Partnerships in Care Limited

Priory Hospital Arnold

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location stayed the same. The hospital remains in special measures.

We rated it as inadequate because:

- We have not seen sufficient improvement to the safety of patients since a previous inspection published in March 2020, where the rating for safe has remained inadequate.
- The governance processes and the way the service was consistently led did not always ensure that patients remained safe.
- The provider did not always deliver safe care to patients. Although they minimised the use of restrictive practices, they did not always manage this well. Staff did not manage items which could present a risk to the patients and this led to incidents where harm may occur. They had not learnt from previous incidents where patients had been harmed through access to items which should have been safely stored to keep patients safe..
- Patients privacy and dignity was not always protected. This was primarily towards women who used the service where sanitary bins were not routinely available and led to women having to hand used items for sanitary use directly to staff.
- Patients did not routinely feel that they were treated with kindness and compassion by non-regular staff whose aim was to care for them. Although patients said regular staff who knew them well treated them with kindness and compassion, and supported them.
- There was a lack of training for staff to support patients with a personality disorder. The provider had not met its aim of providing training for staff since the previous inspection. This meant that patients did not receive a consistent approach from staff that impacted on their care pathway.
- The environment and furniture required improvement. Patients said that furniture was poor and not fit for purpose. There was a lack of provision of furniture to support outside places.
- Patients said there was not enough to do and were bored. There was were concerns about access to psychological therapies and that activities were not age appropriate.

However:

- The provider actively involved patients and families in care decisions.
- 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 provider managed medicines well and followed good practice with regard to safeguarding.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- Managers ensured that staff received supervision and an appraisal, and mandatory training was mostly up to date.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Inadequate 	We rated this service inadequate. See summary above for more information.

Summary of findings

Contents

Summary of this inspection

Background to Priory Hospital Arnold

Priory Hospital Arnold is provided by Priory Healthcare Limited and registered with the CQC to provide the following the following regulated activities;

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

Treatment of disease, disorder or injury

Diagnostic and screening procedures.

The hospital provides two acute mental health wards for men and women on Newstead and Bestwood wards, and provided a psychiatric intensive care unit on Rufford ward for women, and for men on Clumber ward. Following our inspection in March 2021 the provider closed Newstead and Clumber wards. They reopened Newstead ward in September 2022, but Clumber ward remains closed.

There are16 beds on both Bestwood Ward and Newstead Wards, and 10 beds on Rufford ward. Wards are commissioned through Nottinghamshire Healthcare NHS Foundation Trust.

There have been 19 previous inspections to Priory Hospital Arnold. The previous inspection to this was December 2022 and the report was published on 15 March 2022.

The hospital was placed into special measures in March 2021 and placed conditions registration. We removed five of the seven conditions imposed in October 2021 following an application from the provider to remove all seven.

We inspected Bestwood, Newstead and Rufford Wards unannounced on the 2, 3 and 4 August 2022 due to concerns raised following incidents that had occurred at the hospital.

This was a comprehensive inspection where we inspected all five key questions: Safe, Effective, Caring, Responsive and Well led.

What people who use the service say

Patients on Rufford ward told us that there were no sanitary protection disposal bins available and were upset and embarrassed about having to hand over used sanitary protection to staff. Patients told us that there is a real difference in care provided by regular staff compared to bank or agency staff. Two patients told us that non regular staff won't speak to patients.

Patients told us that there is a lack of therapy and access to psychological therapies is not routinely available.

Patients told us that they are bored. However, they told us that the activities that occupational therapy provide are varied and interesting.

One patient told us that they felt the activity timetable on the ward was not age appropriate.

Summary of this inspection

Patients told us they had access to drinks and snacks on the ward when they wanted and when appropriate, from the hospital vending machine.

Patients told us that they found permanent staff to be nice and friendly.

Patients told us that they felt the wards to have tired and worn furniture.

Patients told us that they had access to outside areas and the hospital grounds.

One patient told us that whilst secluded they were treated well and looked after.

A carer told us that they are pleased with the staff and the support given to their relatives.

A carer told us that they are asked to contribute to care plans if they would like to.

Carers told us that the service explained why some information is not given due to the patient's preference.

How we carried out this inspection

This was a comprehensive inspection and looked at all five key questions: safe, effective, caring, responsive and well-led.

We visited Rufford, Newstead and Bestwood wards at this inspection.

The inspection team comprised of three CQC inspectors, one specialist advisor who was a registered nurse and had experience of these settings and an expert by experience.

The inspection team;

Spoke with 12 patients who were using the hospital.

Spoke to one carer.

Observed staff interacting with patients.

Observed handovers of Rufford and Bestwood ward from day staff to night staff on 3 August 2022.

Spoke with 22 staff members including nurses, support workers, ward managers, a clinical lead, a specialist doctor and lead consultant psychiatrists.

Reviewed the quality of the hospital environment.

Reviewed 11 patient care records plus physical health records and medicine charts.

Reviewed a range of documents relating to the running of the hospital.

Summary of this inspection

You can find 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.

Areas for improvement

Action the service 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 service MUST take to improve:

The provider must ensure that patient's dignity is protected and they are provided with risk assessed sanitary disposal units in their bedrooms (Regulation 10 (2)(c))

The provider must ensure that staff are trained to meet the needs of patients who have a diagnosis of personality disorder. (Regulation 18 (1)(2)(a))

The provider must ensure that all staff understand how to consistently manage items which may present a risk to patients. (Regulation 12 (1) (2) (a) (b))

The provider must ensure that staff use least restrictive practice standards when searching patients. (Regulation (12) (1) (2) (a) (b) (c))

The provider must ensure all medical equipment in all clinic rooms are in working order. (Regulation 15 (1)(e))

The provider must ensure that effective governance processes are in place and maintained to improve safety and care to patients. (Regulation 17(1)(2)(a)(b))

The provider must ensure that staff are trained in immediate life support. (Regulation 12 (1) (2) (a) (b)(c))

The provider must ensure that patient activities reflect their needs and prevent boredom, including support in the community. (Regulation 9 (1) (a) (b))

Action the service SHOULD take to improve:

The provider should ensure that the environment, including outside areas, are always fit for patients to use. (Regulation 15)

The provider should ensure that staff maintain using personal protective equipment correctly in relation to face masks. (Regulation 12)

The provider should ensure all staff that leave the service complete an exit interview (Regulation 17)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

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

Inadequate

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

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

Inadequate

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

Safe and clean care environments

All wards were not always safe, clean, well equipped, well furnished and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas. plus removed or reduced any risks they identified. However, at the time of our inspection we found inconsistencies in the recording and whereabouts of restricted and banned items on Bestwood and Newstead wards. Managers were able to find and locate the items that were deemed missing by the end of the inspection.

Staff could observe patients in all parts of the wards. The provider had installed convex mirrors to manage blind spots identified in the service and closed-circuit television cameras were present in communal areas of all wards.

Following our previous inspection we told the provider they should ensure that both female and male lounges are clearly identified for patients. Bestwood and Newstead wards were mixed sex wards, both offered separate bedrooms corridors for each gender and the provider now displayed clearly that separate lounge areas where available for patients. This complied with guidance and expectations about governing the provision of single sex accommodation. Rufford ward was for female patients only.

The provider completed annual ligature assessment across the hospital. In addition, senior staff completed regular assessments of potential ligature anchor points in the service for their own assurance Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. Ward offices displayed a ligature map of the environment and patient bedrooms had ligature reducing fittings. Staff had easy access to alarms. The provider had replaced the alarm system for staff in April 2021. Staff collected personal alarms from the hospital reception, and they were checked daily to ensure they were charged and in working order. Patients had easy access to nurse call points, including from their bedroom and bathroom areas.

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

Inadequate

Maintenance, cleanliness and infection control

Ward areas were clean but ward furniture was not always well maintained. At the time of our inspection we found some of the ward furniture to be worn, stained or scuffed. The secure garden area for Bestwood had little furniture for patients to use whilst accessing the area. It was not fit for purpose, we found it overgrown with weeds and had lots of wasp's present. We also found discarded food on the floor. However, the provider promptly addressed these issues. A gardener was booked and garden furniture was ordered and pest control was booked to resolve the wasp issue

Staff made sure cleaning records were up-to-date and the premises were clean. We found the wards to be clean and odour free. The hospitals domestic team had enough supplies to be able to do their duties and we found cleaning store cupboards to be in order and maintained well.

Staff followed the providers infection control policy, including handwashing. At the time of our inspection the service was following the Department of Health guidance on how to manage COVID-19. Staff had access to the appropriate personal protective equipment (PPE). However, on occasions we observed staff wearing their masks below their mouths. Managers addressed this concern with their staff during our inspection.

Seclusion room

The hospital had two seclusion rooms and were based on Rufford ward. At the time of this inspection, no patients were in seclusion.

Both seclusion rooms were compliant with the Mental Health Act Code of Practice and were fit for purpose.

The seclusions rooms allowed clear observation and two-way observations, they had a toilet and shower facilities.

Rufford ward was the only ward that had access to two seclusion rooms. At the time of our inspection both seclusion rooms were in use. Both seclusion rooms provided staff with clear observation and two-way communication of patients. Patients cared for in seclusion had access to a toilet, shower and a clock was visible to them. One seclusion room had access to fresh air in an enclosed garden. However, the other seclusion room did not. The service would allow access to the communal garden based on clinical decisions on risk for patients to gain access to fresh air.

Staffed risked assessed patients prior to entering seclusion rooms. As neither seclusion room had a hatch, staff were required to open seclusion doors to support patients and to offer food or medicines. We had been told no incidents had happened due to this and doors were opened following risk management.

We found one seclusion room was being utilised as long-term segregation for one patient that included access to a lounge and outside space. This was undertaken appropriately and within the provider's policy. We found staff were working closely with the placing clinical commissioning group (CCG) and the patient. We observed seclusion reviews for the patient in seclusion, this was carried out by a doctor and a nurse both patients with no concerns on how these were undertaken. We saw multi-disciplinary staff contributed to these reviews.

When required the provider adapted seclusion practices to meet the individual needs of patients. In one example, staff operated a "flexi seclusion programme" to provide the patient with access to the garden and lounge area at certain times of the day. We found that both patients had exit plans in place to leave seclusion.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Our checks on resuscitation equipment and clinic rooms confirmed this.

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

Inadequate

Staff checked, maintained, and cleaned clinical equipment. However, on Rufford ward we found both the medicine fridge and air conditioning unit in the clinic room was not working. Medicine that needed to be chilled was being stored in the medicine fridge on Newstead ward. Staff told us there was a fault with the electrical supply to the clinic room on Rufford ward. Managers were aware of the fault as it happened and had escalated it to be fixed. The works had not been completed at the time of the inspection.

Safe staffing

The service had enough regular registered nurses and support workers. They had enough medical staff. The service actively recruited staff and had recently employed a number of new staff who were either on induction or waiting to commence within the service. Most staff knew the patients and all staff received basic training to keep people safe from avoidable harm, although there were unmet training needs for patients with a diagnosis of a personality disorder..

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service required 28.5 whole time equivalent registered nurses of which 9.65 were vacant. The service required 72 whole time equivalent support workers of which 28.6 were vacant.

Managers told us they had successfully recruited 16 health care support workers in June 2022 and they were completing their induction at the time of our inspection. This was a mix of bank and permanent staff. They also had 12 nurses waiting to commence employment the service.

Reviewing the governance paperwork available to us for June 2022, the service had used bank or agency nurses for 98 shifts during that month and 221 shifts for bank or agency health care support workers for that month. This was due to covering sickness, annual leave and vacancies.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, when reviewing restricted items practices we found the provider did not always check the competency of temporary staff and were not aware to do so to manage this safely and in line with their policy.

From the data reviewed we found that the service had 10 members of staff leave in June 2022 that included a consultant psychiatrist, a charge nurse and a senior staff nurse. We found that no exit interviews had been completed in that month and there was no explanation as to why those staff members had chosen to leave.

Managers supported staff who needed time off for ill health. Managers told us that the current sickness rate within the service was at 6%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. At the time of the inspection all shifts were covered and the ward managers told us they could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse. This was supported in the care plans we looked at.

Patients rarely had their escorted leave or activities cancelled. Our conversations with patients confirmed this.

The service had enough staff on each shift to carry out any physical interventions safely.

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

Inadequate

Staff shared key information to keep patients safe when handing over their care to others. We observed two handovers day to night and staff shared essential information including observation and risk factors.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency as there was a doctor on site 24 hours a day on 7 days a week. The service had a full medical team and could call locum doctors when they needed additional medical cover. At the time of our inspection one consultant psychiatrist was employed in a locum capacity.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. We found the locum consultant was involved in meetings attached to their role which included management meetings.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. At the time of our inspection, the provider reported an overall staff completion rate of 83%. This covered all wards, only one training module fell below the providers target which was "leading health and safety for managers" this was at a completion rate of 60%. The hospitals training programme covered different modules for example reducing restrictive intervention breakaway training, infection control and basic life support which included how to use a defibrillator and air way management. Completion was 77% on this module. However, the provider did not train its staff in immediate life support. National Institute for Health and Care Excellence guidance recommends that any setting where restrictive interventions (rapid tranquilisation, restraint or seclusion) are used have immediate access to staff trained in immediate life support (ILS) and to appropriate ILS medication and equipment.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was a regular agenda item in governance meetings.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well in particular the management of risk items. However, staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool and reviewed this regularly, including after any incident.

The multidisciplinary team were involved in completing patient risk assessments.

However, we found inconsistencies in risk assessments completed on every ward. Specifically we found that two wards had not completed risk assessments around the use of sanitary disposal units in patients' bedrooms.

Management of patient risk

Staff did not always act to prevent or reduce risks to patients. They had an inconsistent approach when managing risk items. We found this had not improved since our previous inspection when we told the provider they must ensure ward environments are always safe for patients. During our inspection we found inconsistencies in the management of risk

items on two of the wards we inspected. For example, on Bestwood Ward we found risk items which could present a risk to patients listed on the inventories but were not present and secured in the allocated patient lockers. These included head phone cables, phone charger cable, nail clippers and a wired notebook all of which are listed as being restricted items on the hospitals policy on banned and restricted items.

Staff told us they did not always understand the providers policy on the management of risk items. On Newstead ward staff could not always describe the providers policy to manage risk items. We found staff had not understood and followed the providers policy and we found staff securely stored a patient's risk items in the patient bedroom, this was not in line with the providers policy.

Staff identified and responded to any changes in risks to, or posed by, patients. This included up dated risk assessments and risk management plans as risks changed.

Staff could observe patients in all areas of the wards and staff followed procedures to minimise risks where they could not easily observe patients. This included convex mirrors to manage blind spots.

Staff did not always follow provider policies and procedures in searching patients or their bedrooms to keep them safe from harm, this included the management of risk items.This had resulted in patients being able to bring risk items onto the ward unchallenged. In two incidents this resulted in harm to patients.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met national best practice standards. Ward managers completed a "restrictive practice self-assessment audit tool" on each ward monthly. This ensured that most care and treatment was provided in the least restrictive way for patients but not in the case of search.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Between September 2021 and June 2021, the provider recorded an average of 70 incidents of physical interventions with patients per month. This showed an increase from the figures from January 2021 to August 2021 where the average incidents per month was 27. The provider reported from January 2021 to June 2022, there were 8 supine (face up) and 6 prone (face down) restraints. At the time of the inspection there was increased numbers of patients and high acuity of risk.

Training figures showed the provider trained staff in the use of physical interventions with patients. The provider recorded staff completion rate of 85%.

Staff we spoke with understood the Mental Capacity Act definition of restraint and worked within it.

Evidence from the provider showed that between January and June 2022 rapid tranquilisation was used 123 times across the service. The breakdown of the month by month figures did show a reduction in use. For example, in February 2022 staff used rapid tranquilisation 42 times compared to June 2022 when staff used it 7 times. Following our previous inspection we told the provider they must complete physical health checks on patients following rapid tranquilisation. We found during this inspection this was being completed. When rapid tranquilisation was used with patients, staff followed National Institute for Health and Care Excellence guidance. We found evidence of correct record keeping on this procedure.

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

Inadequate

Staff followed best practice, included guidance in the Mental Health Act Code of Practice when patients were long-term segregation. There were no identified long-term segregation suites in the hospital. This meant that the two patients who were in long-term segregation were placed in the two seclusion rooms on Rufford ward. The reason for placing both patients in long-term segregation was a clinical decision based on risk.

Patients in long-term segregation had access to a lounge area and outside space. Each patient had an identified exit plan to support a transition back into a ward area. The multi-disciplinary team including doctors and nurses reviewed each patient daily to assess the need to remain in long-term segregation.

We reviewed 4 long-term segregation records and we found staff kept clear records and followed best practice guidelines.

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 kept up to date with their safeguarding training and we saw training figures of 94% completed both safeguarding adults and safeguarding children training.

When speaking to staff they gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff followed clear procedures to keep children visiting the ward safe. We saw a dedicated room away from the wards ward where both children and adults could safely visit.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw safeguarding referrals being made and how these are stored at the service.

Managers took part in serious case reviews and made changes based on the outcomes. We saw improvements since our last inspection following a death of a patient in September 2020 where we told the provider they must improve ligature audits and risk assessments which we found have improved. However, the provider did not have an overall track record on safety.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. All notes were held electronically and all staff had easy access including access for agency and bank staff.

When patients transferred to a new ward team, there were no delays in staff accessing their records due to the records being electronic.

Records were stored securely.

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

Inadequate

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. We looked at all medicine records and found no errors in recording of the administration of medicines. 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. Staff regularly repeated advice to patients about their medicines during ward rounds. This ensured all patients were able to engage and understand information about their medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. This includes guidance on medicines management from the National Institute for Health and Care Excellence. We found evidence of this in patient records on all wards.

Staff learned from safety alerts and incidents to improve practice.

When we reviewed all medicine care records we found 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 National Institute for Health and Care Excellence guidance. We saw staff discussed the medicines of each patient during ward rounds and multi-disciplinary meetings.

Following our last inspection we told the provider they must ensure that medicines are given at the time they are prescribed. We found during this inspection that the provider has made improvements and nurses were given protected time to administer medicines.

Track record on safety

The service did not have a good track record on safety. This service was placed under special measures following the previous inspection of March 2021. The service remained in Special Measures following two further inspections of June 2021 and December 2021. Records showed there had been 1092 incidents involving patients since December 2021 to June 2022.

We reported in our previous report published in March 2022 that a patient had died in the hospital by suicide. The coroner recorded a narrative verdict that detailed the death was by suicide which was contributed to by neglect.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. However, staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, during our inspection we found lessons learnt were not embedded with staff. When things went wrong, staff apologised and gave patients honest information and suitable support.

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

Inadequate

The service did not manage patient safety incidents well. We found the sharing of lessons learnt did not prevent further incidents of a similar nature. During our previous inspection we told the provider to ensure the environment is always safe for patients, that included managing banned and restricted items where patients could use them to self-harm. During this inspection we found there had been two incidents of a similar nature evidencing lessons had not been embedded by staff.

However, staff knew what incidents to report and how to report them appropriately. Managers investigated incidents. Staff received feedback from investigation of incidents, both internal and external to the service. This was done by email, during staff meetings and daily risk meetings. These issues were then discussed at monthly clinical governance meetings.

Staff raised concerns and reported incidents and near misses in line with provider's policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw an example of letters sent to patients regarding the workings of bedroom windows after being made aware patients did not know how to lock them.

Managers debriefed and supported staff after any serious incident. Staff told us debriefs occurred and managers told us there were opportunities for staff to attend reflective practice sessions with psychology.

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

Requires Improvement

Our rating of effective stayed the same. 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. However, we found inconsistencies in what risks were assessed on each ward.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We saw evidence in the 11 we reviewed during this inspection.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We saw that when patients declined physical investigations at admission staff followed up and completed them later.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We saw care plans were updated when needed and discussed in multi-disciplinary meetings. However, in one patient's record there was no information regarding diabetes management. For example, how to escalate monitoring readings that were outside of normal parameters.

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

Care plans were personalised, holistic and recovery-orientated. Staff offered patients copies of their care plans and recorded if they accepted them or not.

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. However, there were inconsistencies in approach as the psychologist did not provide therapy on site and there were only 2 occupational therapists meaning delivery was not meeting the needs of all patients.

Staff provided a range of care and treatment suitable for the patients in the service. This included psychological therapies and intervention as recommended in national guidance. For example Cognitive Behavioural Therapy, Dialectical Behaviour Therapy, Compassion Focused Therapy skills, Acceptance Commitment Therapy and Eye-movement desensitisation and reprocessing. However, this did not always meet the needs of patients whose preference was face to face psychological interventions. This impacted on the experience and care pathways of some patients.

Staff identified patients' physical health needs and recorded them in their care plans. We saw evidence of assessments of National Early Warning Score (NEWs), a tool to check physical health deterioration. We also saw assessments of patients' nutritional health using the Malnutrition Universal Screening Tool (MUST).

Staff made sure patients had access to physical health care, including specialists as required. Specialist doctors were in place for each ward and available during the evenings and weekends through an on call system.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The service had access to speech and language therapists for patients who may had any needs in swallowing or chewing. We saw in patients care plans that these needs were assessed.

Patients' told us they were bored and activities did not always meet their needs. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This including healthy choices in the providers food menus.. Occupational therapists supported patients to participate in exercise and physical activities. The service is situated within large grounds and we saw patients accessing those grounds during either escorted or unescorted leave.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This included Health of the Nation Outcome Scales (HoNOS).

Staff used technology to support patients. The provider had ward computers in place specifically for use by patients.. However, a patient told us that the computer on Newstead ward was broken and has been for months. During COVID-19 restrictions patients were able to keep in contact with their relatives and friends through video calls. The provider had given access to computers to facilitate these calls.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example quality walk rounds by ward managers and the senior team, we found that these were discussed in the senior management team's governance meetings. However, there was a lack of senior leader oversight at ward level to ensure actions from audits were completed. For example, we found no evidence that the lack of personality disorder training was discussed at ward level and was put in place.

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

Inadequate

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers did not always ensure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers did not always ensure staff had the right skills and qualifications due to lack of personality disorder training in place. The training was due to take place in December 2021 but had been postponed until the end of August 2022. Therefore, at the time of our inspection the staff were not trained and did not have the skills and experience to care for these patients. However, we saw 6 staff files that showed that recruitment was done correctly and the provider employed staff who were experienced to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Managers explained that staff got through 2 weeks of training before working on the wards. This included basic mandatory training such as reducing restrictive intervention breakaway making sure staff knew how to manage violent or aggressive behaviour safely. During our inspection an induction was being conducted.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. The figures shared at the time of our inspection showed the service was achieving an overall completion rate of 97.37% for all staff.

Managers supported medical staff through regular, constructive clinical supervision of their work. Figures shared were that medical staff had an overall completion rate of 97.06%. Managers also had clinical supervision and we saw evidence of a 98.67% completion rate.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We were shown copies of past team meetings, how things were discussed, actions made and ideas put forward. Managers had brought in a new initiative for staff named 'Friday Five', an opportunity for managers to respond to questions sent to them by staff via email. Each "Friday five" was themed and gave management an opportunity to analyse any gaps in staff knowledge and to act on this.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The mandatory training programme did not meet the needs of patients with a diagnosis of personality disorder as staff were not provided with the right training. The service admitted patients with a diagnosis of personality disorder. We found no evidence the provider offered personality disorder training to staff. We were told during the inspection that the planned personality disorder training had been postponed and had been planned for end of August 2022. This meant staff did not have the skills and experience to care for these patients.

However, although training figures were in line with the services policy of completion rate we saw that managers had identified a gap in training but had not addressed it with the lack of personality training on offer this meant staff were not able to develop their skills on this topic.

Managers recognised poor performance, could identify the reasons why and dealt with these. We saw evidence of how managers approached poor performance and how they dealt with it appropriately.

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

Inadequate

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 team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. We observed 3 ward rounds where the meetings included community teams including social workers who were involved in the patient's care, they were open and transparent in information shared.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We attended 2 handovers from the day shift and the information handed over was effective.

Ward teams had effective working relationships with other teams in the organisation. We saw evidence that ward managers are part of walk rounds of other wards and staff worked on different wards when needed.

Ward teams had effective working relationships with external teams and organisations. We received feedback that the service worked closely with the commissioners involved.

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 guiding principles. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff 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. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw posters displayed and information on the newly implemented TV screens that provided information for patients on the ward and in the reception area. This included information for informal patients.

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. We found Mental Health Act information in individual care plans. This was seen in ward rounds and handover meetings that we observed.

Staff made 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. We saw patients use their section 17 leave and how staff discussed and planned it in handover meetings and daily risk meetings.

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

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

Inadequate

We saw that care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

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. We saw evidence in care plans where families were involved in best interest meetings.

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

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. However, they did not always respect patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff did not always understand and respect the individual needs of each patient. During our inspection female patients told us they were unhappy about a lack of disposal bins for used sanitary protection products. We found Rufford ward, a ward for only females, had no disposal bins. Two patients from Rufford ward, told us they had to give staff members their used sanitary protection and this was having a negative impact on their wellbeing. When asked, staff believed disposal bins were available in the bedroom of each patient. When we asked staff on the ward about the disposal bins they told us that they were assured that each bedroom on Rufford ward had these units in place. Staff then checked each bedroom and found they did not have bins in place. When raised to managers, they found bins had been removed from Rufford ward and not replaced. We checked other wards and found sanitary disposal bins were not always in place for each female patient. Managers investigated our concern and found replacement disposal bins intended for wards had not been installed. Managers corrected this during our inspection.

During the inspection we also saw a patient asking for a different option of sanitary protection. Staff told the patient only one option was available in the service.

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

Inadequate

Patients said staff treated them well and behaved kindly.

During the inspection we saw staff be discreet, respectful, and responsive when caring for patients. We observed staff supporting a patient in distress with respect and care. In our observations of handovers and ward rounds we heard how staff were able to support patients to understand and manage their own care, treatment or condition. This included directing patients to other services and support to access those services if they needed help.

When speaking to staff they told us they felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff did not always follow policy to keep patient information confidential. On Bestwood ward staff were not always using a blind that was in place to protect patient information recorded on an office board. This information could be seen by patients. The blind was broken and had not been reported to maintenance. However, managers corrected this during our inspection.

Involvement in care

Staff involved patients in 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

The service had implemented television screens for information purposes on each ward and in the hospital's reception area. The screens showed pictures of key members of staff and their roles. This included the multidisciplinary staff, , managers and advocacy services. Staff introduced patients to the ward and the services as part of the admission process.

Staff involved patients and gave them access to their care plans and risk assessments. This was evidenced in the patient records we reviewed.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff told us that if a patient was not able to understand and retain information at the time of discussion they would continue to try until the patient was able to..

Patients could give feedback on the service and their treatment. Staff supported them to do this. We saw evidence of community meetings that occurred on every ward. These meetings included the involvement of patients in decisions about the service, where appropriate. However, the 5 meeting minutes we reviewed we saw staff did not always feedback on actions or decisions made at the previous meeting.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We saw that staff from all disciplines contacted families and provided support to them. During the inspection we also saw visits to patients from friends and family members.

Staff helped families to give feedback on the service. Carers told us staff explained to them when patients have chosen not to consent to information on their care being shared.

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

Inadequate

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

Requires Improvement

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. During ward rounds we saw staff discussed and reviewed this.

The service had low out-of-area placements. All wards apart from Rufford ward were commissioned for patients from the local area. Rufford ward had 5 beds which could be commissioned from anywhere within the country.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available to them when they returned. We observed ward rounds where discharge plans were discussed and how information about discharge was shared with the patient's family and staff from community services.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. We were told of scenarios where this has happened, decisions were made due to the nature of the patient mix at the time and was appropriate to the needs of the patient being moved. We were told that patients are given an opportunity to visit the new ward before being moved.

Staff did not move or discharge patients at night or very early in the morning. Staff told us they planned discharges to take place during normal working hours, preferably before midday.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. During the time of our inspection there was 2 beds available on Rufford ward. Clumber ward was closed at the time of our inspection.

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. During the inspection we observed multi-disciplinary team meeting where a delayed discharge was discussed and actions planned to manage this delay. There were two patents at the hospital where there discharge was delayed. Both patients were in long term segregation and were subject to assessment by other services. External stakeholders were engaged and the provider was actively pursuing discharge for the two patients.

Patients did not have to stay in hospital when they were well enough to leave. Staff discussed and agreed discharge plans during ward rounds and multi-disciplinary meetings.

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

Inadequate

When a patient was ready to be discharged staff carefully planned patients' discharge and worked with community staff to ensure discharges went well. We saw evidence of this in ward rounds.

Staff supported patients when they were referred or transferred between services. We were told that detailed handover documents were produced to support a good transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. However, we saw 3 bedrooms on Bestwood ward had leaks from the shower areas and water was entering the bedroom. We saw patients sometimes had to use their own towels to mop the water up. Management told us that showers were being refurbished. We saw during this inspection maintenance present on the ward repairing a patients shower due to this issue.

Patients had a secure place to store personal possessions. Locked storage was found underneath beds in each patient's room. Patients were able to store clothing in their bedroom following risk assessments.

Staff used a full range of rooms and equipment to support treatment and care. We found equipment to be well maintained. However, we found broken fridge in Rufford ward clinic ward and broken air conditioning unit on this ward as well.

The service had quiet areas and a room where patients could meet with visitors in private. The service had procedures in place to facilitate visitors safely and this included children.

Patients could make phone calls in private. We found that most patients had access to their own mobile phones but ward phones were also available for patients .

The service had an outside space that patients could access easily. We found that Bestwood ward outside space was not well maintained and had a lack of facilities for patients. For example, there was no seating area. Managers had ordered new furniture and arranged a gardener to visit..

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients did not have access to ward kitchens but did have access to an area in each dining room where they could make a hot drink. Wards also had storage for patients to have and keep their own individual snacks.

The service offered a variety of good quality food. Patients told us that the food was of a good quality and we saw different food options to cater for individual dietary requirements.

Patients' engagement with the wider community

Patients did not benefit from a range of activities to keep them engaged with their local community. However, staff supported patients with family relationships.

We saw activities were available for patients. However, due to their being 2 occupational therapists shared across three wards, sessions were limited. This impacted on patients' ability to access community activities and led to feedback that they were bored.

Staff helped patients to stay in contact with families and carers. Staff supported patients with visits from their relatives and friends where appropriate. Patients had access to their own mobile phones and could contact their relatives or friends.

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. We found all wards were on one level and accessible. This included specific bedrooms with adjustments to meet the needs of disabled patients.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Leaflets were available in different languages for patients who required them.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us the food provided was of a reasonable standard. Staff told us meals could be adapted to meet the cultural needs of patients. For example, Halal or kosher diets. We saw staff detailed individual dietary needs in patients care plans.

Patients had access to spiritual, religious and cultural support. The service had a dedicated multi-faith available for patients.

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 knew how to complain or raise concerns. We saw that managers investigated complaints, identified themes and discussed complaints at clinical governance meetings.

The service clearly displayed information for patients about how to raise a concern. We saw this on the information display television screens on each ward and at reception.

Staff understood the policy on complaints and how to acknowledge complaints. Patients received written feedback from managers following investigation of their complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint. We saw evidence of how managers communicate with letters and by speaking to patients.

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Inadequate

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed but they were visible in the service and approachable for patients and staff. The previous registered manager had left the service in March 2022 and a hospital director was in post to cover this position. The improvements that the hospital director was working towards since the previous inspection had not been embedded across the service.

Breach of the regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) have continued since March 2020 meaning that leaders have not consistently made patients safe in the service.

We found improvements to the service since our last inspection for example care plans were detailed and person centred. Ligature audits and assessments were in place and covered every area of the hospital. Multi-disciplinary teams worked well together and we saw evidence of how information was shared between the management team. The introduction to the information display screen demonstrated how leaders had listened to the needs of the patients.

During this inspection we found that leaders had not organised and implemented specialist training in personality disorder despite being part of the action plan since the previous inspection of March 2022. This meant that patients were being supported by staff who did not understand the needs of this patient group.

Vision and strategy

The vision of the Priory was not met by the provider in relation to the safety of patients. Progress about the delivery of the strategy and action plans had shown there is a lack of progress to improve the service.

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

Staff told us that they knew the providers values and how this applied ot the work they did. At induction this was discussed and we saw throughout the hospital the values were displayed for people to see.

Culture

We found that policies were not fully embedded, for example the misunderstanding towards restricted items and how this had put patients at risk of harm.

However, staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. The service had improved how they communicate with staff at ward level following our previous inspection.

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

Inadequate

Staff told us that they could raise any concerns without fear and how they knew how to contact the providers Freedom to Speak Up Guardian if they needed to.

Governance

The service was not improving quickly enough to mitigate risk to patients and support a pathway to recovery.

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level and that performance and risk were not managed well. We found that although policies and audits had been put in place there were gaps in the dissemination of these at ward level. We found that the restricted items policy was not effective and due to this had allowed for restricted items to be brought onto the wards. We also found that the policy was not being adhered to in the compliancy checks for bank and agency staff and was not clear at the time of our inspection whose role it was to check on this.

Management had in place audits which would be discussed at governance meetings, this included audits of ward walk rounds, cleaning, maintenance and clinic rooms. However, during this inspection we found maintenance issues that had failed to be notified to management including damage to flooring, walls and a unkept outside area for patients on Bestwood ward. This meant that the system was not fully embedded with all staff.

Management of risk, issues and performance

Although teams had access to the information they needed to provide safe and effective care staff had not used that information to good effect. There was not sufficient oversight in the management of risk that meant patients remained at risk to themselves.

Information management

Staff collected analysed data about outcomes and performance however our findings from this inspection did not show this always led to improvement.

Engagement

Managers engaged actively with their commissioners and the local safeguarding team. Regular on site visits were conducted. Managers had worked with commissioners to improve medication administration. This gave the registered nurses on the wards the confidence to communicate protected time for administrations of medicines.

Learning, continuous improvement and innovation

The findings from this inspection showed that systems were still not yet fully embedded since our previous inspection in December 2021 to proactively manage the service provided. During this inspection, managers reacted when we raised risks and took action to reduce at the time. However, learning from these lessons was not always successfully embedded into the work of staff on the wards to reduce future risk.

For example following the inspection in December 2021 we served the provider with warning notices against their management of risk due to staff allowing patients to have access to items which caused harm. During this inspection we found evidence that this was still an ongoing risk that was not being managed well. Patients were still allowed access to risk items and both managers and staff did not have full oversight of the situation.

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

Inadequate

Managers shared learning with staff at daily risk meetings, team meetings on the wards, staff supervision and reflective practice sessions. However, we found the governance was not robust enough to ensure these messages were fully embedded. For example the practice of the management of risk items did not demonstrate effectiveness of shared learning.

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 Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure all medical equipment in all clinic rooms are in working order.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that effective governance processes are in place and maintained to improve safety and care to patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that staff are trained in immediate life support.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure that patient activities reflect their needs and prevent boredom, including support in the community.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider must ensure that patient's dignity is protected and they are provided with risk assessed sanitary disposal units in their bedrooms (Regulation 10 (2)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that staff are trained to meet the needs of patients who have a diagnosis of personality disorder.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that all staff understand how to consistently manage items which may present a risk to patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that staff use least restrictive practice standards when searching patients.