Cambian - Raglan House Hospital

Quality Report

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

Ratings

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

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

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

Summary of findings

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

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

Overall summary

We rated Raglan House as good because:

- There had been a recent ligature risk audit of the service in October 2015, this contained detailed information and plans to mitigate risks identified. The clinic room for the storage of medication was well maintained. Equipment was present and checked in line with manufacturers recommendations. All areas were clean and furniture was in good order. All cleaning records reviewed were up to date and complete.
- Staff vacancies and sickness levels were low and the manager had access to bank staff that had been trained by the provider and were familiar with the patients and service. All shifts were covered by staff of a suitable discipline and skill mix. Most staff were up to date with statutory and mandatory training.
- Risk assessments were present in all care records and were detailed and in date. The multi disciplinary team reviewed the risk and wellbeing of all patients on a daily basis and adapted the care provided to reflect changes.
- All of the care records reviewed contained person centred and holistic care plans with a wide range of identified needs to support patients. Patients strengths and goals were evident in the care planning process and were reviewed regularly in 1:1 sessions and multi-disciplinary meetings. There was evidence of discharge planning in all eight of the care records reviewed
- Medication audits and reconciliations were carried out regularly by qualified staff. All medication was stored securely.
- Staff knew how to report incidents and there were robust governance structures to support them in doing so and to receive feedback.
- All prescription charts had evidence of consent and capacity to consent to treatment being documented.
- There was evidence of physical health needs being assessed and monitored and effective links had been established with the local general practice for information sharing and physical health monitoring.
- Medication was prescribed in line with national guidance and regular audits were carried out to monitor this. Recognised outcome measures and rating scales were used by all disciplines to measure the effectiveness of interventions that were offered by the service..
- Staff employed by the service had undertaken the appropriate checks to ensure they were skilled and qualified to provide quality care. Management systems were in place to address poor staff performance and this was reviewed through regular supervision and appraisal.
- Specialist training was available for staff to support them in their role alongside statutory and mandatory training from the provider.
- Well structured and effective staff handovers and multi-disciplinary team meetings took place daily and included a review of all patients and an updated risk rating.
- We observed staff treating patients with dignity and respect. Staff had developed a good rapport with patients and showed awareness of their individual needs. Patients reported that they had regular 1:1 sessions with staff and that staff took time to listen to them and provide practical and emotional support.
- Patients carers and families were involved in the care planning process when appropriate. Copies of leave forms could be provided if required and families and carers attended regular review meetings at the service.
- A weekly community meeting for patients took place and provided an opportunity for patients to provide feedback into the running of the service.
- There had been sixteen admissions and fourteen discharges from the service in the year prior to our

Summary of findings

inspection. This represented a patient throughput of approximately 50%. Eleven of the discharges that took place in the year prior to our inspection had been to step down or community services.

- There was a variety of therapeutic and education based activities for patients to attend and feedback about these was positive. A range of rooms and facilities were available for patients including therapy kitchens, lounges, areas to carry out daily activities and a hairdressing salon. The occupational therapist and psychologist collaborated to deliver some groups to support patients and links had been made with local voluntary services and colleges for patients to attend.
- Quiet areas were available for patients to use including a newly equipped sensory room. All patients who used this had individual sensory care plans to support them and followed a sensory diet sheet including strategies that were helpful for them when distressed.
- Most patients we spoke to said that the food provided was of a good quality. Kitchen staff attended the weekly patient community meeting to discuss menu options with patients.
- Interpreting services had been used to support patient and family involvement in the care planning process where English was not their first language.
- Robust governance procedures were in place to enable patients to complain or register concerns. All complaints that had been registered had been investigated and patients had been provided with verbal and written feedback regarding the outcome. Duty of candour had been displayed by the services senior management team when responding to a complaint from patients about the structure of clinical meetings.
- Most staff we spoke to knew and agreed with the organisation's values. All staff we spoke with described the principles of treating patients with dignity and respect.
- All staff said they felt able to contribute to the running of the service and their views were listened to and valued by senior staff. Staff morale was good. All staff reported feeling supported and that there was a culture of team working and providing good quality care for patients.
- There were effective systems for information and clinical governance in place on a local and provider level and regular meetings took place to review the services performance. Systems were in place to audit the effectiveness of the service, this included a monthly review of patient engagement in meaningful activity, staff education and training compliance levels and risk management.
- All staff we spoke to described a strong culture of leadership and openness from the registered manager and that they felt comfortable to approach them if they had concerns. All staff said they felt able to raise concerns without fear of victimisation and were aware of the providers whistleblowing policy.
- Staff were open and transparent with patients and we saw that duty of candour was exhibited when the service had made mistakes.

Summary of findings

However:

- We did not always see that where complaints had been upheld regarding staff behaviours and attitudes this was included in personnel files or addressed during the supervision or appraisal process. The registered manager and operations manager were made aware of this during our visit
- We did not see individual risk assessments to reflect the use of the service's contraband list of banned items. This was not in line with Mental Health Act Code of Practice guidance. However, following our inspection, the provider was in the process of updating its policies and procedures. The use of a contraband list was discontinued.
- Staff reported poor communication links with the local advocacy service. The registered manager was seeking to resolve this at the time of our inspection.

Summary of findings

Contents

Good

Location name here

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cambian - Raglan House Hospital

Raglan House is a 25 bed mental health hospital designed to provide an environment which promotes mental health recovery for women, by focusing on space, personal privacy and dignity.

Regulated activities that Raglan House is registered with the CQC to provide are:

- Accommodation of persons requiring nursing or personal care.
- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the mental health act 1983/2007
- Diagnostic and Screening procedures.

Patients cared for at Raglan house:

- may be detained under the Mental Health Act (1983), 3, 37, 37/41 or informal.
- have a primary diagnosis of mental illness with complex needs.
- typical diagnoses include: personality disorder, schizophrenia, schizo-affective disorder, bipolar affective disorder or depression.
- may have a history of substance, drug and alcohol misuse.
- may present with a forensic history.
- have a history of sexual abuse or domestic violence.
- may be treatment resistant.

At the time of our inspection a registered manager was in place and had been since 2013. The registered manager also held controlled drug accountable officer status.

There have been three previous inspections at Raglan House Hospital, the most recent of these was December 2013 using the CQC's previous inspection methodology, the essential standards. Raglan House Hospital was rated as compliant with the essential standards as of 31 April 2014.

Our inspection team

Team leader: Jon Petty, CQC inspector (Mental Health). Central West region.

The team that carried out this inspection comprised two CQC inspectors, an inspection assistant, a specialist nurse advisor, a mental health act reviewer and an expert by experience. Experts by experience are people who have experience of using or caring for someone who uses health and/or social care services. The role involves helping us hear the voices of people who use services during inspections and Mental Health Act visits.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

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

During the inspection visit, the inspection team:

- Carried out a tour of the ward environment, looked at the quality of the premises and observed how staff were caring for patients.
- Spoke with eight patients that were using the service.
- Reviewed eight care and treatment records of patients.
- Spoke with seven carers of patients using the service.
- Spoke with the registered manager of the service, the head of care and the regional director of operations for the provider.
- Spoke with twelve other members of staff including doctors, nurses, support workers, occupational therapists, domestic staff and psychologists
- Carried out a specific check of the medication management including a review of ten patients prescription cards.
- Received feedback from eight commissioners and the local adult safeguarding panel.
- Attended a pet therapy group and a coffee morning with patients
- Attended and observed a morning handover meeting with the multi disciplinary team.
- Carried out a Mental Health Act review of the paperwork of eight patients detained under the Mental Health Act 1983/2007
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Most patients said that staff were supportive and understood their individual needs. Patients reported that staff used 1:1 sessions with them to listen to their needs and offer advice when appropriate.
- Patients reported that staff were hard working and treated them with dignity and respect.
- Feedback from stakeholders was that staff were responsive to patient needs and open to communication with external organisations. Stakeholders also fed back that on the occasions they visited the environment it was clean and safe..
- Most carers we spoke to were very positive about the service and the care it provided.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There had been a recent ligature risk audit of the service in October 2015, this contained detailed information and plans to mitigate any risks identified.
- The clinic room for the storage of medication was well maintained. Equipment was present and checked in line with manufacturers recommendations.
- All areas were clean and furniture was in good order. All cleaning records reviewed were up to date and complete.
- All staff had access to personal alarms and were able to describe how they worked and the process for responding to them if they were activated.
- Staff vacancies and sickness levels were low and the manager had access to bank staff that had been trained by the provider and were familiar with the patients and service.
- Patients told us that 1:1 sessions took place with staff and were meaningful. Escorted leave was rarely if ever cancelled.
- Most staff were up to date with statutory and mandatory training.
- Risk assessments were present in all care records and were detailed and in date.
- The multi disciplinary team reviewed the risk and wellbeing of all patients on a daily basis and adapted the care provided to reflect changes.
- Medication audits and reconciliations were carried out regularly by qualified staff. All medication was stored securely.
- Staff knew how to report incidents and there were robust governance structures to support them in doing so and to receive feedback.
- All prescription charts had evidence of consent and capacity to consent to treatment being documented

However:

- We did not see individual risk assessments to reflect the use of the services contraband list of banned items.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- All of the care records reviewed contained person centred and holistic care plans with a wide range of identified needs to support patients.
- Patient's strengths and goals were evident in the care planning process and were reviewed regularly in 1:1 sessions and multi-disciplinary meetings.
- There was evidence of physical health needs being assessed and monitored and effective links had been established with the local general practice for information sharing.
- All information needed to deliver care was stored securely and available to staff when required.
- Medication was prescribed in line with national guidance and regular audits were carried out to monitor this,
- Recognised outcome measures and rating scales were used by all disciplines to measure the effectiveness of interventions that were offered by the service.
- Most staff had received an annual appraisal and had received supervision in the six weeks prior to our inspection.
- Staff employed by the service had undertaken the appropriate checks to ensure they were skilled and qualified to provide quality care. Management systems were in place to address poor staff performance and this was reviewed through regular supervision and appraisal.
- Specialist training was available for staff to support them in their role alongside statutory and mandatory training from the provider. Training in the updated 2015 mental health act code of practice was available and 93% of staff had attended this.
- Well structured and effective staff handovers and multi-disciplinary team meetings took place daily and included a review of all patients and an updated risk rating.

Are services caring?

Good

We rated caring as good because:

- There was a variety of therapeutic and education based activities for patients to attend and feedback about these was positive.
- We observed staff treating patients with dignity and respect. Staff had developed a good rapport with patients and showed awareness of their individual needs.
- Patients reported that they had regular 1:1 sessions with staff and that staff took time to listen to them and provide practical and emotional support.

Summary of this inspection

- Stakeholder feedback was mostly positive. Stakeholders reported that staff knew patients well and were responsive and open to communication.
- Detailed care records and discharge plans were in place. Patients strengths and goals were evident in care records and minutes from multi-disciplinary meetings were typed up and included in patients notes.
- Admission checklists and welcome processes were in place and used for all patients, including allocation of a named nurse and keyworker.
- Patients, carers and families were involved in the care planning process when appropriate. Copies of leave forms could be provided if required and families and carers attended regular review meetings at the service.
- A weekly community meeting for patients took place and provided an opportunity for patients to provide feedback into the running of the service.
- A patient survey had been commissioned in May 2015 to gain feedback from patients and identify areas where acre could be improved.

However:

- Staff reported poor communication links with the local advocacy service, although patients did still have access to the service.The registered manager was seeking to resolve this at the time of our inspection.

Are services responsive?

Good

We rated responsive as good because:

- There had been sixteen admissions and fourteen discharges from the service in the year prior to our inspection. This represented a patient throughput of approximately 50%.
- Eleven of the discharges that took place in the year prior to our inspection had been to step down or community services.
- There was evidence of discharge planning in all eight of the care records reviewed.
- A range of rooms and facilities were available for patients including therapy kitchens, lounges, areas to carry out daily activities and a hairdressing salon.
- The occupational therapist and psychologist collaborated to deliver some groups to support patients and links had been made with local voluntary services and colleges for patients to attend.
- Lockable drawers were available for patient use in their bedrooms for secure storage of their possessions.

Summary of this inspection

- Most patients we spoke to said that the food provided was of a good quality. Kitchen staff attended the weekly patient community meeting to discuss menu options with patients.
- Quiet areas were available for patients to use including a newly equipped sensory room. All patients who used this had individual sensory care plans to support them and followed a sensory diet sheet including strategies that were helpful for them when distressed.
- Patients had access to a private telephone with information for advocacy and legal advice support services available if required.
- Interpreting services had been used to support patient and family involvement in the care planning process where English was not their first language.
- Robust governance procedures were in place to enable complaints or register concerns. Duty of candour had been displayed by the services senior management team when responding to a complaint from patients about the structure of clinical meetings.
- All complaints that had been registered had been investigated and patients had been provided with verbal and written feedback regarding the outcome.

However:

- We did not always see that where complaints had been upheld regarding individual staffs members' behaviours and attitudes this was included in personnel files or addressed during the supervision or appraisal process. The registered manager and operations manager were made aware of this during our visit.

Are services well-led?

Good

We rated well led as good because:

- Most staff we spoke to knew and agreed with the organisations values. All staff we spoke with described the principles of treating patients with dignity and respect.
- All staff said they felt able to contribute to the running of the service and their views were listened to and valued by senior staff.
- All staff knew who senior managers in the service were and were able to name them. Staff reported that members of the providers senior management team had visited the service recently.

Summary of this inspection

- There were robust and effective systems for information and clinical governance in place on a local and provider level and regular meetings took place to review the services performance.
- Systems were in place to audit the effectiveness of the service, this included a monthly review of patient engagement in meaningful activity, staff education and training compliance levels and risk management.
- All shifts were covered by staff of a suitable discipline and skill mix.
- At the time of our inspection there were no grievance procedures being pursued within the team and there were no allegations of bullying or harassment.
- All staff we spoke to described a strong culture of leadership and openness from the registered manager and that they felt comfortable to approach them if they had concerns. All staff said they felt able to raise concerns without fear of victimisation and were aware of the providers whistleblowing policy.
- Staff morale was good. All staff reported feeling supported and that there was a culture of team working and providing good quality care for patients.
- There were opportunities for staff development including nurse preceptorship programmes and promotions for staff that had demonstrated leadership skills.
- Staff were open and transparent with patients and we saw that duty of candour was exhibited when the service had made mistakes.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider:

- At the time of our inspection 93% of staff had received training in the MHA and the 2015 updated code of practice. The manager had arranged further training opportunities for staff. The staff who we spoke to were aware of the main principles of the mental health act (MHA) and code of practice guidance.
- All care records reviewed had evidence of staff discussing with patients their rights under section 132 of the MHA on admission to the service and regularly following this. Consent to treatment was obtained from patients in line with MHA requirements and was documented consistently. All medication was given under a lawful authority. Section 17 leave was recorded on a standard form and patients and carers received a copy. All leave forms were clearly dated but out of date forms had not been struck through or removed which could lead to confusion.
- Administrative support and legal advice on the use of the MHA and the updated code of practice was available for the service by a designated mental health act administrator. Audits of MHA paperwork had taken place twice annually.
- Independent mental health advocacy (IMHA) services were commissioned via local authorities in line with the mental health act code of practice although staff reported that effective communication between the IMHA service and themselves was not happening. The manager was aware of this and was taking steps to resolve this with the service provider at the time of our visit. The registered manager informed us that the provider was considering commissioning their own IMHA service, however this was not in line with the mental health act code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of our inspection 93% of staff had received training in the mental capacity act (MCA). Training was completed as part of the staff induction checklist and annual refresher training sessions were mandatory.
- There had been no deprivation of liberty safeguards (DoLs) assessments made in the six months prior to our inspection and there were no patients subject to DoLS at the time of our inspection.
- Most staff we spoke with had a clear understanding of the MCA and the five guiding principles of the 2005 MCA. T3 forms had been completed for patients who lacked the capacity to consent to continued treatment under the MHA and were kept in care records and with prescription charts.
- All staff we spoke to told us that restraint was only used as a last resort when other interventions had failed, was proportionate when it was used and was for the least time possible, this was in line with MCA guidance for restraint and the national institute for clinical health and excellence (NICE) guidance (NG10) for the short term management of violence and aggression in inpatient and community mental health settings.
- Arrangements were in place for adherence to the mental capacity act to be audited by the mental health act administrator.
- All medication was given under a lawful authority. However, there was not always enough detail about the discussion between the responsible clinician and the patient in the record of their consent to treatment.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment:

- The ward layout allowed staff to observe most parts of it, where there were blind spots these were mitigated by staff presence in all areas. A sanctuary room was available for patients to access with staff support and when patients accessed this independently a risk assessment was carried out and agreed following a multi disciplinary meeting (MDT). The sanctuary room was designed to assist patients who suffer from sensory deprivation. All patients had their own sensory box containing objects that helped them when in emotional distress and followed a sensory diet sheet which was individualised and personalised.
- The service provided care for female patients only. All patients had keys to their bedrooms and were able to access them 24 hours a day following a risk assessment by the MDT that they would be safe to do so.
- A comprehensive ligature risk audit of the internal and external aspects of the building was carried out on an annual basis. The most recent audit had been completed in October of 2015 and contained detailed information identifying potential ligature risks and plans put in place to mitigate this with a red, amber, green (RAG) rating for each risk.
- A seclusion room had not been commissioned and was not in use at this service.
- The clinic room was well stocked with a range of equipment available for staff to carry out physical health assessments of patients, this included BP machines, oxygen meters and weighing scales. All equipment had been checked and calibrated in line with the manufacturers recommendations. The clinic room fridge for the storage of medication was clean and well ordered, the fridge temperatures were checked daily with a log kept of this process. this was checked and complete and up to date.
- Resuscitation equipment was available for use including a defibrillator and a response bag containing emergency drugs, this was checked daily and the log to evidence this was available and reviewed as part of the inspection process.
- All ward areas were clean and tidy, furniture was in good condition and the carpets were clean other than a small localised area by the patients phone which the inspection team reported as having an odour of urine, this concern was brought to the attention of the registered manager during the inspection and they were able to evidence that plans were in place for this flooring to be removed and replaced.
- Cleaning schedules were available for daily and weekly tasks with the environment divided into zones . Each zone had a detailed sheet for that area and space for staff to sign and date when actions had been completed. All cleaning records reviewed were up to date. Cleaning records contained schedules for the cleaning of clinical waste bins, emptying of general waste bins and rota-washing of hard floor surfaces. Sanitising equipment in communal areas were reviewed weekly and replenished as required.

Long stay/rehabilitation mental health wards for working age adults

Good

- A building general risk assessment was carried out annually of all areas of the building including a review of cleaning schedules, the use and storage of COSHH products, management of risk relating to MRSA and the management of clinical waste. This had recently been completed in October 2015.
- We observed staff adhering to infection control principles, all staff had hand sanitiser available for personal use attached to their ID and personal alarms.
- A premises and quality audit was carried out twice yearly as part of the providers audit schedule. This had recently been completed in December of 2015 with all areas compliant and no recommendations for improvement made.
- All staff had access to personal alarms with an electronic system in place that enabled staff to identify the location where the alarm had been activated. All staff we spoke to were aware of how this alarm system worked and describe how they would use them.

Safe staffing:

- At the time of our inspection there were seven whole time equivalent (WTE) qualified nurses employed by the provider and twenty four WTE nursing assistants. staff vacancies were low with one WTE qualified nurse vacancy. Recruitment for this post was in progress at the time of our inspection.
- Staff sickness rates were low with an average of 1.5% for the twelve month period prior to inspection. Staff turnover was 13% for the year 2014-2015.
- The registered manager used a staffing analysis and minimum staffing level tool developed by the provider to ensure that all shifts had a suitable number of qualified and unqualified staff to ensure patient safety. The staffing level estimate for the service reflected current and historical risks of the patients using the service, staff training requirements to ensure patient safety and included the procedure to be followed if staffing levels needed to be increased to ensure patient safety.
- Staffing levels during day shifts consisted of two qualified Nurses and six support workers. However, if there was one qualified nurse on duty due to staff sickness or nurse vacancies then support workers were increased to seven. During night shifts, staffing comprised two qualified Nurses and five support workers. The numbers of support workers at night could also be increased to six to reflect qualified staff absence or vacancies. We reviewed rota's for the previous six weeks and saw that all shifts had been fully staffed. Staffing rota's were reviewed daily as part of the morning MDT meeting and could be changed to meet the needs of the service.
- Agency staff were not used by the service. Bank staff usage for the six months prior to our inspection was 12%. The registered manager was able to access a bank staff co-ordinator employed by the provider, this meant that bank staff were often familiar with the service and the patients needs and had received a provider specific induction and training.
- A minimum of one senior nurse was on every shift and maintained a presence in the ward area. Senior nurses were supported during day shifts by a dedicated head of care, this was a senior staff member not included in the shift numbers and who provided an oversight and support function for the service.
- Patients that we spoke to told us that staffing levels ensured that they received planned 1:1 sessions with their named carer and that they could access staff support as and when required.
- Staff and patients that we spoke to told us that escorted leave and ward activities were rarely if ever cancelled. the registered manager had implemented a policy where cancellation of either escorted leave or scheduled activities required authorisation by themselves or the senior management team.
- Medical cover for the service was provided by a consultant psychiatrist who held responsible clinician status and a specialist registrar grade doctor. Both medics were employed full time by the provider and had a contract to provide out of hours cover including night times and to respond to emergencies.
- Most staff were up to date with statutory and mandatory training, this included management of violence and aggression, mental health act, mental capacity act and deprivation of liberty safeguards training, The average mandatory training rate for all staff was 90%. A training schedule had been put in place by the registered manager to ensure all staff could attend training updates.

Assessing and managing risk to patients and staff:

- There were no reported incidents of seclusion or segregation in the six months prior to our inspection.

The service did not seclude patients and a policy was in place to inform staff of the definition of seclusion under the mental health act code of practice to ensure that de facto seclusion did not occur.

- There were 34 incidents of restraint involving ten patients recorded in the period between July 2015 and October 2015. All incidents of the use of restraint required staff to carry out a debrief and prompted a review of patients risk assessment, care plan and observation levels. We did not see evidence of advance decisions or statements being made by patients about the use of restrictive interventions as identified in the national institute for clinical health and excellence (NICE) guidance (NG10) for the short term management of violence and aggression in inpatient and community mental health settings.
- Staff reported that blanket restrictions were not in use in the service. We were made aware that a contraband list was in the reception area for items not allowed onto the ward and that visitors could only use the available visitors room and not the ward area. We did not see individual risk assessments justifying the application of list of contraband items and visitors were unable to see patients in their own bedroom if they wished to do so. This was not in line with current mental health act code of practice guidance. Following our inspection, the provider was in the process of reviewing their policies and procedures. The registered manager informed us that restricted items would not be risk assessed and care planned on an individual basis and that a service wide contraband list was no longer in place.
- Concerns had been raised via the independent mental health advocate that patients were not allowed bed wear in communal areas from 10am and that this could constitute a blanket restriction. This was discussed with the registered manager who fed back that this had been agreed in collaboration with patients at their community meeting to reflect the rehabilitation aims of the service, the agreement was also flexible to suit the needs of individual service users.
- Of the eight sets of care records reviewed, all had detailed and comprehensive risk assessments included within them. We saw that risk assessments were reviewed following incidents and that the information contained within the risks assessments was individualised with detailed risk management strategies. Personalised risk management strategies were available for patients that required the use of walking aids or who wished to use the bath.
- Recognised risk assessment tools were used throughout the service and were accessible by all staff for review. These included the short term assessment of risk tool (START) and the historical clinical risk management-20 (HCR-20) tool for patients who had been convicted in the criminal justice system.
- Every patient had their current risk level reviewed on a daily basis as part of the shift handover process between day and night staff, this information was then fed into the daily MDT meeting attended by staff of each discipline, the registered manager and the responsible clinician. All patients were allocated either a red, amber or green (RAG) rating following daily reviews of their needs and this was used to decide levels of observation and support required for individual needs and whether staffing levels needed to be increased or decreased to ensure patient safety.
- At the time of our inspection there was one patient who had informal status under the mental health act. Notices were placed in communal areas and at the entrance to the building providing guidance to informal patients on their right to leave without restriction.
- A therapeutic engagement and observation policy was in place and had been updated in December of 2015. All staff we spoke to were aware of this policy and were able to describe how it was used to safely manage patient risk. Observation levels of each patient were reviewed as part of the shift handover process and formed part of the wider MDT meeting which took place daily. Increases in observation levels were able to be made by nurses on shift in response to the needs of the patients, decreases in observation levels could only be authorised by either the responsible clinician or specialist registrar following a medical review.
- The service had a policy in place to ensure the safety of children visiting the ward. Patient searches were carried out either as a result of a risk assessment or if staff had concerns that a patient could be bringing items onto the unit from the contraband list kept in reception and communal areas. Blanket searches were not carried out and the use of searches was discussed individually with

patients as part of their 1:1's with staff and the MDT review with the care team. Staff we spoke to said that they had good links with the local police force and were able to seek support from them if required.

- All staff we spoke to told us that restraint was only used as a last resort to manage patient and staff safety. All staff had been trained in the management of violence and aggression (MVA), including bank staff.
- Raglan House Hospital reported that there were 62 incidents of rapid tranquilisation between June 2015 and September 2015. Restraint and rapid tranquilisation forms were used to monitor the well-being of patients when these interventions were used including required observation levels, monitoring of blood pressure, temperature and respiratory rate of the patient, this followed national institute for clinical health and excellence (NICE) guidance (NG10) for the short term management of violence and aggression in inpatient and community mental health settings. A report had also been commissioned by the provider to explore the relationship between restraint and the use of rapid tranquilisation and to identify areas where practice could be improved.
- All staff were trained in safeguarding and were able to describe the process for making a safeguarding recommendation. There had been five safeguarding referrals made in the six months prior to our inspection, all but one of these had been closed at the time of our visit. An updated safeguarding adults policy was in place from November of 2015 and was due for review in 2018. All staff had access to this via the services intranet.
- Medication reconciliation and ordering was carried out weekly by the head of care and nursing staff. A sample medication audit was carried out monthly with full medication audits of the service completed annually in April, August and December. Annual audits of medication management were also completed by an external pharmacist. Of the ten medication files reviewed as part of the inspection process, all had evidence of capacity and consent to treatment being obtained where applicable and there was evidence of discussion with patients regarding their treatment options.
- Stock medication was checked weekly and a log of this was kept, this was reviewed as part of the inspection and found to be complete and up to date. All medication was stored in either a locked cupboard or fridge.
- Safe procedures were in place for children visiting the service. A designated visitors room was available for family use outside of the locked ward environment and was equipped with soft furnishings and toys for the use of young people.

Track record on safety:

- There had been no serious incidents reported in the twelve months prior to our inspection.

Reporting incidents and learning from when things go wrong:

- All staff we spoke to were aware of the procedures for incident reporting and received annual training for the safeguarding of adults. Incident report (IR1) forms could be submitted by staff of all grades. Robust governance systems were in place for IR1 forms to be submitted monthly to the providers central quality intelligence group, this data was then analysed for trends and emerging themes and fed back to the staff via a monthly governance meeting with representatives of all staff groups.
- Duty of candour was evident. Patients had used their weekly meeting to discuss with staff aspects of their monthly care reviews that they felt were not therapeutic, including the length and time of the reviews. The management team had written to all patients, acknowledged their concerns and offered an apology. the format of the care reviews had subsequently changed to reflect patients wishes.
- There was evidence that staff debriefed following the use of restraint and rapid tranquilisation and that minutes from these meetings were collated for future learning and were accessible to all staff. Staff also attended a monthly reflective practice group chaired by the lead psychologist to identify learning opportunities and explore changes in practice.

Long stay/rehabilitation mental health wards for working age adults

Good

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care:

- Eight care records were reviewed as part of the inspection process. All records we reviewed contained a comprehensive risk assessment using recognised tools including the short term assessment of risk tool (START) and the historical clinical risk management tool (HCR-20).
- Care plans were person centred, including the views of patients in their own words in most cases. There was evidence of discharge planning in all the records, and the records of ward reviews showed that staff discussed whether the service was the most suitable placement in all cases.
- All care plans reviewed contained a wide range of identified needs to support patients. Patients strengths and goals were evident in the care planning process and were reviewed monthly at MDT meetings
- An assessment of patients physical needs was present in all records reviewed and medical staff reported close working links with the local general practice (GP) surgery where all patients had been registered. An agreement between the provider and the local GP surgery had been developed and two appointments per day were available for patients if required.
- Evidence was available that staff continually monitored patients physical health needs and received specialist training in health conditions including diabetes which was then incorporated into the care planning process. A care plan we reviewed for a patient with diabetes contained detailed information on the monitoring of blood sugars, diet and fluid intake, actions to take if staff had concerns and the management of section 17 leave.
- All information needed to deliver care was stored securely and available to all staff when required. Patient records and mental health act documentation was kept separately in two folders and available for review as part of the inspection process. All documentation relating to patient care was in paper form.

Best practice in treatment and care:

- There were no nurse prescribers in post at the time of our inspection. All medication prescribing was completed by either the consultant psychiatrist or specialist registrar and followed national institute for clinical health and excellence (NICE) guidelines for the treatment of schizophrenia (CG178) and the treatment of Bipolar disorder (CG185). Medication audits were carried out on a monthly basis and annual basis by qualified nursing staff with support from the providers pharmacy.
- Patients had access to psychological therapies including cognitive behavioural therapy (CBT) in accordance with NICE guidance for the treatment of schizophrenia and personality disorder. A weekly CBT group was available for all patients to attend and individualised therapy sessions were also available. A psychological review of all patients was provided as part of their six monthly care planning approach (CPA) meeting and included a formulation of the patients needs, risk factors and protective strategies.
- Training for staff on understanding and working with personality disorders was provided by the psychologist for the service, this included the development and maintenance of effective therapeutic relationships and boundaries between staff and patients.
- Staff from all disciplines used profession specific rating scales and outcome measures to assess and record patient progress and the effectiveness of the interventions offered. The health of the nation outcome scale (HoNOS) was completed following admission to the service and reviewed as part of the CPA process. The model of human occupation (MOHO) was used by occupational therapy staff and a screening tool was used (MOHOST) to provide evidence on patient progress for MDT reviews in line with national guidance from the college of occupational therapists (COT).

Skilled staff to deliver care:

- The multi disciplinary team contained doctors, nurses, support workers, occupational therapists and psychologists. All disciplines fed into the care planning process for patients and there was evidence in all care records of collaborative working between staff and patients.
- Four personnel files were reviewed as part of the inspection process. All files reviewed had evidence of

satisfactory references having been obtained prior to staff commencing employment. Disclosure and barring service (DBS) checks had been obtained for all staff and probationary assessment records were completed.

- A staff induction checklist was in place and had been completed in the four personnel files that were reviewed. Supervision records included a review of staff key performance indicators, training requirements and identified learning opportunities. Group and individual supervision was available and qualified nursing staff had access to a preceptorship development programme. At the time of our inspection 93% of non medical staff had received supervision in the previous six weeks, this complied with the services supervision and appraisal policy.
- Staff appraisals took place annually, at the time of our inspection 93% of non medical staff had received an appraisal in the previous twelve months.
- Specialist training was available for staff to support them in their role. This included understanding and working with personality disorders, awareness of substance misuse and legal highs and value based roles and responsibilities. Attendance at specialist training was identified through the supervision process with senior staff and the registered manager had developed a training programme for the year which was available for all staff.
- Evidence was available in personnel files that action plans had been implemented where poor staff performance had been identified, this included attendance and sickness monitoring and formal meetings were held with staff if required. Outcomes from these meetings were documented for supervision and appraisal purposes.

Multi-disciplinary and inter-agency working:

- Handovers took place between staff twice daily at shift changes, this provided an opportunity for staff to be updated with any changes in patients care needs, observation levels and to be updated about any incidents that had occurred during the previous shift.
- A multi-disciplinary team (MDT) meeting took place daily for staff that worked core hours (9-5), this included the registered manager, the head of care, psychology, occupational therapy and nursing staff. Medical input to these meetings was provided by either the responsible clinician or specialist registrar and also included housekeeping and maintenance staff. All patients were discussed at the MDT and included a review of their progress for the previous 24 hours and any changes to their risk assessment. Incidents that occurred were reviewed and a brief formulation and plan for how to manage patients with increased support needs was developed by all staff in attendance.
- Designated first aid responders, fire wardens and a security nurse were identified as part of the daily MDT meeting.
- Scheduled activity plans for patients were reviewed daily and staff were allocated tasks to ensure there was adequate staffing provision for all activities to take place, this included escorted leave and transport for external appointments.
- Staff in teams that were external to the organisation were contacted as part of the inspection process and fed back that communication from the service was excellent and that they were kept aware of any changes in patients wellbeing, involved in care planning meetings and that doctors and nurses knew the patients well.

Adherence to the MHA and the MHA Code of Practice:

- At the time of our inspection 93% of staff had received training in the MHA and the 2015 updated code of practice, and the manager had arranged further training opportunities for staff.
- The staff who we spoke to were aware of the main principles of the mental health act (MHA) and code of practice guidance.
- All care records reviewed had evidence of staff discussing with patients their rights under section 132 of the MHA on admission to the service and regularly following this. However, some forms were sparsely completed and one form was blank apart from the staff signature.
- All medication was given under a lawful authority. Consent to treatment was obtained from patients in line with MHA requirements and was documented on T2 forms accompanying prescription charts.
- Administrative support and legal advice on the use of the MHA and the updated code of practice was available for the service by a designated mental health act administrator. Audits of MHA paperwork had taken place twice annually.

Long stay/rehabilitation mental health wards for working age adults

Good

- Section 17 leave was recorded on a standard form and patients and carers received a copy. All leave forms were clearly dated but out of date forms had not been struck through or removed which could lead to confusion.
- Independent mental health advocacy (IMHA) services were commissioned via local authorities in line with the mental health act code of practice although staff reported that effective communication between the IMHA service and themselves was not happening. The manager was aware of this and was taking steps to resolve this with the service provider at the time of our visit. The registered manager informed us that the provider was considering commissioning their own IMHA service, however this was not in line with the mental health act code of practice.

Good practice in applying the MCA:

- At the time of our inspection 93% of staff had received training in the mental capacity act (MCA). Training was completed as part of the staff induction checklist and annual refresher training sessions were mandatory.
- There had been no deprivation of liberty safeguard (DoLs) assessments made in the six months prior to our inspection and there were no patients subject to DoLS at the time of our inspection.
- Most staff we spoke with had a clear understanding of the MCA and the five guiding principles of the 2005 MCA. T3 forms had been completed for patients who lacked the capacity to consent to continued treatment under the MHA and were kept in care records and with prescription charts.
- All staff we spoke to told us that restraint was only used as a last resort when other interventions had failed, was proportionate when it was used and was for the least time possible, this was in line with MCA guidance for restraint and the national institute for clinical health and excellence (NICE) guidance (NG10) for the short term management of violence and aggression in inpatient and community mental health settings.
- Arrangements were in place for adherence to the mental capacity act to be audited by the mental health act administrator.
- All medication was given under a lawful authority. However, there was not enough detail about the discussion between the responsible clinician and the patient in the record of their consent to treatment.

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

Good

Kindness, dignity, respect and support:

- We attended a pet therapy group and met with patients for coffee as part of our inspection process. We also observed staff interacting and caring for patients in communal areas. We saw that staff treated patients with dignity and respect and provided practical and emotional support. The interactions we observed demonstrated that staff had developed a good rapport with patients and understood their individual needs.
- Most patients said that staff treated them with dignity and respect. We reviewed 13 comments cards that had been completed by patients and stakeholders prior to our inspection. Key themes that patients had noted were that staff were supportive and understood their individual needs. Patients reported that staff used 1:1 sessions to listen to their concerns and offer advice when needed. Staff were described as good listeners by most patients. One patient had raised concerns that there was not enough fruit in communal kitchens.
- Stakeholder feedback including commissioners and representatives from community teams was mostly positive. Stakeholders reported that the environment was clean and safe and that staff were responsive and open to communication.

The involvement of people in the care they receive:

- Detailed and individualised care plans were in place for all patients and contained a wide range of identified needs. Discharge and goal setting was also evident and patients views and wishes were reflected in their care plans and in feedback from their care programme approach (CPA) meeting. Minutes from these meetings were typed up and included in all patients care records that we reviewed.
- An admission checklist was in place for patients, this included a tour of the building, welcome leaflets and identifying dietary preferences. Staff were required to

Long stay/rehabilitation mental health wards for working age adults

Good

document that patients had been informed who their named nurse and key worker was and that they had received copies of their rights under the mental health act and the complaints procedure.

- Access to advocacy was provided by voiceability and had been commissioned by local authorities in line with mental health act code of practice guidance. Staff at the provider reported poor communication with the advocacy service and were seeking to resolve this with the provider at the time of our inspection. The advocate that attended the service had provided feedback about their findings to the local safeguarding panel and the inspection lead had liaised with them prior to our visit.
- There was evidence that patients carers and families were involved in the care review and planning process. The views of carers and families were reflected in the care records and in CPA meetings. Copies of leave forms were provided for carers and families as required.
- Patients were able to give feedback on the service they received through weekly community meetings with staff. We reviewed the minutes from the previous 5 weeks and saw that on average 7 patients attended each week. Issues that were discussed included the provision of weekend activities, a review of the menu and any other business that impacted on the daily running of the service. Patients were not involved in the recruitment of staff at the time of our visit.
- A patient survey report had been carried out by the service in May 2015 as part of the providers cycle of internal audits. The percentage of returned completed surveys was 56%. Areas covered in the survey included environment and living conditions, involvement of family and friends, activities, complaints and safeguarding. In most areas the patient response was positive, any areas that were identified as requiring improvement had an action plan drawn up by the senior management team including input from all staff disciplines with time scales for actions to be taken.
- Advance decisions were not in place

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

Good

Access and Discharge:

- Average bed occupancy for the six months prior to our inspection was 100%. There had been sixteen admissions in the year prior to our inspection and fourteen discharges from the service. Eleven discharges had been to either community or step down placements and three discharges were to services that could provide more intensive care to meet the needs of the patients. The service was using an active care recovery model to structure the mental health rehabilitation services if provided. It offered the patients a wide range of outcome measures. These were integrated into care plans and subsequently reviewed regularly by the members of the multi-disciplinary team.
- Evidence of discharge planning was available in all of the care records reviewed and most commissioners and stakeholders from external services said they felt well involved in the care planning and discharge process for patients.
- Patients that no longer required the level of support at the service had access to a local step down service by the provider. Staff and patients we spoke to said they felt this worked well and provided continuity of care.

The facilities promote recovery, comfort, dignity and confidentiality:

- A range of rooms and facilities were available for patients including therapy kitchens, lounges, areas to carry out daily activities and a hairdressing salon. A laundry room was available for patients to use and had a rota system devised to ensure fair access. A separate therapy room was available for patient activities and 1:1 sessions with therapy staff.
- A comprehensive programme of therapeutic and meaningful activities was in place including pet therapy, walking groups, swimming and sports groups. Psycho-educational groups were available for all patients to access. A work programme was in place to encourage patients to take responsibility for daily tasks including writing up menu sheets in communal areas. Patients received payment as part of the works programme and said that they valued the opportunity to earn money and have a meaningful work role they

were responsible for. An animal assisted therapy (pet therapy) group took place weekly as part of the programme of planned activities for patients and we attended this during our inspection. Patients were able to have the opportunity to meet and hold a variety of animals including snakes and spiders. All patients spoke very highly of the group and that they found it therapeutic and enjoyed attending.

- The occupational therapist and the psychologist delivered some groups together in order to support changes in patients' behaviour. These groups supported patients to discuss shared experiences such as hearing voices. Although staff told us that dialectical behavioural therapy (DBT) was not offered, they said that some elements of the approach, such as mindfulness, were incorporated into the therapy programme.
- The occupational therapy team had developed links with local colleges and the local voluntary work bureau and patients we spoke to were able to identify their future plans to engage in these opportunities.
- Quiet areas were available for patients to use including a newly equipped sanctuary room, designed to assist patients who suffer from sensory deprivation. The sanctuary room was available for all patients to use with support from staff. Patients were able to use the sensory room without supervision following agreement with the MDT and a risk assessment and care plan being completed. All patients had their own sensory box containing objects that helped them when in emotional distress and followed a sensory diet sheet which was individualised and personalised.
- A visitors room was available, we observed this in use during the inspection. The room had soft furnishings, sofa's and toys were available for children to use. Patients had access to a private phone on the ward and there was also one within the visitors room. There was access to an enclosed patio area at the rear of the building and access to this was unrestricted.
- Patients had access to drinks and snacks 24 hours a day outside of set meal times. Facilities for making tea and coffee were available and patients were expected to take responsibility for the cleanliness of this area when using it.
- Bedrooms were personalised by patients with pictures and personal effects evident. Patients were assisted to tidy their rooms where necessary and regular deep cleans took place as part of the housekeeping schedule. Lockable drawers were available for patient use in their bedrooms for secure storage of their possessions.
- The unit had a food rating of 5/5 by the food standards agency and this was displayed at the entrance to the building. Menu's were rotated on a seasonal basis and kitchen staff received feedback from, and attended the patients weekly meeting. Most people we spoke to said that the food was of a good quality, one person said that their could be more culturally specific food but that they had the opportunity to cook individualised food choices as part of their occupational therapy programme. Details on daily menus and healthy eating were available in communal areas.
- Activities were available for patients at weekends and were discussed and agreed as part of the weekly patient meeting. Activities included ward based film groups and creative arts session for people who were unable to access the local community. External activities included walking groups and visits to local areas of interest.

Meeting the needs of all who use the service:

- Adjustments had been made for people requiring disabled access. A lift was in place and disabled access parking, bathrooms and facilities were available.
- Information boards were in communal areas and provided details for patients on their rights under the mental health act, access to advocacy services and support services. Sheets detailing patients rights to leave the ward if they had informal status under the mental health act were evident in communal areas. Details on the whistleblowing process for patients who had concerns was available in the communal areas.
- Interpreting services could be accessed and had been used to promote patient involvement in psychology sessions and family inclusion in the care planning process where English was not their first language.
- Spiritual support for patients was available via weekly drop in sessions led by the pastor from the local church.

Listening to and learning from concerns and complaints:

- There had been twenty complaints by patients in the twelve months prior to the inspection. One

Long stay/rehabilitation mental health wards for working age adults

Good

complaint was not upheld and nineteen had partial elements of the complaint upheld, there had been no complaints referred to the parliamentary health service ombudsman (PHSO). Most complaints received were in relation to staff attitudes. The management team had recognised the need for specialised training for the staff group due to the complex needs of the patients and were providing this at the time of our inspection.

- All complaints received had been investigated and evidence of this process was available and collated in a complaints folder. Patients received an acknowledgement letter from the service manager at the start of the complaint process and an outcome letter following investigation into their concerns. Patients were given a reply slip to complete to say if they were happy with the outcome of the complaint process and advising them of actions to take if they required further support.
- Staff were able to describe the procedure for registering complaints from service users and how they would support them to do so. There was evidence that actions were taken as a result of complaints received and duty of candour was evident. Patients were offered apologies when the service had made mistakes and staff received increased supervision and support to improve their practice. Evidence was not always available in personnel folders where individual staff members had received feedback regarding their attitudes and behaviours, this was raised with the registered manager and operations director of the service at the time of our inspection.

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

Good

Visions and values:

- Most staff we spoke to knew and agreed with the organisations values which were that everyone has a personal best. Staff were able to identify how they combined the care planning process and the use of occupational therapy and psychological interventions to help patients achieve their goals. All staff we spoke with described the principles of treating patients with respect and dignity and identified the importance of an individualised approach to the care of patients.
- Team objectives reflected the organisations values, staff from all disciplines said that they were able to contribute to the running of the service on a daily basis and that their views were listened to and valued.
- All staff knew who the senior managers in the organisation were and were able to name them. Staff reported that members of the providers senior management team had visited recently and we were able to meet with the operations director on the day of our inspection.

Good governance:

- Structures for effective clinical governance were in place in the service at the time of our inspection. The registered manager and representatives from all staff groups met on a monthly basis for a local governance meeting which fed into and received feedback from regional and national governance agenda's.
- Systems were in place to audit the effectiveness of the service, this included a monthly review of patient engagement in meaningful activity, staff education and training compliance levels and risk management.
- Safeguarding referrals, incident forms and medication errors were reviewed monthly and analysis of this data was used to identify any areas of concern and develop action plans to improve the service.
- Safeguarding referrals were being completed where required. Six safeguarding referrals had been made in the six months prior to our inspection, all but one of these were closed at the time of our visit. We saw that where recommendations had been made to the service from local safeguarding boards and stakeholders, these had been embedded in the service, this included increased training for staff in the management of diabetes for patients.
- All shifts were covered by staff of a suitable skill mix and discipline, the registered manager was able to adjust staffing to meet the needs of patients and to ensure that planned activities took place and section 17 leave was not cancelled.
- Mandatory training was available for staff and 93% of staff had attended this.
- Duty of candour was evident and staff had acted on service user feedback. Patients had criticised the

structure of ward reviews and care plan approach (CPA) meetings. Staff had written to all patients to acknowledge this and to apologise and carried out a survey to find out about patients' views on how to make ward reviews less formal and intimidating.

- Training had been put in place by the psychologist to develop staff awareness of working with patients with personality disorder, development of therapeutic relationships and maintenance of staff and patient boundaries. This was in response to concerns raised by some patients about staff attitudes.
- The service manager had the autonomy to make decisions and to make changes where required to improve the effectiveness of the service. All staff we spoke to described a strong culture of leadership and openness from the registered manager and that they felt comfortable to approach them if they had concerns.
- Admin support was available from a whole time equivalent (WTE) mental health act administrator and a WTE hospital administrator.

Leadership, morale and staff engagement:

- Sickness and absence rates were low with an average of 1.5% staff sickness per month for the 12 months prior to our inspection. Staff sickness and performance was monitored in supervision and appraisal by the registered manager and lead nurse of the service through the supervision and appraisal process and this was reflected in personnel files that we reviewed.
- At the time of our inspection there were no grievance procedures being pursued within the team and there were no allegations of bullying or harassment.
- All staff we spoke to said they felt able to raise concerns without fear of victimisation. staff reported that the senior management team within the service were approachable and accessible if they had concerns and they were aware of the providers whistleblowing policy and how to use it.
- The morale of staff was good. We spoke to a range of staff from different disciplines including housekeeping and all described being proud of the service and the care they provided for the patients. Staff fed back that there was a culture of team working and all staff felt they could contribute to the care planning process and their views were listened to and respected.
- There were opportunities for the development of staff who had showed leadership. We spoke with a team lead who had joined the service as a nursing assistant and then been promoted to their current role. All staff received emails from the provider with information about other services and job opportunities.Qualified nursing staff had access to a preceptorship development programme.
- Staff were open and transparent with patients and explained to patients it and when something went wrong. We saw that duty of candour was evident, patients had complained that they did not like the structure of their care reviews, staff had acknowledged this, apologised in a letter to all patients and commissioned a survey to gain patient feedback and improve the process. Weekly patient meetings took place to promote the views and feedback of patients.

Commitment to quality improvement and innovation:

- A report had also been commissioned by the provider to explore the relationship between restraint and the use of rapid tranquilisation and to identify areas where practice could be improved.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the provider MUST take to improve
Start here...

Action the provider SHOULD take to improve

- The provider should ensure that where complaints are made about staff attitudes or behaviours and upheld, this is documented within the supervision and appraisal process
- The provider should ensure that patients have individualised risk assessments that reflect the use of the services contraband items list.
- The provider should consider the appropriateness of visitors not being able to see patients in their bedrooms and the mental health act code of practice guidance for this area.
- The provider should consider the current arrangements for independent mental health advocacy and steps required to build effective links with the service.

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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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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