff felt they could approach them with any concerns they had. Staff told us they rarely saw members of the senior executive team.

However, the executive trio had a programme of planned visits to wards, and other members of senior management had visited wards as part of oversight, assurance and engagement, including quality monitoring visits and attendance at learning events.

### Vision and strategy

**Staff knew and understood the provider's vision and values and how they applied to the work of their team.**

# Our findings

Ward managers could tell us about the trust vision and values and told us about how they modelled these values within teams. Staff were aware of the providers visions and values.

### Culture

**Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.**

Most staff told us they had a supportive team who worked together well. Most staff told us they felt respected and valued. Staff felt that high numbers of bank and agency staff caused some challenges and stress for the staff team and that this sometimes impacted on patient care.

Staff were aware there was a whistleblowing policy and that the trust had a freedom to speak up guardian. All staff told us they could raise any concerns they had about patient care with managers.

### Governance

**Our findings from other key questions did not demonstrate that governance processes operated effectively at team level. Some areas for improvement were not always identified or acted on in a timely way. Performance and risk were mostly managed well.**

Managers attended governance meetings every month and had regular meetings with a governance coach. There was a range of meetings in place to review particular areas of governance, these included a monthly security meeting, a monthly medium secure management meeting and a fortnightly ward manager meeting. Senior managers attended some of these meetings to provide feedback and to enable information to be escalated where needed. Senior managers attended a daily management huddle in order to review the last 24 hours and identify any immediate actions regarding safety, quality and performance. However, these meetings did not always ensure that governance was effective at ward level.

There was a range of policies and procedures to provide guidance to staff. Policies and procedures generally provided clear information and advice for staff. However, we found some of the procedures on the wards were out of date. For example, the care of keys and security procedure and the search procedure we looked at on Newhaven were out of date.

Some governance systems were complex and lengthy. This resulted in the ligature risk assessments being out of date, due to it taking up to 6 months to go through the relevant governance processes. When we highlighted this, the trust told us this was an issue they had identified and they were putting measures in place to address this. Following our inspection, the trust produced a folder for each ward containing key risk information.

There were inconsistencies in service quality across the wards. For example, some wards offered a range of activities for patients, whereas other wards provided very limited activities. Cancelled activities were not collated which meant that there was no process for monitoring this and the potential impact to patients. Following our inspection, the trust took action to improve information gathering and reporting relating to these concerns. Levels of compliance with supervision varied between wards with some wards achieving high levels of compliance and others much lower. Levels of compliance with training varied significantly between wards, staff groups and courses.

The trust were not monitoring restraint effectively. Staff were not monitoring restraint from a longitudinal perspective or carrying out functional analysis. When we highlighted this following our inspection the trust identified learning and improvements in relation to monitoring restraint and positive behavioural plans.

# Our findings

Staff training was not comprehensive. The trust had started to put training in place to support staff working with people with learning disability and autistic people, however this was very recent and not completed with staff or embedded in the service.

Staffing was a challenge across the service and this impacted on patient care. However, the trust had a recruitment plan in place to increase staffing and plans were in place, to allocate staff to areas with the highest levels of risk and patient vulnerability.

Staff were not carrying out the duty of candour in accordance with legislation. This requires that a verbal apology is followed by a written apology. Although, this is reflected in the trust policy this was not being followed by staff and this had not been identified through trust systems.

Following our inspection the trust told us they had taken a range of actions in reponse to the issues that we raised immediately following our inspection. This included work carried out on ligature risks to improve staff understanding and access to ligature risks, work on fridge temperature recording, the completion of one page profiles and work on positive behavioural plans and work on improving the quality of the food. They also told us they had taken action to improve contact with families, were addressing the concerns around the staff wearing scrubs when they were out with patients and had carried out work to increase supervision and training compliance rates. The trust told us they had shared lessons learnt across the trust, regarding the checking of equipment.

### Management of risk, issues and performance

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect.**

The trust held a risk register for the forensics service where key risks were identified, mitigated and reviewed. Managers knew about this and were able to escalate any risks that were relevant to the service.

The trust had a system in place for identifying risk from incidents. These were then reviewed by the relevant members of senior staff including the safeguarding team. Learning was identified and disseminated to staff.

### Information management

**Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.**

Staff carried out a range of audits and there was a system in place for reviewing these. The trust also carried out a programme of quality monitoring visits including reviewing specific aspects of wards such as infection prevention control.

### Engagement

**Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.**

The trust engaged with other local health and social care providers to ensure that patient needs were met. This included engagement with the police, housing and social care providers to provide support for patients during their time at the service and to support their needs once they had been discharged. The trust had links with the acute hospital and access to primary care to support patients with their physical health needs.

# Our findings

### Learning, continuous improvement and innovation

The trust had a culture of learning and improvement. Staff were involved in a range of projects to improve services and the wellbeing of patients. For example, the forensic service was involved with testing, treating and raising awareness about hepatitis C.

Staff were also involved in a project which aimed to provide more gender sensitive risk assessments for use in forensic psychiatry settings.

Staff and patients were involved in projects to improve the physical health of patients including providing swimming sessions for some of the patients and a football project which provided the opportunity for patients to engage with other patients form the community and play football together as a team.

# Our findings

## Outstanding practice

We found the following outstanding practice:

- Following incidents at the service, staff and patients worked together to create a cultural events calendar to promote positive education and a greater understanding of diversity in all its forms.
- The trust initiated a community football project. This involved patients and staff playing in a team together against other locally based social care related organisations, charities, groups, and societies. Hosting the event in community settings provided wider opportunities for service users to engage with other patients from the community who shared common interests/hobbies.

## Areas for improvement

Action the Trust MUST take is necessary to comply with its legal obligations. Action a Trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the Trust MUST take to improve:**

- Regulation 9 (3)(a)(b) The trust must ensure patients, who require them, have relevant, behavioural support plans that enable staff to meet their needs and provide person centred care.
- Regulation 10(1)(2)(a) The trust must ensure confidential spaces where service users share sensitive information are private and that conversations cannot be overheard by others.
- Regulation12(d)(e) The trust must ensure ligature risk assessments are up to date and accessible for all staff and that all equipment used has been checked to ensure it is safe to use.
- Regulation 13 (4)(b) The trust must ensure that the use of restraint is proportionate to the risks posed. This includes ensuring person centred attempts at de-escalation have been attempted in line with patients' care and positive behavioural support plans prior to restraint. The trust must also ensure prone restraint is only used as a last resort and is carried out safely.
- Regulation 17(1) The trust must ensure that it is accurately monitoring and managing the quality and safety of all wards and ensure it has effective oversight of the use of prone restraint and is managing this appropriately.
- Reg 18(2)(a) The Trust must ensure all staff are receiving the required level of supervision and training in accordance with trust policy. The Trust must ensure all staff receive appropriate training to enable them to meet the needs of people with a learning disability and autistic people.
- Regulation 20 The trust must ensure that all staff understand the duty of candour and follow this correctly. Staff must send a letter following a verbal apology.

**Action the Trust Should take to improve:**

- The trust should ensure that patients are able to engage in a range of activities across all wards.

# Our findings

- The trust should ensure patients are supported to take section 17 leave, particularly where this involves patients attending medical appointments.
- The trust should consider its options for improving the provision of food for patients.
- The trust should ensure patients privacy and dignity is considered when staff accompany them on section 17 leave, in relation to the wearing of scrubs.
- The trust should ensure that all patient's one-page profiles are easily accessible for staff.
- The trust should ensure where appropriate carers have opportunities to be involved in their loved ones support.
- The trust should ensure that restrictions are individually assessed and blanket restrictions are a proportionate response to risks posed.

# Our inspection team

The team that inspected the service comprised of a CQC lead inspector, 1 other inspector, 1 assistant inspector, 3 specialist advisors and 1 expert by experience. The inspection team was overseen by Sheila Grant – Deputy Director of Operations.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

This section is primarily information for the provider

# Requirement notices

Treatment of disease, disorder or injury

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment |

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |