

North Essex Partnership University NHS Foundation
Trust

Acute wards for adults of working age and psychiatric intensive care units

Quality Report

The Linden Centre Mental Health Wards
Puddings Wood Drive
Broomfield
Chelmsford
Essex
CM1 7LF
Tel: 01245 318802
Website: www.nep.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRDAH	The Linden Centre Mental Health Wards	Finchingfield and Galleywood wards	CM1 7LF

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

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

Summary of findings

Where applicable, we have reported on each core service provided by North Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of North Essex Partnership University NHS Foundation Trust.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Our findings at The Linden Centre Mental Health Wards were:

- We noticed environmental risk areas around the wards and it was not apparent that actions had been taken to fully address these. Most risk assessments seen lacked detail and did not include clear guidance for staff to follow. Following a serious incident in 2012 an action point was to review the door hinges in place throughout this location and this had yet to be fully addressed by the trust.
- Those care plans seen lacked sufficient detail to enable staff to provide informed interventions. There were no care plans seen for physical healthcare monitoring or potential interventions for these if required.
- Some actions were required to ensure that all staff were adhering to the Mental Health Act and the code of practice relating to section 17 leave and recording clearly that patients were informed of their rights under section 132. Three patients told us they had not received information about their rights as a detained patient.
- Individual records did not demonstrate an involvement in their care and treatment by all patients. Five patients told us that there were not enough activities taking place, particularly at weekends. Some issues affecting the privacy and dignity of patients were identified.
- Staffing levels and the granting of section 17 leave was affected by changes in patient dependency. Both wards were full and staff reported a high turnover of admissions and there were some delayed discharges.

However:

- Patients us that they felt safe on the wards. Most patients told us staff treated them with dignity and respect and felt staff were approachable. We observed interactions with staff and patients and found that staff communicated in a calm and professional way. Staff showed an understanding of individual needs of the patient. Most patients told us they had been involved in developing their care plan. Patients had opportunities for attending group activities. We found examples of how staff supported patients to raise complaints. Patients were aware of the independent advocacy service and information regarding patient rights under the Act was on display. We saw that people's mental capacity to consent to their care and treatment had been assessed where relevant.
- We found that some actions had been taken by the trust to mitigate risks to patients. For example the provision of high dependency bedrooms. Staff had received safeguarding training and were aware of their responsibilities for reporting concerns. Staff knew how to report incidents and these were reviewed by the trust's clinical governance structure. Staff were aware of the trust's policy on enhanced observation levels and these records were mostly well completed. Patients told us that physical healthcare assessments took place following admission.
- Staff confirmed that they had received mandatory training and there were systems for monitoring supervision attendance and staff appraisals. Governance systems were in place and managers had access to trust data to gauge the performance of the team and compare against other locations within the trust. Staff reported good morale and being supported by their colleagues.

Summary of findings

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

Are services safe?

Our findings at The Linden Centre Mental Health Wards were:

- We noticed environmental risk areas around the wards and it was not apparent that actions had been taken to fully address these. Those risk assessments seen lacked detail and did not include clear guidance for staff to follow. Post incident debriefing was not offered routinely to patients. Parts of the environment on both wards were in need of redecoration and minor repair.
- Staffing levels and the granting of section 17 leave was affected by changes in patient dependency. A ward manager told us that due to staffing pressures they had not been able to review incident reports as quickly as they would want.

However:

- Most patients felt safe on the wards and told us that staff reacted promptly to any identified concerns. We found that some actions had been taken by the trust to mitigate risks to patients. For example the provision of high dependency bedrooms.
- Some partial redecoration was taking place.
- There was use of bank and agency staff and a recruitment plan was in place.
- Staff had received safeguarding training and were aware of their responsibilities for reporting concerns. Staff knew how to report incidents and these were reviewed by the trust's clinical governance structure. Staff were aware of the trust's policy on enhanced observation levels and these records were mostly well completed.

Are services effective?

Our findings at The Linden Centre Mental Health Wards were:

- Those care plans seen lacked sufficient detail to enable staff to provide informed interventions. Most care plans seen did not include physical healthcare monitoring or potential interventions for these if required.
- We found that formalised checklist inductions for bank/agency staff were not consistently taking place. On Galleywood ward supervision was not taking place regularly as per the trust standard.

Summary of findings

- Some actions were required to ensure that all staff were adhering to the Mental Health Act and the code of practice relating to section 17 leave and recording clearly that patients were informed of their rights under section 132. Three patients told us they had not received information about their rights.

However:

- Patients told us that physical healthcare assessments took place following admission.
- Staff confirmed that they had received mandatory training. Managers had systems for monitoring supervision attendance and staff appraisals. Staff reported systems for engaging with multi-disciplinary teams.
- Patients were aware of the independent advocacy service and information regarding patient rights under the Act was on display. We saw that people's mental capacity to consent to their care and treatment had been assessed where relevant. Informal patients received a leaflet informing them of their rights whilst in hospital.

Are services caring?

Our findings at The Linden Centre Mental Health Wards were:

- Most patients told us staff treated them with dignity and respect and felt staff were approachable. We observed interactions with staff and patients and found that staff communicated in a calm and professional way. Staff showed an understanding of individual needs of the patient. Most patients told us they had been involved in developing their care plan

However:

- Individual records did not demonstrate an involvement in their care and treatment by all patients.

Are services responsive to people's needs?

Our findings at The Linden Centre Mental Health Wards were:

- Patients had opportunities for attending group activities. We found examples of where staff were able to meet patient's diverse needs.
- We found examples of how staff supported patients to raise complaints. Staff told us they had access to interpreters and translation services, as and when this service was required. Information was displayed for patients about the chaplaincy service and multi faith room.

However:

Summary of findings

- At the time of our visit both wards were full and staff reported a high turnover of admissions. Previous occupancy rates for both wards was over 100%. For example in September 2014 occupancy rates for both wards had exceeded 100% including patients on home leave. There were some delayed discharges mainly due to difficulties with suitable community accommodation being available.
- Five patients told us that there were not enough activities taking place, particularly at weekends. We found some issues affecting the privacy and dignity of patients. Some community meeting minutes lacked detail of what actions had been taken in response to patient's requests.

Are services well-led?

Our findings at The Linden Centre Mental Health Wards were:

- Staff explained governance systems in place and managers had access to trust data to gauge the performance of the team and compare against others. Staff reported good morale and being supported by their colleagues. A range of audits took place to assess the quality of the service.

Summary of findings

Background to the service

The Linden Centre Mental Health Wards is a location registered by North Essex Partnership University NHS Trust. It is located in Chelmsford in the grounds of the local NHS acute trust.

There were two acute admission wards for adults at this location.

Galleywood ward - 24 beds for male and female patients.

Finchingfield ward - 23 beds for male and female patients.

Both wards were full and eight patients on each ward were detained under the Mental Health Act on the day of our inspection.

The location was last inspected by the Care Quality Commission on 13 June 2013 and there were no regulatory breaches identified.

Our inspection team

Our inspection team was led by:

Inspection managers: **Peter Johnson (mental Health) CQC**

The team that inspected this location were:

- One CQC hospital inspection manager
- One CQC inspector
- One Mental Health Act reviewer.
- Two experts by experience that had experience of using mental health services.

Why we carried out this inspection

We carried out an unannounced focused inspection of this core service following concerns identified by the Care Quality Commission.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting this location, we reviewed a number of incidents that were reported directly to the Care Quality Commission.

During the inspection visit the inspection team:

- Visited both wards, looked at the quality of the ward environment and observed how staff were caring for patients.

- Spoke with ten patients across both wards.
- Interviewed the ward managers for each ward.
- Spoke with two senior trust managers with accountability and responsibility for this core service. These were the area deputy director and the operational services manager.
- Spoke with one consultant psychiatrist.
- Spoke with nine frontline staff members including trained nurses and health care assistants.

We also:

- Reviewed nine individual assessment and treatment records, including five patients detained under the Mental Health Act 1983
- Reviewed five prescription charts in detail.
- Looked at a range of policies, procedures and other records relating to the running of this service.

Summary of findings

- Visited the (ECT) electroconvulsive therapy suite adjacent to the unit.

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

What people who use the provider's services say

During the inspection the team spoke with ten patients across both wards.

- Most patients told us they felt safe on the wards and that staff reacted promptly to any identified concerns. They told us that staff treated them with dignity and respect and were involved in their own care planning.

However:

- Five patients told us that there were not enough activities taking place, particularly at weekends. Three patients told us they had not received information about their rights under the Mental Health Act. Three patients told us there was not enough staff on duty and that some bank and agency staff were not supportive.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Actions the trust **MUST** take to improve:

- The trust must ensure that actions are taken to address the identified environmental risk areas around the wards.
- The trust must ensure that individual patient's risk assessments and care plans provide sufficient detail and guidance for staff to follow.

Actions the trust **SHOULD** take to improve:

- The trust should consider using a patient acuity tool to assess and plan staffing levels.

- The trust should ensure that staff follow the Mental Health Act code of practice relating to section 17 leave and informing patients of their rights under section 132.
- The trust should ensure that the activity provision at the weekends is reviewed.
- The trust should ensure that steps are taken to maintain the privacy and dignity of patients at all times.
- The trust should ensure that all staff have regular supervision.

North Essex Partnership University NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Finchingfield and Galleywood wards	The Linden Centre Mental Health Wards

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.

- Most patients were aware of the independent advocacy service. The trust had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice. Information regarding patient rights under the Act was on display.

However:

- No records of risk assessments having been carried out before patients had section 17 leave were seen. No records of the outcome of section 17 leave including the patient's views were documented. There were some gaps in the recording of patients having been informed of their rights under Section 132 of the Act. No records were in place to show that the patient or their escort (if family) had received a copy of the section 17 leave form including authorisation and conditions.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that people's mental capacity to consent to their care and treatment had been assessed where relevant. Informal patients had received a leaflet informing them of their rights whilst in hospital.
- Both wards were locked and there was no signage in place informing informal patients of how they could leave the ward if they wished. Three patients told us they had not received information about their rights under the Act.

However:

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

The Linden Centre Mental Health Wards - Finchingfield and Galleywood wards

Safe and clean ward environment

- Gaps were seen in the completion of the action plan drawn up in response to the annual ligature risk audit and the patient safety audit. The trust's programme for managing ligature risks was not available. We noticed a number of potential high risk ligature areas around the ward and these were brought to the attention of staff. The trust's own patient safety audit did not reflect these findings and the actions that were required to address these. Parts of the wards did not provide clear lines of sight for example there were corridors with rooms off them. Alarms were not available in bedrooms for patients to use.
- Inappropriate storage of equipment was noted in one cupboard and brought to the attention of staff. We found gaps in the recording of fridge temperatures in the clinics on both wards. On Galleywood ward the record keeping for checking resuscitation equipment had gaps for February 2015. We found three hand hygiene gel dispensers were empty indicating checks may not be robust.
- Some patients had perishable food items and milk in their rooms, which could pose a health risk. Staff took action remove the items.
- Staff informed us that there were five bedrooms allocated to those patients assessed as being at high risk of self-ligature. If these rooms were not available then other bedrooms were adapted in accordance with individual risk assessments. There were male and female identified areas and gender designated facilities. Some relational security measures were noted for example, enhanced staff observation levels and information provision during staff handovers. We saw

that a report to the trust's 'Risk and Governance Executive', dated October 2014 referred to replacements of doors and windows following a review of the latest developments in anti-ligature furniture.

- Both wards were clean and there were dedicated cleaners employed.

Safe staffing

- Core staffing levels had been set by the trust. This included having two trained nurses on at all times including the night shift. Staff reported two vacancies on Finchingfield ward. This included a trained nurse vacancy. Two trained nurses were on secondment to other areas in Galleywood ward and there was 0.4 of a healthcare assistant post vacant. Trust data for December 2014 showed 63% substantive staffing levels were achieved. We noted that the ward manager was supernumerary. There were three student nurses on the wards and they were also supernumerary. The ward manager confirmed that they could book additional staff if required by patient dependency. Ward managers were aware of the need to constantly review staffing levels based on assessed patient need. The trust's own staff bank were used if needed to ensure staffing consistency. One additional nurse was rostered on Tuesdays and Thursdays to cover the ECT suite and act as the recovery nurse.
- Senior managers referred to reporting staffing levels on wards and on the trust website for the public, with reference to the 'Hard Truths' commitment, under guidance issued by NHS England and the Care Quality Commission.
- There was no evidence of a patient acuity tool being used to plan staffing levels. Two staff and three patients said they felt staffing levels had been affected by the increased level of bed occupancy.

Assessing and managing risks to patients and staff

- Most risk assessments seen lacked detail and did not include clear guidance for staff to follow. There was a lack of individualised information noted on risk assessments. Most individual risk assessments seen had not been updated to reflect assessed changes in clinical

Are services safe?

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

need. For example one person had recently absconded and records did not show that a risk assessment had taken place following this and that future care needs were re-assessed.

- A ward manager explained there were challenges with recording information such as historical risk details on the trust electronic patient record system. Post incident debriefing was not offered routinely to patients. Senior managers told us they would take action to address this.
- Patients felt safe on the wards and told us that staff reacted promptly to any identified concerns. Staff had received safeguarding training. We found that staff were attending their three yearly refresher training. Staff were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly. They knew who the trust's safeguarding lead was. Safeguarding incidents had been reported through the trust's safeguarding protocols and where required had been investigated appropriately.
- Staff informed us that if seclusion was required; the patient would be transferred to the trust's psychiatric intensive care unit (PICU). Staff knew how to report incidents and the trust provided clear guidance to staff on incident reporting. All serious untoward incidents were reviewed by the trust's clinical governance structure. Post incident debriefing was available for staff and we saw examples of this. Staff confirmed that safety alarms worked effectively and there was a prompt response should concerns be identified. Staff were

aware of the trust's policy on enhanced observation levels and these records were mostly well completed. Weekly audits of a sample of prescription and medicine administration cards took place.

Track record on safety

- There had been several serious incidents (SI) within this service in the last year. Some of these remained under investigation by the trust.

Reporting incidents and learning from when things go wrong

- Ward based staff knew how to report any incidents on the trust's electronic reporting system. Senior staff were aware of incidents and these had been discussed daily and escalated appropriately for action. Actions identified from incident reviews had been followed up by the trust. Staff received feedback about the outcome of incidents that had happened. Staff had received a debrief following a recent serious incident.
- Following a serious incident in 2012 an action point was to review door hinges to prevent potential for use as ligature points. We found that whilst the trust had investigated and trialled options. A final decision had not been taken. A senior manager told us funding was agreed for 2015/16. We found that the trust had addressed the other action points arising following this incident.
- A ward manager told us that due to staffing pressures they had not been able to review incident reports as quickly as they wanted.

Are services effective?

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

Summary of findings

Our findings

The Linden Centre Mental Health Wards - Finchingfield and Galleywood wards

Assessment of needs and planning of care

- Those care plans seen lacked sufficient detail to enable staff to provide informed interventions. Most care plans seen did not include physical healthcare monitoring or potential interventions for these if required. Care plans did not detail any outcome measures for staff to use.
- Patients told us that physical healthcare assessments took place following admission.

Skilled staff to deliver care

- Staff confirmed that they had received mandatory training. This was confirmed by those records reviewed. Managers had systems for monitoring supervision attendance and staff appraisals.
- A bank/agency staff member told us they had received an orientation to the ward but this was not formalised. However, managers told us there was a formalised checklist staff should complete. Information for Galleywood ward and feedback from the ward manager was that supervision was not taking place regularly as per the trust standard.

Multi-disciplinary and intra-agency team work

- Care programme approach (CPA) meetings were scheduled and attendance was encouraged by all involved in the patient's care and treatment. Handovers

between staff shifts had systems for communicating areas of improvement or risks. Staff reported some effective team working and joint working across units and other trust services. A nurse gave an example of liaising with a psychologist regarding the care plan for one person however the psychologist kept separate notes.

Adherence to the MHA and MHA code of practice

- Patients were aware of the independent advocacy service. The provider had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice. Information regarding patient rights under the Act was on display. The records showed that patients had been informed of their rights of appeal against their detention.
- No records of risk assessments having been carried out before patients had section 17 leave were seen. No records of the outcome of section 17 leave including the patient's views were documented. There were some gaps in the recording of patients having been informed of their rights under Section 132 of the Act. No records were in place to show that the patient or their escort (if family) had received a copy of the section 17 leave form including authorisation and conditions.

Good practice in applying the MCA

- We saw that people's mental capacity to consent to their care and treatment had been assessed where relevant. Informal patients received a leaflet informing them of their rights whilst in hospital.
- Both wards were locked and there was no signage in place informing these patients of how they could leave the ward if they wished. Three patients told us they had not received information about their rights under the Mental Health Act.

Are services caring?

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

Summary of findings

Our findings

The Linden Centre Mental Health Wards - Finchingfield and Galleywood wards

Kindness dignity respect and support

- Most patients told us staff treated them with dignity and respect and felt staff were approachable. Staff spoke

about patient in a caring and compassionate manner. We observed interactions between staff and patients and found that staff communicated in a calm and professional way. Staff showed an understanding of individual patient need. Advocacy service details were displayed on the ward.

The involvement of people in the care they receive

- Most patients told us they had been involved in developing their care plan. However, individual records did not demonstrate an involvement in their care and treatment by all patients.

Are services responsive to people's needs?

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

Summary of findings

Our findings

The Linden Centre Mental Health Wards - Finchingfield and Galleywood wards

Access discharge and bed management

- At the time of our visit both wards were full and staff reported a high turnover of admissions. Previous occupancy rates for both wards was over 100%. For example in September 2014 occupancy rates for both wards had exceeded 100% including patients on home leave. For December 2014 there was 93% occupancy for Galleywood. From April 2014 to January 2015 there were 566 patient admissions across wards and 568 patient discharges.
- There were four delayed discharges for Finchingfield ward and five for Galleywood on the day of our inspection. Trust information showed these were mainly due to difficulties with community accommodation being available. One person had been on the ward for two years.

The ward optimises recovery comfort and dignity

- Patients had access to an enclosed garden. Some bedrooms were shared between two patients. They had access to a kitchen to make hot/cold drinks. We saw a ward activities programme for patients. They were opportunities for art therapy, groups such as managing emotions, arts and crafts groups, understanding your medication, mindfulness, relaxation and family group conferencing.
- Doors had vision panels which staff could access to carry out observations. This minimised intrusion for patients.
- Closed circuit television (CCTV) was available in the unit and wards. Signage informing people of this was not apparent, although the 'Inpatient Information Leaflet' held details of this. Some redecoration was taking place although staff reported that this was only partial. An (ECT) electroconvulsive therapy suite was adjacent to the unit and could be accessed for inpatients as appropriate.

However:

- Five patients told us that there were not enough activities taking place, particularly at weekends.
- On Galleywood ward we found the nursing office had large windows and confidential patient information on display on the whiteboard was visible from the corridor patients. This was less evident on Finchingfield ward.
- Parts of the environment on both wards were in need of redecoration and minor repair.
- Privacy curtains were missing in one double room. This was brought to the attention of ward based staff.

Meeting the needs of all the people who use the service

- Staff told us they had access to interpreters and translation services, as and when this service was required.
- Information was displayed for patients about the chaplaincy service and multi faith room.
- We saw assisted bathrooms/toilets were available for patients with mobility difficulties.

However:

- We saw a bariatric wheelchair was left outside a patient's bedroom as it was not able to fit through the door. This meant that the patient lacked easy access to their wheelchair.

Listening and learning from concerns and complaints

- A manager told us that any complaints were discussed via team meetings for managers and cascaded via team meetings.
- The 'Inpatient Information Leaflet' gave details on how to make any complaints and suggestions.
- Two people had contacted us with concerns about these wards and the trust were investigating their complaints.
- We found examples of how staff supported patients to raise complaints.
- We saw that patients were able to raise issues at community meetings. Minutes did not always detail what actions had been taken in response with timeframes for completion. For example a request was made on Galleywood for a microwave in November 2014 and the matter had been raised again in January 2015.

Are services well-led?

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

Summary of findings

Our findings

The Linden Centre Mental Health Wards - Finchingfield and Galleywood wards

Good governance

- Trust governance systems were robust.
- Managers had access to trust data such as monthly 'barometers' to gauge the performance of the team and compare against others. This included information on care documentation completion and other staff performance indicators

- Information from the trust and other similar wards were discussed at team meetings.

Leadership morale and staff engagement

- Staff reported good morale and being supported by their colleagues.
- Staff approached their manager if they had any concerns about clinical practice and were aware of the trust whistleblowing policy.
- The trust had a human resources department and occupational health services were available to staff.

Commitment to quality improvement and innovation

- A range of audits took place, for example one ensuring care records were completed.
- Managers confirmed that actions were taken as a result of these findings.

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 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>We found that the trust had not protected patients by taking action to fully address the identified environmental risk areas around the wards. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>15 The registered person must ensure that service users and others having access to the premises are protected from the risks associated with unsafe or unsuitable premises by means of –</p> <ul style="list-style-type: none">• Suitable design and lay out <p>and</p> <p>Care and treatment must be provided in a safe way for service users. The trust must:</p> <ul style="list-style-type: none">• assess the risks to the health and safety of patients of receiving the care or treatment.• do all that is reasonably practicable to mitigate any such risks.• ensure that the premises used by the trust are safe to use for their intended purpose and are used in a safe way <p>The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) (a)(b)2d).</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p>

This section is primarily information for the provider

Requirement notices

We found that the trust had not protected patients by ensuring that individual patient's risk assessments and care plans provided sufficient detail and guidance for staff to follow. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

9 The trust must take proper steps to ensure that each person is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the person; and the planning and delivery of care and, where appropriate, treatment in such a way as to meet the person's individual needs, ensure the welfare and safety of the person. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 9(1)(a)(b)(i)(ii).

and

9 Care and treatment must be provided in a safe way for service users. The trust must:

- assess the risks to the health and safety of patients of receiving the care or treatment.
- do all that is reasonably practicable to mitigate any such risks.

12. Care and treatment must be provided in a safe way for service users.

1. Without limiting paragraph (1), the things which a trust must do to comply with that paragraph include—
 - A. assessing the risks to the health and safety of service users of receiving the care or treatment;
 - B. doing all that is reasonably practicable to mitigate any such risks

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9 (1)(2)(a)(b) and 12(1) (a)(b).