Northamptonshire Healthcare NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Date of inspection visit: 3 - 5 February 2015
Date of publication: 26/08/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP1V4	Berrywood Hospital	Quayside	NN5 6UD

This report describes our judgement of the quality of care provided within this core service by Northamptonshire Healthcare 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 Northamptonshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire Healthcare 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?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

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

Summary of findings

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Overall summary

We gave an overall rating for long stay/rehabilitation mental health wards for working age adult of **requires improvement** because:

- There was no risk management or action plan in place to adequately manage the potential ligature risks identified in the communal bathroom.
- The unit did not comply with the guidance on same sex accommodation. There were not enough rooms where patients could relax and or sit privately and quietly. There was one lounge shared by both females and males.
- The unit had a tiny clinic room which was not fit for purpose. The unit did not have a physical examination room and resuscitation equipment. Staff did not know about the requirements of emergency equipment.
- In some cases the risk assessments were not followed. There was risk identified that patients were smoking in their bedrooms. However, no plan was put in place to manage this.
- Staff demonstrated an understanding of how to identify and report abuse to ensure that patients were safeguarded from harm. However, we found that some incidents were not reported as safeguarding.
- Staff knew how to recognise and report incidents through the reporting system. However, we found that some of the incidents were not reported and these were confirmed by staff.
- Care records were not detailed enough and did not contain all relevant information about care provided.
- A patient on a high dose of clozapine for some time was not checked for the level of Clozaril in the blood to find out if they were on the right dose. Another patient who had abnormal blood test results had no further investigations to assess the reason.
- Clinical audits were not carried out regularly to monitor the effectiveness of the service.
- Staff told us that they had not received training on the Mental Health Act (MHA) and the Code of Practice. There was some inconsistent practice on patients' capacity to consent to their treatment.
- Staff had not received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff did not demonstrate a good understanding of MCA and DoLS.
- Our observation of practice, review of records and discussion with staff confirmed that the unit was admitting patients with more complex needs than what the staff in the rehabilitation service were used to and skilled to care for.
- Patients' privacy and dignity was not always protected.
- Patients told us that they knew how to raise complaints when they wanted to but most of them felt that they were not listned to and did not feel confident to complain as staff would not act to resolve the issues.
- We found that the team's and the organisation's values were not embedded in practice. The staff knew who their senior managers were and told us that they rarely visited the unit.
- The trust had governance processes in place to manage quality and safety. However, we identified areas of improvements in safeguarding and incident reporting, clinical audits, MHA and MCA procedures.
- We found that there was lack of good clinical leadership. The consultant was a locum and provided one session a week to the team. The senior management and clinical team did not share information about underlying issues on the unit that could affect care and treatment.
- Morale within the staff team was very low. All staff told us they felt demoralised by changes over the past year. Staff felt there is a huge disconnect with senior management. They told us that senior management did not listen to them or get them involved or consulted in changes.
- The units were not participating in a national quality improvement programme such as AIMS.

However, during our inspection the senior management immediately implemented and shared an action plan with us to resolve some of the issues. The following actions were taken, introduce additional staff, clinical

Summary of findings

reviews with all patients to start the most appropriate pathway for their presentation, review access to the ward and the practicability to create a female-only access directly on to the female corridor, review operational policy, including referral/acceptance criteria and review pathways to create the most appropriate environment for single gender and to move clinic room to a larger room on the unit.

On admission every patient had an assessment of needs that took account of previous history, risk, social and health factors. There was good collaborative working within the multi-disciplinary teams (MDT) and had a number of different professionals who attended review meetings. Staff were polite, friendly and willing to help and treated patients with respect and dignity. Staff demonstrated a good understanding of the individual needs. Patients' individual needs such as cultural and religious needs were met. Staff were aware of the trust's whistleblowing policy and felt free to raise concerns.

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:

- There was no risk management or action plan in place to adequately manage the potential ligature risks identified in the assisted communal bathroom.
- The unit did not comply with the guidance on same sex accommodation. There was one lounge shared by both females and males. Patients' privacy and dignity was not protected as females and visitors passing through the male corridor area would see through the observation panels into bedrooms which were left in the open position by staff.
- The unit had a tiny clinic room which had no resuscitation equipment. Staff did not know about the requirements of emergency equipment. They were unsure if they could access the equipment from other units. Staff told us that they were not trained in basic life support.
- In some cases the risk assessments were not followed. There was risk identified that patients were smoking in their bedrooms. This risk continued with no clear action taken even though it was highlighted since the unit was open.
- Staff demonstrated an understanding of how to identify and report abuse to ensure that patients were safeguarded from harm. However, we found that some incidents that patients told us and confirmed by staff were not reported as safeguarding.
- Staff knew how to recognise and report incidents through the reporting system. However, we found that some of the incidents were not reported and these were confirmed by staff.

The unit was clean, with good furnishings and was well maintained. On admission every patient had an assessment of needs carried out that took account of previous history, risk, social and health factors. Patients were able to access medical input day and night. There were appropriate arrangements for the management of medicines.

Are services effective?

Requires improvement

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

- Care records were not detailed enough and did not contain all relevant information about care provided. The incidents that were reported to us were not clearly recorded and did not capture all relevant information about what had happened.

Summary of findings

- A patient on a high dose of clozapine for some time was not checked for the level of Clozaril in the blood to find out if they were on the right dose. Another patient that had low levels of B12 vitamins from blood tests had no further investigations to assess the reason.
- Clinical audits were not carried out regularly to monitor the effectiveness of the service.
- Records reviewed and discussion with staff confirmed that staff had not received training on the MHA and the Code of Practice. There was some inconsistent practice on patients' capacity to consent to their treatment.
- Records reviewed and discussion with the manager confirmed that staff had not received training in the use of the MCA and DoLS. Staff did not demonstrate a good understanding of MCA and DoLS. The manager and staff were not able to provide evidence that checks were taking place to monitor the use of the MCA.

There were comprehensive assessments that had been completed when patients were admitted. Most of the staff were up-to-date with statutory and mandatory training. There was good collaborative working within the multi-disciplinary teams and a number of different professionals internally and externally who attended review meetings.

Are services caring?

Good

We rated caring as **good** because:

Staff were polite, friendly and willing to help and treated patients with respect and dignity. Staff demonstrated a good understanding of individuals' needs and were able to explain how they were supporting patients with a wide range of needs. Patients were involved in their care planning and reviews and were free to air their views and where appropriate. Their families were also involved. There were ways to actively collect feedback from patients and their families on how they felt about the care provided.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Our observation of practice, review of records and discussion with staff confirmed that the unit was admitting patients with more complex needs than what the staff in the rehabilitation service were used to and skilled to care for.

Summary of findings

- There were not enough rooms where patients could relax and or sit privately and quietly. There was limited space for therapeutic activities which was also used by other professionals for one to one sessions with patients.
- The unit had a tiny clinic room which was not fit for purpose. There was no examination room to support treatment and care.
- There was no designated room where patients could meet visitors in private. Patients and staff told us that patients meet with their relatives in the lounge or away from the unit in the main hospital reception.
- We noted that there was no see through protection on the patients' bedroom windows which looked directly on to a footpath that the public had access to.
- Patients told us that they knew how to raise complaints when they wanted to but most of them felt that they were not listned to. One patient told us that their food had been going missing but nothing had been done to resolve the issue. Another patient told us that they do not feel confident to complain as staff would not act to resolve the issues.

All admissions to these units were planned well ahead and they did not have any emergency admissions. We saw that discharges were well co-ordinated, managed and there were good links with the local authority. Patients' individual needs such as cultural and religious needs were met. Patients had a programme of activities which was also linked to an individual programme.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Most of the staff did not have a good understand of the vision and values of the organisation. Those who knew the values of the organisation felt that the senior management did not demonstrate the values into practice.
- We found that the team's and the organisation's values were not embedded in practice. The staff knew who their senior managers were and told us that they rarely visited the unit.
- The trust had governance processes in place to manage quality and safety. However, we identified areas of improvements in safeguarding and incident reporting, clinical audits, MHA and MCA procedures.

Summary of findings

- We found that there was lack of good clinical leadership. The consultant was a locum and provided one session a week to the team. The senior management and clinical team did not share information about underlying issues on the unit that could affect care and treatment.
- Morale within the staff team was very low. However, staff were passionate about their work and showed a genuine compassion for people. All staff told us they felt demoralised by changes over the past year. Staff felt there is a huge disconnect with senior management.
- The units were not participating in a national quality improvement programme such as AIMS.

The manager provided data on performance to the trust consistently. All information provided was analysed and this was measured against set targets. Staff were aware of the trust's whistleblowing policy and felt free to raise their concerns but felt that their managers did not listen. Staff told us that they were supported by their line manager and were encouraged to access clinical and professional development courses if that benefited to meet the needs of their patients.

Summary of findings

Information about the service

Quayside is a nine-bedded inpatient rehabilitation unit based at Berrywood Hospital, Northampton. It provides rehabilitation opportunities for men and women who have a severe and enduring mental health problem affecting their independent living. It provides twenty four hour care to people aged between 18 and 65 years who may be detained under a section of MHA. The ward had nine patients on the day of our visit, five men and four women. Four patients were detained under the MHA.

The service had previously been located in two separate bungalows known as "The Brambles" and "Kent" situated in the centre of community. There were separate single sex units, one seven bedded female and one eight bedded male. Men moved to Quayside in December 2013 and women in September 2014. The mental health rehabilitation pathway had been through a lot of change over the last two years. The pathways had been combined to bring the male and female pathways together at Quayside. At the same time the two staff teams were brought together to create a full complement of staff.

Our inspection team

The team that inspected the long stay/rehabilitation mental health wards for working age adult services consisted of six people: one expert by experience, one inspector, one Mental Health Act reviewer, one nurse, one psychiatrist and one psychologist.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before 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 focus groups.

During the inspection visit, the inspection team:

• visited Quayside unit and looked at the quality of the unit environment and observed how staff were caring for patients.

• spoke with five patients who were using the service

• spoke with the manager for the unit

• spoke with seven other staff members; including doctors, nurses, psychologist and OT.

• attended and observed one afternoon hand-over meeting.

We also:

• Looked at six treatment records of patients.

Summary of findings

• carried out a specific check of the medicines management on the unit.

• looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Most of the patients were pleased with the care provided. Patients told us about their positive experiences of care. Patients told us that their interaction with staff was quite encouraging to engage in treatment and care. People told us that staff were very supportive, polite, and warm, included them in their care planning and gave them information that helped them to make choices about their care. People told us that they felt staff treated them with respect and dignity.

Where there were negative comments, they concerned staff being unable to support them to access community leave because of staff shortage, and not being able to resolve concerns when they arose.

Good practice

There is nothing specific to note.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that the unit complies with the guidance on same sex accommodation.
- The trust must ensure that there is a clinic and physical examination room that is fit for purpose and resuscitation equipment that is checked regularly for use in emergency caes.
- The trust must ensure that all risk assessments are followed. There was risk identified that patients were smoking in their bedrooms.
- The trust must ensure that all incidents and safeguarding concerns are reported.
- The trust must ensure that care records are detailed enough and contain all relevant information about care provided.
- The trust must ensure that clinical audits are carried out regularly to monitor quality and the effectiveness of the service.
- The trust must start work on training all staff and develop systems to monitor and manage the effective use of the Mental Capacity Act and Deprivation of Liberty Safeguards. This is important to ensure that staff can use the legislation with confidence to protect people's human rights. Assessments of patients' capacity to consent under MHA are detailed enough and available for all patients.
- The trust must ensure that all patients on high doses of clozapine were checked regularly for clozapine levels in their blood. It must also ensure that abnormal blood results were followed with further investigations.
- The trust must ensure that patients' privacy and dignity is protected at all times.
- The trust must ensure that the governance processes in place to manage quality and safety monitors all areas of quality and safety within the units to ensure that improvements are made.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that there is a detailed risk management plan or action plan to adequately manage the risk of potential ligature in the disabled communal bathroom.

Summary of findings

- The trust should ensure that there is a clear policy on referral and acceptance criteria on patients admitted to rehabilitation service and that it is followed.
- The trust should ensure that there are rooms where patients could relax or sit privately and quietly, consider enough space for therapeutic activities and that there is a designated room where patients could meet visitors in private.
- Although patients told us that they knew how to raise complaints when they wanted to, the trust should ensure that they were listened to and feel confident to complain and that staff would act to resolve the issues.
- The trust should ensure that the team's and the organisation's values are embedded in practice and that senior managers regularly visit the unit.
- The trust should ensure that the unit has strong clinical leadership that has got a good understanding of the unit's dynamics.
- The trust should consider that the senior management involves and consults staff with changes that happen within the unit.
- The trust should consider participating in a national quality improvement programme such as AIMS.

Northamptonshire Healthcare NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Quayside	Berrywood 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.

Records sampled and discussion with staff confirmed that staff had not received training on the Mental Health Act and the Code of Practice.

We found a system in place for the administration of the Mental Health Act and noted that all detention documentation was available for scrutiny. The documentation we reviewed in detained patients' files was compliant with the Act and the Code of Practice.

Three out four patients had been informed of their rights in accordance with Section 132 of the MHA and provided with information regarding independent mental health advocacy. Patients we spoke with confirmed that their rights under the MHA had been explained to them.

Completed consent to treatment forms were attached to the medication charts of detained patients. There was no evidence that four patients had their capacity and consent to treatment assessed as part of the admission process and that the assessment had been recorded by the responsible clinician (RC) in the medical notes in line with the code of practice. Capacity and consent were not being routinely reviewed as part of the MDT reviews.

Detailed findings

Section 17 leave was recorded in a standardised way and conditions of leave were reasonably detailed and patients had signed their forms. Ward staff had a process for ensuring leave was authorised before each person left the ward.

Staff knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff discussion and records reviewed showed us that staff had not received training in the use of the MCA and DoLS. There were no formal mental capacity assessments that explained how capacity had been assessed. Staff did not demonstrate a good understanding of MCA and DoLS. Most of the staff did not understand their responsibility in applying MCA and how the legislation applied to their work with patients.

The trust had a policy on MCA and DoLS. However, staff were not aware of it.

The manager confirmed the trust did not train all staff in MCA and DoLS to provide them with the knowledge required in applying the legislation appropriately. Staff were not able to tell us who they could contact as the lead person on MCA within the trust.

The use of the Mental Capacity Act was not checked by the units.

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

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

- There was no risk management or action plan in place to adequately manage the potential ligature risks identified in the assisted communal bathroom.
- The unit did not comply with the guidance on same sex accommodation. There was one lounge shared by both females and males. Patients' privacy and dignity was not protected as females and visitors passing through the male corridor area would see through the observation panels into bedrooms which were left in the open position by staff.
- The unit had a tiny clinic room which had no resuscitation equipment. Staff did not know about the requirements of emergency equipment. They were unsure if they could access the equipment from other units. Staff told us that they were not trained in basic life support.
- Staff did not know about the requirements of emergency equipment. They were unsure if they could access the equipment from other units. Staff told us that they were not trained in basic life support.
- In some cases the risk assessments were not followed. There was risk identified that patients were smoking in their bedrooms. This risk continued with no clear action taken even though it was highlighted since the unit was open.
- Staff demonstrated an understanding of how to identify and report abuse to ensure that patients were safeguarded from harm. However, we found that some incidents that patients told us and confirmed by staff were not reported as safeguarding.
- Staff knew how to recognise and report incidents through the reporting system. However, we found that some of the incidents were not reported and these were confirmed by staff.

The unit was clean, with good furnishings and was well maintained. On admission every patient had an assessment of needs carried out that took account of previous history, risk, social and health factors. Patients were able to access medical input day and night. There were appropriate arrangements for the management of medicines.

Our findings

Safe and clean ward environment

- All patients had their own single rooms with ensuite facilities. The unit was clean, with good furnishings and was well maintained. The unit was small, with wide corridors. The layout of the unit gave clear views from the centre to all the bedroom, lounge and entrance which was helpful for safe observations.
- The environment had anti-ligature fittings in most areas to ensure the safety of patients. There were potential ligature points such as taps and hand rails in the assisted communal bathroom. Patients used the bathroom without supervision. All patients admitted at the time were deemed not at risk of suicide. Staff told us that there was no risk management plan in place to address that risk. However, they told us that observations would be maintained if patients with risk of suicide were to use the bathroom.
- The unit did not comply with the guidance on same sex accommodation. There was only one lounge for both male and female patients with no separate female lounge area. Female patients had to pass through the male bedrooms to leave or enter the unit. One patient told us that females saw them undressed through the observation panel on the door when they were going out. Male patients who used the assisted communal bathroom had to pass through the central point of the unit where female patients were standing. These issues were discussed with the senior management who immediately proposed and shared an action plan with us to create a female-only access directly on to the female corridor and establish the most appropriate environment for single gender.

Requires improvement

Are services safe?

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

- The unit did not have resuscitation equipment. Staff told us that in an emergency they would call an ambulance. Staff were unsure if they could access the equipment from other units. Staff told us that they were not trained in basic life support.
- Environmental risk assessments were carried out in areas such as health and safety and infection control and prevention.
- There was a safety alarm system in place to call for help when needed from other staff on the unit. This helped to ensure the safety of patients and that of staff.

Safe staffing

- Staffing levels on the unit were clearly defined. It consisted of one qualified and three unqualified staff during the day, and one qualified and one unqualified staff at night. One qualified and one unqualified during weekends. The manager was available during the day on weekdays to provide support. We looked at the rota and saw that in the previous four weeks these numbers of staff had been available and an additional staff were brought in during weekends to support with community leave.
- Staff told us that qualified staff were unable to get their breaks when there is only one on shift during weekends or nights. Staff told us that they had raised concerns about staffing and there was an agreement to increase the staffing by one unqualified staff on shift during the day. Staff told us that the need for additional staff was needed due to patients now admitted to the unit who have more complex needs than the ones they used to have. An action plan implemented by senior management during our inspection was to provide additional staff to meet the needs of patients.
- There were no vacancies for qualified or unqualified staff. The team had a whole time equivalence of seven qualified and 9.4 unqualified. The unit did not use agency staff but used bank staff to cover shifts. There was a 30% of shifts covered by bank staff as a result of sickness and enhanced observations in the last three months. The sickness rate in the 12 month period was nine percent. In January this year there was a 26% sickness rate.
- Staffing levels were increased according to the needs of the people being supported on the unit. When patients needed higher levels of observation or support, additional staff were brought in. The manager told us that there was flexibility within staffing resources for additional staff to meet the people's needs. The unit used bank staff and the trust had a structured induction process in place for all bank staff. They told us that bank staff used were familiar with the ward and able to engage with patients well. Sickness and special observations resulted in use of bank staff to maintain the staffing levels.
- Staff told us that before moving to Quayside most their patients were on unescorted leave and were able to access community anytime. Since moving to Quayside the location and the nature of patients admitted now were not suitable for a rehabilitation service which led to staff struggling to support patients with escorted leave most of the time. Most of the patients admitted require more support than what is expected in a rehabilitation unit. This meant leave and appointments had to be cancelled due to staffing levels.
- The unit was supported by a locum consultant psychiatrist and a speciality doctor. The consultant was rarely seen on the unit as they covered four other areas and provided one session a week. The speciality doctor could be contacted during the day if needed.
- Staff told us they could access medical input day and night and that out of hours a doctor on call was accessible and would arrive on site in under an hour.

Assessing and managing risk to patients and staff

- On admission every patient had an assessment of needs that took account of previous history, risk, social and health factors. It included the agreed risk assessments and a plan of care to manage any identified risks.
- There were risk assessments and risk management plans which identified how staff were to support each patient when they behaved in a way that could cause harm to themselves or others. Patients' needs were appropriately assessed and clearly identified and these were regularly reviewed.
- However, in some cases these risk assessments were not followed. There was risk identified that patients were smoking in their bedrooms. On the day of

Requires improvement

Are services safe?

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

inspection staff were called for assistance that one patient was smoking in their bedroom. This risk continued with no clear action taken even though it was highlighted since the unit was open.

- Some of the procedural security measures and operational policies and procedures were followed by staff to ensure safety of patients, visitors and staff. For example, ligature cutters were checked and observations were carried out according to the needs of the patients.
- There was information on the units to let informal patients know that they were able to leave the unit if they wanted to.
- Our review of records and discussion with staff and patients confirmed that restraint and rapid tranquilisation aws not used. Staff told us that they were trained in the use of de-escalation and breakaway techniques only. They told us that the philosophy of rehabilitation was focussed on people who were ready to move on in the community and motivated to be independent. In the event of severe aggression they would call the police.
- Staff spoken with demonstrated an understanding of how to identify and report abuse to ensure that patients were safeguarded from harm. We saw some records of safeguarding concerns that had been reported. However, we found that some incidents that patients told us and staff confirmed that they had happened were not reported as safeguarding. For example, one male patient exposed themselves to a female patient and there had been several incidents of patient to patient assault. This meant that not all safeguarding concerns were reported. Staff knew the trust's designated lead for safeguarding who was available to provide support and guidance. Information on safeguarding was readily available to inform patients and staff on how to report abuse.
- 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.
- Some patients were self-administering their medication and this was stored safely in their single locked cabinets. A risk assessment had been carried out for each patient that was self-administering.
- A separate family room away from the ward was available in the main hospital area for children who visited the patients.

Track record on safety

- The trust shared with us their reports on serious untoward incidents that had happened within the last year.
- One patient died unexpectedly last year before relocated to Quayside as result of medication error and the trust developed an action plan to address the key issues from the investigation.
- There had been a number of changes recommended to ensure that lessons learnt resulted in changes in the practice. For example, the trust implemented staff medicines competency assessment, large medicine photos and training to ensure that nurses were skilled to give medicines safely.
- At the time of the inspection we saw that changes had been made to improve safety standards through training and changes in practice and procedures. This was in response to learning from previous incidents.

Reporting incidents and learning from when things go wrong

- There was a way of recording incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff had different views on what should or should not be reported as incidents. Most staff showed that they knew how to recognise and report incidents through the reporting system. However, we found that some of the incidents reported to us by patients and staff confirmed them were not recorded as incidents. For example, a patient had been aggressive towards staff in the clinic room and a patient exposing to others. This meant that not all incidents were reported and captured.
- There was a governance framework which reviewed all reported incidents. Incidents sampled during our visit showed that thorough investigations and root cause analysis took place, with clear action plans for staff and sharing within the team.

Requires improvement

Are services safe?

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

- Staff were able to explain how learning from incidents was rolled out to all staff. Their responses indicated that learning from incidents was circulated to staff. Learning from incidents was discussed in staff meetings, handovers and circulated through the newsletter.

Are services effective?

Requires improvement

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

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

- Care records were not detailed enough and did not contain all relevant information about care provided. The incidents that were reported to us were not clearly recorded and did not capture all relevant information about what had happened.
- A patient on a high dose of clozapine for some time was not checked for the level of Clozaril in the blood to find out if they were on the right dose. Another patient that had low levels of B12 vitamins from blood tests had no further investigations to assess the reason.
- Clinical audits were not carried out regularly to monitor the effectiveness of the service.
- Records reviewed and discussion with staff confirmed that staff had not received training on the MHA and the Code of Practice. There was some inconsistent practice on patients' capacity to consent to their treatment.
- Records reviewed and discussion with the manager confirmed that staff had not received training in the use of the MCA and DoLS. Staff did not demonstrate a good understanding of MCA and DoLS. The manager and staff were not able to provide evidence that checks were taking place to monitor the use of the MCA.

There were comprehensive assessments that had been completed when patients were admitted. Most of the staff were up-to-date with statutory and mandatory training. There was good collaborative working within the multi-disciplinary teams and a number of different professionals internally and externally who attended review meetings.

Our findings

Assessment of needs and planning of care

- There were comprehensive assessments that had been completed when patients were admitted which covered all aspects of care as part of a holistic assessment. Individualised care plans and risk assessments were in place, regularly reviewed and updated to reflect discussions held within the multidisciplinary team meetings.
- There was evidence of regular physical health checks and monitoring in records. We saw that physical health was discussed and further assessment of these needs had been offered. Where physical health concerns were identified, patients were referred to specialist services and care plans were implemented to ensure that patients' needs were met.
- Physical health issues were monitored by speciality doctor and the physical health team which consisted of two nurses.
- Care records within the team both paper based and electronic were stored securely and available to staff when needed. We found that care records were not detailed enough and did not contain all relevant information about care provided. For example, the incidents that were reported to us were not clearly recorded and did not capture all relevant information about what had happened and care provided.

Best practice in treatment and care

- NICE guidelines were mostly followed in respect of medication prescribed and in delivering psychological therapies. However, we saw that one patient on a high dose of clozapine for some time had not been monitored for clozapine levels in blood to find out if the dose prescribed was therapeutic. Regular blood tests to check the number of white blood cells were carried out. Another patient who had low levels of B12 vitamins from blood tests had no further investigations to assess the reason.
- There were good psychological therapies offered which included cognitive behavioural therapy (CBT) and mindfulness. Following assessment by the psychologist the psychological therapies that best meet their needs were provided.
- The unit had links with nurses for physical health who took a lead in patients' physical health needs and ensured that care plans were followed. This ensured that information was shared and appropriate referrals were made to other health professionals. Patients had access to specialists such as dentists, podiatrist, diabetic team and smoking cessation.

Are services effective?

Requires improvement

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.

- The Health of the Nation Outcome Scales was used as a clinical outcome measure and this is recommended by National Service Framework for Mental Health. The scale aids the assessment process and can determine through its evaluation the progress of therapeutic intervention.
- Staff were not actively participating in clinical audits. The unit lacked a robust programme of measures to monitor the effectiveness of the service provided. The unit did not provide evidence of clinical audits that were carried out regularly and consistently.

Skilled staff to deliver care

- The team consisted of nurses, a locum consultant, a speciality doctor, a psychologist, an OT and recovery workers. Staff told us and we saw that they attended patients' review meetings. The social workers were external and were only invited to MDT meetings when required. The pharmacist did not have direct input to the MDT meetings and was only responsible for medicines management.
- Staff received mandatory training and where updates were required, this was monitored and highlighted through a monitoring system. Records showed that most staff were up-to-date with statutory and mandatory training. We saw that all staff that were due for updates were booked to attend training. All bank staff were provided with an induction period in which they shadowed experienced staff to ensure that they knew how to support patients safely.
- Most staff told us they received clinical and managerial supervision regularly, where they were able to review their practice and identify training and continuing development needs. Records we looked at showed that 73% supervision had taken place.
- Staff told us that they received annual appraisals and records we looked at showed that all staff had received an annual appraisal. Staff we spoke with understood their aims and objectives in regard to performance and development through their annual appraisal and told us these objectives were reviewed on a regular basis.
- There were staff team meetings taking place regularly. Staff felt team meetings gave them an opportunity to share information together.

Multi-disciplinary and inter-agency team work

- The handover discussed each patient in depth and was effective in sharing of information about patients' care. There were discussions about changes in care plans, patients' presentation including physical health, activities and risk. MDT meetings were taking place regularly and consistently and discussed patients' needs in detail to ensure that all care aspects were addressed.
- We observed good collaborative working within the multi-disciplinary teams following the care programme approach (CPA) frame work. People we spoke with confirmed they were supported by a number of different professionals internally and externally who attended their review meetings. The information was shared across different professionals involved in patients' care.
- There was evidence of working with others including internal and external partnership working, such as multi-disciplinary working with, hospitals, community mental health team (CMHT), independent sector and local authority teams. Staff told us that they worked closely with the CMHT and social workers to coordinate care to support with discharges.

Adherence to the MHA and the MHA Code of Practice

- Records reviewed and discussion with staff confirmed that staff had not received training on the MHA and the Code of Practice.
- We found a system in place for the administration of the Mental Health Act and noted that all detention documentation was available for scrutiny. The documentation we reviewed in detained patients' files was compliant with the Act and the Code of Practice.
- Three out four patients had been informed of their rights in accordance with Section 132 of the MHA and provided with information regarding Independent Mental Health Advocacy. Patients we spoke with confirmed that their rights under the MHA had been explained to them.
- Completed consent to treatment forms were attached to the medication charts of detained patients. There was no evidence that four patients had their capacity to consent to treatment assessed as part of the admission process and that the assessment had been recorded by

Are services effective?

Requires improvement

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.

the responsible clinician (RC) in the medical notes in line with the code of practice. Capacity and consent were not being routinely reviewed as part of the MDT reviews.

- Section 17 leave was recorded in a standardised way and conditions of leave were reasonably detailed and patients had signed their forms. Ward staff had a process for ensuring leave was authorised before each person left the ward.
- Staff knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.

Good practice in applying the MCA

- Staff discussion and records reviewed showed us that staff had not received training in the use of the MCA and DoLS. There were no formal mental capacity assessments that explained how patients had been assessed for their ability to understand the treatment provided. Staff did not demonstrate a good understanding of MCA and DoLS. Most of the staff did not understand their responsibility in applying MCA and how the legislation applied to their work with patients.
- The trust had a policy on MCA and DoLS. However, staff were not aware of it.
- The manager confirmed the trust did not train all staff in MCA and DoLS to provide them with the knowledge required in applying the legislation appropriately. Staff were not able to tell us who they could contact as the lead person on MCA within the trust.
- The use of the Mental Capacity Act was not checked by the units.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

Staff were polite, friendly and willing to help and treated patients with respect and dignity. Staff demonstrated a good understanding of individuals' needs and were able to explain how they were supporting patients with a wide range of needs. Patients were involved in their care planning and reviews and were free to air their views and where appropriate. Their families were also involved. There were ways to actively collect feedback from patients and their families on how they felt about the care provided.

Our findings

Kindness, dignity, respect and support

- Staff were unhappy about the decision made in 2014 to relocate the service back to the hospital site. They also reported pressure on the staff team due to increase in patients with high needs that were not suitable for a rehabilitation unit. However, staff had a caring attitude and showed commitment to the patients they supported. We saw that they treated patients with respect and dignity and were polite, friendly and willing to help.
- Patients were complimentary 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 kind.
- We observed positive interactions between staff and patients. Staff engaged well, communicated softly, effectively and encouraged patients to follow their care and treatment.
- Staff showed a good understanding of the individual needs and were able to demonstrate how they were supporting patients with complex needs. Patients told us that staff knew them well and supported them the way they wanted.

The involvement of people in the care they receive

- There were information and leaflets available to be given to patients as a welcome pack to explain and help them understand how the service worked and what to expect. This explained about further information available to patients and relatives.
- Patients spoken with told us that they were involved in their care reviews and were able to express their views. Records of MDT meetings showed that patients and their family members were involved in care planning and reviews and they were supported to make informed choices. Some patients told us that they had copies of their care plans.
- Staff told us that patients' carers and family members were asked for their views in the assessment and care planning where appropriate. We saw recorded evidence from MDT reviews which captured what was discussed and jointly agreed. These showed that patients and their relatives were involved in decisions about the care they received.
- Staff were aware how to access advocacy services for patients and there was information on the unit available to patients about relevant local advocacy contacts. Patients told us that they were able to access advocacy services when needed.
- Questionnaires were used to collect feedback from patients and their families on how they felt about the care provided. Community meetings were held Monday to Friday and but patients rarely attended these. Staff told us that this current group of patients were particularly difficult to engage and to motivate. They rarely attended the community meetings and staff were attempting to find more creative ways to engage them. The meetings were recorded; however the content was mainly about maintenance of the unit rather than any patient requests or involvement with the day to day management of their care and treatment on the unit.

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

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

- Our observation of practice, review of records and discussion with staff confirmed that the unit was admitting patients with more complex needs than what the staff in the rehabilitation service were used to and skilled to care for.
- There were not enough rooms where patients could relax and or sit privately and quietly. There was limited space for therapeutic activities which was also used by other professionals for one to one sessions with patients.
- The unit had a tiny clinic room which was not fit for purpose. There was no examination room to support treatment and care.
- There was no designated room where patients could meet visitors in private. Patients and staff told us that patients meet with their relatives in the lounge or away from the unit in the main hospital reception.
- We noted that there was no see through protection on the patients' bedroom windows which looked directly on to a footpath that the public had access to.
- Patients told us that they knew how to raise complaints when they wanted to but most of them felt that they were not listned to. One patient told us that their food had been going missing but nothing had been done to resolve the issue. Another patient told us that they do not feel confident to complain as staff would not act to resolve the issues.

All admissions to these units were planned well ahead and they did not have any emergency admissions. We saw that discharges were well co-ordinated, managed and there were good links with the local authority. Patients' individual needs such as cultural and religious needs were met. Patients had a programme of activities which was also linked to an individual programme.

Our findings

Access, discharge and bed management

- Referrals were made direct to the unit manager and once referral documentation was received, the MDT would assess if they were able to meet the needs of the individual. However, staff told us that lately that was not the case as new admissions were patients returned to the trust from out of county placements and were not ready for rehabilitation. Our observation of practice, review of records and discussion with staff confirmed that the unit was admitting patients with more complex needs than what the staff in the rehabilitation service were used to and skilled to care for. These issues were also discussed with the senior management who immediately proposed in their action plan to conduct clinical reviews with all patients to establish the most appropriate pathway for their acuity/presentation and desired outcomes. This also included review of the rehabilitation operational policy, including referral/ acceptance criteria.
- The unit was operating at 100% bed occupancy with an average length of stay between six to 12 months. The manager told us that there were times when beds can be available and at times there would be a waiting list.
- Staff informed us that considering the nature of patients currently admitted to the unit the target would be difficult to achieve as most of the newly admitted patients were not suitable for a rehabilitation service. The pressure on beds now came from patients returned to the trust from out of county placements. Patients used to be admitted from acute wards and the community and would move towards supported housing or specialist care on discharge.
- All admissions were planned and they did not have any emergency admissions. The units worked closely with the CMHT and local authority to ensure that patients who had been admitted were identified and helped through their discharge.
- Patients on leave were able to access their beds on return from leave.
- Patients remained on the same unit during their admission period. Staff told us that patients had been moved to acute beds due to deterioration in mental state. The manager told us that all transfers were discussed in the MDT meeting and were managed in a planned or co-ordinated way.

Are services responsive to people's needs?

Requires improvement

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

- Staff told us that they had experienced delayed discharges in the past due to lack of suitable placements to adequately meet patients' needs in the community. We saw that discharges were well co-ordinated, managed and there were good links with the local authority.

The ward environment optimises recovery, comfort and dignity

- The patient areas of the unit were adequately furnished and decorated. However, there were not enough rooms where patients could relax and or sit privately and quietly. There was limited space for therapeutic activities which was also used by other professionals for one to one sessions with patients.
- The unit had a tiny clinic room and there was no physical examination room to examine patients. Staff told us that they were using patients' bedrooms to dress wounds and give injections. These issues were also discussed with the senior management who immediately proposed in their action plan to move the clinic room to larger room on the unit.
- The observation panels on bedroom doors were left in the open position by staff and females and visitors passing through the male corridor would see through into bedrooms. One male patient told us that two female patients saw them undressed in their bedroom and the females later talked about the incident. This meant that patients' privacy and dignity was not protected. We also noted that there was no see through protection on the patients' bedroom windows which looked directly on to a footpath that the public had access to.
- Male patients told us that they could not sit in the lounge with females as they controlled what to watch on TV which was always different from what they wanted.
- There was no designated room where patients could meet visitors in private. Patients and staff told us that patients meet with their relatives in the lounge or away from the unit in the main hospital reception.
- All patients were allowed mobiles phones and they could use them anytime they wanted to in privacy. There was a unit mobile phone for those who did not have one.
- The units had access to secure garden area, which included a smoking area which patients had free access to throughout the day and until 11pm.
- There was a large kitchen area where each patient was provided with a cupboard to store their food and a shelf in the fridge and freezer. However, one patient complained about their food going missing and staff confirmed that. All patients made the menus of their choice, cooked their own meals and were supported by staff with healthy eating when shopping their food. All patients had access to hot drinks and snacks up to midnight.
- Each patient had an individual bedroom with ensuite facilities. Bedrooms were fitted with a solid door and an allocated locked cabinet where values could be secured.
- Each patient had a programme with a range of activities which were linked to their individual needs. We saw some good therapeutic activities provided by the OT. Patients spoke positively about the activities available to them. However, patients told us that there were few activities during weekends.

Meeting the needs of all people who use the service

- There was an assisted bathroom for patients with mobility issues.
- There were information leaflets which were specific to the services provided. Patients had access to relevant information which was useful to them such as treatment guidelines, advocacy, religion, faith and culture, patient's rights and how to make complaints.
- Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment when needed.
- Patients made the choice of food want they wanted to meet their dietary requirements to meet their religious and ethnic needs.
- Patients' individual needs such as cultural and religious needs were met. Contact details for representatives from different faiths were available. Local faith representatives were contacted for those who needed them.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Requires improvement

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

- Information on how to make a complaint was displayed on the boards including leaflets from the patient advice and liaison service (PALS).
- Patients told us that they knew how to raise complaints when they wanted to but most of them felt that they were not listened to. One patient told us that their food had been going missing but nothing had been done to resolve the issue. Another patient told us that they did not feel confident to complain as staff would not act to resolve the issues. The community meetings were recorded; however the content did not capture any issues or concerns raised by patients.
- Staff told us and patients confirmed that they could approach staff anytime with their concerns and staff would try to resolve them. However, the unit did not have any records of informal complaints raised by patients. The managers told us that complaints which were received verbally were not logged. This meant that some concerns might not lead to wider understanding of the services and how they were delivered.
- Staff were aware of the formal complaints process and how to support patients and their relatives to make a complaint following the trust's complaints policy or through PALS.
- Staff told us that any learning from complaints was shared with the staff team through the handovers and staff meetings.

Are services well-led?

Requires improvement

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

We rated well-led as **requires improvement** because:

- Most of the staff did not have a good understand of the vision and values of the organisation. Those who knew the values of the organisation felt that the senior management did not demonstrate the values into practice.
- We found that the team's and the organisation's values were not embedded in practice. The staff knew who their senior managers were and told us that they rarely visited the unit.
- The trust had governance processes in place to manage quality and safety. However, we identified areas of improvements in safeguarding and incident reporting, clinical audits, MHA and MCA procedures.
- We found that there was lack of good clinical leadership. The consultant was a locum and provided one session a week to the team. The senior management and clinical team did not share information about underlying issues on the unit that could affect care and treatment.
- Morale within the staff team was very low. However, staff were passionate about their work and showed a genuine compassion for people. All staff told us they felt demoralised by changes over the past year. Staff felt there is a huge disconnect with senior management.
- The units were not participating in a national quality improvement programme such as AIMS.

The manager provided data on performance to the trust consistently. All information provided was analysed and this was measured against set targets. Staff were aware of the trust's whistleblowing policy and felt free to raise their concerns but felt that their managers did not listen. Staff told us that they were supported by their line manager and were encouraged to access clinical and professional development courses if that benefited to meet the needs of their patients.

Our findings

Vision and values

- Most of the staff did not have a good understand of the vision and values of the trust.
- Staff were very clear about their team objectives. However, all staff felt that the team's objectives were no longer what the service was set up for. They strongly felt that the environment and the current patient group were not appropriate to match the objectives of the rehabilitation service that they were used to and what they expected. Staff felt that they were not skilled enough to cater for the patients they were now admitting. We found that the team's and the organisation's values were not embedded in practice. The staff knew who their senior managers were and told us that they rarely visited the unit.

Good governance

- The trust had governance processes in place to manage quality and safety. The unit manager used these methods to give information to senior managers in the trust and to monitor and manage the unit. The manager would attend local quality and safety forums where aspects of quality and safety were discussed. The information was then discussed with staff and used to act on where there were gaps. For example, monitoring of mandatory training, staffing issues, incidents, appraisals, and complaints. However, we identified areas where improvements were neded in care records, safeguarding and incident reporting, clinical audits, MHA and MCA procedures.
- The manager provided data on performance to the trust consistently. All information provided was analysed and this was measured against set targets. These performance indicators were discussed with the service matron regularly. Where performance did not meet the expected standard action plans were put in place. However, we found that not all this information was easily accessible to the manager and staff on the units. Staff felt that there was no fluid flow of information between the management and the wards.

Are services well-led?

Requires improvement

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.

- The manager felt there was limited independence to manage the unit. 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.

Leadership, morale and staff engagement

- The sickness rate in the 12 month period was nine percent. In January this year there was a 26% sickness rate.
- At the time of our inspection there were no grievances being pursued within the units, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the trust's whistleblowing policy and that they felt free to raise concerns but were unsure if they would be listened to.
- Staff told us that they were supported by their line manager and were encouraged to access clinical and professional development courses if that benefited to meet the needs of their patients.
- We found that there was lack of good clinical leadership. The consultant was a locum and provided one session a week to the team. The consultant was to leave the trust in a month's time. The senior management and clinical team did not share information about underlying issues on the unit that could affect care and treatment.
- Morale within the staff team was very low. However, staff were passionate about their work and showed a genuine compassion for people. All staff told us they felt demoralised by changes over the past year. Staff felt there is a huge disconnect with senior management.

Staff spoke highly about their work; although many told us that lack of support from senior management was an issue for them. They communicated clearly to us that staff supported each other within the team. They told us that senior management were aware of the issues but they did not listen to them.

- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff survey.

Commitment to quality improvement and innovation

- At the time of this inspection the unit was not participating in a national quality improvement programme such as AIMS.
- Most of the issues we identified during our inspection were discussed with the senior management who immediately fulfilled and shared an action plan with us to resolve the issues. The senior management acted on the gaps identified by putting time scales and identifying a responsible person for changes to be made.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated activities) Regulations 2010** Care and welfare of service users People were not being protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of planning and delivery of care to meet individual needs and ensure the welfare and safety of people. Patients were not monitored for their clozapine blood levels and further investigations were not carried out for a patient with abnormal blood tests. This was a breach of Regulation 9(1)(b)(ii)(iii)

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 HSCA 2008 (Regulated activities) Regulations 2010** Assessing and monitoring the quality of service provision People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although the trust had the governance processes in place to manage quality and safety not all areas of quality and safety within the units to were monitored to ensure that improvements were made. Clinical audits to include MCA audits were not carried out to monitor quality and the effectiveness of the service. Patients were smoking in their bedrooms. Not all incidents were reported.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 10 (1)(a)(b) (2)(c)(i)(ii)

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Regulation 11 HSCA 2008 (Regulated activities) Regulations 2010** Safeguarding service users from abuse. People were not suitably safeguarded against the risk of abuse by taking reasonable steps to identify the possibility of abuse and responding appropriately to any allegations of abuse. Not all incidents that could be reported under safeguarding were reported by staff. This was a breach of Regulation 11(1)(a)(b)

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 **Regulation 15 HSCA 2008 (Regulated activities) Regulations 2010** Safety and suitability of premises. Patients were not protected against risks associated with unsafe or unsuitable premises by means of design and layout. The unit did not comply with the guidance on same sex accommodation. The clinic room was not fit for purpose and there was no physical examination room. This was a breach of Regulation 15(1)(a).

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 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	Regulation 16 HSCA 2008 (Regulated activities) Regulations 2010 Safety, availability and suitability of equipment. The safety of patients was not ensured by unavailability of equipment. There were no resuscitation equipment on the unit. This was a breach of Regulation 16(2).

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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 HSCA 2008 (Regulated activities) Regulations 2010 Respecting and involving service users Suitable arrangements were not made as far as reasonably practicable to ensure that dignity and privacy of people. Patients' privacy and dignity was not protected at all times by leaving observation panels open, layout of unit and bedrooms windows without see through protection. This was a breach of Regulation 17(1)(a)

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 HSCA 2008 (Regulated activities) Regulations 2010 Consent to care and treatment The trust did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people or where that did not apply for establishing and acting in accordance with people's best interests. Many

This section is primarily information for the provider

Requirement notices

staff had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There was some inconsistent practice on patients' capacity to consent to their treatment under the MHA.

This was a breach of Regulation 18

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 HSCA 2008 (Regulated activities) Regulations 2010 Records People were not protected against the risks of unsafe or inappropriate care and treatment as a result of lack of proper information by means of accurate record in respect of each patient in relation to care and treatment provided. Care records were not detailed enough and did not contain all relevant information about care provided. This is a breach of Regulation 20(1)(a).