Requires improvement

Cornwall Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ866	Bodmin Hospital	Fletcher ward	PL31 2QT
RJ866	Bodmin Hospital	Harvest ward	PL31 2QT
RJ863	Longreach house	Perran ward	TR15 3ER
RJ863	Longreach house	Carbis ward	TR15 3ER

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** because:

- There were ligature risks that had been identified but with no timescales to reduce.
- The seclusion rooms did not contain toilet or washing facilities and there were blind spots that restricted views of patients in seclusion.
- The intercom in one seclusion room did not work making communication between staff and secluded patients difficult.
- Cleanliness was poor in the kitchen on Harvest ward and the water cooler was dirty.
- The privacy panels in bedroom doors were locked open which did not protect the privacy and dignity of patients.
- Rapid tranquilisation was used on Harvest ward but we did not find evidence that staff were following the guidelines on monitoring patients' physical state. Staff told us they do not use a rapid tranquilisation monitoring form even though the trust's own policy said they should.
- Patients experienced delays in discharge from Harvest ward because beds were on available on the acute wards.
- Patients special dietary needs could not always be met on Harvest ward on admission.

However;

- Equipment was regularly checked and was accessible to staff in the wards. Staff had been trained in safeguarding people who used the services and there were good arrangements in place for the management and administration of medicines.
- The needs of patients were assessed and care planning ensured that staff had the information they needed to care for them and to plan for their discharge. Patients were treated with dignity and respect and patients mostly spoke well of how staff treated them.
- Patients had access to outside spaces and were able to make drinks and snacks throughout the day.
- When patients spoke English as a second language, interpreters were provided to support them with communication.
- There was a new governance structure that involved clinicians at different levels in the development of quality services. Staff were very happy with their ward managers.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Ligature risks had been identified in audits but it was not clear when these risks would be reduced. Plans did not show staff how to mitigate these risks.
- The seclusion rooms on Harvest ward contained blind spots and patients needing toilet and washing facilities had to be taken out of seclusion which could pose a risk to staff and other patients.
- Rapid tranquilisation was used on Harvest ward but we did not find evidence that staff were following the guidelines on monitoring patients' physical state. Staff told us they do not use a rapid tranquilisation monitoring form even though the trust's own policy said they should.
- The intercom in one seclusion room did not work which meant that communication between a patient in seclusion and staff was limited.
- The cleanliness on Harvest ward was poor.
- Patients privacy and dignity was not protected on the PICU

However;

- Three of the wards were clean. Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was accessible.
- Staff used de-escalation techniques effectively to prevent the usage of seclusion. Restraint was used only as a last resort.
- Staff had been trained in safeguarding and knew how to make a safeguarding alert.
- Appropriate arrangements were in place for the management of medicines.

Are services effective?

Good

We rated effective as **good** because**:**

- Patients' needs were assessed and care was planned to meet those needs so that staff knew how to look after patients.
- There were assessments from psychological services that ensured interventions were started before patients left hospital.
- There was robust planning for discharge that involved other partners from the community.
- Staff received training to enable them to do their jobs effectively and as part of a multi-disciplinary team.

Summary of findings

- All staff were trained in the use of the Mental Health Act and the Deprivation of Liberty safeguards.

Are services caring?

Good

We rated caring as **good** because:

- Patients were treated with dignity and respect.
- Patients were complimentary about how staff treated them.
- Staff knew about patients' needs and how to support them.
- Patients were orientated to the wards and given information about living on the wards.
- Although we did not always see involvement in their care planning we did see that patient's comments about their care plans were recorded in their care notes.
- There was good access to advocacy across all the wards.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **Requires Improvement** because**:**

- The kitchen on Fletcher ward was in need of improvement to make it safe for patients to use.
- Patients privacy and dignity was not protected because the privacy windows in doors to their bedrooms was locked open at all times.
- Fletcher ward was hot and airless with no air conditioning to make the environment comfortable for patients and staff.
- The dining area on Fletcher ward was small and was the focal point of activities. When patients were using the space it felt busy and congested.
- Patients on Harvest experienced delayed discharges because the acute wards did not have beds to take them back when they were ready to return.
- Patients dietary needs could not always be met by the service when admitted to Harvest ward.
- However:
- There was robust discharge planning that involved a variety of services from the hospital and partners from the community.
- Patients had access to quiet rooms where they could spend time when they needed to.
- There was good access to outside space for patients to use. There was access to hot and cold drinks throughout the day and staff made sure people could get drinks at night if they could not sleep.
- When people spoke English as a second language there was access to interpreter services.

Summary of findings

- Patients knew how to complain and received a response to their complaints.

Are services well-led?

Good

We rated well-led as **good** because**:**

- Staff had been involved in the development of the trusts vision and values.
- Staff knew who their senior managers were and some had visited the wards.
- There were newly developed governance structures that involved staff from the wards to participate and develop a quality approach to care in the acute wards.
- Ward managers had autonomy to vary the staffing levels on their wards.
- Staff knew what and how to report incidents.
- Morale on the wards had improved and staff highlighted the support they received from their ward managers.

Summary of findings

Information about the service

There are three acute admission wards for adults of working age, Carbis and Perran wards are located at Longreach House, and Fletcher Ward is at Bodmin Hospital. The wards aim to provide a safe environment for assessment and treatment of people over the age of 18 with a mental health condition.

Fletcher is a 24 bedded mixed gender ward. Perran and Carbis are both 15 bedded mixed gender wards for adults of working age from age 18 to end of life.

Harvest ward is a psychiatric intensive care unit (PICU) at Bodmin Hospital. This ward provides intensive treatment to people aged 18 years or above who, because they are mentally very unwell, need a level of nursing input that cannot be provided on an acute psychiatric ward.

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt, Independent Consultant

Head of Inspection: Pauline Carpenter, Head of Hospitals Inspection

Team Leader: Serena Allen, Inspection Manager

The team who inspected this core service included CQC inspectors and a variety of specialists: three nurses, one consultant psychiatrist, one mental health act reviewer, one expert by experience.

Why we carried out this inspection

We inspected this core service as part of our ongoing 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?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- Visited all four of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with 37 patients who were using the service
- Spoke with the managers or acting managers for each of the wards
- Spoke with 30 other staff members; including doctors, nurses and social workers
- Interviewed the divisional director with responsibility for these services
- Attended and observed two hand-over meetings and three multi-disciplinary meetings
- Carried out a specific check of the medication management on all four wards
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Carried out an unannounced visit to Harvest and Fletcher ward out of hours

Summary of findings

What people who use the provider's services say

We spoke with 37 patients and four relatives. Most patients were positive about their experience of care. They told us that staff were caring, kind, friendly, listened to them, and treated them with dignity and respect.

Patients said that staff always knocked on their doors and waited to be invited in.

Some patients told us that staff spent time with them and they were assisted to participate in activities.

Patients told us that restraint was not used often. However, when they had to be restrained for their own safety all the staff did their best to reassure them.

Most patients told us they felt safe and staff ensured their safety when there was an incident on the ward.

Good practice

The multi-disciplinary meeting held on Fletcher ward involved teams and partners from housing, benefits, and voluntary organisations that effectively plans for patients discharge.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure all staff working in the acute wards and PICU are clear about the steps they need to take to reduce the risks of ligature points to patients.
- The provider must take action to reduce the blind spots in the seclusion rooms so that staff can observe patients at all times when secluded.
- The provider must ensure the repair of the intercom in the seclusion room to ensure staff and patients can communicate when patients are in seclusion.
- The cleaning and maintenance of the wards at Bodmin hospital must be improved to reduce the risk of infection to patients and staff.

Action the provider SHOULD take to improve

- The privacy windows in bedroom doors should afford patients privacy and dignity when they are in their bedrooms.

Cornwall Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Fletcher ward	Bodmin Hospital
Harvest ward	Bodmin Hospital
Carbis ward	Longreach Hospital
Perran ward	Longreach Hospital

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.

98% of staff had received training in the use of the Mental Health Act (MHA) and Code of Practice as part of their mandatory training.

We found a good system in place to ensure that consent had been obtained and recorded on the correct documentation, when patients did not consent to treatment a referral to the Second Opinion Appointed Doctor (SOAD) was made. Consent documentation was completed and correctly stored with medication charts.

Staff routinely informed patients of their rights under the Mental Health Act. These were repeated to patients to ensure they understood them. Information was provided to patients about their rights in leaflets which were produced in other languages where needed.

Patients had access to the Independent Mental Health Advocacy (IMHA) service and staff knew how to make a referral or support patients to self refer. We found that IMHAs access to patient's notes could be delayed as the trust withheld access until they had reviewed the notes and removed third party information.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

98% of staff had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff we spoke with had an understanding of this legislation.

We saw that staff in had an understanding of assessing patients' mental capacity and their individual role in this.

Staff had a good understanding that capacity was linked to specific decisions. Records showed that where it was assessed that the patient lacked mental capacity this was for decisions the patient would make.

Requires improvement

Are services safe?

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

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

Summary of findings

Please see summary at beginning of report.

Our findings

Safe and clean environment

- The design and layout of Harvest and Fletcher wards did not allow for clear lines of sight. Areas of the ward that could not be seen were managed through regular observation checks carried out by nursing staff.
- We observed some ligature risks in Fletcher ward including door closures and the locks on windows. The manager showed us the ligatures risk assessment and these were included on it. Staff were mitigating the risks using observation. The ward manager told us ligatures had been assessed by a specialist team. Managers risk assessed their own wards with a nurse consultant and this information was collated by a risk team. The ligatures risk assessment was completed annually and was last completed in July 2014. An action plan had been produced as a result of the audit and some checks were undertaken, for example bars and curtain rails were weight tested and none needed replacing. Some items on the action plan had not yet been addressed including ligatures in the assisted shower and door locks needing replacement.
- Staff knew where ligature cutters were located and told us they knew how to use them. There were clear signs for all staff stating where ligature knives could be found in an emergency. These were the manager's office, the occupational therapist's office and the doctor's office.
- On all the acute wards visited, except Fletcher ward, male and female sleeping areas were separate. On Fletcher ward there was a corridor of bedrooms where vulnerable male and female patients slept. All of those rooms had en-suite facilities, and there was a visible staff presence in the corridor to support patients. There were female only lounges on all wards where women had a safe space for their use away from men on the wards.
- The clinic rooms were accessible with a range of equipment. Emergency equipment, including automated external defibrillators and oxygen was in place. They were checked regularly to ensure they were fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked regularly. Most staff had had training in life support techniques.
- Most of the wards were well-maintained with corridors that were clear and free of clutter. Fletcher ward had some furniture that needed repair or replacement; there were other repairs that needed to be done however there was a slow response from the Private Finance Initiative (PFI) provider. To improve the response to requests a health care assistant's post was dedicated to working with the PFI manager to constantly chase up the repair requests. Managers told us that this approach had improved the response times for repairs. A different PFI provider maintained Longreach house and there we found that there was a much quicker response to requests for repairs and maintenance.
- There were audits of infection control and prevention and staff hand hygiene to ensure that patients who use services and staff were protected against the risk of infection. Sharp objects such as needles and syringes were appropriately disposed of in yellow bins.
- Alarms were located in bedrooms, toilets, and bathrooms. Staff said when used the alarms were responded to promptly.

Safe staffing

- The number of nurses identified in the staffing levels set by the trust matched the number on all shifts on all wards. Across the acute inpatient areas there was a total of 84.74 staff. There were 1.5 vacancies that had been advertised by the trust.
- Staff received training to ensure they were trained and skilled to provide care to patients in the acute wards. Training records showed that statutory and mandatory training was at 98%.
- On Fletcher ward when we visited there were 4 trained nurses on duty. One was sick. There would normally be 5 nurses on duty on this ward. Managers described

Requires improvement

Are services safe?

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being active in the process of trying to procure replacement staff, moving staff from other wards if needed or offering overtime before using bank or agency staff.

- The ward managers explained they have the flexibility to get more staff if needed although this is monitored. They can add a nurse for every patient above level one observation automatically. The ward use a system called ' E-Roster' to search for staff but remain actively engaged in trying to source staff by from other wards, the bank and offering overtime. Switchboard sends out texts to bank staff offering additional shifts. Managers told us their priority was to keep the ward safe. Agency staff are used as a last resort.
- When a patient needed closer observation because of their safety risk the staffing levels were increased. Managers on Fletcher, Carbis and Perran ward told us they were able to obtain additional staff when more than one patients needs had changed and more staff were required to ensure their safety.
- Generally where bank and agency nurses were used, these staff were familiar with the ward. On Fletcher ward we saw that some of the temporary staff had previously worked there before retirement.
- The ward operated a shifts system and staff were offered flexible working.
- There was a risk assessment of how many staff there should be on duty.
- Managers would also help out if staffing was limited although they were supernumerary in terms of nursing cover.
- Events such as Section 17 leave, tribunals and escorting people to medical appointments all had an impact on the staff available to run the ward. Managers were able to book additional staff to ensure sufficient staffing to enable the ward to run effectively.
- Qualified nurses were present in communal areas of the wards at all times.

Assessing and managing risk to patients and staff

- Following admission we saw that patients had a 72 hour care plan completed. Care plans were continued from other wards and services that patients came from.
- Where care plans had been completed they contained information from patient's previous history and focused on how the patient was to be supported. The agreed level of observation, risk assessments, and a plan of care to manage identified risks was put in place. Patients were reviewed at the weekly meeting with consultant psychiatrists.
- Where increased risks had been identified there was not always a clear, regularly reviewed management plan in place to ensure staff knew how these risks could be reduced.
- Smoking was restricted to set times during the day beginning at 08:00hrs and then every 90 minutes till 20:00hrs. Patients were escorted by a staff member into the enclosed garden, who held the lighter. One patient said they felt the time between smoke breaks was too long.
- Patient's notes were looked at to check that risk assessments were carried out prior to section 17 leave. We could not locate risk assessments prior to patients going out. We were told that not all risk assessments prior to a patient taking section 17 leave were recorded.
- There were good policies and procedures for the use of observation and we saw staff carrying out regular checks throughout the wards.
- On all wards de-escalation was used and staff gave us examples of how communicating with the patient helped to ensure that the number of restraints used had reduced.
- All staff had been trained in the physical intervention method used within the trust, Management of Actual and Potential Aggression (MAPA). This was a three day training with a one day annual update. MAPA uses a range of restraint techniques beginning with minimal touch. High level restraint was avoided where possible. Staff felt this was a good technique but if the patient was excessively strong it could be difficult. The team would also assist on other wards when MAPA was needed. All restraint events were reported on a safeguard system.
- Staff followed the trust rapid tranquillisation policy that prescribed medicines to be given in an emergency and followed the NICE guidance.

Requires improvement

Are services safe?

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- Training records indicated that all staff were trained in safeguarding vulnerable adults. Staff demonstrated that they knew how to identify and report any abuse to ensure that patients were safeguarded from harm.
- There were appropriate arrangements for the management of medicines. We reviewed the medicine administration records and the recording of administration was complete and correctly recorded as prescribed. Patients were provided with information about their medicines. Most patients we spoke with confirmed they had received information about medicines and knew what they were for.
- Medicines were stored securely on the wards. Temperature records were kept of the medicines fridge and clinical room in which medicines were stored, providing evidence that medicines were stored appropriately to remain suitable for use.

Track record on safety

- In the last year there had been five serious untoward incidents involving in-patient areas. Three incidents were aggressive behaviour to other patients and two aggressive behaviour to staff.
- Staff told us that the daily handover meeting reduced risks by actively sharing information in a written handover to all staff.
- We found that information was shared with all staff during this meeting and was recorded on an electronic system.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents.
- Staff received feedback from investigation of incidents and met to discuss this.
- There was evidence in Fletcher and Longreach hospital that change had been made as a result of feedback. In Fletcher the safety and cleanliness of the courtyard used for smoking had been improved as a result of patients concerns.
- In Longreach house following a self-harm attempt we saw that the patient's care plan and risk assessment was updated to show staff how to identify risks in the future. This showed that sufficient action had been taken to learn from the incident.

Harvest Ward - PICU

Safe and clean ward environment

- The seclusion room had blind spots that could pose a risk when patients were in there. The design of the ward meant that there were not clear lines of sight and meant the staff had to carry out regular checks to ensure the safety of patients. The ward office window was covered with notices and posters this prevented patients looking in but also prevented staff from being able to see what was happening in the lounge area.
- We identified a number of ligature risks which had not been identified at the time of our inspection. We also identified a number of risks which had been identified previously but no action had been taken to mitigate or address the risk identified. We discussed these with managers who confirmed the issues had been reported but had not been addressed by either the trust or the PFI Company. After we raised these issues with management, steps were taken to address some of the immediate concerns. However, other potential ligature risks identified had still to be addressed.
- There were separate corridors for female patients, separate female-only lounge and bathroom facilities provided.
- We found that there was no regular checking of both the nurses and doctors' resuscitation bags. On the day of our inspection we saw they were last checked on 4th April 2015. We raised this with staff but when we rechecked the following day they still had not undertaken check of the equipment.
- There were three seclusion rooms on the ward however only two were in use. The design of the rooms meant that they did not have integrated toilet and washing facilitates. These were located outside the room. Patients needing to use the toilet or to wash had to be taken out of seclusion and to use those facilities or use a bottle or a bed pan in the seclusion room.
- The intercom to one of the seclusion rooms was broken and had not been repaired, which meant that two-way communication was not possible with any patient placed in that room. Both seclusion rooms had visible clocks.
- At the time of inspection we found a number of areas of the ward were not clean. A communal bathroom and

toilet had a sink and bath which were both dirty. The communal water fountain was unclean, very badly stained and appeared unsanitary. In the kitchen, the splash back area at the back of the sink was very badly damaged and a potential infection control risk..

- There were no shower curtains for any of the en-suite showers, and patient's bedroom floor was consequently flooded from the shower due to the lack of curtain. After we raised this and other issues with management, steps were taken to address some of the immediate concerns raised. For example, we checked on the night time visit and saw that a patient now had a shower curtain up and their room had been cleaned. They told us that having a shower curtain was a big improvement for them.
- External windows had two way glass, the coating was cracked and flaking, very unsightly. The outside space was unkempt. Potential escape points were identified, staff were aware of these but they had not been addressed. Seating was damaged and loose, presenting a potential risk of being used as a weapon for harm to self or others. There were sharp broken edge to handles on TV cabinets and pictures on the walls in the corridors were not fixed and patients could have easily pulled the paintings off the wall and used them as a weapon.
- We discussed our concerns and findings with managers. We were told that there was always a problem getting repairs and maintenance completed in a timely way which meant the environment on the ward often looked uncared for. A consequence of this was that ward staff actually did some of the maintenance and decorating themselves because those tasks were not being done through the formal channels.
- Environmental checks are undertaken by the PFI Company but we did not see those audits during the inspection. The ward undertakes its own environmental audits. These checks were not effective as they had either not identified some of the risks we identified very early in the inspection, or not addressed other risks which had been identified

Safe staffing

- All staff spoken with raised significant concerns in relation to the trust's electronic rostering system. One staff member told us it resulted in the staff gender mix and skill mix not being appropriate to effectively meeting the needs of people and the risks on the ward. Harvest ward had a complement of 36.93 staff with no vacancies
- We were told that the E-Roster system sometimes resulted in staff being sent to different locations in the trust which meant they had to travel long distances to work on the ward they are allocated.
- Staff rotas are generated by the E-Rostering system however there are occasional issues with staffing on weekends in that sufficient regular staff are not schedule to work and are covered by bank and agency staff.
- Any gaps in the staff rotas are highlighted to the E-Rostering staff and they are able to get additional bank staff or staff from an agency if necessary.
- There was no clear induction process for temporary staff coming onto the ward. Staff spoken with were not able to explain how temporary staff were inducted to the ward to ensure they knew how to work with patients safely.
- Patient told us that activities were cancelled regularly because of too few staff. Two of five patients we spoke to stated they had had leave cancelled due to there being insufficient staff. Staff on the ward told us that leave would not be cancelled unless there was an emergency.
- Some concern was identified about the alarm response system, which meant staff were only alerted on PICU when there was a serious incident. The alarm system did not summon staff from neighbouring wards. On occasions this had potentially contributed to staff having to call police to respond to an incident because the staff available had been unable to carry out the physical interventions necessary to control the situation.
- Six consultants admit to the ward and six junior doctors provide medical cover to the ward. There was always junior doctor on the ward. Out of hours cover was provided by a Core trainee 2 (CT2). A junior doctor told us when they were working out of hours they were able to attend within 10 minutes, which was well within the trust's specified maximum 30 minutes response time.

Assessing and managing risk to patients and staff

Requires improvement

Are services safe?

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- Risk was not always managed effectively. For example, when we reviewed recent incidents we found a record of an incident from 9 Jan 2015 – damage to window of laundry room, metal opening bar, latch missing and not found. The incident had been closed down as addressed on the system 10 Feb, despite the missing metal bar not having been found, and the staff were unable to confirm how or if the risk had been effectively mitigated prior to their closing it on the system.
- Two patients told us they didn't feel safe on the ward. One person had suffered racist abuse from other patients. Another patient told us, I don't feel safe where I am, because of other patients on the ward, they have threatening behaviour.
- A blanket policy was in place regarding personal mobile phones and laptops not being allowed on the ward. We were told this was because people had accessed inappropriate materials previously and because of risks associated with inappropriate use of cameras. However, a purpose-built cabinet enclosed computer had been ordered to allow patients controlled access to the internet.
- Staff told us they used a range of de-escalation techniques and that restraint and seclusion were used only as a last option if de-escalation had failed.
- Staff told us they had appropriate training in restraint, through training such as MAPA, and they felt sufficiently trained to deal with aggression. Training records confirmed that all staff had undertaken MAPA training.
- We saw that the unqualified nurses were out on the ward with patients supporting patients as part of an ongoing process of de-escalation. The qualified nursing staff were available to support but were often in the office carrying out administrative tasks.
- We noted from the critical incident reviews that when patients were restrained the post incident reviews contained useful information including details of how the patient was physically restrained. Under the old MHA Code of Practice there is a requirement for post incident support, review and for the reassessment of the care plan. We could not see in the records that this had been done.
- Rapid tranquilisation was used on the ward but we did not find evidence that staff were following the guidelines on monitoring patient's physical state. We checked records for physical monitoring following rapid tranquilisation but could find no written entries. Staff told us they do not use a rapid tranquilisation monitoring form even though the trust's own policy said they should.
- We were told that the ward had tried to move away from the use of seclusion as much as possible, following on from a historic situation where seclusion had been over-used. Records supported that there had been a reduction in the use of seclusion. However, some staff felt that the move away from use of seclusion had resulted in increased incidence of violence and aggression towards staff.
- Staff spoken with were aware of safeguarding processes and systems, what to report and to whom. They gave examples of having identified potential abuse situations and raising subsequent safeguarding alerts. For example, on behalf of a patient who was potentially being abused financially and another who was racially abused.

Are services effective?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Assessment of needs and planning of care

- Patients' needs were assessed following their admission to the wards. The format of care plans and risk assessments used showed staff how to support the patients to meet their individual needs.
- In Fletcher ward there was a whiteboard in the nursing office which was used to record patient information. This had been updated so it was possible to see how many patients were on the ward, what their risks were, and who was detained under the Mental Health Act (MHA).
- Most records showed that patients' physical health was monitored. However, some patient's records showed that their physical health needs were reviewed because the patient had refused a physical examination.

Best practice in treatment and care

- There was a strong occupational therapy team across the acute wards. The team consisted of occupational therapists, sports therapists, and occupational therapy support staff. At Fletcher ward we saw a group facilitated by the occupational therapist to manage the discharge of patients. The group consisted of housing officer, benefits advisors, community psychiatric nurses, representatives from the rehabilitation services.
- Nurses on the ward were trained in Dialectic Behaviour Therapy. Dialectical behaviour therapy (DBT) is a therapy designed to help people change patterns of behaviour that are not helpful, such as self-harm. Some staff had basic counselling and Cognitive Behavioural Therapy skills and staff were keen to give patients talking time. A Mindfulness practitioner also visited the ward weekly and one of the staff were trained in the Tidal Model. The Tidal Model is a recovery model for the promotion of mental health.
- Patients had access to physical healthcare; including access to specialists when needed. One patient with diabetes told us how they had regular monitoring for the condition whilst in the hospital.
- Staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These enabled the clinicians to build up a picture over time of their patients' responses to interventions.

Skilled staff to deliver care

- The staff working on the acute wards came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology, and social work. Other staff from the trust provided support to the wards, such as the pharmacy team.
- On Fletcher ward a clinical psychologist was part of the team but they were on long term sick leave and there had been no replacement. We were told that a new psychologist was due to start on the ward. At Longreach house we found a psychologist was based on the wards as a fundamental part of the teams. This ensured that patients received psychological assessments and pre-treatment interventions that supported their recovery.
- Most staff received appropriate training, supervision, and professional development. Staff received training in safeguarding, life support techniques, and the use of physical interventions. Records showed that most staff were up to date with statutory and mandatory training.
- Qualified and unqualified nursing staff received training in Dialectal Behaviour Therapy (DBT) and Cognitive Behavioural Therapy (CBT) so they could support patients who would benefit from this. They shared their learning across the staff team. Staff said that the wards were sometimes short staffed and this meant that they could not always use their skills with patients because of the demands of the ward.
- Most staff received clinical and managerial supervision every month, where they reflected on their practice and incidents that had occurred on the ward. We saw notes from staff supervision that were kept as a record of the sessions. Staff told us that they were supported by all staff on an informal basis.
- Preceptorship training was offered to newly qualified nurses. This helped ensure that they had the skills needed and were well supported.

Are services effective?

Good

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

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary team (MDT) meetings. However, we found on Fletcher ward that the psychologist did not regularly attend and the primary way of communicating seemed to be through the use of emails. This ensured that psychology input to patient care took place.
- We observed that there were comprehensive handovers between the shifts. Staff had effective working relationships with teams outside of the organisation, for example, the local social services and housing.
- In the wards there were weekly review meetings with the MDT including community mental health teams. This ensured good communication between the different teams that were supporting the patients.

Adherence to the MHA and the MHA Code of Practice

- 98% of staff had received training in the use of the Mental Health Act (MHA) and Code of Practice as part of their mandatory training.
- Records showed that consent to treatment requirements were adhered to and attached to medication charts. We found a good system in place to ensure that consent had been obtained and recorded on the correct documentation. We looked at five patient T2 records and found that all of the forms we saw were completed by the patient's consultant.
- Most patients had their rights under the MHA explained to them on admission and routinely thereafter. Most of the patients confirmed that they had had their rights explained to them but one patient said they could not remember been told on admission however their named nurse had later on talked to them about their rights.
- Patients had access to the Independent Mental Health Advocacy (IMHA) service and staff were clear on how to support patients to access this. We found that access to patient's notes was a difficult process for the advocates because the trust refused immediate access until they had reviewed the notes and removed third party information.

Good practice in applying the MCA

- 98% of staff had received training in the Mental Capacity Act as part of their mandatory training.
- Staff demonstrated that they understood that patients capacity assessments was linked to different decisions that had to be made.
- We saw patient care records which showed recent capacity assessment regarding consent to treatment.

Harvest Ward PICU

Assessment of needs and planning of care

- Patients were examined on admission; however, any patients admitted between 1am – 6am were not seen by a doctor till the following morning. We reviewed patient's records and found that there were no physical health observations recorded on first admission. No ECG or bloods were noted until 2 weeks after admission.
- We found a patient had been recently admitted who had sustained an injury to their hand prior to admission to the ward. We checked the records and saw a full and detailed description of the associated incident and record of doctor having checked out the person's injuries. All appropriate action had been taken and recorded.
- Junior doctors liaised with professionals at local hospitals on an ongoing basis, and that a nurse visited the ward for support with nutrition, skin conditions, diabetes, Parkinson's and other conditions.
- Staff told us that RIO had historic care plans and information, which they found helpful.
- Some important information such as specific risks faced by patients was not reflected in care plans. For example, the risk of racial abuse was identified in the risk assessment but not in the care plan.

Best practice in treatment and care

- There were no psychological services available to patients at the time of inspection as the previous psychologist had left. However, a new psychologist had been appointed and was due to start work assessing patients and offering support to staff.

Skilled staff to deliver care

- There was a full range of health disciplines such as psychiatrist, nurses, occupational therapists and pharmacist that provided input to the ward.

Are services effective?

Good

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

- We reviewed supervison records and spoke with staff to confirm that supervision was taking place. Some staff told us they were not receiving supervision as regularly.
- The medical staff, the doctors, and nurses, spoken with all told us they received effective support and supervision. Medical staff also told us they were able to access specialised training if they needed it.
- Records indicated that most staff training was done as electronic learning on computers, and that staff were mostly up to date with their mandatory training.

Multi-disciplinary and inter-agency team work

- Staff told us that all staff attends handover meetings, between each of the shift handovers. Nursing staff had handovers, and junior doctors had personal handovers of patients if specific issues were identified or for any new patients.
- MDT meetings were attended by a broad spread of appropriate professionals, including nurses, doctors, occupational therapist, pharmacist, and patients themselves or their representatives as required. Although a broad range of staff attended meetings and reviews, it was raised with us that care co-ordinator attendance at reviews was not consistent.
- Consultants told us they thought the model in use of doctors working across both inpatient and community teams was very positive and resulted in better outcomes for patients and greater continuity of care.

Adherence to the MHA and the MHA Code of Practice

- Records seen showed that all staff had completed training in the MHA. All staff spoken with told us they were trained in the MHA and understood its key principles.
- T2 and T3 consent to treatment forms were on medication charts and their status was checked weekly during ward rounds.
- Staff at different levels told us patients had their rights explained to them on admission and then during their stay on the ward. Patients records confirmed that their rights had been explained to them. Patients confirmed they had received information about their rights when they were admitted to the ward.
- Staff spoke very positively about the MHA Office and the support they received from the MHA Administrator. They confirmed they received regular guidance and were able to contact them for advice as needed. They also received prompts from the office to ensure they were following the MHA correctly.
- Advocacy was a visible presence on the ward throughout the inspection. All patients spoken with told us they either accessed the advocacy service or knew they were able to access an advocate if they wished for that support.

Good practice in applying the MCA

- Capacity and consent were regularly being considered and this information was in the electronic record. We saw patient care records which showed recent capacity assessment regarding consent to treatment.

Good

Are services caring?

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

Summary of findings

Please see summary at beginning of report.

Our findings

Kindness, dignity, respect and support

- Most of the patients were positive about the support they received from the staff and felt they get the help they needed. Patients told us and we saw that they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us that staff are nice and are interested in their wellbeing.
- We saw helpful interactions between staff and patients. Staff spoke to patients in a way that was encouraging, respectful, clear and simple and demonstrated positive commitment, and willingness to support patients.
- Staffs showed a good knowledge of the individuals needs and were able to explain how they were supporting patients with a range of needs. Patients told us that staff knew them very well and supported them the way they wanted and made them felt safe.
- We observed meal times and saw that staff and patients interacted throughout. Patients commented on the meals saying they were mostly good and they enjoyed eating together. Fletcher ward sometimes had patients with a learning disability who found it difficult to eat with others. Staff supported them to eat in their rooms so they are able to enjoy their meal.

The involvement of people in the care they receive

- The admission process informed and orientated the patient to the ward.
- Care records did not always show the involvement of the patient in their care plan. We saw that staff had recorded patient's comments on the care plans once they had been shared with them. Most of the patients knew what a care plan was and some had been offered a copy but did not always want a copy of the plan.
- We observed that patients were involved in their ward round and were treated by all staff with dignity and respect. The patients we saw attend the ward round said they felt involved in their care.
- Patients had access to advocacy services. The advocate attended patient's review meetings where this was appropriate.
- Patient's families and carers were involved where this was appropriate.
- There were daily meetings held on the wards. These meetings were attended by both patients and staff with a patient as chair. We observed two meetings and saw that all patients were encouraged to contribute by giving their opinion on planned activities for the day or about anything concerning them.

Harvest PICU

Kindness, dignity, respect and support

- Staff interaction with patients was observed to be polite and respectful during our time on the ward, including during the night time visit. Although it was a noticeably younger staff team at the night visit, the atmosphere was calmer and staff and patients seemed to be interacting more positively.

The involvement of people in the care they receive

- Staff told us that patients were taken through the induction checklist and then given a guided tour of the ward. One patient confirmed that, they were given information about the ward and rules of the ward. Another patient said they had not been given any information when they were admitted. The Patient Information leaflet was very limited and did not talk about the care planning process and patient and carer involvement in the process
- We saw patients had copies of their own care plans. Feedback from patients was mixed, but mostly positive.
- Patients were unable to make hot drinks or food for themselves and were unable to use the outside space freely (only at set times).
- Advocacy was a visible presence on the ward throughout the inspection. All patients spoken with told us they either accessed the advocacy service or knew they were able to access an advocate if they wished for that support.

Good

Are services caring?

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

- Patients told us they felt able to feedback (involvement in ward round, for example). One patient told us they had been given a questionnaire previously in relation to the service.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

Please see summary at beginning of report.

Our findings

Access, discharge and bed management

- When we visited the wards we found that there were patients on leave. On Fletcher ward there were five patients on leave and the ward was full. Whilst on long term leave, patients were supported by the community mental health teams and/or the home treatment team.
- Patients were informed that when they went on leave their bed could not be kept open due to pressure on beds. However, there was evidence that patients were not discharged until they were ready to leave.
- There was good discharge planning. There was liaison with community teams and community services to ensure that the patient was supported in the way they needed following discharge.

The ward optimises recovery, comfort and dignity

- We found Fletcher ward to be hot and airless and staff agreed this was an issue. There was no air conditioning. The wards at Longreach House were bright and airy having recently undergone refurbishment. Patients on Carbis and Perrin ward told us how comfortable the wards were and they enjoyed staying on the wards.
- There were a range of rooms provided in each ward. These were used to good effect in Carbis and Perrin wards. In Fletcher ward there were a number of rooms where people could go for relaxation and quiet time. The dining area was small and formed the main area of the ward, which meant when patients were there it felt very busy and congested.
- The patient's telephone was located in a corridor which was noisy. Patients were able to make a phone call in private on wards using a hand free set provided.
- In all wards there were single bedrooms with en-suite facilities. Patients were given swipe cards on Fletcher ward to access their corridors and rooms. During our visit to the ward, there was an incident. The cards to unlock one of the bedroom areas failed. This meant the door to the bedrooms could not be opened and this presented a fire risk. The ward staff did not know if anyone was in this part of the ward and unable to get out. Staff acted quickly to resolve the situation. The error was caused by a maintenance worker working on the computer system and they hadn't expected the doors to fail.
- Patients had access to outside space in all wards.
- In the wards patients told us that the food was okay and they had a choice. We observed the mealtimes and saw that these were occasions where staff and patients interacted.
- Patients were able to make hot drinks and snacks throughout the day. During the night patients told us that night staff would make them a hot drink if they needed one and it was not detrimental to their sleep pattern. The kitchen on Fletcher ward was unsuitable for patients to use without being accompanied because of the risks of self-harm. Hot and cold drinks were provided on a trolley every 2 hours. There was a water machine permanently in the dining area which patients could use at any time.
- We saw that activities were provided on each ward and patients on told us they enjoyed these and they helped to aid their treatment. Some patients told us they sometimes found there was not enough to do every day. They told us they were often bored during these times.

Meeting the needs of all people who use the service

- Accessible bath, toilet, and shower facilities were provided on all wards.
- There was access to interpreters when patients spoke English as a second language. Staff could access a translator through an agency over the phone or by appointment someone could attend the ward to interpret for a patient. We saw an example of a patient who had an interpreter attend their ward round and whose care plan was also translated into their first language.
- A choice of food was provided to meet patients' religious and ethnic requirements. Some patients told us that the choice of vegetarian diets was often limited.

Are services responsive to people's needs?

Requires improvement

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

- Patients had access to spiritual support. We saw posters displayed with information about the spiritual care team and the times they visit the wards. Staff would contact the team if a patient wanted to see a priest or spiritual leader from another faith.
- Wi-Fi was provided for patients and they could use mobile phones and other devices. There were sometimes problems with patients, for example, repeatedly calling the police and this was managed by the staff.
- Patients were able to wash, dry and iron their own clothes in the laundry provided. On Fletcher ward the laundry was off the ward patients with section 17 leave or informal could do their own laundry following risk assessments. Otherwise staff would do their washing for them.

Listening to and learning from concerns and complaints

- Some patients told us they knew how to make a complaint and would do so if they if something happened that they were unhappy about.
- In Fletcher ward we saw that staff had learnt from a complaint made. There had been several complaints about the state of the smoking area on Fletcher ward. Patients were informed of the outcome of the investigation and saw the improvements made as a result.
- Staff did not always receive feedback on the outcome of investigations of complaints.

Harvest PICU

Access, discharge and bed management

- The ward manager, care, and medical staff spoken with all raised issues in relation to delayed discharge, and we were told discharge from the ward to other wards or the community was often delayed for non-clinical reasons. A consultant told us that discharge was sometimes delayed due to issues beyond the ward's control, such as lack of available alternative accommodation / housing, and also due to safety issues.

The ward optimises recovery, comfort and dignity

- Patient's bedroom privacy windows were not closable from the inside, but were locked open and only closable by staff. This meant people were not able to have privacy in their bedroom if they wanted it, but could potentially be observed by staff and other patients at any time when they were in their bedroom.
- The de-escalation room had been used to hold meetings and still had a table and chair in it, which presented a clear risk if a person was taken there as part of de-escalation, in that the furniture could be used to injure themselves and others.
- There was a quiet lounge area at the end of one of the corridors where patients could meet visitors.
- Calls could be made on mobiles in a room next to the office. Also, there was a phone box where patients could make calls – there was some concern that the location of the phone meant staff may have been able to hear private conversations and there was a lot of staff and patient transit in that particular area.
- There was an outside space, but access to this was controlled and only at set times. People were not able to access the outside space freely at all times.
- People were not able to make hot drinks and snacks, but patients told us they were able to ask staff and get food and hot drinks whenever they wanted.
- Patients' belongings were stored securely in lockers. Inventories of people's possessions were compiled on admission.
- All patients, and all staff of all different levels spoken with, identified issues in relation to inappropriate activities and lack of activities on the ward. Lack of activities was identified as a particular problem on the weekends, due to staffing.

Meeting the needs of all people who use the service

- A patient who spoke English as a second language told us they had been given information in their preferred language.
- Section rights were provided on admission to a non English speaker and an interpreter had initially been made available; however, this had changed by the time of our inspection and the manager told us they had difficulty getting an interpreter in weekly.
- Parts of the ward were monitored by CCTV. Patients were not well informed and there was insufficient signage on ward telling patients about the CCTV

Are services responsive to people's needs?

Requires improvement

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

recordings. Patient information booklet on the ward did not mention use of CCTV. One poster on the ward informed patients they were being monitored on CCTV. We spoke with four patients who stated they knew they were on CCTV, but they did not realise it was being recorded and they had not seen information regarding this fact.

- A patient had been given only vegetables for the first ten days after admission to the ward, as the catering company had been unable to provide halal food. Eventually, a member of the ward's staff had taken matters into their own hands and gone to get halal food from another site. The person was being provided with halal food at the time of inspection.
- One patient told us the ward was not meeting their spiritual needs because they had no access to an Imam, neither were they able to access a mosque because of a lack of staff. The patient was formally held in hospital and the clinical team had not agreed to section 17 leave in order for them to leave the unit.

Listening to and learning from concerns and complaints

- Patients told us they were able to complain and generally felt confident to do so.
- Staff told us that all complaints are given to the ward manager who always attempted local resolution but if unable to do so will log it as a formal complaint and it would be investigated. The manager confirmed that all formal complaints are investigated and responded to.
- Staff told us that the ward manager was proactive in responding to complaints, and that they received feedback if a complaint was made about them.

Are services well-led?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Vision and values

- Some staff told us they had been consulted about the trust vision and values. Managers told us development of the values had been co-ordinated to enable staff at various levels to be included in the process and to contribute. Managers told us the new vision and values had been launched four months earlier and they were becoming embedded. They said staff had been informed via publications and notice boards.
- Staff spoken with demonstrated an understanding of their ward objectives however, we identified that the ward's and the organisation's values were new and not yet set in practice.
- Staff knew who their immediate senior managers were and told us that they visited the wards.

Good governance

- The service line had newly launched governance processes in place to manage quality and safety. The Operational Assurance Group had a number of groups looking at various issues of quality and development that reported to it. These groups were structured around the CQC five domains and focussed on different aspects of their services.
- The managers, psychologist, and occupational therapists attend the feeder groups where aspects of quality and safety were discussed. Information was then shared with staff and used to improve the service provided. For example, monitoring of mandatory training, staffing issues, incidents, and rolling 12 month appraisals.
- The managers felt they were given the autonomy to manage their wards. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trust's risk register.
- Supervision was provided inconsistently for staff, planned supervision sessions had sometimes been cancelled due to staffing levels or the acuity of the wards.
- Healthcare assistants spent much of their shift in direct care activities but qualified nurses were involved with administration tasks.
- Staff knew how to report incidents.
- There was feedback to staff on incidents and complaints through the email system and at handovers.
- Staff received training in MHA and MCA as part of their statutory and mandatory training.

Leadership, morale and staff engagement

- Staff were positive about leadership on the wards. Managers were available on the units when care and treatment was provided. The managers were accessible to staff and provided them with support.
- Staff told us that the managers were approachable, had an open door policy, and encouraged transparency. A few staff told us that they felt pressured to due to staffing issues.
- Communication between services was good with clear contact between the wards and the managers who attend governance meetings.
- Staff on units told us they were supported by their managers. We saw and staff confirmed that the team was cohesive with good but variable staff morale. The majority spoke positively about their role and demonstrated their dedication to providing high quality patient care.
- Staff were kept up to date about developments in the trust through regular emails, newsletters and the managers would share information in the ward meetings and supervision meetings.

Harvest PICU

Vision and values

- Staff spoke warmly and positively about the support they received from the ward manager, but were not as positive about the organisation's more senior management. One member of staff told us that they

Are services well-led?

Good

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

only saw senior staff on the ward when there was trouble. They told us they didn't feel supported by more senior management, but felt they were penalised when things went wrong.

Good governance

- Ward systems were effective in ensuring that staff had received mandatory training, were supervised, shifts were always covered by a sufficient number of staff and staff maximised their time on direct care activities, incidents were reported and staff learnt from these, complaints and feedback from patients and safeguarding procedures were followed.
- We saw that shifts are covered by a sufficient number of staff of the right grades and experience as agreed through the staff rostering system.
- The ward manager was able to book additional staff to ensure the ward was sufficiently staffed to manage the care of patients.

Leadership, morale and staff engagement

- There was a sickness rate of 9% on the ward resulting in use of bank and agency staff to maintain safe staffing levels.
- Some staff felt bullied because of the E-Rostering system which they felt impacted on their personal lives and senior management was unsympathetic to their concerns.
- Staff told us they were able to whistleblow and knew about the trusts whistleblowing policy.
- Staff told us they felt able to speak up freely and voice any concerns with the ward manager. Other staff told us they had previously felt unable to raise concerns or provide feedback to management, but felt they could now do this freely under the current ward manager.
- There was a split in the staff team in terms of their experience at work and how satisfied and empowered they felt. Although medical staff told us they felt empowered and valued by the trust, it was evident that the care staff did not feel equally empowered or valued by the trust and senior management.
- Staff told us that morale on the ward was improving under the leadership of the current ward manager, who had been in post for two months, who they found to be supportive.
- All staff we spoke with were positive about the ward manager and the support they received from them. For example, one staff told us they thought the ward manager was, "The nicest manager we have ever had – we love him to bits."
- One member of staff spoke about how they had felt well supported by colleagues after they had been racially abused by a patient.
- The manager operated an 'open door' policy and also set aside dedicated times so they could be available to staff.
- We saw evidence that regular staff meetings were held, and minutes to these were forwarded on to all staff who were unable to attend in person.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Premises must be fit for purpose in line with statutory requirements and should take account of national best practice.** **On Harvest ward the seclusion rooms had blind spots and did not have toilet and washing facilities adjoining. Patients needing the toilet had to either use a bottle or be taken out of seclusion which could pose a serious risk to staff and patients. The intercom did not work in one seclusion room thereby preventing patients communicating to staff**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Care and treatment must be provided in a safe way for service users.** **Harvest ward was not clean and presented infection risks to patients using the service.**